EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE (GENERAL MEDICAL SERVICES CONTRACTS AND PERSONAL MEDICAL SERVICES AGREEMENTS) (AMENDMENT) REGULATIONS 2026

2026 No. 532

1. Introduction

1.1 This Explanatory Memorandum has been prepared by the Department of Health and Social Care (DHSC) and is laid before Parliament by Command of His Majesty.

2. Declaration

2.1 Stephen Kinnock, Minister of State at the Department of Health and Social Care, can confirm that this Explanatory Memorandum meets the required standard.

2.2 Claire Amal, Deputy Director for General Practice Policy at DHSC, can confirm that this Explanatory Memorandum meets the required standard.

3. Contact

3.1 Emily Ashford at the DHSC (email:generalpracticemailbox@dhsc.gov.uk; telephone: 020 7104 7200) can be contacted with any queries regarding the instrument.

Part One: Explanation, and context, of the Instrument

4. Overview of the Instrument

What does the legislation do?

4.1 This instrument amends the regulations underpinning the framework for General Medical Services ("GMS") contracts and Personal Medical Services ("PMS") agreements to implement changes to the terms required to be contained in those contracts and agreements.

4.2 This instrument amends the following Regulations relating to the provision of primary medical services in England (which are collectively referred to as "the Regulations"):

a) the National Health Service (General Medical Services Contracts) Regulations 2015 (S.I. 2015/1862) (the "GMS Contracts Regulations") which set out the framework for GMS contracts; and

b) the National Health Service (Personal Medical Services Agreements) Regulations 2015 (S.I. 2015/1879) (the "PMS Agreements Regulations"), which set out the framework for PMS agreements.

Where does the legislation extend to, and apply?

4.3 The extent of this instrument (that is, the jurisdiction(s) which the instrument forms part of the law of) is England and Wales.

4.4 The territorial application of this instrument (that is, where the instrument produces a practical effect) is England.

5. Policy Context

What is being done and why?

5.1 Every GP practice must hold a National Health Service (NHS) General Practice (GP) contract to run an NHS-commissioned general practice. The contract sets out mandatory requirements and services for all GP practices, as well as making provisions for several types of other services that practices may provide, if they so choose. There are three different types of GP contract arrangements in England: GMS, PMS and Alternative Provider Medical Services (APMS). These regulations relate to GMS contracts and PMS agreements only; the terms of APMS contracts are governed by separate directions, which will also be amended to come into force in line with these amendments. All types of GP contract arrangements are managed by NHS England (NHSE) or Integrated Care Boards (ICBs). The Statutory Instrument for these amendments refers to NHSE, as the statutory commissioner of GP contract arrangements. In practice, NHSE has delegated responsibility for managing these arrangements to ICBs under its statutory delegation powers. As a result, whilst the statutory amendments are made to duties that sit formally with NHSE, the day-to-day implementation and operational effect of these provisions will fall to ICBs by virtue of those delegation arrangements, which can be found at: https://www.england.nhs.uk/commissioning/publication/delegation-of-primary-medical-dental-ophthalmic-and-pharmaceutical-functions/. For clarity, the policy explanation therefore refers to ICBs where this reflects how the amended provisions will operate in practice for GP practices.

5.2 With the exception of the changes to Directed Enhanced Services, the amendments made by these Regulations are being made to implement policies announced in Changes to the GP Contract in 2026/27 (which was published by NHSE on 24 February 2026 and is available at: https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2026-27/).

Information relating to the Lung Cancer Screening Programme

5.3 This amendment is a new requirement for GMS contracts and PMS agreements to contain provision requiring practices to share the relevant patient cohort data with NHSE, or persons authorised by NHSE, that is reasonably required for the operation of the Lung Cancer Screening Pathway (LCSP).

5.4 The LCSP invites current and former smokers aged 55-74-years-old for a lung health check using GP data. Since 2019, the LCSP has been steadily rolling out across the country and is now available to over 40% of the population and this legislative change will mean that the programme is available to all eligible patients across England. In practice, most GP practices already share the data required for the LCSP. However, there is currently some variation in how data is shared for this purpose. This legislative change will ensure consistent, standardised data sharing across all practices so that all eligible patients can be identified. It is estimated that, after full rollout of this programme, an additional 6,578 lung cancers will be diagnosed each year; 75% of these cancers will be at an early stage, compared to 28.9% before the programme was introduced. Currently the LCSP Standard Protocol recommends, after the initial GP record query, that GP records should be queried at least every two years. This is to find any new participants that become eligible, either by aging into the programme cohort or moving into the GP practice.

