Londonwide LMCs General Practice Survival Guide

GMS Contract 2026/27 Webinars
Tuesday 28th April 2026
Wednesday 29th April 2026

lmc.org.uk/survival-guide

Londonwide LMCs
The professional voice of London general practice

Today is about clarifying the contract changes and creating space for your questions and concerns.

Londonwide LMCs

One simple mission:

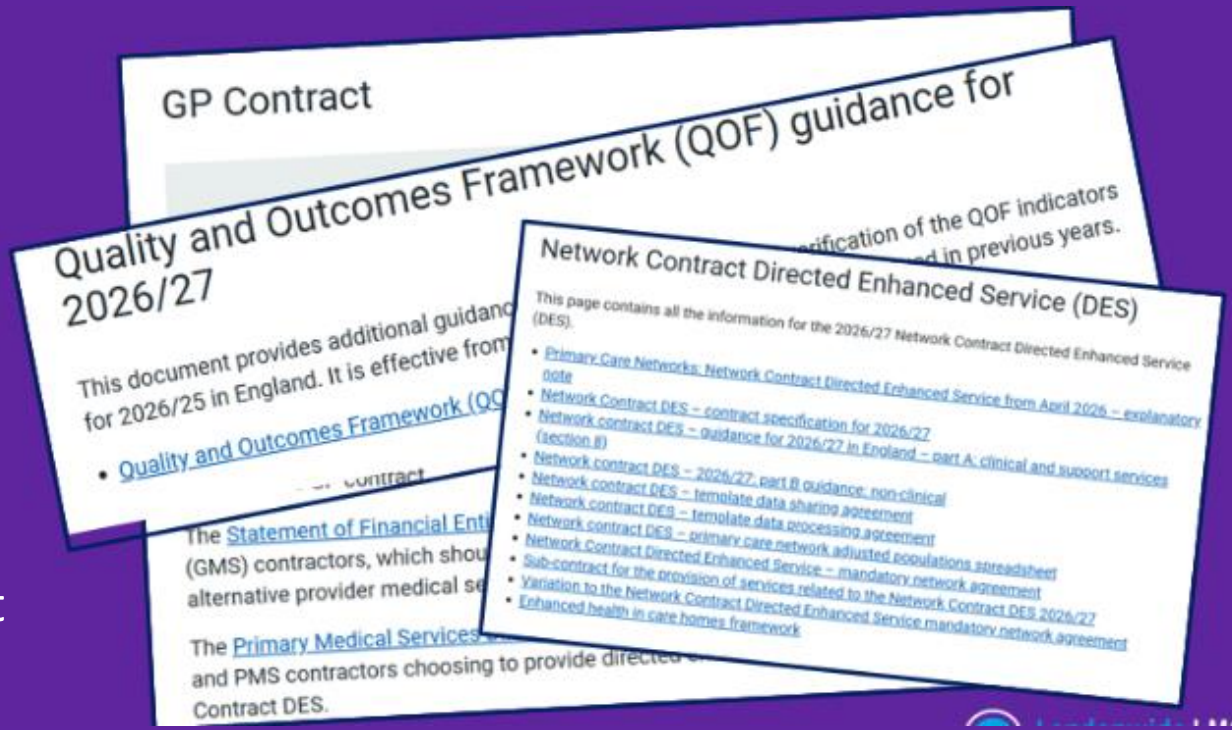
To value, care for and protect GPs, their teams and their practices.

We do that in three main ways:

- Representation
- Advocacy
- Services

Contents

- Review of GP funding
- QOF changes
- Vaccinations and immunisations
- Directed enhanced services
- Impact of the contract changes on ways of working



GP funding

GP Contract Finances 2026-27

- In this section I will discuss…
  - The headline figures
  - What the headline figures really mean in the real world
  - Are there real world Gains?
  - Transfers and Losses
  - What this all means in terms of Global Sum per patient
  - Other financial changes
  - Where there are no changes

