



CONTRACT COMMENTARY & BMA REFERENDUM

Sheffield LMC have had an opportunity to review what is currently known about the 2026/27 GP contract. We have summarised the different elements and RAG rated them in relation to the LMCs view on the impact this will have on general practice. We have also included a reminder about the opportunity to feedback to the BMA on the contract imposition.

CONTRACT COMMENTARY

Headlines

NHSE have announced an overall increase in investment of £485m across GP contract. This breaks down into £416m going into core practice and £69m into PCN DES and is designed to include "national cost pressures" e.g. list size. In return for this investment, practices will be expected to shift their focus towards same day access. And for the first time, there will be practice level reimbursement for additional GP capacity available via the ARRS (Additional Roles Reimbursement Scheme)

What does this mean in terms of funding? – RED

There is a significant lack of clarity on what is new investment and what isn't and further guidance is awaited.

As per the NHSE announcement, £292m is being shifted from the PCN level Capacity and Access Payment. A further £80m that was being available for the Advice and Guidance for 2025/26 is being repurposed. So, at least £372m is money that is being repurposed. There is mention of £25m for new QOF indicators – this is new money for new work. The weight management enhanced service worth £7.2m has also been retired. That needs to account for an inflation of 3.0%, a projected pay uplift of 2.5% and the increase in National Minimum Living Wage. April 2026 Global Sum is expected to be £128.69, which is a £5.35 uplift.

ARRS changes: Practice level – RED

Whilst the change to a practice level reimbursement for additional GP capacity will be

seen by many as a positive step, it is important to note that this money is recycled. So, there isn't new money. It is important that practices don't see this as an avenue to increase capacity as the details about final reimbursement amounts are not confirmed. The maximum reimbursement for GPs is expected to be increased to the 'top of the salaried GP pay range' (£114,743 – this is expected to be reviewed after DDRB announcement) What was essentially guaranteed in 2025/26 (70% paid up front and 30% on achievement of targets) is now going to be available to claim via ARRS.

PCN Funding – RED

The shift of £292m funding away from PCNs can destabilise them – essentially destabilising practices. This is portrayed in the NHSE document as a positive step and the LMC urges the networks in the city to consider the implications of this going forward. PCNs will need to look at their costs and work streams and cut back on them as dictated by the changing finances.

Access requirements – RED

Some of the requirements are not new per se this year. They result from the negotiated and agreed contract in 2025/26. The main headlines are:

- Same day response for clinically urgent cases
- Non-urgent contacts to receive a response by end of next working day
- Practices must not ask patients to call back another day
- No capping of online consultation volumes

These will be very challenging for practices to achieve in the best of scenarios. The relentless workload this will result in, can and may result in the end of long-term relationships we have with our patients and start a new era of transactional care. There will be a requirement on practices to provide data and information relating to online and video consultation services. The new access requirements will be underpinned by 5 new access metrics:

1. 8–10am call waiting time
2. Call waiting time across core hours
3. % clinically urgent seen same day
4. % non-urgent seen within 1 week
5. % non-urgent seen within 2 weeks

QOF Indicators – RED

QOF expands by 18 points and that is backed by £25m additional investment. The major changes are:

- New diabetes indicator requiring all 8 NICE care processes
 - Will increase practice nurse and HCA workload.
 - Requires robust annual review templates.
- New obesity indicators (including pharmacotherapy shared decision-making)
 - Practices must increase referrals + discuss weight loss medications.
 - Weight Management Enhanced Service is retired. Therefore there will be no payment per referral, only a payment when a threshold is met.
 - Increased administrative demand on obesity follow-up and coding.

- Childhood immunisations: improvement thresholds added
 - More nuanced payment for deprived areas – there is an assumption here that a new QOF indicator will incentivise practices in the deprived areas to work harder. Whilst some incentives can help, what was needed is an overhaul of the vaccination indicators which did not happen
- Heart Failure 4 pillars indicator
 - Additional workload.
 - Requires upskilling of staff and a different approach in managing and monitoring.

Overall, whilst the clinical principles of the QOF changes are based on evidence, the lack of proportionate resources will mean that this will become very difficult for practice to work with. 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.

