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Changes to the GP Contract in 2025/26

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To:

- All GP practices in England
- Primary care network clinical directors

cc.

- Integrated care boards
 - Primary care leads
 - Chief executive officers
- NHS England regions:
 - regional directors
 - regional directors of commissioning
- Regional directors of primary care and public health
- Regional primary care medical directors

Dear colleagues,

Changes to the GP Contract in 2025/26

The government and NHS England are determined to improve people's access to, and experience of, GP services. The consultation on changes to the GP Contract for 2025/26 has now concluded and I am writing to confirm the final arrangements for the upcoming financial year. Throughout the contract consultation, the engagement with GPC England has been positive and constructive. We are pleased that GPC England are supportive of the contract changes.

The contribution of general practice is vital to the NHS and continues to be highly valued and appreciated. Over the course of the last year, NHS England and the Department of Health and Social Care (DHSC) have continued to listen to the views of the profession and have responded accordingly. Government agreed to fund in full in 2024/25 the 6% pay recommendation for GPs by the Review Body on Doctors and

Dentists Remuneration (DDRB), and recently qualified GPs were also added to the Additional Roles Reimbursement Scheme (ARRS), with additional funding, from October 2024 following strong feedback from the profession.

The changes to the GP Contract for 2025/26 mark a major step forward in the government's mission to shift care into the community, to focus on prevention and to move from analogue to digital. The changes also provide greater freedom to GPs by cutting red tape and empowering patients by improving digital access to practices.

1. In 2025/26 there will be an overall increase in investment of £889 million across the core practice contract and the Network Contract Directed Enhanced Service (DES). This will take the combined total estimated contract value from £12,287 million in 2024/25 to £13,176 million in 2025/26.

2. This provides 7.2% cash growth on the contract funding envelope (estimated 4.8% real growth on overall 24/25 contract costs). This is the biggest increase in investment into general practice in over a decade with general practice contract funding growing at a faster rate than NHS funding as a whole.

3. In addition to the £889m increase in investment, practices will also have the opportunity to take part in a new enhanced service for advice and guidance, which is worth up to £80 million. This enhanced service supports the government's commitment to move more care from secondary care into community settings and will ensure patients receive care in the right place at the right time via the use of specialist advice and guidance whilst also supporting elective recovery.

4. We will continue to reduce bureaucracy for practices by permanently retiring the 32 QOF indicators which were income protected in 2024/25. This equates to 212 QOF points worth c. £298m in 2025/26.

5. Of the 212 points, 71 points (worth c£100 million) will be removed outright and will be invested into Global Sum and (following feedback from GPC England) into increases in both the Item of Service Fee for routine childhood vaccinations (from £10.06 to £12.06) and the locum reimbursement rates in the Statement of Financial Entitlements (SFE).

6. The remaining 141 QOF points (worth c£198 million) will be targeted towards cardiovascular disease (CVD) prevention to support the government's ambition to reduce premature mortality from heart disease or stroke by 25% within a decade. The points will be redistributed proportionately across nine CVD prevention indicators. While the lower thresholds for these indicators will be maintained at 2024/25 levels to offer the maximum opportunity to earn QOF points, the upper achievement levels will be raised for 2025/26.

7. We want patients to contact their practice, by phone, online or by walking in, and for people to have an equitable experience across these access modes. This will be a key intervention in the government's ambition to end the 8am scramble. 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. Guidance will be displayed on practice websites and reflected in the wording of the patient charter (see below).

8. By no later than 1 October 2025, practices will be also 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 providers of private healthcare where the private provider obtains explicit permission from the patient to access their NHS GP care record and they are providing direct care to the patient.
- allows Community Pharmacy registered professionals to send consultation summaries into the GP practice workflow – which will reduce administrative burden for general practice teams.

9. NHS England will 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. This will improve transparency for patients and make it easier for them to know how practices will handle their request and what to expect from their practice.