Headline contract numbers

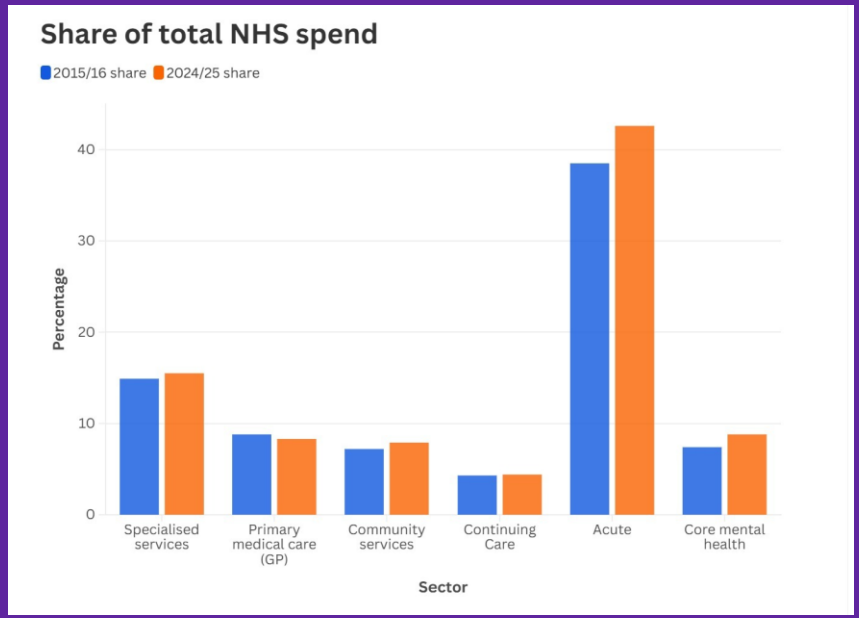
- **£485 million** funding increase overall
- Includes **£69 million** into the PCN DES
- Representing a **3.6% cash increase**
  - which means before inflation is taken into account
- Or **1.4% real terms growth**
  - which is supposed to take inflation into account
- **Bringing the total contract value to <u>£13.863 billion</u>**

So let's break down the figures…

- The **£485 million** funding increase consists of
  - **£416 million** into Global Sum, itself consisting of
    - **£260 million** uplift
    - **£121 million** for list growth pressures
    - **£25 million** of additional QOF money
    - **£11 million** into SFE for locum reimbursement
  - **£69 million** into the PCN DES
    - **£53 million** of this is the ARRS salary uplift alone

But this is still good… right?

Where does that leave us?



Inflationary Uplifts in the Contract: GDP Deflator vs CPI

- The DHSC use the **GDP Deflator** to calculate inflation.
  - This is a measure of economy-wide inflation. It covers all goods and services produced in the UK, including government services and investment.
- But real-world Practice expenses costs more closely track **CPI** (Consumer Price Index)
  - This reflects a fixed basket of goods and services, and captures rises in utilities, estates costs, and day-to-day operating expenses.
  - It doesn't cover staff – but DDRB and AfC cover that.

The GDP Deflator almost always underestimates real-world cost pressures faced by General Practice, often by significant sums.

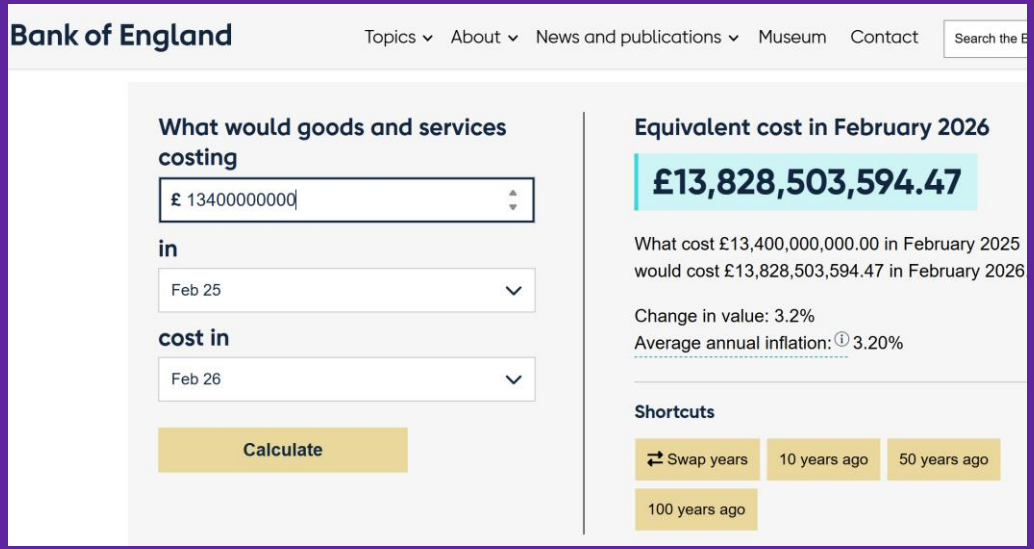
How does this affect the numbers?