QOF point value will rise from £225.49 to £227.95, an increase of £2.46 (1.1%) following the change in the CPI

New vaccination workload – AMBER

There will be increased workload associated with the updated childhood vaccination QOF indicators to reflect the introduction of the MMRV vaccine. 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 will also result in extra workload.

There has been no uplift to the IOS fees for vaccinations, which will translate to a pay cut once inflation is considered.

The Network Contract Directed Enhanced Service (DES) – RED

- Additional Roles Reimbursement Scheme (ARRS): 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. There is also an indication that suggests that PCNs might be able to recruit a broader range of ARRS roles, where agreed with the commissioner. However, there is no additional investment. Therefore, there is no increased capacity, merely more options with a real terms cut.
- Vaccination requirements in care homes: PCNs are expected to ensure that eligible care home residents are identified and offered seasonal and routine vaccinations in line with national recommendations. Contractually this does not make sense as the vaccination programmes are practice based contracts. There will be provisions to support collaborate where network practices want to, to deliver flu and COVID-19 vaccination programmes
- Amending cancer requirements: The 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 are going to be very challenging for practices. These new requirements will be stretching the practices in both directions – acute, on day demand and proactive long-term care without the resources

- Continuity of care (risk-stratified cohorts): as above, this is unachievable for many in the current climate. The wording around continuity of care being a core expectation within primary care and to support future work to embed more meaningful continuity models in subsequent contract reform tells us what to expect for the future
- PCN and neighbourhood alignment: This may pose challenges for practice that pan across different 'neighbourhoods' in the city. What are neighbourhoods and what will this mean for the future? These remain unanswered till date. Please note that the national LMC conference policy is that the NHS 10 year plan will be an existential threat to the independent contractor model for General Practice.

Interface working with community pharmacy – AMBER

There are some bureaucratic measures which will add more tick boxes in day to day practice:

- Requiring practices to reconfirm the nominated pharmacy whenever a new prescription (not a repeat prescription) is issued
- To ensure that referrals and triage tools used for community pharmacy clinical services offer patients a full choice of providers.
- Practices to have a dedicated, monitored email address to receive information from community pharmacies if GP Connect is unavailable and for new or emerging pharmacy activity that is not yet supported through GP Connect. This will disproportionately affect those practices who turned GP connect off following GPC guidance last year.

Other – AMBER

- The Lung Cancer Screening Programme requirement is already in place in Sheffield.
- 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.
- There are new requirements in relation to the interface with community pharmacy:
- General Practice Staff Survey – the irony of this is not lost on the LMC. Two years of severely damaging contract changes, followed by a 'hope you are doing fine' type exercise is a proper kick in the teeth for the profession
- There will be a requirement on practices to display opening times for all modes of access (walk-in, telephone and online consultation). As a minimum this must be core hours for all modes of access. There is further clarity required in relation to PLI events and subcontracting

Conclusion – RED

This is the first non-negotiated contract in General Practice's history. Not unexpectedly, this contract built on most of the damaging aspects of the negotiated contract from 2025-26. 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. At best, practices will find that their workload will increase, finances will drop and it will make General Practice unstable in the city.

At the time of publication, General Practice no longer has national negotiating rights for the GP contract, and it is difficult to see who and how these concerns will be addressed at a national level. The LMC will continue to work with commissioning colleagues locally to try and mitigate the challenges where possible. As ever, if you have concerns or wish to discuss this further, please contact the office.

BMA REFERENDUM

BMA members should have received an email link to vote in a referendum on the 26/27 imposed contract. Further details can be found on the BMA's website [here](#) and below.

"GPC England [voted to reject the Government's 2026/27 GMS contract and to open a contract referendum of the profession](#) on these imposed contract changes.

GP and GP registrar BMA members should have received an email from Civica, inviting you to vote. You'll be asked if you accept the Government's changes to GP contracts for 2026/27, and its approach to making them, or if you want the Government to return to direct, meaningful negotiations with GPCE to jointly develop a new national GMS contract to restore the viability of partnerships, provide fair remuneration for all GPs, and implement workload safeguards to keep GPs and patients safe.

If you have not received an email from Civica with your voting link, please check your junk folders and contact GPContract@bma.org.uk if you don't have one.

The referendum opened on 4 March and is open until 12pm, 25 March."