Digest GP Contract (settlement_ 2025/26 - (BMA 8th April)

These are the key headlines from the 25/26 GP contract changes:

- £969 million new investment uplift – comprises £889m additional core contract funding and £80m for use of e-RS advice and guidance between GPs and consultants.
- This investment is on top of the £433m added to the contract during autumn last year.
- Enhancement of ARRS, with GPs and practice nurses added in to the main scheme, minimum GP salary + on-cost reimbursement increased in line with the BMA salaried GP pay range and with no caps on numbers
- Enhanced service for 'pre-referral' advice and guidance with a £20 item of service fee payment per request by GPs
- Restoration / uplift of SFE payments (sickness/parental leave cover) in line with 2025-26 real-terms values (compared to 2018/19), including locum reimbursements and childhood vaccination payments.
- Changes to requirements for patient online e-consultation access to general practice from October 2025

Funding

There will be £969 million of new investment into the contract – comprising £889m additional core contract funding and £80m for use of e-RS advice and guidance between GPs and consultants. In addition £100m of QOF funding will be recycled into core GMS. These are summarised below.

Global Sum

The Global Sum payment per weighted patient will be £121.79 per patient, an uplift of £9.29 (8.26%).

SFE payments

Locum reimbursement amounts will increase to take into account DDRB increases over recent years. The new reimbursement rates will be:

- Parental leave (including shared parental leave): £1,418.43 for the first two weeks, £2,151.96 per week thereafter
- Sick leave: £2,151.96 per week after the first 2 weeks of absence
- Prolonged study leave: £1,404.38 per week

- Suspension: £1,404.38 per week

The reimbursement of costs can be claimed where the cover is provided by a locum, a salaried GP on a fixed term contract, or a GP already working in the practice but who is not full-time (either employed or a partner).

Whilst this increase will still not cover the full cost of a locum to cover an absent GP in many areas, it represents an important step in recognising that the current situation is untenable for both practices and those locums currently struggling to find employment, as well as the need to ensure that such reimbursements rise in accordance with costs.

In order to access these reimbursements, practices will need to follow the requirements as set out within the relevant section of the SFE (sections 9-12).

The NHS England 'Primary medical services policy and guidance manual' provides further information on these processes as well as a sample declaration form.

QOF (Quality and Outcomes Framework)

The 32 indicators (worth 212 points) that were temporarily frozen for 2024/25 will be permanently retired. The funding for these will be split across the Global Sum and additional funding for a renewed focus on the 9 CVD QOF indicators. 141 points will be added to the nine CVD indicators (totalling an additional £198m). Alongside this the upper thresholds for these indicators will be increased, whilst the lower thresholds remain the same.

With the increased points and funding for the nine CVD indicators set out in the table below, it is recommended that practices consider how they may organise relevant services in order to maximise their achievement for these areas.

For full descriptions of each of these indicators, please refer to the 25/26 QOF Guidance.

ID	Lower threshold (2024/2025)	Upper threshold (2024/2025)	QOF points (2024/2025)	Lower threshold (2025/2026)
CHOL003	70%	95%	14	70%
CHOL004	20%	35%	16	20%
HYP008	40%	77%	14	40%

ID	Lower threshold (2024/2025)	Upper threshold (2024/2025)	QOF points (2024/2025)	Lower threshold (2025/2026)
HYP009	40%	80%	5	40%
STIA014	40%	73%	3	40%
STIA015	46%	86%	2	46%
CHD015	40%	77%	12	40%
CHD016	46%	86%	5	46%
DM0362	38%	78%	10	38%

IT and Digital

Online Access to general practice

A new requirement will begin from 1 October 2025 for practices to allow patients to submit routine, non-urgent appointment requests, medication queries and admin requests via online consultation tools during core hours.

This will be subject to necessary safeguards being in place to avoid urgent clinical requests being erroneously submitted online. GPC England and the Joint GP IT Committee (JGPIT) will work with NHS England on the design and implementation of this over the coming months.

