Department of Health & Social Care

To:
- GP practices in England
- Primary care network clinical directors

24 February 2026

cc.
- Integrated care board:
  - chief executive officers
  - primary care executive leads
  - medical directors
- NHS England region:
  - directors
  - directors of commissioning
  - directors of primary care
  - primary care medical directors

Dear colleagues

Changes to the GP Contract in 2026/27

The contract consultation on changes to the GP Contract in 2026/27 has now concluded and I am writing to inform you of the final arrangements for the upcoming financial year. My thanks to stakeholders who took part in the consultation.

General practice is the front door of the NHS and we are committed to ensuring that it can continue to deliver for patients now and in the future.

The changes to the contract in 2026/27 continue to build on the changes you have made over recent years, particularly those that have improved access for patients; three-quarters of patients now say it is easy to contact their GP. Our focus this year is GP capacity, supporting the shift from treatment to prevention through changes to the Quality and Outcomes Framework (QOF) and vaccinations and enabling practices to prioritise clinically urgent needs.

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In 2026/27, investment in the GP contract will increase by £485 million, bringing the combined total estimated contract value to £13,863 million. This provides a 3.6% cash growth or 1.4% real terms growth relative to the GDP deflator.

GP capacity is the most effective and sustainable way to improve access and patient experience of general practice, particularly in delivering same day access for clinically urgent patients. In 2026/27 2 changes to the contract will support this.

First, we will introduce a new practice-level GP reimbursement scheme to enable practices to recruit new GPs or increase the number of sessions from GPs already working in the practice. We will repurpose £292 million of funding currently allocated to the primary care network (PCN) level Capacity and Access Payment (CAP) for the scheme. The changes will support clinically urgent same day access in general practice.

Second, we will amend the rules for PCNs recruiting GPs via the Additional Roles Reimbursement Scheme (ARRS). The current restriction of use of ARRS funding to recruit recently qualified GPs will be removed. This will enable the recruitment of a wider range of GPs via the scheme. In parallel, the maximum reimbursement that PCNs can claim for GPs employed via the ARRS will be increased to reflect that the recruited GPs will not only be those who have recently qualified.

We will also make a series of refinements to the QOF for 2026/27 to strengthen alignment with updated NICE guidance and support more clinically effective care. This includes adding 2 new obesity related indicators to support referrals into structured weight management programmes and medicines optimisation. The changes to QOF are supported by an additional 18 QOF points (c £25 million) and are intended to enhance clinical outcomes, modernise the scheme and ensure indicators reflect current evidence and best practice.

There will also be changes to support the delivery of vaccinations:

- Amendment of the QOF to introduce additional improvement thresholds for the 3 childhood vaccination QOF indicators. These changes are intended to recognise and reward practices, particularly those in more deprived areas that may not meet the existing achievement thresholds but demonstrate meaningful and sustained improvement in vaccination uptake.
- The extension of the RSV vaccination programme to all adults aged 80 and over and all residents in care homes for older adults will be reflected in the Statement of Financial Entitlements (SFE), in addition to existing cohorts.
- A new requirement for PCNs to ensure that eligible residents in aligned care homes are identified and offered seasonal and routine vaccinations in line with national recommendations. This will not necessarily mean that PCNs are responsible for administering the vaccinations but they must ensure arrangements are in place to offer vaccination.

We will introduce a new requirement that patients identified as clinically urgent will be dealt with on the same day. It is for the GP practice to determine which patients are clinically urgent.

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For patients whose needs are assessed as non-urgent, practices will be required to provide an appropriate response by the end of the next core hours period. For non-urgent cases, this does not necessarily mean an appointment, but it does mean patients will know how their presenting issue will be managed and what the next steps are.

To support practices where unwarranted variation has been identified in contractor performance, we will require them to engage with support from their integrated care board (ICB).

Further changes to the contract embed the use of Advice and Guidance and extend the General Practice Staff Survey to all practice and PCN staff. We will also make changes to the core contract to clarify that patients should not be asked to call the practice back and to explicitly require that online consultation systems must not cap the number of requests.

The full list of contract changes is set out in annex A with a table of the detailed QOF changes included in annex B.

We will now begin implementing the 2026/27 contract changes. New and updated specifications and guidance will be published in the coming weeks. NHS England will hold a webinar between 5pm and 6pm on Monday 2 March 2026 to go through the 2026/27 contract changes. You can sign up online.

Lastly, I want to thank you for your continued hard work. The improvements we are seeing in general practice are benefitting patients and I'm extremely grateful for your ongoing work.