10. In 2025/26 the Additional Roles Reimbursement Scheme (ARRS) will increase in flexibility to support PCNs to respond to their local workforce requirements. We will combine the funding in the two ARRS pots to create 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.

11. In order to support both the recruitment of GPs via the ARRS and the governments' ambition to bring back the family doctor, the salary element of the maximum reimbursement

amount that PCNs can claim for GPs will be increased from £73,113 in 2024/25 (the bottom of the salaried GP pay range) to £82,418 (an uplift of £9,305 representing the lower quartile of the salaried GP pay range) reflecting that some GPs will be entering their second year in the scheme. Proportionate employer on-costs will also be included within the overall maximum reimbursement amount which PCNs will be able to claim.

12. In 2025/26 the Capacity and Access Improvement (CAIP) payment will continue (worth £87.6 million) but will change from three domains down to two. One domain will continue to focus on supporting modern general practice access (worth £58.4 million) while the other (worth £29.2 million) will incentivise PCNs to risk stratify their patients in accordance with need – including to identify those that would benefit most from continuity of care.

13. There will be 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. These are set out in full in at [annex A](https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/#annex-a-detail-of-the-changes-to-the-gp-contract-in-2025-26) (<https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/#annex-a-detail-of-the-changes-to-the-gp-contract-in-2025-26>) along with the detail of all the other contract changes.

The process of implementing the contract changes will now take place, with new and updated specifications and guidance being published in the coming weeks along with additional information. NHS England will hold a webinar between 5pm and 6pm on Monday 3 March where information about the

2025/26 contract changes will be shared. You can [sign up online \(https://www.events.england.nhs.uk/events/general-practice-webinar-series\)](https://www.events.england.nhs.uk/events/general-practice-webinar-series).

Lastly, I'd like to thank you all for the hard work and dedication of general practice and PCN teams. I hope the changes to the contract in 2025/26 will be seen as positive for practices, PCNs and for patients.

Yours sincerely,

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

Annex A – detail of the changes to the GP Contract in 2025/26

GP contract finance

1. In 2025/26 there will be an overall increase in investment of £889 million across the core practice contract and the Network Contract Directed Enhanced Service (DES). This will take the combined total estimated contract value from £12,287 million in 2024/25 to £13,176 million.

2. This provides 7.2% cash growth on the contract funding envelope (estimated 4.8% real growth on overall 24/25 contract costs) and includes:

- a. funding an assumed increase in salaries of 2.8% in 2025/26
- b. continuation of GPs in ARRS
- c. funding to cover the costs nationally:
 - i. of other cost growth pressures, including from

- premises and list growth
- ii. to reflect the increased level and complexity of activity.

3. A further uplift may be made following the government's response to the Doctors' and Dentists' Pay Review Body (DDRB) outcomes for 2025/26.

Core practice contract

Streamlining incentives and supporting secondary prevention – QOF

4. DHSC and NHS England will permanently retire the 32 QOF indicators income protected in 24/25 (see annex B). This equates to 212 QOF points worth c.£298m in 25/26 of which:

- a. 71 will be removed outright, with the corresponding c£100m invested into Global Sum (c£70.4m in 2025/26) and to support both an increase in the Item of Service (IoS fee) to £12.06 for routine childhood vaccinations (c£17.8m in 2025/26) and the locum reimbursement rates in the Statement of Financial Entitlements (c£12m in 2025/26).

- b. the remaining 141 redistributed proportionately across nine CVD prevention indicators (see Annex C), resulting in the balance (an additional c£198m more than 2024/25) targeted towards CVD prevention – a key driver of excess mortality.

5. In order to support the government's ambition to reduce premature mortality from heart disease or stroke by 25% within a decade:

- a. the upper achievement levels will be raised for the CVD prevention indicators that will increase in value for 25/26; and
- b. the lower thresholds will be maintained at 2024/25 levels to offer the maximum opportunity to earn QOF points for these indicators. Annex C (<https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/#annex-c-cvd-prevention-indicators-2025-26-qof-points-and-thresholds>) also sets out the proposed threshold changes.