GP Connect (Update Record)

From October 2025, registered pharmacy professionals will have access to patient records via GP Connect (Update Record).

Other NHS providers and private providers (where patients have provided explicit consent) will be limited to read only access for the purposes of direct patient care.

GPCE will work with NHS England to determine exactly, which providers will be included and what level of access they can have compliant with data protection legislation.

PCNs and ARRS (additional roles reimbursement scheme)

The PCN DES will largely remain the same, with changes to just the ARRS and Capacity and Access Payments. Read a full breakdown of PCN funding including the ARRS.

ARRS

The GP ARRS scheme, announced in the summer of 2024, has been amalgamated with the main ARRS with practice nurses also added to the Scheme. PCNs will be able to receive reimbursement for both 'experienced practice nurses' and 'new to general practice nurses' provided that they have not held a post within the PCN, or its member practices, within the last 12 months.

The reimbursable amount for GPs employed under the scheme will be increased by £9,305 to £82,418 (plus on costs), in line with the BMA recommended pay range for salaried GPs. There will be no cap on the number of GPs that can be engaged under the scheme, although it will continue to be limited to those within 2 years of their CCT date at the time of recruitment and have not been previously substantively employed as a GP in general practice. GPs employed under the ARRS must be on terms 'no less favourable' than the BMA salaried model contract, as with those employed directly by practices.

Whilst there are no formal restrictions on how GPs engaged under the scheme should be deployed, GPC England and the Sessional GP Committee previously released some joint principles setting out best practice for employing GPs within the ARRS. PCNs and practices are strongly encouraged to continue to follow these.

We continue to recommend that such GPs are deployed at a practice level, ideally situated within just one practice, rather than working across the whole PCN and are provided with the necessary level of professional and personal support. This is especially important as, given the current restrictions of the scheme, these GPs will be recently qualified. As such, mentorship and support delivered by experienced GPs embedded within one of the member practice will help with the ARRS GP's development and prevent isolation. Practice have decades of experience of supporting and mentoring GP Registrars and newly qualified GPs, and this must not be lost.

PCN Enhanced Access

The PCN DES has been amended to clarify that enhanced access requirements do not preclude practices from booking appropriate patients into appointments within Network Standard Hours, which are delivered at the patient's registered practice. This means that practices can utilise EA appointments to see their own patients for any general practice or PCN related services.

PCN Capacity and Access funding

The Capacity and Access Improvement Payment (CAIP) for 2025/26 will be split into two parts. One aspect will continue to focus on access (worth £58.4m) while the other will focus on using intelligence from population health risk stratification tools (worth £29.2m) to risk stratify their patients in accordance with need - including to identify those that would benefit most from continuity of care.

To meet this, PCNs will have to certify that they are 'using the intelligence provided by digital risk stratification tools', and 'should risk stratify their patients in accordance with need, including to identify those that would benefit most from continuity of care (with a named GP, where appropriate)' by March 31 2026.

The 'modern general practice access' requirements remain similar to 2024/25. By March 31 2026, PCNs will need to confirm that:

- Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.
- Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests.
- The approach should include asking patients their preference to wait for a preferred clinician if appropriate, for continuity.
- Online consultation (OC) is available for patients to make administrative and clinical requests at least during core hours.

Further detail on these requirements are set out in the 'PCN DES Part B Guidance'.

Vaccinations and Immunisations

Item of service (IoS) fees for childhood immunisations will be uplifted by £2 to £12.06. This includes all childhood routine vaccinations set out within Table 1 of the SFE, plus Hepatitis B immunisations at birth/four weeks and 12 months and MMR for those 6 and over.

The payments for all other vaccination remain the same.

