GP Contract Deal 2025-26

Sheffield LMC

March 2025

Headlines

NHS England (NHSE) and the British Medical Association (BMA) have announced an overall increase in investment of £889m across the Core Practice Contract and the Primary Care Network (PCN) Directed Enhanced Service (DES). In addition to this investment, practices will have the opportunity to take part in a new enhanced service for advice and guidance, which is worth up to £80m. Prior to the announcement, the figure that the BMA quoted as being required to end collective action for 2025/26 was £2.5bn of additional investment. The BMA has declared that they are no longer in dispute with the Government and NHSE and more guidance around this will be forthcoming in the weeks ahead.

What Does This Mean in Terms of Funding?

There is a significant lack of clarity on what is new investment and what is not, and further guidance is awaited. The global sum is projected to increase to £121.90 from £112.50 (8.4% increase).

According to the BMA's estimates, the increase in National Insurance and National Living Wage will cost approximately £280m. So, of the £742m that is allocated to the increase in global sum, £280m will come straight in and then go straight out. That leaves £462m. The NHSE document states that some of the retired Quality and Outcomes Framework (QOF) indicators (£100m worth) will be shifted into the global sum uplift. From the data provided, it is clear that this £100m is included in the £742m. Therefore, the real additional investment into the global sum is £362m (approximately £6 per patient).

A salary uplift of 2.8% is what is referenced in the NHSE announcement. A further uplift may be made following the Government's response to the Doctors' and Dentists' Pay Review Body (DDRB) outcomes for 2025/26. This tends to be varied where the Government sometimes announces a further pay uplift to come within the allocations (means practices lose funding for local initiatives to be shifted to pay, ie no extra investment) or sometimes the allocations are added to (meaning that practices will receive additional funding). Whilst the LMC would not want to speculate on this added element, the burden of financial pressures in the public sector is clearly not news to colleagues.

QOF Indicators

32 QOF indicators which were income protected in 2024/25 are now being permanently retired. This equates to 212 QOF points worth £298m in 2025/26. Of the 212 points, 71 points (worth £100m) will be removed outright, and will be invested into Global Sum (as per above) and into increases in both the Item of Service (IoS) fee for routine childhood vaccinations (from £10.06 to £12.06) and the locum reimbursement rates in the Statement of Financial Entitlements (SFE). So, no additional investment, but funding has been moved from protected indicators from QOF which practices were guaranteed in 2024/25, to childhood vaccinations that a lot of practices in deprived areas already struggle with, or locum reimbursements which can only be used by practices that have staff on long term sick leave or on parental leave. So, locum GPs could see an increase in their pay with practices seeing a drop in their QOF income. This in reality means more work to retain the same income

The remaining 141 QOF points (worth £198m) are being targeted at Cardiovascular Disease (CVD) where the upper achievement levels will be raised for 2025/26.

Whilst the intention to invest in CVD is laudable, looking at QOF achievement for these indicators from previous years, it is clear that the vast majority of practices will have to work significantly harder to simply maintain the same level of income from the previous year, or work the same as they did in 2024/25 and prepare for a drop in QOF income. Funding that was protected in 2024/25 for practices will now be moved to targets based payments where the targets are set so high that most practices will struggle to achieve these.

The small number of technical changes to QOF indicators that seem to bring indicators into alignment with National Institute for Health and Care Excellence (NICE) guidelines seem appropriate.

Overall, the QOF changes are not positive for General Practice, and we expect the practices in Sheffield to lose out both in terms of workload and finances.

ONLINE ACCESS AND DEVELOPMENTS

From 1 October 2025 practices will be required to keep their online consultation tool open for the duration of core hours for non-urgent appointment requests, medication queries and admin requests. This will be subject to necessary safeguards in place to avoid urgent clinical requests being erroneously submitted online. This will have a mixed effect on practices. Practices who already do this will naturally not see any difference. The ones who are already struggling with access will see this as an additional burden. Overall, it is difficult to see how this is a win for practices.

NHSE will also publish a patient charter which will set out the standards a patient can expect from their practice, as outlined in the GP contract. The charter will need to be published on the practice website. It is important to note that there is no mention of a discussion or negotiation in relation to this charter. At best, it might be a set of words that makes it easier for patients to understand what their GP practice can and cannot do for them. At worst, it could raise expectations and demands on the practices; and go beyond the definition of essential services in the regulations. At a time when local GPs have faced abuse and violence, the LMC is concerned what something like this could mean for Sheffield GPs. We await further details.