6. There will also be a small number of technical changes to QOF indicators that will bring indicators into alignment with NICE guidelines that have been updated and republished since the scheme was last published (see annex D (<https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/#annex-d-qof-technical-changes-highlighted-text-to-signify-wording-change>)).

Increasing locum reimbursement payments in the SFE

7. In response to feedback from GPC England, the locum reimbursement payments in the Statement of Financial Entitlements (SFE) relating to parental leave, sickness absence, prolonged study leave (including educational allowance payment) and suspended doctors will be increased in 2025/26. These payments were increased by 6% in 2024/25 following the government response to the Review Body on Doctors' and Dentists' Remuneration (DDRB) recommendations but had not been increased for a number of years previously.

8. The payments will increase in line with previous pay uplifts (effectively unwinding the previous freeze) with the new payment amounts set out in the 2025/26 SFE. The overall cost of this will be c£12 million in 2025/26 with funding drawn from a portion of the removed QOF indicators (see paragraph 4a of this annex).

Vaccinations and Immunisations

9. 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. two 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 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 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.

10. The detailed changes to the routine childhood schedule are attached at annex E (<https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/#annex-e-programme-changes-to-routine-childhood-schedule>) and will be supplemented with further guidance. All changes (to both the childhood and adult routine schedules) will be included in an amended version of the SFE in 2025/26.

11. In response to feedback from GPC England and reflecting the key role that general practice plays in efforts to increase uptake in childhood vaccinations, the Item of Service (IoS) fee for routine childhood immunisations that are part of essential services will increase by £2 to £12.06 in 2025/26. There will be an evaluation during 2025/26 of the effect that these changes have on activity, uptake and inequalities in uptake.

12. The 2025/26 SFE will list all the vaccinations and immunisations which are in scope of the increase in the Item of Service fee. c.£17.8 million of the funding generated through the retired QOF indicators (see paragraph 4a of this annex) will be used to cover the estimated costs of this increase.

13. 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 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.

Online consultation tools switched on for the duration of core hours

14. From 1 October 2025 practices will be required to keep their online consultation tool open for the duration of core hours (8am – 6:30pm) for non-urgent appointment requests, medication queries and admin requests. This will be subject to necessary safeguards in place to avoid urgent clinical requests erroneously submitted online. Guidance will be displayed on practice websites and reflected in the wording of the patient charter.

Enabling GP Connect

15. By no later than 1 October 2025 GP contractors will be required to ensure the following functionality is enabled in GP Connect which:

- a. allows read only access to patients' care records (GP Connect Access Record HTML and Structured) by other NHS commissioned providers, for the purposes of direct patient care and read only access for providers of private healthcare (only in cases where the private provider obtains explicit permission from the patient to access their NHS GP care record, and they are providing direct care to the patient).
- b. allows Community Pharmacy registered professionals to send consultation summaries into the GP practice workflow (GP Connect Update Record).

Patient safety strategy

16. The primary care patient safety strategy (<https://www.england.nhs.uk/publication/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 service (LFPSE) for the purposes of:

- a. 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.
- b. 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).
- c. individuals recording patient safety events being able to download a copy of the record for purposes of supporting appraisal and revalidation.

What patients can expect from general practice

17. NHS England will 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. This will improve transparency for patients and make it easier for them to know how practices will handle their request and what to expect from their practice.

Safe and effective provision of high quality primary medical services to patients registered out of area

18. There will be a contractual requirement that GP contractors work collaboratively with commissioners to implement out of area registration. This will provide safeguards when practice lists are expanding rapidly with the registration of out of area patients.

19. 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.

20. The trigger for the approval being required will be commissioner determined following consultation with the Local Medical Committee (LMC). At the point that such an application is required and made, the contractors patient list should be closed to new out of area registrations until the commissioner is assured of the arrangements the contractor has in place. In making the decision, the commissioner should always seek to enable and maintain patient choice of GP practice.