- The uplift using the GDP Deflator was **£260 million**
- If CPI had been used, the uplift would have been **£428 million**
- Arguably, this means that the new contract underestimates the rise in our costs by **£168 million**.
- If we accept that the real-world rise in costs is £428 million and not £260 million…
- The actual real terms growth is not the **1.4%** claimed by the DHSC, it is £35 million or **0.26%**.

This is supposed to pay for all the extra workload in the contract.

Bank of England inflation calculator

- We used the online Bank of England Calculator to calculate CPI
- (It is an excellent tool and well worth playing with when looking at costs)



Transfers

- **£292 million** from the PCN DES (from the retirement of CAIP) to a new practice-based GP reimbursement scheme
  - …taken from us and given back, but with strings - more on this later
  - ...and the work previously funded by this is now in our core contract, without extra funding.
- **£82 million** moved into core from retired Advice and Guidance Scheme
  - …and no extra money to support the planned huge extension of this scheme.

Losses

- £7 million lost from retired Weight Management Enhanced Service
  - …though some new QOF points for weight management.

What does Global Sum consist of?

- For the purposes of negotiations, Global Sum is considered to consist of three elements:
  - **Contractor (Partner) 'pay'** = 31%
  - **Staff Costs** = 53%
    - though a 2025 BMA Survey suggested that the real figure was closer to 72% on average
  - **Other Expenses** = 16%

What does it mean for your Global Sum?

- This will increase to **£130.07 per patient**
  - After the recent DDRB uplift is applied.
- This is an uplift **of £6.73**, or **5.5%**
  - These figures are ‘unweighted’ – Carr-Hill is not yet applied.
- Additional London Adjustment of **£2.18**
  - If the patient’s registered address is within Greater London Authority area.

The Statement of Financial Entitlement

- Statement of Financial Entitlements (SFE)
  - Locum reimbursements (sickness, parental leave etc) will be uplifted by **3.5%**
  - Immunisations – no increase in the Item of Service (IoS) for the seasonal vaccination (Covid 19 and Influenza) programmes, which remain at **£10.06**

Other financial matters - DDRB and OOH

- Prior to DDRB reporting, the estimated staff uplift was 2.5%
  - DDRB increased that to **3.5%**, which was accepted by the government
- OOH Deduction
  - Remains the same at **4.7%** of Global Sum
  - This means that the actual figure increases to **£6.11**

Other financial matters – ARRS, EA and QOF

- ARRS staff reimbursement (GP) uplifted by **3.5%**
- ARRS staff reimbursement (other staff) uplifted by **3.3%**
  - matching the Agenda for Change uplift
- Enhanced Access element of the PCN DES uplifted by **3.5%**
- An additional 18 QOF points (worth **£25 million**)

Financial Footnotes: unchanged finances

- Unchanged are
  - CQC Fees Reimbursement Scheme
    - 100% reimbursement
  - Learning Disabilities (LD) Health Check
    - £140 per patient
  - Network Participation Payment
    - £0.147 per weighted patient per month

Summary

In this section we covered GP Funding, including:

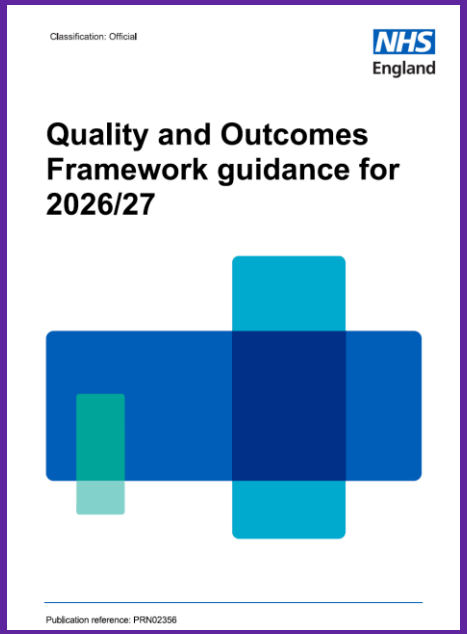
- GP Contract finances 2026-2027
- Headline contract numbers
- Considering inflation measures
- Transfers and losses
- Global Sum

Reflections:

- Funding is effectively static...
- ...but workload has increased significantly.
- PCN DES has lost a big chunk of funding, but it has been given back to us with strings.
- If there is one part of the contract you should familiarise yourself with, it is the Statement of Financial Entitlements.

Any questions?

QoF 2026-27


Classification: Official
NHS England
Quality and Outcomes Framework guidance for 2026/27
Publication reference: PRN02356

QoF 2026/27

£25 million of 'new' money – 18 points

95 points from retired indicators have been reassigned

Value of QoF point £227.95

QoF 2026/27 points reallocation

Source		Points		Moved to		Points
Retired	CHD015&016	47		New	CHD001	41
Retired	STIA014&015	14		New	CHD002	20
Retired	HF003&006	12		New	HF009	12
Retired	DM012	4		New	DM037	10
Reduced	CHOL003	Points reduced from 38 to 20		Increased	DM0034	Points increased from 4 to 8
					DM035	Points increased from 2 to 8
					NHD003	Points increased from 18 to 20
	Points released	95			Points assigned	95

QoF 2026/27 new indicators - obesity

OB004 (5 points)	Adults living with obesity referral to weight management within 90 days of BMI being recorded.
OB005 (13 points)	Shared decision-making and are offered NICE approved medicines management for use in primary care.

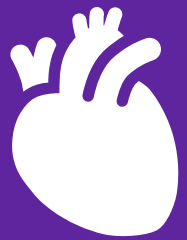
Creates a clinical workload, including explaining to patient's NICE guidance (4 out of 5 co-morbidities).

QoF 2026/27 change to indicators - BP

- BP indicators from CHD/Stroke & TIA have been reallocated (67 points) to CD001 & CD002.
- BP Tier 1 BP control less than 140/90 in 79yrs and under **without frailty.**
- BP Tier 2 BP control less than 150/90 in 80yrs and over **without frailty.**

!!Ensure frailty is coded to get the right cohort!!

QoF 2026/27 changes to indicators



Heart Failure (HF009)

Consolidated into '4-pillar' therapy

Diabetes (DM037)

8 care processes

QoF 2026/27 - vaccinations & immunisations

This will be covered later.

Personalised Care Adjustment (PCA)

- This replaces exception reporting.
- Personalisation of care can occur for 6 reasons:
  - Unavailable service
  - Clinically unsuitable
  - Patient choice
  - Non-responder
  - New diagnosis
  - New patient

An approach to QoF

What practice approaches have you experienced to address the QoF workload?

QOF as a QI Project

- Analyse the QoF workload
- Identify skills and expertise
- Divide tasks
- Coding and data capture
- Recall system
- Use technology

Review your process!

QoF 2026/27 - Time for a QoF reset!