Practices will also be required to ensure the functionality in GP Connect is enabled which allows read only access to patients' care records. This will apply to other NHS commissioned providers for direct patient care, and also to private healthcare providers. This will invariably start ringing alarm bells. The timeframes stipulated are a significant concern. As custodians of patient data, this level of data sharing brings with it significant workload challenges as practices still have the duties of data controllers. There may also be opportunities where the need for Subject Access Requests (SARs) will decrease in practices as a result of this. At present, it is difficult to comment on the true impact without further information.

PCN DES AND ADDITIONAL ROLES REIMBURSEMENT SCHEME (ARRS)

The changes for ARRS will result in the creation of a single pot for reimbursement of patient facing staff costs, with no restrictions on numbers or type of staff who are covered - including GPs and practice nurses is a step in the right direction. We need to see the contract specification to understand the finer details. The profession's views on PCNs and ARRS are mixed, and that is what will determine how these changes will be perceived - will it result in a 2-tier GP employment model or offer more flexibility for the profession in who they can recruit.

We urge caution in interpreting the £104m of new investment. £82m of this was already announced for 2024/25. Therefore, an increase to £104m appears to actually be an increase of £22m (£0.33 per patient). There is also mention of £13m uplift to workforce streams. There is not enough detail in relation to this. This funding is needed to absorb the increase in National Insurance contributions for PCN staff and for any additional staff that PCNs may wish to recruit.

CAPACITY ACCESS IMPROVEMENT PAYMENT (CAIP)

In 2025/26 the CAIP will continue (worth £87.6m), but will change from 3 domains to 2. One domain will continue to focus on supporting modern General Practice access (worth £58.4m), while the other (worth £29.2m) will incentivise PCNs to risk stratify their patients in accordance with need - including to identify those that would benefit most from continuity of care.

There is no additional investment here. Some GPs will see the move away from 3 to 2 indicators a step in reduction of workload, whereas some will see the new indicator of stratifying patients yet another new workstream for the profession to deal with.

STATEMENT OF FINANCIAL ENTITLEMENTS (SFE)

There are some other technical changes to the core GP contract and to the SFE, which will either create new provisions (eg in relation to out of area registration) or clarify existing requirements.

There are also SFE changes for parental leave and sickness leave. The payments will increase in line with previous pay uplifts. The overall cost of this will be £12m in 2025/26, with funding shifted from the removed QOF indicators.

There will be additional amendments to the SFE to:

a) Clarify that the adjustment to Global Sum for Care Home patients should apply only to Care Quality Commission (CQC) registered Nursing and Residential Homes.
b) Enable claims for high-volume personally administered vaccines to be returned either via the new digital portal, or via the current process through post. This could help address the current paper heavy process, as long as the digital process is functional and does not require the practices to scan all the prescriptions. If it only applies to flu vaccinations, then it is less of an issue.

VACCINATIONS AND IMMUNISATIONS

Following recommendations by The Joint Committee on Vaccination and Immunisations (JCVI), the following changes will be made to the routine childhood and adult schedules in 2025/26:

a) 2 changes to the childhood vaccination schedule, driven by the discontinuation of the Menitorix (Hib / MenC) vaccine, including:
    i. an additional dose of Hib-containing multivalent (6-in-1) vaccine, offered at a new immunisation visit at 18 months of age.
    ii. the second dose of Measles, Mumps and Rubella (MMR) vaccine brought forwards from 3 years 4 months to the new immunisation visit at 18 months of age to improve coverage.
b) The exchange of MenB and Pneumococcal (PCV) vaccines within the childhood schedule (subject to final ministerial agreement).
c) A change to the adult shingles programme, reflecting new evidence on the effectiveness of the vaccination for a broader Severely Immunosuppressed (SIS) cohort.
d) The potential introduction of a varicella vaccine, subject to final ministerial agreement, in quarter 2 of 2025/26.
e) An amendment to the requirement to record the dried blood spot test for at risk babies, allowing that recording to take place between 12 and 18 months.

The IoS fees for routine childhood immunisations that are part of essential services will increase by £2 to £12.06 in 2025/26. There will also be an evaluation during 2025/26 of the effect that these changes have on activity, uptake and inequalities in uptake. This is funded by £17.8m shifted from the retired QOF indicators. Overall, this will see the funding received by practices for childhood vaccines increase and funding for QOF decrease.

