

GP CONTRACT BRIEFING 2026/27

PCN DES & QOF Changes for 2026/27

Income changes · QOF movements · Access obligations · ARRS opportunities · Financial entitlements

Sources: Network Contract DES Specification 2026/27 · QOF 2026/27 · GP Contract Changes Summary

The Headline Numbers in Context

£485m

Total GP contract uplift

3.6% cash / 1.4% real growth

£13,863m

Total contract value 2026/27

Up from £13,176m in 2025/26

2.5%

Assumed pay uplift

Subject to pay review body — not yet confirmed

⚠ What the headline hides:

The £485m includes A&G funding (folded in, not preserved separately), assumes a 2.5% pay uplift that is not yet finalised, and reflects real growth against the GDP deflator — not headline cash. Not all of it lands as clean, attributable practice income. Some replaces old visible streams. Some only becomes useful if your operating model can actually earn it.

Where the £485 Million Actually Goes

£292m

Practice-level GP reimbursement scheme

CASP and CAIP removed from PCN DES. Money redirected for direct GP time and urgent same-day access at practice level.

£197m

ARRS — earlier GP cohorts continue

ARRS continues with expanded GP eligibility and sharply higher reimbursement ceilings (up to £152,900 with on-costs).

~£25m

QOF expansion — net 18 new points

New indicators OB004, OB005, CD001, CD002, DM037, HF009 replace the Weight Management Enhanced Service.

Folded in

Advice & Guidance funding absorbed

The £80m A&G Enhanced Service is retired. The £20 per request payment disappears. The work remains in the core contract.

PCN Core Financial Entitlements 2026/27

£1.761

NPP per contractor weighted patient

Paid directly to each Core Network Practice in 12 monthly instalments. Backdating may apply if confirmation is delayed.

£3.059

Core PCN Funding per patient

Built from list-size element and adjusted population element. Paid to the Nominated Payee.

£8.903

Enhanced Access per adjusted patient

Commissioner may withhold an appropriate proportion with Core Funding where requirements are not met.

£133.158

Care Home Premium per bed/year

Dependent on comprehensive SNOMED coding of residents and delivery of EHCH requirements.

IIF: 58 points × £198 point value. Key indicators: HI03 (36 pts — LD health checks, 60%/80% thresholds) · CAN04 (22 pts — Lower GI urgent suspected cancer with FIT, 65%/80%)

What You Are Losing from April 2026

Advice & Guidance Enhanced Service

2025/26 payment	£20 per eligible e-RS request
National funding	Up to £80 million
2026/27 status	Retired as enhanced service
2026/27 requirement	Core contract — where clinically appropriate
Income at risk	Pull CQRS claims × £20 to model

Weight Management Enhanced Service

2025/26 payment	£11.50 per referral
National funding	£7.2 million
2026/27 status	Retired — income now via OB004/OB005
OB004	5 QOF points — referral to WM programmes
OB005	13 QOF points — pharmacotherapy SDM

Action: Model both losses against your 2025/26 CQRS data before assuming your income position improves.

QOF 2026/27: The Big Picture

43

Total indicators
2026/27

17

New + adjusted
indicators

10

Retired
indicators

26

Unchanged
indicators

INTEGRATION

4 BP indicators became 2: CHD015, CHD016, STIA014, STIA015 replaced by CD001 and CD002

PREVENTION

Public health points rose from 127 to 145 (+18). OB004 and OB005 added. VI001–003 gained improvement-based rewards

CLINICAL DEPTH

HF003 + HF006 became HF009. DM037 added 8 annual diabetes care processes. Asthma register includes patients from age 5

Retired indicators (10):

CHD015 · CHD016 · DM012 · HF003 · HF006 · HYP008 · HYP009 · NDH002 · STIA014 · STIA015

One-line summary: QOF 2026/27 keeps the total count almost flat but restructures indicators toward integration, prevention and broader treatment bundles.

QOF 2026/27: Key Indicator Changes

Indicator	Change	Threshold	Points	Dir
AF006	Upper threshold increased +5pp	40–95%	12 (unch.)	→
CD001	NEW: BP control CHD/stroke/TIA ≤79	40–90%	41 reallocated	★
CD002	NEW: BP control CHD/stroke/TIA 80+	46–90%	20 reallocated	★
CHOL003	Points cut for consistency	70–95%	38 → 20	▼
DM034	Primary prevention statin doubled	50–90%	4 → 8	▲
DM035	Secondary prevention statin 4× increase	50–90%	2 → 8	▲
DM037	NEW: 8 annual diabetes care processes	35–75%	10 reallocated	★
HF009	NEW: Four-pillar HFrEF therapy	20–50%	12 reallocated	★
HYP010/11	Frail patients removed from cohort	40–85%	38+14 (unch.)	→
NDH003	Gestational diabetes cohort added	50–90%	18 → 20	▲
OB004	NEW: Referral to weight management	10–30%	NEW 5	★
OB005	NEW: SDM & pharmacotherapy obesity	50–80%	NEW 13	★

Childhood Immunisations: A Second Route to Points

VI001, VI002 and VI003 now allow practices to earn points via either the standard threshold OR an improvement calculation — whichever is higher. VI002 and VI003 also now include MMRV.