In addition to the changes to IoS fee for routine childhood vaccinations described, there will also be the following changes in 25/26, in line with recommendations by The Joint Committee on Vaccination and Immunisations:

- two changes to the childhood vaccination schedule, necessitated by the discontinuation of the Menitorix (Hib/MenC) vaccine
- the exchange of MenB and PCV vaccines within the childhood schedule (subject to final ministerial agreement) – to note this a change from our

original proposal, reflecting a late recommendation from JCVI, but is a workload-neutral change

- a change to the adult shingles programme, reflecting new evidence on the effectiveness of the vaccination for a broader severely Immunosuppressed (SIS) cohorts
- the potential introduction of a varicella vaccine, subject to final agreement
- 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
- changes to the SFE to address inconsistencies in treatment of patients that move practice as set out in paragraphs 15-17 of annex F.

Advice and Guidance Enhanced Service

An Enhanced Service specification for Advice and Guidance will provide a £20 Item of Service fee (IoS) per 'pre-referral' A&G request. ICBs will receive funding according to activity delivered so they are not incentivised to withhold it from general practice, with capped spend per ICB.

The Service will be available on CQRS from 30 April 2025 and Commissioners must invite all GP practices to participate in this ES on CQRS no later than 13 May 2025.

Practices have until 27 May 2025 to sign up to participate on CQRS, unless their Commissioner agrees otherwise, and any claims made can be backdated to the 1 April 2025.

Once signed up to the ES, practices will be entitled to claim a £20 IoS fee per request for pre-referral advice and guidance. Only one claim can be made per episode of care (i.e. multiple contacts between the practice and specialist for the same clinical issue are counted as one A&G referral).

Claims for payment of pre-referral A&G requests will be made via CQRS. Practices will need to make manual monthly claims which will then be approved by their ICB. Claims for payment should be made within 12 days of the end of the month when the pre-referral advice and guidance was requested.

Important: record all A&G requests correctly

It is important, therefore, that practices ensure that all A&G requests are recorded correctly in order to claim for all eligible interactions from 1st April 2025 using the appropriate SNOMED CT code (401000003 'advice and guidance (procedure)).

Advice and Guidance in the ES is defined as GP led, non-face to face activity which could be real-time/synchronous advice, such as a telephone call, or asynchronous advice when carried out electronically through the NHS e-Referral Service (e-RS) or dedicated email addresses.

Ongoing communication between the referrer and the respondent regarding the same episode of care will not attract a further IoS fee.

Full detail and requirements for the ES can be found in the service specification.

2025/26 contract changes: FAQs

Global sum

What will be the increase in the GS PPWP (Global Sum Payment Per Weighted Patient)?

The GS PPWP will increase by £9.29, from £112.50 in 2024/25, to £121.79. This represents an increase of 8.26%.

How does the £743 million uplift to 'Global Sum' – the name for the national funding pot for GP practice contracts - result in a £9.29 increase per patient?

The headline Global Sum increase does not directly correlate with a divisible sum per weighted patient. The main reason for this is that a proportion of the increased funding is used to pay for the true increase in the number of patients, and thus the number of payments.

Business pressures

What will be the cost of business pressures resulting from changes announced in the Autumn Statement?

The latest Autumn Statement announced measures which will impact GP practices as employers, including increases to ENICs (Employer National Insurance Contributions) and National and Minimum Living Wages. Exactly how these measures will cost will vary from practice to practice, as the impact depends on a specific practice's staffing structure, and current staff salary arrangements.

Nevertheless, the BMA has estimated the total expected cost at a national level for all practices in England, via a calculator tool that allowed practices to submit data about their practice staffing structure and list size. This data was used to estimate the additional cost of increases to ENICs as well as Minimum and Living Wages. We also included any additional pension contribution costs incurred because of these increases. We calculated the average net additional cost per patient, which was £2.97. We then scaled that up to obtain a national cost estimate of £187million.