Information relating to NHS staff surveys

5.5 This amendment is a new requirement for GMS contracts and PMS agreements to contain provision requiring practices to make available the information needed for NHS staff surveys within the timeframe specified by NHSE, to facilitate general practice staff to participate in the General Practice Staff Survey (GPSS). By this we mean that practices are required to share relevant staff email addresses which will be used to distribute individual survey links to eligible staff members. Completion of the survey is voluntary for individual members of staff.

5.6 The GPSS is a workforce survey and is strongly aligned to the NHS Staff Survey that has been conducted every year since 2003 and is a vital component in the NHS approach to employee listening. The GPSS is tailored to the environment of General Practice and is currently rolled out on a voluntary basis; 33 out of 42 ICBs opted to support access to the General Practice Staff Survey in 2025/26. This change will mandate that practices are involved in the survey and that all eligible staff receive the GPSS. This will help to provide a national and local picture of staff experience in General Practice, enabling practices and ICBs to understand workforce experience within their own organisations and identify where targeted improvements could support staff satisfaction, wellbeing and retention. Obtaining staff feedback, and taking account of their views, is vital for driving improvements in the NHS.

GP Registration

5.7 This amendment is a new requirement for GMS contracts and PMS agreements to contain provision requiring contractors to use the online registration system for all GP registration activity. Where patients present with a paper form, practices will now be required to enter this information directly into the online registration service rather than into their clinical system. Where the contractor's computerised clinical system does not facilitate interconnectivity with NHSE's online registration service, the practice may continue to enter the patient registration details directly into their clinical system.

5.8 The current system requires GP practices to use the online Register with a GP surgery service when registering online, introduced mandatorily in October 2024, but practices may still manually process paper forms using their clinical systems. This results in inconsistent processes and prevents full realisation of the efficiencies the digital system is designed to deliver. The legislation therefore aims to streamline and standardise registration, completing the shift to a fully digital registration process. Mandating that all registrations, whether initiated online or using paper, must be entered into the online system will reduce administrative burden, prevent duplicate data entry, and minimise errors.

Digital practice area map

5.9 This amendment requires changes to GMS contracts and PMS agreements to contain provision requiring contractors to seek approval from NHSE when making changes to their digital practice area map.

5.10 The Regulations currently contain provision for contracts to require practices to make available to NHSE a digital practice area map, which is a map reflecting the practice area. This requirement is being extended to require the digital practice area map to be approved by NHSE, to prevent discrepancies between the agreed practice area and the digital practice area map.

Patient Choice: Pharmaceutical Services

5.11 This amendment is a new requirement for GMS contracts and PMS agreements to contain provision mandating that, when a patient is prescribed a new prescription and already has a nominated dispenser, the practice must re-confirm with the patient as to their choice of dispenser. Further, where a patient needs help choosing a chemist, because they do not have a nominated dispenser, they ask for a recommendation, or the GP practice is referring them to a pharmacy service, the practice must signpost the patient to a full list of local NHS pharmacies that can provide the relevant services. This signposting duty is intended to support patient choice by directing patients to information made available by NHS England, which is typically presented on a geographical basis reflecting the area selected by the patient (for example, based on postcode or another chosen location, such as near a workplace), rather than as a single national list. Where a practice is discussing pharmaceutical options with the patient present, they may use the Directory of Services to identify appropriate local pharmacies and available services. Where the patient is not present, practices may instead signpost patients to the NHS website service finder, which enables patients to view pharmacies offering relevant services and see their distance from the patient's home postcode.

5.12 Patients have the right to choose any pharmacy for electronic prescriptions, but NHSE continues to receive reports of GP practices influencing this choice, either through direct recommendation, financial or familial links, or through online triage tools that only display subscribing pharmacies, resulting in restricted and sometimes misleading options for services such as Pharmacy First. Although current regulations prohibit GPs from directing choice, gaps remain as there is no requirement to reconfirm a patient's nominated pharmacy when issuing a new prescription, and no regulatory safeguards ensuring that referrals or digital tools offer a full list of eligible community pharmacies. The proposed amendments therefore aim to protect genuine patient choice by mandating reconfirmation of nominated pharmacies and requiring that all referrals present the complete set of pharmacies registered to provide the relevant service. These amendments are not intended to limit or discourage the valuable clinical conversations between GPs and patients, including situations where advising a patient of a particular chemist is clinically appropriate, for example due to stock availability or service issues. The changes are designed to be proportionate and not burdensome for practices; importantly, they do not require reconfirmation of nominated pharmacies for repeat prescriptions. These amendments are expected to standardise practice, reduce prescription direction, and strengthen patient autonomy, with minimal additional burden on practices.