Establish clinical pathways for obesity referrals and pharmacotherapy

Ensure your team doesn't start working on the retired indicators

Audit your frailty register to ensure frail patients are removed from the hypertension cohort

Upskill staff for the heart failure '4 pillar' checks

Upskill staff for the diabetic 8 care processes checks

Consider ways of increasing childhood vaccine uptake

Review Personal Care Adjustments

Top Tips:

- Check frailty coding.
- Check templates are update to review the 4 pillars for heart failure and the 8 care processes for diabetes.
- Set up monthly searches for new records of BMI>30, or >27.5 depending on ethnicity.
- Understand the Personalised Care Adjustment (PCA) flags.

Any questions?

Focus on vaccination & immunisation

Childhood vaccination & immunisation QoF 2026/27 changes

New for 26/27: practice can achieve points by making a significant improvement from baseline in the uptake of the childhood vaccinations

Practices will be awarded points for the calculation which yields the higher points value:

EITHER: **Standard QoF calculation**- Practice achievement is within lower (LT) and upper (UT) thresholds;

OR: **Improvement calculation**: Practice improvement achievement as compared to the practice's two-year baseline.

- The improvement achievement requires a minimum increase of 5 percentage points (%pts) from the baseline in order to start qualifying for QoF points.
- These will be awarded on a sliding scale capped dependent on the level of improvement.
- Practices achieving an improvement below 5%pts will not earn QoF points for this calculation method.

Vaccination & immunisation other changes

Core Contract/ QoF

SFE updated to include the expanded eligible cohort for RSV (all patients aged 75 and above as well as those below the age of 75 in care homes for older adults).

SFE updated to include MMRV vaccine in addition to MMR.

Network DES

PCN responsibility for ensuring access to vaccinations for seasonal and routine immunisations.

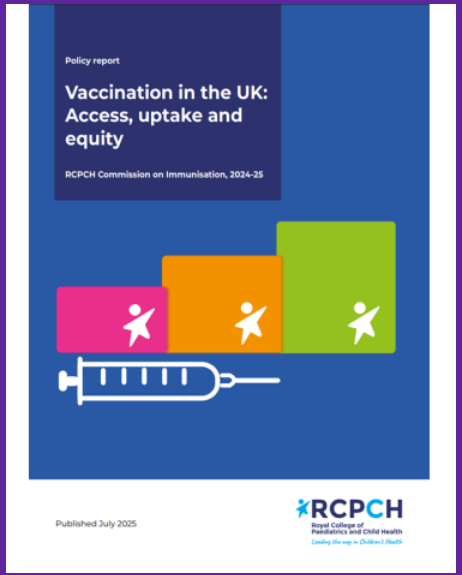
DES updated to support collaborative arrangements for delivering flu and covid vaccinations.

Barriers to uptake

Socioeconomic factors affecting vaccine demand, decision making and behaviour	Healthcare access	Systemic barriers
• Income level • Employment status • Insecure housing • Lack of security causing pressure	• Availability of healthcare services • Area-level deprivation	• Health literacy • Bureaucratic complexity of NHS • Trust in authorities • Communication and information barriers

Evidence to improve vaccine uptake

- Reminders/recall systems
- Opportunistic vaccination
- Flexible access
- Ease of booking appointments
- Outreach & community clinics
- One-stop clinics
- Personalised engagement



Top Tips:

- Change to QOF is opportunity for London practices to improve from base line.
- SFE updates including RSV and MMRV eligible cohorts.
- Review practice processes for invites and appointment availability.
- Review Vaccination in the UK: Access, uptake and equity | RCPCH.

Any questions?

Directed Enhanced Services

PCN DES basics 2026/27

- New DES spec published March 2026.
- DES varied into core contracts.
- Automatic roll-over if previously participated, just need to confirm on CQRS & sign contract variation when issued.
- Opt-out or PCN changes notification by 30/04/26 or within 30 calendar days of PCN DES variation being published. There is commissioner flexibility on this.
- Eligibility & participation requirements unchanged.
- Ensure Network Agreement is updated.

PCN DES changes 2026/27

- PCN Network Area – if not aligned with neighbourhood boundaries, PCN must work collaboratively with commissioners to achieve alignment – concerns re disruption of well-established PCNs who may cross over different neighbourhood boundaries.
- PCNs & member practices to participate in GP Staff Survey.

