306 Medical Centre

Minutes of PPG Meeting held on Thu 12 March 2026

Present: **Staff:** Mo Dawood (MD-PM), Patricia G (PG), Dr M Chawdhery (MC)
Patients: Tina Thorpe (TT), (KL), Kwame Ocloo (KO), Sandra Floy (SF), David Barlow (DB), Roger Beckett (RB) Khurshid Qureshi (KQ), Jacqueline Pick (JP), Clive Cockram (CC)
Online MS Teams:
Apologies: Richard Cooke (RC), Vajira Wignarajah (VW), Phillip Lipsidge (PL), Kathleen Lipsidge (KL), Alan Robertson (AR)

	Agenda Item	Timings
1	**Meet & Greet**	12.15 - 12.30
2	**Welcome & Introductions**	12.30 – 12.35
3	**Minutes of the last meeting and any matters arising** • The minutes of the last meeting (11 Dec 2025) were agreed with minor corrections. **Matters arising** • MD gave a brief update that letters planned, were sent to both Rt Hon Helen Hayes MP and Rt Hon, Ellie Reeves MP. Responses received from both. • Rt Hon, Ellie Reeves MP's office agreed to forward our concerns on. • We received what seemed like a generic response from Rt Hon. Stephen Kinnock MP (Minister of State of Care) regarding our concerns. • Rt Hon. Helen Hayes MP tentatively agreed to attend the next meeting, and Rt Hon Ellie Reeves will further consider our invitation. • Copies of correspondence shared.	12.35 - 12.45
4	**Practice Slot –** UK GP Contract changes which the BMA and General Practice Committee have urged for this to be rejected as unsafe and consider action to vote against the changes from 1 April 2026 **UK GP Contract 2026/27 – Key Points** **1. Funding uplift** • 3.6% cash uplift (≈ 1.4% real-terms growth). • Assumes ~2.5% pay uplift for staff. • ⚠️ Notably much smaller than 2025/26 uplift (~£969m / 7.2%). **Access and patient demand rules** **2. Same-day response for urgent problems** • Clinically urgent requests must receive same-day response. • GP practice decides what counts as urgent.	T

The response may include:

- Telephone assessment, advice, appointment, referral
- Not necessarily a face-to-face visit.

3. Practices cannot tell patients to "call back tomorrow"

- Explicit contractual requirement: Practices must not ask patients to call again another day to request care.
- Instead: Non-urgent requests must receive a response by the end of the next working day, explaining next steps.

4. Online consultation systems cannot cap requests

- Practices must not limit the number of online requests during core hours (8am–6:30pm).
- Purpose: Improve access, Reduce digital gatekeeping, Provide patient choice of contact method.

GP workforce and capacity

5. New GP reimbursement scheme

- Funds moved from PCN-level funding to practices.
- Supports: hiring additional GPs; increasing GP sessions.
- The aim is to improve same-day urgent access capacity.

6. Additional Roles Reimbursement Scheme (ARRS) scheme expanded and now allows:

- recruitment of experienced GPs (not just newly qualified)
- increased reimbursement levels.
- This gives Primary Care Networks more flexibility in workforce planning.

Quality and Outcomes Framework (QOF)

7. QOF changes and new indicators

- Additional 18 QOF points (~£25m) with new indicators.
- New or updated areas include childhood vaccinations; diabetes (all 8 NICE care processes); obesity management; heart failure treatment (four-pillar therapy).
- Also: Weight Management Enhanced Service removed.

8. New vaccination improvement thresholds

- Practices can earn QOF points through improvement from baseline, not just hitting national thresholds.
- Example: ≥5% improvement above baseline may earn points**.**

Data and performance monitoring

9. New practice-level access metrics

- NHS England will collect five demand/access indicators:
- Call waiting time (8–10am); Call waiting time during core hours
- % urgent cases seen same day; % non-urgent seen within 1 week; % non-urgent seen within 2 weeks
- This data may inform future policy or funding interventions.

Referrals and secondary care

- **10. Advice & Guidance (A&G) embedded into core contract**
- Funding for Advice and Guidance moved into core contract.
- GPs expected to use A&G before referral where appropriate.
- Purpose: reduce unnecessary outpatient referrals; improve specialist input earlier.

Pharmacy and communication changes

- **11. Mandatory pharmacy communication channel**
- Practices must maintain a dedicated monitored email address for communication with community pharmacies, especially when GP Connect is unavailable.