Directory of Services

5.13 This amendment introduces a new requirement for GMS contracts and PMS agreements to contain provision requiring practices to record in the Directory of Services ("DoS" - the national directory of NHS services manged by NHSE which facilitates the clinical decision support system) an electronic mail address nominated for the purpose of communicating with health service providers clinical information relating to the practices' patients. This electronic mail address must be monitored by the practices at least once per day during core hours.

5.14 GP Connect Update Record is the primary mechanism for community pharmacies and other providers to send clinical information to practices. However, where GP Connect is not available or cannot be used for certain services, providers must rely on locally maintained email lists or telephone contact. As there is no single, authoritative national source of practice email addresses, these local lists are often incomplete or

outdated, which can lead to mis-directed or delayed clinical information and associated patient-safety risks. This has primarily been an issue for communication with community pharmacies. The policy objective is therefore to establish a reliable, standardised communication route for all health service providers to securely send clinical information needed to maintain accurate GP records. The legislation achieves this by requiring each GP practice to nominate an email address for two-way clinical communication, ensure it is recorded in the nationally managed DoS, and monitor it daily during core hours. Practices can continue to use existing practice mailboxes for this purpose, rather than requiring the creation of new email addresses, to minimise any additional burden on practices. This provides a consistent, dependable mechanism for transferring information, reduces the need for providers to maintain their own contact lists, and supports timely and accurate updates to patient records.

Co-operation with NHSE: performance management

5.15 This amendment introduces a new requirement for GMS contracts and PMS agreements to contain provision requiring practices to engage with support from ICBs where the ICB has identified areas of concern relating to practice performance and/or where the practice is at risk of contractual breach.

5.16 GP practices are currently required to collaborate with their ICB only when applying to close their patient list, but there is no equivalent obligation for practices to engage with support where the ICB has identified that the practice could benefit from support. ICBs use the assurance framework in the Primary Medical Services Policy and Guidance Manual, together with national tools such as the General Practice Annual Electronic Self-Declaration and the General Practice Dashboard, to identify where improvement support may be beneficial. The policy objective is therefore to ensure that, when performance concerns have been identified or a practice is at risk of contractual breach, practices must engage with their ICB to agree and act on appropriate support interventions. This requirement is intended to facilitate improvement and early resolution and is not designed to be punitive. The legislation achieves this by creating a new contractual requirement within the GMS and PMS Regulations for practices to engage with ICB support in these circumstances, separate from and in addition to the existing process for patient list closures. This change is expected to make ICB oversight more effective and targeted, enabling earlier action to address performance issues and improving service quality for patients.

Contact with the Practice

5.17 This amendment requires changes to GMS contracts and PMS agreements to contain provision mandating that practices cannot ask patients to call back on a different day. It also intends to clarify that where a request is clinically urgent (as determined by the clinical discretion of the GP) then it must be dealt with in the same period of core hours, or if the contact is made outside core hours, during the following core hours. Where the request is not deemed as clinically urgent by the practitioner, the practice is asked to deal with these requests by the end of the next working day.

5.18 Some GP practices continue to ask patients to call back on another day, resulting in access barriers, despite the 2023 policy intent that patients should not be asked to re-contact the practice later, as the Regulations specified appropriate responses. The objective of this proposal is to ensure that patients receive an appropriate response when they first contact the practice, that clinically urgent needs are managed on the same day during core hours, and routine requests may be handled by the end of the next working day. Currently, GMS contracts and PMS agreements require an "appropriate response", but do not explicitly prevent practices from instructing

patients to call back, nor do they clearly distinguish same-day action for clinically urgent needs, which this amendment now rectifies. These changes are expected to improve timely access, reduce unnecessary repeat contacts, and provide clearer, more consistent triage processes.

Sub-contracting of clinical matters and out of hours service

5.19 This amendment requires changes to PMS agreements to contain provision on sub-contracting of clinical matters, to align them with the requirements already included in the GMS contracts. In addition, a minor amendment is required to GMS contracts to include provision that contractors must seek approval before entering into a sub-contract.

5.20 Under current regulations, NHSE may object to GMS contractors sub-contracting clinical matters where patient safety would be put at serious risk, where NHSE may face material financial loss, or where a proposed sub-contractor would be unable to meet the contractor's obligations. PMS Regulations, however, do not provide equivalent provision, resulting in weaker safeguards and inconsistency between contract types. The policy objective is therefore to ensure parity across GMS contracts and PMS agreements so that NHSE can intervene where sub-contracting poses risks to patients or service delivery. The legislation achieves this by amending the PMS Regulations to replicate the existing GMS contract grounds for objection, aligning the frameworks governing sub-contracting of clinical matters. These changes are expected to strengthen NHSE oversight and ensure consistent protection for patients across all contract types, with limited risks given that this already operates effectively within GMS contracts.