VI001	VI002	VI003
Standard threshold 89%–96%	Standard threshold 86%–96%	Standard threshold 81%–96%
Improvement route 5–18 pp improvement	Improvement route 5–23 pp improvement	Improvement route 5–30 pp improvement
18 points	18 points	18 points

Baseline = average achievement 2024–2026. Improvement route activates at 5 percentage point uplift from baseline. Higher performing practices keep the threshold model; lower performers now have a realistic points route — making recovery, outreach and recall work more strategically valuable than under a threshold-only model.

ARRS: Expanded GP Eligibility & Reimbursement Rates

GP Eligibility Change

2025/26: Restricted to recently qualified GPs only.

2026/27: Any GP not substantively employed by a Core Network Practice in the PCN in the previous 12 months. Earlier GP ARRS cohorts continue under separate rules.

ARRS claims baseline: 31 Mar 2019 · Workforce plan deadline: 31 Oct 2026 · 3 month vacancy period before funding reduction

GP Maximum Reimbursement

	2025/26	2026/27
Salary (outside London)	£82,418	£118,759
Salary (London)	—	£120,921
With on-costs (outside London)	Lower	£152,900
With on-costs (London)	Lower	£155,698

Selected ARRS maximum reimbursement rates 2026/27

ROLE	Max reimbursement (national / inner London / outer London)
Clinical Pharmacist (Bd 7–8a)	£71,725 / £83,040 / £79,665
Social Prescribing LW (up to Bd 5)	£46,447 / £55,887 / £53,527
First Contact Physio (Bd 7–8a)	£71,725 / £83,040 / £79,665
Advanced Nurse Practitioner (Bd 8a)	£78,534 / £89,848 / £86,474
Care Co-ordinator (Bd 4)	£38,739 / £46,637 / £45,039
Mental Health Practitioner (Adult/CYP)	50% initially; up to 100% with commissioner agreement

The £292m Practice-Level Access Shift

REMOVED

CASP + CAIP at PCN level

Capacity and Access Support and Improvement Payments removed from Network Contract DES.

REPLACED BY

Practice-level GP reimbursement

£292m redirected to recruit additional GPs or increase sessions from GPs already in post.

TIED TO

Clinically urgent same-day access

Not a general uplift. Practices measured on 5 data metrics via GPAD. ICBs monitor monthly.

⚠ What is still unclear: exact distribution formula · per-session reimbursement rates · practice-level cap · whether locums and sessional models qualify equally · whether high GP-to-patient ratio practices face a different route.

Same-Day Access: How Performance is Measured

How same-day performance is calculated

Appointment category to use:

General Consultation Acute — for ALL clinically urgent patients (telephone, walk-in and online). Introduced March 2021. Must be correctly applied from 2026/27 onwards.

Numerator:

Appts mapped to General Consultation Acute that took place on same day as booking

Denominator:

Total appointments mapped to General Consultation Acute category

Output: % same-day · Made publicly available via GPAD · ICBs monitor monthly

4 Steps Practices Must Take Now

1

Prioritise urgent slots review

Ensure all clinically urgent activity is mapped to General Consultation Acute. Do this first.

2

Audit all other appointment slots

Urgent activity may be hidden inside non-urgent categories without the practice being aware.

3

Review non-urgent category mapping

Align Routine & Care Home Visit slots to support 7 & 14-day collection.

4

Use your GPAD dashboard

Review practice-level data to identify mapping issues and improvement opportunities.

Key risk if not acted on:

Inaccurate GPAD data leads to poor performance scores, missed improvement opportunities, and failure to meet the 2026/27 GP Contract requirement. Practice decides urgency — based on presenting complaint, not retrospective judgement.

The Five Access Metrics

1

Call waiting time 8am–10am

Measures how the practice handles peak demand — the highest pressure period of the day

2

Call waiting time during core hours

Shows whether access pressure is a peak-only issue or runs across the full working day

3

% clinically urgent patients seen same day

Directly reflects compliance with the new same-day access obligation — the key GPAD metric

4

% non-urgent patients seen within one week

Shows routine access is still flowing while urgent demand is being prioritised

5

% non-urgent patients seen within two weeks

Indicates whether backlog or capacity slippage is building under the surface

Three Access Rules — Live from Day One

1

Same-day urgent response

'Dealt with' is broader than face-to-face — it includes triage, remote clinical contact, and a clear management decision. The practice decides urgency based on presenting complaint, not retrospective judgement.