Yours sincerely,

Dr Amanda Doyle OBE, MRCGP,
National Director for Primary Care and
Community Services
NHS England

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Annex A – Detail of the changes to the GP Contract in 2026/27

GP contract finance

1. The GP contract uplift for 2026/27 is £485 million, bringing it to a total of £13,863 million, including Advice and Guidance funding. This uplift represents a 3.6% cash increase or 1.4% real terms growth relative to the GDP deflator. This includes:
    - a pay assumption of 2.5% in 2026/27, to revisit in light of pay review bodies' recommendations
    - additional funding to support the changes to QOF outlined below
    - funding to cover the costs nationally of other cost growth pressures, including from premises cost inflation

Core practice contract

Practice-level GP reimbursement

2. We will introduce a practice-level GP reimbursement scheme, using £292 million of repurposed funding from the current PCN level Capacity and Access Payment. The funding will be available to practices to recruit additional GPs or fund additional sessions from existing GPs to support clinical same day urgent access in general practice. The Capacity and Access Payment (CASP and CAIP) will be removed from the Network Contract DES.
3. To support understanding of demand in general practice we will collect data against 5 metrics and encourage practices to use this data to improve services for patients:
    i. call waiting time between 8am and 10am
    ii. call waiting time during core hours
    iii. percentage of clinically urgent (as determined by the practice) seen on the same day
    iv. percentage of 'non-clinically urgent' seen within 1 week
    v. percentage of 'non-clinically urgent' seen within 2 weeks

The Quality and Outcomes Framework (QOF)

4. We will make a series of refinements to the QOF for 2026/27 to strengthen alignment with updated NICE guidance and support more clinically effective care. This includes:
    a. updating the childhood vaccination indicators to reflect the introduction of the MMRV vaccine
    b. introducing a new diabetes indicator requiring delivery of all 8 NICE recommended care processes

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c. adding 2 new obesity related indicators to support referrals into structured weight management programmes and medicines optimisation. The Weight Management Enhanced Service will be retired

d. updating the heart failure indicators to reflect the NICE recommended ‘4 pillars’ of treatment

e. streamlining by combining and simplifying existing measures

5. These changes are supported by an additional 18 QOF points (c £25 million) and are intended to enhance clinical outcomes, modernise the scheme and ensure indicators reflect current evidence and best practice.

6. We will update the QOF guidance to introduce additional improvement thresholds for the 3 childhood vaccination QOF indicators (VI001, VI002 and VI003) for 2026/27. The Statement of Financial Entitlements (SFE) will be updated during 2026/27 to reflect this change. These changes are intended to recognise and reward practices, particularly those in more deprived areas that may not meet the existing achievement thresholds but demonstrate meaningful and sustained improvement in vaccination uptake.

7. Current thresholds for these vaccination indicators remain unchanged. However, for 2026/27, practices will have an additional opportunity to earn QOF points by improving against their own baseline, calculated as a 2-year average. At year-end, practices will receive whichever points allocation is higher:

- points based on traditional achievement thresholds, or
- points awarded on a sliding scale for improvement from baseline

8. The improvement thresholds will be stretching but achievable, with the lower improvement threshold set at 5 percentage points above baseline for all 3 indicators and an expanded range between lower and upper improvement thresholds to reward significant progress. The maximum QOF points available for each indicator is unchanged.

9. Proposed new improvement thresholds for 2026/27:

- VI001: 5–18 percentage points
- VI002: 5–23 percentage points
- VI003: 5–30 percentage points

Same-day response for clinically urgent needs

10. We will amend the core practice contract to explicitly require that requests identified as clinically urgent, as determined by the GP practice, must be dealt with on the same day.

Practices must not ask patients to call back another day

11. We will update the contract to specifically set out the requirement that practices must not ask patients to call back, or make contact, on another day. In parallel, we will amend the existing 'appropriate response' requirement to provide greater flexibility for non-clinically urgent contacts. Practices will still need to provide patients with a timely appropriate response confirming next steps, but this will be required by the end of the next working day (rather than within the same core hours period). This does not mean the patient's non-clinically urgent request must be fully dealt with by then; rather the patient should understand how and when their issue will be managed.

No capping of online consultation volumes

12. We will amend the core practice contract to explicitly require that online consultation systems must not cap the number of requests that can be submitted during core hours. This will ensure that patients are able to contact their practice throughout core hours via all routes of access, and that online consultations operate with the same parity as telephone and walk-in access.

