



## Calderdale LMC Critical Analysis GP Contract Changes 2026/27 – Implications for Practices

### Executive Summary

The 2026/27 GP contract introduces a modest national funding uplift alongside several significant contractual changes relating to access, referral management, workforce deployment and system oversight.

The contract uplift is £485 million nationally, described as a 3.6% cash increase and approximately 1.4% real-terms growth relative to the GDP deflator.

At the same time, several operational requirements are being strengthened or made explicit within the contract. These include same-day responses for clinically urgent requests, prohibition on asking patients to call back another day, removal of caps on online consultation requests, embedding Advice & Guidance into core contractual expectations, and expanded data monitoring requirements.

Taken together, the contract continues a national direction toward increasing urgent-care capacity in general practice and integrating primary care more closely into system pathways. For practices, careful planning will be required to meet these expectations safely within the existing workforce's availability and infrastructure.

### 1. What GP Partners Need to Understand

From a practice perspective, the key questions are:

- Will practice income rise faster than practice costs?
- What new workload is expected?
- Can additional staff realistically be recruited?
- What are the operational risks of the new requirements?
- What does this contract signal about the future direction of general practice?

This paper is structured around those questions.

### 2. Funding Changes

#### 2.1 Headline uplift and the GDP deflator

The contract uplift is expressed relative to the GDP deflator, a general measure of inflation across the economy. However, GP practice expenses are driven by specific cost pressures such as staff salaries, locum rates, indemnity costs, premises maintenance and energy prices. If these costs rise faster than the GDP deflator—as has happened in recent years—practice profitability may fall even when contract funding increases.

For practices, the key issue is therefore whether income rises faster than expenses.

#### 2.2 Repurposing CAIP funding

£292 million currently allocated through PCN Capacity & Access Payments will be repurposed into a practice-level GP reimbursement scheme intended to support recruitment of additional GP sessions. This additional capacity is required to focus on supporting clinical same day urgent access.

In Calderdale, PCNs have used CAIP funding in different ways. Some have used it to directly employ staff supporting practices, while others have used it for shared services or infrastructure to improve access.

Because CAIP funding has been used differently across PCNs, the impact of repurposing it will vary. Some PCNs may struggle to sustain shared workforce roles, while some practices may find it difficult to recruit additional GPs despite funding availability. Premises constraints may also limit expansion.

## 2.3 ARRS flexibility

ARRS rules are being changed to allow PCNs to employ a wider range of GPs, including experienced GPs, with increased reimbursement ceilings.

This may help workforce planning in some areas, but recruitment challenges remain locally.

## 2.4 QOF changes

### QOF Changes for 2026/27 – Detailed Narrative Summary

Annex B of the contract letter sets out several changes to QOF indicators. These include new indicators, adjustments to achievement thresholds, and redistribution of existing QOF points rather than large additions of new funding.

#### 1. Atrial Fibrillation

Indicator AF006 has an increased upper achievement threshold, rising from 90 % to 95 %, while the number of points allocated to the indicator remains unchanged at 12 points. This means practices must achieve a higher level of performance to receive maximum points.

#### 2. Cardiovascular Disease – Blood Pressure Control

Two new indicators, CD001 and CD002, have been introduced for blood pressure control in patients aged 79 years or under without frailty. These replace the previous separate coronary heart disease (CHD) and stroke/TIA blood-pressure indicators.

- CD001 threshold: 40 %–90 %
- CD002 threshold: 46 %–90 %

Points have been reallocated from the previous CHD and stroke/TIA indicators rather than creating entirely new funding.

#### 3. Cholesterol Management

Indicator CHOL003 has had its points reduced from 38 to 20 points, while achievement thresholds remain unchanged at 70 %–95 %. This aligns the points more closely with other lipid-lowering indicators.

#### 4. Diabetes Indicators

Several changes affect diabetes:

- DM034 and DM035 (statin prescribing indicators) have increased points for primary and secondary prevention.
- DM037 is a new indicator requiring completion of the recognised annual diabetes care processes.

Points for these indicators are largely redistributed from elsewhere in QOF rather than representing new funding.

#### 5. Heart Failure

A new indicator, HF009, has been introduced relating to prescribing recommended “four-pillar” therapy in heart failure with reduced ejection fraction. Thresholds are 20 %–50 %, with points reallocated from existing indicators.

#### 6. Hypertension Indicators

Indicators HYP008 and HYP009 have been renumbered to HYP010 and HYP011. The frailty cohort has been removed from the denominator, but thresholds (40 %–85 %) and points remain unchanged.

## 7. Non-Diabetic Hyperglycaemia

Indicator NDH002 has been replaced by NDH003, which adds patients with a history of gestational diabetes to the cohort. Points increase slightly from 18 to 20 points.

## 8. Obesity Indicators

Two new indicators are introduced:

- OB004 – referral to weight-management programmes (threshold 10 %–30 %, 5 points)
- OB005 – shared decision-making and pharmacotherapy consideration for obesity (threshold 50 %–80 %, 13 points)

These represent new QOF indicators but with relatively small point allocations.

## 9. Stroke/TIA Indicators

Indicator STIA007 has been updated to include ticagrelor as an accepted antiplatelet medication for achievement purposes. Points and thresholds remain unchanged.