2

No call-backs tomorrow

Practices must not ask patients to call back or make contact on another day. This is a contractual obligation, not guidance — and practices must have a consistent internal urgency definition from day one.

3

No online caps during core hours

Online consultation systems must not cap the number of requests patients can submit during core hours. Practices must also display opening hours for all access modes — walk-in, phone and online.

Enhanced Access & Care Home Requirements

Enhanced Access Headline Rules

<p>18:30–20:00</p> <p>Mon–Fri standard hours</p>	<p>09:00–17:00</p> <p>Saturday standard hours</p>	<p>60 mins</p> <p>Per 1,000 adjusted patients weekly</p>	<p>2 weeks</p> <p>Minimum advance booking window</p>	<p>2 weeks</p> <p>Make-up window for cancelled time</p>
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Coverage: All PCN patients must be able to access appointments in standard hours. **Appointment mix:** A mixture of face-to-face and remote required, with enough in-person capacity to meet need. **Clinical oversight:** GP oversight, supervision and availability must be maintained throughout delivery.

Enhanced Health in Care Homes (EHCH)

<p>Weekly care home round</p>	<p>Run a weekly care home round with MDT coordination and actions</p>
<p>Vaccination coordination</p>	<p>All aligned residents must be identified and offered seasonal & routine vaccinations including RSV</p>
<p>RSV now extended to</p>	<p>All people aged 80+ and all residents in care homes for older adults</p>
<p>Coding requirement</p>	<p>Care home premium (£133.158/bed/yr) depends on comprehensive SNOMED coding of residents</p>
<p>Accurate aligned list</p>	<p>PCN must agree aligned care home list with commissioner and keep it current</p>

PCN Structure, Deadlines & Governance

30 Apr 2026

Opt-out / change
deadline

30,000–50,000

PCN list size
(1 Jan 2026)

1 month

Commissioner decision
following full information

31 Oct 2026

ARRS workforce
plan deadline

Eligibility

Practice must hold a primary medical services contract, maintain a registered patient list and deliver essential services during core hours.

Participation

Previously approved PCNs auto-continue unless they opt out. DES variations automatically apply unless the practice opts out within the specified timeframe.

Legal position

Each Core Network Practice remains contractually responsible for delivery of PCN DES obligations, including those delivered on behalf of the PCN.

ODS changes

Core membership, Nominated Payee and merger/split changes need commissioner consent. ODS changes by 14th usually take effect the following month.

Governance rules

DES cannot be varied locally — only national variations apply. Supplementary Network Services must sit in separate contracts.

Data essentials

Only Business Rules SNOMED codes count for CQRS calculations. Monthly NWRS updates required. GPSS contact coverage must include all ARRS roles.

New mandatory: Staff Survey

Participation in the annual General Practice Staff Survey is now mandatory for practices and PCNs, including sharing staff contact details with ICB.

New mandatory: Digital registration

Mandatory use of online registration for all new patients. Practices must maintain a dedicated, monitored email for pharmacy liaison.

What to Do on Monday Morning

For Practice Managers






- 1 Pull 2025/26 A&G claims from CQRS — multiply by £20 for gross income at risk
- 2 Pull 2025/26 Weight Management ES income — compare to realistic OB004/OB005 QOF scenario
- 3 Ask QOF lead to model point shifts: CHOL003, DM037, HF009, immunisations, OB004/OB005
- 4 Check GPAD data — ensure all clinically urgent activity is mapped to General Consultation Acute
- 5 Do not treat the new GP reimbursement scheme as guaranteed income yet

For PCN Clinical Directors & Finance Leads

- 1 Review whether ARRS GP recruitment is now financially viable — reimbursement up to £152,900
- 2 Refresh ARRS governance against new eligibility rules and 31 Oct 2026 workforce plan deadline
- 3 Check care home SNOMED coding — £133.158 per bed/year premium depends on it
- 4 Ensure access obligations are operationally understood — GPAD data is now public-facing
- 5 Challenge the assumption that £485m flows neatly into unchanged practice income — it does not

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More resources for GP practices and PCNs:

-  **PCN DES PDF briefing** [full breakdown of DES funding shifts and operational watch-outs](#)
-  **QOF PDF briefing** [detailed threshold changes, points movements and coding guidance](#)
-  **QOF Income Reference tool** haresign.net/tools/qof-income — prevalence-adjusted QOF values
-  **ARRS Budget Calculator** haresign.net/tools/arrs-calculator — model your workforce plan against your allocation
-  **PCN Funding Split tool** haresign.net/tools/pcn-funding-split — core PCN income breakdown