PCN DES changes 2026/27 - CAP & ARRS (1)

- £292m of CAP (Capacity & Access Payment) to be removed from PCN budgets and moved into practice funding under "Practice-level GP reimbursement scheme".
  - Purpose: recruit additional GPs or fund additional sessions from existing GPs to support same-day access for clinically urgent patients.
  - Concerns: re destabilisation of PCNs and impact on access delivery at PCN level.

PCN DES changes 2026/27 - ARRS (2)

- Restriction on GPs being 2 years post-training completion removed.
- Max reimbursement to be claimed for GPs via ARRS increased to top of salary GP pay range + on-costs (from £82,418 to £118,759, and £120,921 in London).
- PCNs can recruit broader range of non-direct pt care ARRS roles. Must be different to those already working in PCN practices and other existing ARRS roles.

PCN DES 26/27 - Other changes

- PCNs must use risk-stratification tools to identify & prioritise cohorts for continuity of care (core expectation).
- PCNs required to have vaccination arrangements in place – eligible care home residents to be identified & offered seasonal & routine vaccs.
- Adult Influenza and Covid vaccs now included in amended Mandatory Network Agreement, allowing collaborative delivery of the seasonal vacc enhanced service under the PCN DES.
- Requirement to improve cancer referrals, early diagnosis and screening uptake (inc. breast, cervical and bowel cancer).

PCN funding 2026/27

Payment	2025/26	2026/27
Core PCN Funding — fixed component (× registered list size at 1 Jan 2026)	£2.266	£2.311
Core PCN Funding — weighted component (× adjusted population at 1 Jan 2026)	£0.733	£0.748
Enhanced Access (× adjusted population)	£8.427	£8.903
Care Home Premium (per bed)	£130.253	£133.158
ARRS total sum (× contractor weighted population)	£26.631	£27.668
NPP (× contractor weighted population)	£1.761	£1.761
IIF	58 pts at £198.00/pt	58 pts at £198.00/pt
CASP (× adjusted population)	£3.208	Removed
CAIP (× adjusted population)	Up to £1.375	Removed

Summary

In this section we covered:

- Network Contract DES specification 26/27
- Main changes
- PCN Funding 26/27

Top Tips:

- Utilise expanded ARRS flexibility.
- Review ARRS budget (- CAP funding) to enable staff transfer & recruitment at practice level.
- Review EA & same-day access delivery under these structural changes.
- Strengthen cancer screening & referrals.

Any questions?

Take-home messages re: PCN difficulties/disputes

- Update Network Agreement.
- Sub-contracting agreements where appropriate.
- Strengthen governance, decision making and financial arrangements.
- Have clear ARRS employment & management processes in place.
- Engagement & communication.

Any questions?

Areas of Concern

Get in touch

- **Individual support (GPs and practices)**
  GPSupport@lmc.org.uk
- **General enquiries**
  info@lmc.org.uk
- **Website**
  lmc.org.uk/
- **Survival guide**
  lmc.org.uk/survivalguide
- **GP Professional Support Network**
  londonwide.onpld.com/

Final Comments

You may wish to change your view

from "gallery" to "speaker" for the final comments.

Share after webinar: Impact on ways of working

- Appointment systems and coding
- What does ‘dealt with on the same day mean?’
- Understand the data being monitored
- Registering with a gp
- Understanding your data https://caip.app/

Share after webinar: GP Contract 26/27 - Practice staff & Impact of Changes on ways of working

- Requirement to engage with General Practice Staff Survey.
- Appt demand – same day access for clinically urgent requests + inability to cap online consultation requests will require system to monitor and assess incoming online requests 8am – 6:30pm.
- Unclear whether practices will be able to refer clinically urgent pts to other services if at capacity on the day.
- 5 new access metrics will be monitored by NHSE (Call waiting times 8am-10am and during core hrs, % of clinically urgent pts seen on same day, % of non-clinically urgent pts seen within 1 & 2 weeks).
- Mandatory use of A&G for referrals – concerns re: pt safety, delays, loss of autonomy for GPs.