Dissolution of partnerships

21. The GP Contract regulations will be amended to make clear that GMS contracts can be terminated in the situation where there is no clear successor when a partnership dissolves.

Violent patients

22. NHS England and DHSC support GP practices to immediately remove from their patient lists patients who commit acts of violence and threatening behaviour towards practice staff. The relationship between patients and practices

can also breakdown for a variety of other reasons, and it is important to maintain an element of patient choice in choosing an alternative practice.

23. The process for patient removal will be made clearer in the GP Contract regulations, 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.

24. The changes will also reinforce the importance of practices processing the immediate removal of violent and threatening patients alongside reporting this to the police within the period set out in regulations. It will also be made clear that police reports made after this period, should not necessarily affect patient choice of alternative provider and should not necessarily mean that the patient requires allocation through the Special Allocation Scheme.

Managing patient lists

25. Amendments will be made to the GP Contract regulations to enable NHS England to contact a patient digitally (as opposed to in writing) when it becomes aware that a patient has moved from the practice area. This will allow additional routes for NHS England to advise the patient to either obtain the contractor's agreement to remain on the contractor's list of patients or to apply for registration with another provider of essential services.

26. The notice timeframe for deregistration will be reduced from 6 to 3 months when a patient is no longer known to NHS England.

Further changes to the SFE – adjustment factor for care homes and dispensing payments

27. 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 CQC registered nursing and residential homes.
- b. to enable claims for high-volume personally administered vaccines to be returned either via the new digital portal, or via the current process through post.

The Network Contract Directed Enhanced Service (DES)

28. The following changes will be made to the Network Contract DES in 2025/26.

The Additional Roles Reimbursement Scheme (ARRS)

29. The ARRS will be made more flexible in 2025/26 with the following changes:

- a. the continuation of funding into 2025/26 for the cohort of ARRS GPs recruited during 2024/25 which equates to £186 million for the full year.
- b. combining the GP ARRS funding with the main ARRS pot (removing the GP ARRS ringfence).
- c. from the combined funding pot, allowing PCNs to claim reimbursement for GPs alongside existing ARRS roles plus practice nurse roles which will be added to the scheme.

30 .The eligibility criteria for GPs will remain those individuals who have obtained the CCT within the last two years (at the point of recruitment) and who have not been previously substantively employed as a GP in general practice.

31. In order to support the recruitment of GPs via the ARRS, the salary element of the maximum reimbursement amount that PCNs can claim will be increased from £73,113 in 2024/25 (the bottom of the salaried GP pay range) to £82,418 in 2025/26 (an uplift of £9,305 representing the lower quartile of the salaried GP pay range) reflecting that some GPs will be entering their second year on the scheme. Proportionate employer on-costs will also be included within the overall maximum reimbursement amount. As in 2024/25, there will be a maximum reimbursement amount for those GPs outside London and a maximum reimbursement amount including London weighting which will be set out in the 2025/26 Network Contract DES specification.

Changes to the Capacity and Access Improvement (CAIP) Payment

32. The Capacity and Access Support Payment (CASP – worth £204m) will continue in 2025/26 and remain unconditional for PCNs. The Capacity and Access Improvement (CAIP) payment will continue (worth £87.6 million) but will change from three domains down to two.

33. One domain will continue to focus on supporting modern general practice access (worth £58.4m) while the other (worth £29.2 million) will incentivise PCNs to use the intelligence

gained from population health risk stratification tools to stratify their patients – including to identify those that would benefit most from continuity of care.

34. The full details will be set out in the 2025/26 Network Contract DES specification and guidance.

Enhanced services

General practice requests for advice and guidance

35. Practices will have the opportunity to take part in a new enhanced service worth up to £80 million for advice and guidance (which will begin in April 2025). This funding is in addition to the increase of £889 million across the core practice contract and the Network Contract DES.