PCN and system changes

- **12. PCN responsibilities clarified**
- Network responsibilities clarified around: vaccinations, cancer screening, continuity of care, neighbourhood geography.

Overall policy direction

- The 2026 contract focuses on three themes:
- Improving access (urgent same-day response, no call-back systems)
- Increasing GP capacity (practice-level funding + ARRS flexibility)
- Prevention and population health (QOF changes).

However, critics note that much funding is repurposed rather than new; focus on same-day access may reduce continuity of care.

A general discussion on the pros and cons of the new contract took place. MD gave an overview of concerns generally:

- **New Contract main concerns:**

  We feel there are essentially two main issues. The first is the continued shift of unfunded work from secondary to primary care, and the second is the expectation that practices will absorb additional urgent demand without any real increase in resources.

  The DHSC's funding settlement for 26/27 was an increase in its revenue budget of 4.5% in cash terms (see here 3.26). The total increase in the GP contract is 3.6%, so less than the NHS as a whole is receiving. When you factor in the disproportionate impact of the 4.1% increase of the National Living Wage on general practice, on top of multiple years of below inflationary increases, it's not hard to see why the funding envelope feels unsatisfactory.

  The shift from secondary to primary is exemplified by the withdrawal of the Advice and Guidance DES and the new core requirement on practices to *"use Advice and Guidance prior to or in place of a planned care referral where clinically appropriate and to follow locally agreed referral pathways, including single point of access models once introduced"*.

  The GMC is concerned that this may mean removing the right to refer, a core principle of safe general practice. What is certain, however, is that this carries an expectation of more work previously carried out in secondary care now being carried out in general practice. The amount of this work, and the number of Advice and Guidance referrals, is expected to grow rapidly over the next few years. This also raises concerns on medicolegal concerns and may not be in line with Jess's Rule

  The funding, meanwhile, is a block payment that will not grow relative to the amount of activity. While the NHS strives to move hospitals away from block contracts, there appears to be the opposite move for general practice.
  The second problem is the new expectation on practices that all patients identified as clinically urgent will be dealt with on the same day. Practices must not ask patients to call back on another day. There must be no capping of online consultation systems. If a patient is identified as non-urgent then practices are required to provide an appropriate response by the end of the next core hours period.

  In other words, there are no options available for practices to turn off the tap. Whatever the demand that comes through, practices are now contractually obliged to deal with it. While there's no real uplift in resources, there's going to be a real uplift in workload, and in particular a shift in the time expectations within which this workload will need to be dealt with.

	These two issues are the heart of the problem with the contract the Government is imposing on general practice. The GPC, in our opinion, is right to reject the contract because of these issues. We'll find out if practices agree when the referendum that the GPC has started closes on 25th March. If they do, we may very well see a quick escalation of action by practices in response.	
5	**Open Session – PPG Members Slot & Updates** • TT asks about data collection on type of reasons for appts booked. MD said generally it's variable, with seasonal demand for cold and flu type symptoms in winter. Dr MC added that chronic disease management presentations, are usual and we have data for frequent or repeat attenders. • Some presentations are complex, as explained with examples.	MD
6	**AOB** • Accessibility standard initiative (RSD) – The NHS accessibility standard requires services to identify, record, share and meet communication needs, ensure digital platforms meet set standards and provide physically accessible environments under the Equality Act 2010. The practice must review cohorts of patients, code and flag records with patient consent to meet the requirements. • KO raised that it would be helpful if GPs to go through blood tests in detail, when kidney function or liver functions results are marginally out of range to help patients make any lifestyle changes. Dr MC advised clinicians will cover the most important aspects where the results are marginally out of range but usually not results that are normal. • TT mentioned that indemnity costs and challenges with student loans on healthcare staff. MD explained that crown indemnity gives protection to NHS staff. CC explained that in hospitals there is an expectation or safety net for clinicians to her their own personal cover, though costly but vital for protection where a dispute arises between a trust and a healthcare professional. GPs in general practice also have enhanced cover to for care that falls outside the NHS like travel vaccinations. • RB suggested that each member to prepare a question for Rt Hon. Helen Hayes MP when she visits. Decorum agreed and MD suggested to keep it relaxed, authentic and friendly.	13.00 – 13.15
	Date of next meeting agreed: 11 June 2026 at 12.30pm The meeting was brought to a close at 1.35pm	

Tentative 2026 Meeting dates for the diary: 11 Jun, 10 Sep, 10 Dec