RSV older adult cohort expansion

13. The SFE will be amended to reflect the extension of the RSV vaccination programme to all adults aged 80 and over and all residents in care homes for older adults, in addition to existing cohorts. Practices will receive an Item of Service fee for each vaccination.

Embedding Advice and Guidance

14. We will amend the contract to embed the current Advice and Guidance Enhanced Service funding within core practice funding. Practices will be required to use Advice and Guidance prior to or in place of a planned care referral where clinically appropriate and to follow locally agreed referral pathways, including single point of access models once introduced. Advice and Guidance has shown clear value in supporting timely specialist input, reducing unnecessary referrals and ensuring patients receive timely care in the most appropriate setting. Alongside this, NHS England is asking trusts to work towards achieving national operational processing standards, to ensure the consistent and timely provision of specialist advice across pathways. The Advice and Guidance Enhanced Service will be retired.

Access to data to support monitoring

15. We will amend the GP Contract Regulations to align with existing cloud based telephony (CBT) requirements and to require practices to provide timely data and information related to online and video consultation services, enabling consistent monitoring of access, patient experience and system performance. The intention is not to performance manage practices, but to support a clearer understanding of access, highlight where improvement may be needed and help identify inequalities.

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GP engagement with the Lung Cancer Screening Programme

16. We will amend the core practice contract to require practices to share data with the Lung Cancer Screening Programme to support its operation.

Streamlining GP registration

17. We will amend the core practice contract to mandate the use of online registration in all registration cases. Practices will be required to enter information from paper registration forms into the national online registration system and ensure that changes to practice boundaries submitted through NHS England's digital catchment tool are approved by the ICB.

Patient choice of pharmacy

18. We will amend the core practice contract to expand the provisions on nominated dispensers, requiring practices to reconfirm the nominated pharmacy whenever a new prescription (not a repeat prescription) is issued, and to ensure that referrals and triage tools used for community pharmacy clinical services offer patients a full choice of providers. We expect in practice that most practices do this already and this should not add additional burden to appointments.

Dedicated GP email for pharmacy communications

19. We will amend the core practice contract to require practices to have a dedicated, monitored email address. It will be for receiving information from community pharmacies in the event that GP Connect is unavailable and for new or emerging pharmacy activity that is not yet supported through GP Connect (for example, independent prescribing in community pharmacy). The email address must be kept up to date and shared with the Directory of Services.

20. Existing practice email addresses can be used for this purpose and the provision will not require a new one to be set up. This email address is intended to act as a safety-net where the GP Connect route may be unavailable, helping to ensure that important clinical information is received in a timely way. The intention is to strengthen patient safety and ensure timely transfer of information, while keeping the requirement as simple and proportionate as possible for practices.

General Practice Staff Survey

21. We will amend both the core practice contract and the Network Contract DES to require that practices and PCNs participate in the General Practice Staff Survey, including sharing staff contact details with their ICB so personalised survey links can be issued.

Requirement for practices to engage with ICB support

22. We will amend the core practice contract to require practices to engage with support from their ICB where unwarranted variation has been identified in contractor performance. This includes where practices are not meeting their requirement to see all clinically urgent patients on the same day or are at risk of contractual breach.

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Amending PMS Regulations to align with GMS Regulations on subcontracting

23. We will amend the PMS Regulations to mirror the GMS Regulations. This will give commissioners equivalent powers to object to subcontracting arrangements where patient safety, financial risk or delivery of contractual obligations may be affected. Supporting guidance will be issued to clarify expectations.

Displaying opening times for all access modes

24. We will amend the core practice contract to require practices to display opening times for all modes of access (walk-in, telephone and online consultation) on their website, in their practice leaflet and within practice premises. As a minimum this must be core hours for all modes of access.

The Network Contract Directed Enhanced Service (DES)

Additional Roles Reimbursement Scheme (ARRS)

25. We will amend the Network Contract DES to remove the restriction that ARRS funding can only be claimed for recently qualified GPs. The maximum reimbursement that can be claimed for GPs via the ARRS will be increased. PCNs will be able to claim up to a maximum of the top of salaried GP pay range plus employment on costs. We will also enable PCNs to recruit a broader range of ARRS roles, where agreed with the commissioner.

Vaccination requirements in care homes

26. We will amend the Network Contract DES to include explicit requirements for PCNs to ensure that eligible care home residents are identified and offered seasonal and routine vaccinations in line with national recommendations, with supporting guidance to clarify roles and responsibilities. This does not necessarily mean that PCNs are responsible for delivering the vaccinations but they must ensure arrangements are in place to offer vaccination, which could be delivered by the registered practice or, if agreed, another practice in the PCN or a subcontracting arrangement.