36. The enhanced service will incentivise even closer working between general practice and secondary care and support the government's commitment to move more care from secondary care into community settings. It will help to ensure that patients receive care in the right place at the right time via the use of specialist advice and guidance, whilst also supporting elective recovery.

37. Practices will be able to claim (subject to eligibility criteria set out in the enhanced service specification) a £20 Item of Service (IoS) for pre-referral requests.

The Weight Management Enhanced Service

38. The Weight Management Enhanced Service will continue in 2025/26. Practices will receive £11.50 per referral with total funding of £7.2 million for the enhanced service.

Annex B – income protected indicators, retired from 2025/26

CAN001	The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003
CAN004	The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis
CAN005	The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and informed of the support available from primary care,

	within 3 months of diagnosis
CKD005	The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)
CHD001	The contractor establishes and maintains a register of patients with coronary heart disease
HF001	The contractor establishes and maintains a register of patients with heart failure
HYP001	The contractor establishes and maintains a register of patients with established hypertension
PAD001	The contractor establishes and maintains a register of patients with peripheral arterial disease
STIA001	The contractor establishes and maintains a register of patients with stroke or TIA
DEM001	The contractor establishes and maintains a register of

	patients diagnosed with dementia
DM017	The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed
EP001	The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy
LD004	The contractor establishes and maintains a register of patients with learning disabilities
DEP004	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis
	The contractor establishes and maintains a register of

MH001	patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy
MH021	Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who received all six elements of the Physical Health Check for people with Severe Mental Illness
OB003	The contractor establishes and maintains a register of patients aged 18 years or over living with obesity, appropriately adjusted for ethnicity in line with NICE guidelines – either with a BMI ≥ 30 in the preceding 12 months, or a BMI greater than or equal to 27.5 kg/m ² recorded in the preceding 12 months for patients with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background
	The contractor establishes and maintains a register of patients: Aged 50 or over and who have not attained

OST004	the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis
PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age
AF001	The contractor establishes and maintains a register of patients with atrial fibrillation
AST005	The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months
AST008	The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either

	personal smoking status or exposure to second-hand smoke in the preceding 12 months
COPD014	The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥ 3 at any time in the preceding 12 months, with a subsequent record of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme)
COPD015	The contractor establishes and maintains a register of: patients with a clinical diagnosis of COPD before 1 April 2023 and patients with a clinical diagnosis of COPD on or after 1 April 2021 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before and 6 months after diagnosis (or if newly registered at the practice in

	the preceding 12 months a record of an FEV1/FVC ratio below 0.7 recorded within 6 months of registration) and patients with a clinical diagnosis of COPD on or after 1 April 2023 who are unable to undertake spirometry
RA001	The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months
QI modules	QI x 6

A Word version of this letter (<https://www.england.nhs.uk/wp-content/uploads/2025/02/PRN01866-letter-changes-to-the-gp-contract-in-2025-26.docx>) is available if you cannot read this table.

Annex C – CVD prevention indicators (2025/26 QOF points and thresholds)

-	-	2024/25 scheme			2025/26 scheme		
ID	Description	Lower threshold	Upper threshold	QOF points	Lower threshold	Upper threshold	QOF points
	Percentage of patients on the QOF Coronary Heart Disease (CHD), Perip						

CHO L003	heral Arteri al Dise ase (PAD) Strok e/ Tran sient Ischa emic Attac k (TIA) or Chro nic Kidn ey Dise ase (CK D) Regi ster who are curre ntly pres cribe	70%	95%	14	70%	95%	38
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	<p>d a statin , or wher e a statin is decli ned or clinic ally unsui table , anot her lipid- lower ing thera py</p>						
	<p>Perc enta ge of patie nts on the QOF Coro nary</p>						