## 10. Vaccination Indicators

Indicators VI001, VI002 and VI003 have been updated to include improvement-threshold calculations and to incorporate the MMRV vaccine within achievement calculations. Points remain unchanged.

## 11. Register Changes

Changes have been made to disease registers:

- Asthma register now includes patients aged 5 years and above.
- COPD register business rules amended to address under- and over-recording identified through audit.

## 12. Retired Indicators

Several previous indicator IDs have been retired and replaced with updated indicators across CHD, diabetes, heart failure, hypertension, non-diabetic hyperglycaemia and stroke/TIA domains.

## Important Clarification

Many of the changes involve **redistribution of existing QOF points rather than additional funding**, meaning practices may need to meet new or adjusted requirements to maintain similar QOF income levels.

## 3. Access and Demand Management Changes

Several contractual changes relate to access and demand management, including:

- Same-day response for clinically urgent requests
- Prohibition on asking patients to call back another day
- Requirement not to cap online consultation requests

Most Calderdale practices are already operating at high levels of demand, and recruitment of additional GPs remains difficult. In this context, these measures are unlikely to increase total appointment capacity. Instead, urgent care demand may consume a greater proportion of existing clinical time, potentially increasing waits for routine and planned care.

Practices may therefore need to review triage processes and appointment models carefully to maintain safe care within finite staffing levels.

#### **4. Advice & Guidance and Referral Pathways**

Advice & Guidance funding is being moved into core contract funding and the Enhanced Service is being retired. Practices are expected to use Advice & Guidance before referral where clinically appropriate.

Calderdale LMC is keen to work constructively with Trust and ICB colleagues to ensure that referral pathways are co-designed with primary care involvement, that Advice & Guidance supports timely specialist care rather than delaying it, and that specialties continue to accept appropriate referrals where clinically indicated.

This is particularly important when practices are simultaneously expected to increase urgent appointment availability.

#### **5. Data Monitoring and ICB Oversight**

The contract expands requirements for sharing access-related data and requires practices to engage with ICB support where unwarranted variation is identified. GP contract letter 2026 to 2027

Transparency is important, but practices operate within constraints at times such as workforce shortages, premises limitations and population need. Data, therefore, needs to be interpreted in context.

Calderdale LMC will work with the ICB to ensure monitoring arrangements are supportive and proportionate.

#### **6. Workforce and Premises Considerations**

Workforce supply remains limited locally. Even where funding exists, recruitment of additional GPs may not be feasible. Premises capacity is also constrained across many Calderdale practices.

Workforce expansion therefore requires realistic planning and, in some cases, system-level premises investment.

#### **7. Strategic Direction of the Contract**

Taken together, the contract reflects a continued national direction toward:

- Increasing urgent-care capacity in general practice
- Embedding pre-referral Advice & Guidance
- Increasing data monitoring and system oversight
- Aligning primary care with neighbourhood-level planning

This aligns with wider NHS plans to shift care from hospitals into community settings.

#### **8. Practical Questions for Practices**

Partners may wish to consider:

- What is our expected financial position next year?
- Can we realistically recruit additional staff?
- What premises constraints do we face?
- How will routine care waits be affected?
- How will new pathways affect workload?

These questions will vary between practices.

#### **Conclusion**

The 2026/27 contract introduces new expectations on general practice alongside modest changes to overall funding. While some elements will be straightforward to implement, others may be difficult to deliver safely within the practical realities of general practice capacity. Calderdale LMC shares the concerns raised nationally by the BMA's GP Committee for England, particularly where expectations around urgent access, Advice & Guidance and digital demand risk increasing workload without corresponding workforce or infrastructure support.

We recognise the pressure practices are already under and the uncertainty many partners feel about how these requirements can be delivered safely. The current referendum reflects the seriousness of these concerns across the profession.

A number of important operational details within the 2026/27 contract still require further clarification before practices can fully understand the practical implications. This includes areas such as access requirements, Advice &

Guidance processes, workforce funding arrangements, data monitoring, and referral pathways. Some of this guidance will come nationally through NHS England and the BMA, while other aspects will need to be clarified locally with our ICB and Trust colleagues. As this information becomes available, Calderdale LMC will review it carefully and share clear updates with practices.

**Our priority remains supporting practices to deliver safe, sustainable care for patients within realistic workforce, funding and infrastructure limits.**

### **BMA/GPC Next Steps**

From 4 March to 25 March, GPC England will hold a referendum of all GPs and GP Registrars across England on the imposed changes the Government will make to GP contracts from 1 April 2026. GPCE will ask its members if they accept the Government's 26/27 changes, and their approach to making them, or if they want them to return to direct negotiations with BMA leaders to jointly develop a new practice contract, as repeatedly promised by Wes Streeting, that restores the viability of GP partnerships, provides fair remuneration of all GPs and implements workload safeguards to keep patients and practice staff safe.

**Calderdale LMC will keep you fully updated on the above proposed process.**

### **Reference List**

1. NHS GP Contract Letters and GPC Summary: [GP Contract 2026/27 - Calderdale LMC](#)
2. NHS England – *GP Contract Investment and Evolution Programme*  
<https://www.england.nhs.uk/gp/investment/>
3. NHS Long Term Plan  
<https://www.longtermplan.nhs.uk/>
4. BMA – Safe Working in General Practice  
<https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/safe-working-in-general-practice>
5. BMA Media Centre  
<https://www.bma.org.uk/bma-media-centre>