This estimate does not account for the cost of maintaining wage differentials – that is, the cost of other staff pay rises – because the approach to doing so varies widely from practice to practice. As such, it is to be expected that a portion of the contract rise will be spent on increasing other staff wages – but the exact amount will depend on the practice's precise

staffing structure, current staff salary arrangements and approach to assessing wage differentials uplifts.

Why are there different estimates of business pressures costs circulating?

The IGPM (Institute of General Practice Management) recently published their own estimate, totalling £550mn, which would equate to £7.54 per patient. This figure differs from the BMA estimate for two main reasons:

1. The IGPM's estimate is UK-wide, rather than for England only. For reference, the BMA's estimate of the UK-wide cost of the changes was £215mn.
2. The IGPM's estimate includes the cost of maintaining wage differentials, using surveyed practices stated preferred approach to doing so.

As such, this estimate can be seen as a maximum cost estimate.

BMA research staff have met with the IGPM research team to compare results. The survey samples sizes were similar, and the IGPM's estimate of the minimum cost, i.e. not accounting for wage differentials, was very close to the BMA estimate.

Since staffing structures, current salary arrangements, and approaches to wage differentials will vary from practice to practice, these national-level estimates cannot be reliably used to predict the specific impact on any individual practice.

QoF

Will the changes to QoF reduce practice income?

71 income-protected QoF points will be permanently removed, with the resulting £100mn of funding transferred, as described above, into the Global Sum. In terms of the potentially achievable QoF financial envelope, this change represents a reduction of £1.57 per patient. However, this is offset by a commensurate increase in the Global Sum payment, which is permanently incorporated into the Contract value and not subject to potential future changes in QOF targets.

141 further points will be redistributed proportionately across nine CVD prevention indicators. NHS England calculations, based on 2023/24 actual QOF achievement levels, were that the QOF threshold changes would have a £50 million negative financial impact. However, provisional 2024/25 achievement figures indicated that approximately half this impact (£25m) had already been mitigated, without practices being aware of the changed thresholds.

PCN-DES and ARRS funding

How much more money is going into the PCN-DES?

The total uplift going towards PCN-DES payments in the 2025/26 contract totals £215mn. This includes a £174mn uplift to ARRS (with a £104mn transfer of new money previously ringfenced as for GPs in ARRS), including the DHSC's assumed 2.8% pay uplift for ARRS staff, and a further £41mn uplift to other PCN-DES payments, including Enhanced Access services.

What has happened to the ARRS budget?

The GPs in ARRS scheme has been extended into 2025/26, with a total budget of £186m initially earmarked for this. Since £82m was committed from October 2024 when GPs in ARRS was initially implemented, only £104m of this money is labelled as 'new' investment for 25/26.

During negotiations, whilst GPCE negotiators steadfastly argued for a practice-level GP employment scheme, it was eventually agreed to merge the GPs in ARRS and 'regular' ARRS pot as a short-term measure for 25/26 to help reduce GP under/unemployment.

NHSE argue that this gives PCNs/practices the opportunity to re-balance staffing much more towards GPs and nurses. Discussions on the practice-level employment alterative will begin in the coming weeks and months when collective focus switches to 26-27 and beyond.

The total uplift to ARRS funding for 2025/26 is £174m, which includes the £104m uplift initially reserved for GPs in ARRS.

Why was the GPs in ARRS budget for 2025/26 £186m rather than £164m?

The initial budget for ARRS in 2024/25, covering a six-month period, totalled £82m. The initial budget for 2025/26 – eventually added to the overall ARRS budget rather than earmarked – was more than double that. This is because the £82m for 24/25 assumed less than six months funding due to phasing1. Furthermore, the budget for 2025/26 also includes additional funds for 25/26 reserved for pay pressures.

Additional Guidance

- **Focus on dispensing and prescribing**
- **Focus on GP data sharing and GP data controllership**
- **Focus on limited liability partnerships and the GMS contract**
- **Focus on the 2024 premises costs directions**
- **Focus on medical associate professions**
- **Focus on proforma and referral forms**