Hear t Dise ase (CH D), Perip heral Arteri al Dise ase (PAD) , or Strok e/Tra nsien t Ischa emic Attac k (TIA) Regi ster, with the most rece nt chole stero l							
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CHO L004	measurement in the preceding 12 months, showing as ≤ 2.0 mmol/L if it was an LDL (Low-density Lipoprotein) cholesterol reading or ≤ 2.6	20%	35%	16	20%	50%	44
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	mmo I/L if it was a non- HDL (High - densi ty Lipo prote in) chole stero l readi ng. For multi ple readi ngs on the latest date the LDL readi ng takes							
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	priori ty.						
HYP 008	The perc enta ge of patie nts aged 79 year s or unde r with hype rtens ion in who m the last bloo d pres sure readi ng (mea sure d in the prec	40%	77%	14	40%	85%	38

	edin g 12 mont hs) is 140/ 90 mmH g or less (or equiv alent hom e bloo d pres sure readi ng)						
	The perc enta ge of patie nts aged 80 year s or over,						

HYP 009	with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent hom	40%	80%	5	40%	85%	14
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	e bloo d pres sure readi ng)						
	The perc enta ge of patie nts aged 79 year s or unde r, with a histo ry of strok e or TIA, in who m the last bloo						

STIA 014	d pres sure readi ng (mea sure d in the prec edin g 12 mont hs) is 140/ 90 mmH g or less (or equiv alent hom e bloo d pres sure readi ng)	40%	73%	3	40%	90%	8
	The						

STIA 015	percentage of patients aged 80 years or over, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the previous	46%	86%	2	46%	90%	6
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	edin g 12 mont hs) is 150/ 90 mmH g or less, (or equiv alent hom e bloo d pres sure readi ng)						
	The perc enta ge of patie nts aged 79 year s or unde r,						

CHD 015	with coro nary heart disea se, in who m the last bloo d pres sure readi ng (mea sure d in the prec edin g 12 mont hs) is 140/ 90 mmH g or less, (or equiv alent	40%	77%	12	40%	90%	33
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	home blood pressure reading)						
	The percentage of patients aged 80 years or over, with coronary heart disease, in whom the last blood pressure						

CHD 016	sure readi ng (mea sure d in the prec edin g 12 mont hs) is 150/ 90 mmH g or less, (or equiv alent hom e bloo d pres sure readi ng)	46%	86%	5	46%	90%	14
	The perc enta ge of						

DM0 36*	patients with diabetes, on the register, aged 79 years and under without moderate or severe frailty in whom the last blood pressure	38%	78%	10	38%	90%	27
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	reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)						
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* Note that DM036 replaces DM033, as set out in annex D (<https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/#annex-d-qof-technical-changes-highlighted-text-to-signify-wording-change>) below.

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Annex D – QOF technical changes

Highlighted text signifies a wording change.

Current ID	Current indicator	New ID	New indicator	Change and rationale
CHOL003	Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease	CHOL003	Percentage of patients on the QOF Coronary Heart Disease (CHD), Peripheral Arterial Disease (PAD), Stroke/Transient Ischaemic Attack (TIA) or Chronic	Removed icosapent ethyl from the other lipid lowering therapies cluster as only NICE

	Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy		Kidney Disease (CKD) Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy	recommended for use with, rather than instead of, a statin.
	Percentage of patients on the QOF Coronary Heart Disease (CHD), Peripheral Arterial		Percentage of patients on the QOF Coronary Heart Disease (CHD), Peripheral Arterial Disease (PAD), or Stroke/Tr	Technical change made to amend how the indicators measure cases where measures of both