The SFE will also be amended to address inconsistencies in the treatment of patients that move practice. Currently, if a patient receives a vaccination at their practice and subsequently moves to a new practice in a month, either only the new practice is paid or no practice is paid, depending on the receiving GP system supplier. The SFE will make clear that the receiving practice will be paid for the intervention. This is consistent with the approach to payments for departing patients taken elsewhere in the GP contract and will be a positive change.

PATIENT SAFETY STRATEGY

The Primary Care Patient Safety Strategy was published in September 2024.

In 2025/26 GP practices will be required to have regard to the Patient Safety Strategy, and also register for an administrator account (unless their local risk management system is already connected) with the learn from patient safety events (LFPSE) service for the purposes of:

1. Recording patient safety events at the practice about the services delivered by the practice, thereby contributing to the national NHS-wide data source to support learning, improvement and learning culture.
2. Enabling the practice to record patient safety events occurring in other health care settings (for instance if a GP practice wished to record an unsafe discharge from hospital).
3. Individuals recording patient safety events being able to download a copy of the record for purposes of supporting appraisal and revalidation.

Whilst elements of this come across as positive, one cannot see how practices will be able to deal with yet another form filling exercise.

OUT OF AREA REGISTRATION

There will be a contractual requirement that GP contractors work collaboratively with commissioners to implement out of area registration. This seems specifically for areas expanding rapidly with the registration of out of area patients, perhaps aiming at addressing some online providers cherry picking patients for provision of mainly online services. In these instances, contractors will need to seek approval of their plans to enable commissioner oversight of the safety and effectiveness of the arrangements so patients can access the full range of primary medical services. The trigger for the approval being required will be commissioner determined following consultation with the LMC.

DISSOLUTION OF PARTNERSHIPS

The GP Contract regulations will be amended to make clear that General Medical Services (GMS) contracts can be terminated in the situation where there is no clear successor when a partnership dissolves. Until the regulations are published, it will be difficult to see how this will impact struggling practices.

VIOLENT PATIENTS

The contract documentation indicates that the process for patient removal will be made clearer ‘in a way that protects the right of practices to immediately remove violent patients, whilst ensuring patient choice is retained when patients have not been immediately removed from their previous practice.’ The document goes on to say that ‘should not necessarily affect patient choice of alternative provider and should not necessarily mean that the patient requires allocation through the Special Allocation Scheme.’

This is a very real issue in Sheffield when colleagues have faced attacks in the last 12 months. It is difficult to see how this change is in line with a zero tolerance policy in the NHS. At a time when safety of GP staff is becoming more important, this can only be seen as a retrograde step (pending the publication of regulations) at present.

MANAGING PATIENT LISTS

This is another area that is difficult to comment on without sight of the regulations. It is likely that this will simply make the processing of patient transfers and removals less cumbersome for the commissioners. That will be a positive move for commissioners.

ENHANCED SERVICES

Practices will be offered a new enhanced service worth up to £80m for advice and guidance (which will begin in April 2025). The details of this are not available at present. Whilst this funding is referenced as additional income, it certainly poses challenges for Sheffield General Practice. Firstly, how this fits with the existing Clinical Assessments, Support and Education Service (CASES) process - at present, the referrals are vetted by GPs with specialist interest areas who are cognisant of how General Practice functions. If this is replaced with an Advice and Guidance (A&G) process where the feedback is provided by Secondary Care clinicians without that expertise, it will only result in a significant shift of work from Secondary Care for very little funding.

Whilst the funding is welcome, we need more details nationally and locally to understand the true impact of this on practices.

No changes are indicated for the Weight Management Enhanced Service, which will continue in 2025/26. Practices will receive £11.50 per referral with total funding of £7.2m for the enhanced service.

CONCLUSION

As with any negotiated agreement, there will be positive aspects and negative aspects that need to be considered before deciding whether it is good for General Practice in Sheffield. Whilst details and contractual documentation are pending, we need to consider the current offer with caution and the LMC's impressions on the contract deal may change as more details emerge.

The 'promise' of negotiating a new contract in the next year needs to be offset against the funding increase this year, which does not appear to be as impressive once the details are considered. Discussions about a new contract may start this year and, in realistic terms, it could take the best part of the next decade to negotiate and embed a new GP contract. In the meantime, workload will continue to increase and the national contract changes that are announced will only add to it.

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