Enabling collaboration for seasonal vaccinations

27. We will amend the Mandatory Network Agreement to remove the existing exclusion of flu and COVID-19 vaccination from collaborative delivery under the Network Contract DES. Should practices wish to collaborate to deliver the seasonal vaccination Enhanced Service, they will be able to do so under the Network Contract DES.

Amending cancer requirements in the Network Contract DES

28. We will amend the Network Contract DES to provide clearer requirements for improving cancer referral practice, early diagnosis and screening uptake. The updated wording introduces explicit expectations around reviewing referral quality against NICE Guideline NG12, strengthening and standardising safety netting (including use of electronic tools) and setting out clearer responsibilities for proactively identifying and supporting eligible patients to engage with cancer and non-cancer screening programmes. These amendments will retain the high-level intent of the DES while

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providing additional operational clarity to support consistent, effective delivery across PCNs.

Continuity of care (risk-stratified cohorts)

29. We will make it a core requirement for PCNs to identify and prioritise cohorts for continuity of care using risk stratification tools as part of their core activities. This will make continuity a core expectation within primary care and support future work to embed more meaningful continuity models in subsequent contract reform.

PCN and neighbourhood alignment

30. We will amend the Network Contract DES to require PCNs to work with their ICB to achieve greater alignment between the PCN registered list and the neighbourhood, where an ICB works with the local authority to define a neighbourhood around a natural community that does not match current PCN geography.

31. This change is not intended to signal widespread reconfiguration of PCNs. It is expected to apply only in limited circumstances and is designed as a pragmatic safety net where existing arrangements clearly do not reflect local communities.

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Annex B – Table on QOF changes

Indicator ID	Indicator change	Threshold changes	Points changes
AF006	Upper achievement threshold increased	Upper threshold ↑ from 90% to 95%	Unchanged – 12 pts
CD001	New blood pressure (BP) control indicator for patients aged ≤79, without frailty, combining and replacing the separate coronary heart disease (CHD) and stroke/TIA (STIA) BP control indicators	New indicator – 40–90%	Reallocated – 41 pts
CD002	New BP control indicator for patients aged ≤79, without frailty, combining and replacing the separate CHD and STIA BP control indicators	New indicator – 46–90%	Reallocated – 20 pts
CHOL003	Points decreased for consistency with lipid lowering indicators	Unchanged – 70–95%	↓ from 38 to 20 pts
DM034	Points increased for primary prevention statin use in diabetes	Unchanged – 50–90%	↑ from 4 to 8 pts
DM035	Points increased for secondary prevention statin use in diabetes	Unchanged – 50–90%	↑ from 2 to 8 pts
DM037	New annual diabetes care processes indicator	New indicator – 40–90%	Reallocated – 10 pts
HF009	New indicator for 4-pillar therapy in heart failure with reduced ejection fraction (HFrEF)	New indicator – 20–50%	Reallocated – 12 pts
HYP010 (previously HYP008)	Adjustment to indicator to remove frailty cohort	Unchanged – 40–85%	Unchanged – 38 pts
HYP011 (previously HYP009)	Adjustment to indicator to remove frailty cohort	Unchanged – 40–85%	Unchanged – 14 pts
NDH003 (previously NDH002)	Gestational diabetes patient cohort added and points increased	Unchanged – 50–90%	↑ from 18 to 20 pts
OB004	New referral to weight management programmes indicator for adults living with obesity	New indicator – 10–30%	New – 5 pts
OB005	New shared decision-making and pharmacotherapy indicator for obesity	New indicator – 50–80%	New – 13 pts
STIA007	Ticagrelor included in the list of antiplatelet medications that count towards QOF achievement	Unchanged – 57–97%	Unchanged – 4 pts

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VI001	Addition of improvement threshold calculations	Unchanged – 89–96%	Unchanged – 18 pts
VI002	Addition of MMRV and improvement threshold calculations	Unchanged – 86–96%	Unchanged – 18 pts
VI003	Addition of MMRV and improvement threshold calculations	Unchanged – 81–96%	Unchanged – 18 pts
Asthma register: underlying business rules amended to include patients from the age of 5			
COPD register: underlying business rules amended to address potential under and over-recording of COPD on the register, identified by audit			
Retired indicator IDs replaced with new indicators: CHD015, CHD016, DM012, HF003, HF006, HYP008, HYP009, NDH002, STIA014, STIA015			

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