CHOL004	Disease (PAD), or Stroke/ Transient Ischaemic Attack (TIA) Register, who have a recording of LDL (Low-density Lipoprotein) cholesterol in the preceding 12 months that is 2.0 mmol/L or lower or where LDL cholesterol is not recorded a recording of non-HDL	CHOL004	ancient Ischaemic Attack (TIA) Register, with the most recent cholesterol measurement in the preceding 12 months, showing as ≤ 2.0 mmol/L if it was an LDL (Low-density Lipoprotein) cholesterol reading or ≤ 2.6 mmol/L if it was a non-HDL (High-density	HDL and LDL are taken at different points in time. <u>NICE Indicator IND278: Cardiovascular disease prevention: cholesterol treatment target (secondary prevention).</u> <u>Indicators NICE</u> (https://www.nice.org.uk/indicators/ind278-cardiovascular-disease-prevention)
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	(High-density Lipoprotein) cholesterol in the preceding 12 months that is 2.6 mmol/L or lower.		Lipoprotein) cholesterol reading. For multiple readings on the latest date the LDL reading takes priority.	<u>n-cholesterol-treatment-target-secondarily-prevention</u>) (published 27 November 2024)
	The percentage of patients with diabetes aged 40 years and over, with no history of		The percentage of patients with diabetes, on the register, aged 40 years or over, with no history of CVD and without	Other lipid lowering therapy cluster added to align with updated NICE indicator on which QOF is based. <u>NICE Indicator IND275:</u>

<p>DM022</p>	<p>cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)</p>	<p>DM034</p>	<p>moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years), or where a statin is declined or clinically unsuitable, another lipid-lowering therapy.</p>	<p><u>Diabetes: lipid-lowering therapies for primary prevention of CVD (40 years and over) Indicators NICE (https://www.nice.org.uk/indicators/ind275-diabetes-lipid-lowering-therapies-for-primary-prevention-of-cvd-40-years-and-over) (published 27 November 2024)</u></p>

<p>DM023</p>	<p>The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin</p>	<p>DM035</p>	<p>The percentage of patients with diabetes, on the register and a history of CVD (excluding haemorrhagic stroke) who are currently treated with a statin, or where a statin is declined or clinically</p>	<p>Other lipid lowering therapy cluster added to align with updated NICE indicator on which QOF is based. NICE Indicator IND276: Diabetes: lipid-lowering therapies for secondary prevention of CVD Indicators NICE (https://www.nice.org.uk/indicators/ind276-lipid-lowering-therapies-for-secondary-prevention-of-CVD)</p>
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			unsuitable, another lipid-lowering therapy.	<u>diabetes-lipid-lowering-therapies-for-secondarily-prevention-of-cvd</u> (published 27 November 2024)
	The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the		The percentage of patients with diabetes, on the register, aged 79 years and under without moderate or severe	'79 years and under' age criteria added to align with updated NICE indicator on which QOF is based. <u>NICE Indicator IND249: Diabetes: blood pressure</u>

DM033	last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)):	DM036	frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	(<u>without moderate or severe frailty</u>). <u>Indicators</u> <u>NICE</u> (https://www.nice.org.uk/indicators/ind249-diabetes-blood-pressure-without-moderate-or-severe-frailty) (published 19 August 2023)
	The percentage of patients with a diagnosis of asthma on or after 1			

<p>AST011</p>	<p>April 2023 with either:</p> <ol style="list-style-type: none"> 1. A record of quality assured spirometry and one other objective test (FeNO or, bronchodilator reversibility or peak flow variability) between 3 months before and 6 months after diagnosis; or 2. If newly registered in the preceding 12 months 	<p>AST012</p>	<p>The percentage of patients with a new diagnosis of asthma on or after 1 April 2025 with a record of an</p>	<p>Removal of reliance on spirometry as main objective test to align with <u>NICE Guideline NG25 Asthma: diagnosis, monitoring and chronic asthma management</u></p>
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	with a diagnosis of asthma recorded on or after 1 April 2023 but no record of objective tests being performed at the date of registration, with a quality assured spirometry and one other objective test (FeNO or, bronchodilator reversibility or peak flow variability) recorded		objective test between 3 months before or 3 months after diagnosis.	<u>ent (BTS, NICE, SIGN). Guidance NICE (https://www.nice.org.uk/guidance/ng245)</u> (published 27 November 2024)
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	within 6 months of registration			
AST007	The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire	AST007	The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control, a recording of the	Removal of requirement to use a validated asthma control questionnaire to align with <u>NICE Guideline NG25 Asthma: diagnosis, monitoring and chronic asthma management (BTS, NICE, SIGN)</u>

	aire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan		number of exacerbations, an assessment of inhaler technique and a written personalised action plan.	<u>Guidance NICE</u> (https://www.nice.org.uk/guidance/ng245) (published 27 November 2024)
	Percentage of patients on the QOF Atrial Fibrillation register and with a CHA ₂ DS ₂ -VASc score of 2 or more who were prescribe		Percentage of patients on the QOF Atrial Fibrillation register and with a CHA ₂ DS ₂ -VASc score of 2 or more, who were prescribe	Invite PCA added in response to

AF008	d a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	AF008	d a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	feedback, to align with indicators of a similar type
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Annex E – programme changes to routine childhood schedule

Programme	Programme change effective from	Proposed changes outlining who practices will be required to offer and provide
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		vaccination to and when
Cessation of Hib/MenC 12- month dose	1 July 2025	<p>Children who turn 12 months on or before 30 June 2025 will remain eligible for Menitorix® until stock levels are depleted, then the infant should be offered a Hexavalent vaccine (to replace the 12-month Hib dose).</p> <p>Children who turn 12 months on or after 1 July 2025 will not be offered a 12-month Hib/MenC vaccine but instead will receive a routine Hexavalent dose at a new 18-month appointment.</p> <p>This change will start from 01</p>

		<p>January 2026 when the new 18-month visit will begin in the childhood vaccination schedule.</p> <p>DBS test recorded for Hep B at risk babies between 12 and 18 months.</p>
MMR programme schedule change and catch-up	1 January 2026	<p>Children turning 18 months on or after 01 January 2026 will receive their 2nd MMR dose at their new 18-month appointment.</p> <p>Children aged 18 months to 2 years 6 months on 01 January 2026 will be invited to a brought forward appointment for their 2nd MMR dose between 01 January 2026 and</p>

		<p>31 October 2026.</p> <p>Children aged 2 years and 7 months to 3 years 4 months on 01 January 2026 will receive their 2nd MMR dose at their existing scheduled 3 years 4 months appointment before 31 October 2026.</p>
		<p>Children turning 12 months on or after 01 January 2026 will receive two doses of MMRV (at 12 and 18 months).</p> <p>Children turning 18 months on or after 01 January 2026 will receive one dose of MMRV (to complete their two-dose MMR schedule).</p>

<p>Varicella introduction and catch-up (subject to final policy decision)</p>	<p>1 January 2026</p>	<p>Children aged 18 months to 3 years 4 months on 01 January 2026 will receive one dose of MMRV instead of their 2nd MMR dose. Of this cohort:</p> <ul style="list-style-type: none"> – those aged 18 months to 2 years 6 months will be invited to a brought forward appointment for their 2nd MMR dose (as MMRV) between 1 January 2026 and 31 October 2026 – those aged 2 years 7 months to 3 years 4 months on 1 January 2026 will receive their 2nd MMR dose (as MMRV) at their existing scheduled 3 years 4 months appointment before 31 October
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2026.

Children aged 3 years 4 months to less than 6 years will be invited for a universal single catch-up dose of MMRV.

Appointments to be scheduled from 1 January 2026 and completed by 31 March 2027.

Children aged 6 years to less than 11 years will be invited to receive a single dose of MMRV if they have no history of chicken pox.

Appointments to be scheduled from 1 January 2026 and completed by 31 March 2027.

From 1 April 2027, an opportunistic or on request offer will remain for

		varicella (as a single dose of MMRV) to all children aged 3 years 4 months to less than 11 years before 1 January 2026 who have no history of chicken pox.
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