Online consultation tool

5.21 This amendment introduces a new requirement that GMS contracts and PMS agreements contain provision mandating that GP practices must not cap the number of requests that can be submitted via their online consultation tool for registered patients.

5.22 Some GP practices currently cap the number of requests that can be submitted through their online consultation system during core hours, resulting in messages informing patients that capacity has been reached and preventing them from contacting the practice digitally once the cap is triggered. This forces patients to use alternative routes, such as calling or walking into the practice, contrary to the policy intent of the 2025 amendments to the Contract with the Practice requirements which intended to ensure parity between modes of access. The objective of this proposal is to ensure patients can make online requests throughout the full duration of core hours, preserving equitable access and preventing digital barriers to care. The legislation achieves this by introducing an explicit contractual requirement that online consultation systems must not limit the number of requests submitted during core hours. This change is expected to improve patient access, reduce pressure on telephony, and ensure online consultation systems function as intended. Evidence from the Health Insight Survey supports the continued importance of digital access: in March 2026, almost 79% of respondents reported that it was easy to contact their GP online or through an app.

Information to be included in practice leaflets

5.23 This amendment introduces a new requirement for GMS and PMS contracts to contain provision requiring practices to display the opening hours of the practice premises and all methods of obtaining access to services throughout core hours in the practice

leaflet. Under the existing regulations, contracts require practices to include the content of the practice leaflet on the practice website.

5.24 GP practices must already open during core hours and ensure patients can contact the practice during these times, but current requirements only oblige practices to publish their opening hours and the method of obtaining access in their website and leaflet. This change will explicitly require practices to update their patient leaflet, practice website and practice premises information on the opening time of all modes of access (walk-in, phone and online), which must be at least core hours. These changes are expected to increase patient awareness of available access routes, promote consistent communication across practices, and reduce confusion around how and when different access channels operate.

Collection of data relating to the use of the online consultation tool and video consultations

5.25 This amendment requires changes to GMS contracts and PMS agreements to contain provision that provides parity between the Cloud-Based Telephony (CBT) and online/video consultation (OC/VC) data provisions.

5.26 NHSE is required, under statutory directions made by the Secretary of State, to collect and analyse CBT and OC/VC data, and GP practices are obliged under the Health and Social Care Act 2012 to provide this information in the form and timeframe specified through Data Provision Notices. Existing regulations already require contracts to contain a provision for practices to share CBT and OC/VC data, but only the CBT provision includes explicit wording requiring practices to provide the information within a reasonable timeframe, resulting in inconsistent expectations and delays in OC/VC data flows. The legislation achieves this by amending GMS and PMS Regulations to replace the current wording with the established CBT formulation, requiring practices to supply OC/VC data within the reasonable timeframe specified by NHSE. The change is expected to strengthen the timeliness and consistency across both datasets so NHSE can effectively monitor activity, support system oversight and maintain alignment with the published OC/VC data specification.

Referral Pathways

5.27 This amendment introduces a new requirement for GMS and PMS contracts to contain provision requiring practices to comply with any referral pathways notified by NHSE, including using Advice and Guidance (A&G) where specified and clinically appropriate, in relation to a patient's referral for services under the National Health Service Act 2006, with "referral pathways" defined as arrangements set by NHSE (including locally determined procedures where applicable).

5.28 A&G has become an increasingly important part of partnership working between GPs and Consultant Specialists, but contractual requirements have not previously explicitly required its routine use in relation to a patient's planned care referral. The A&G Enhanced Service introduced in 2025/26 and taken up by over 99% of practices, demonstrated increased A&G activity, and from 2026/27 this will develop further with a phased rollout of a single point of access (SPoA) model to streamline referrals and A&G requests through consultant-led review. DHSC and NHSE are working closely with trusts, ICBs and practices regarding elective SPoA pathways, with GPs and GP leaders involved in the design and ongoing refinement of pathways to ensure they are clinically appropriate and supported through local GP leadership structures.

5.29 The objective of this proposal is to embed clear expectations for the use of A&G where clinically appropriate, and support adherence to locally agreed referral pathways, including SPoA arrangements where such pathways are in place, so that

patients receive timely consultant specialist assessment and management advice without needing a hospital outpatient appointment. The legislation achieves this by updating the GMS and PMS Regulations for contracts to require practices to use A&G in relation to a referral where clinically appropriate, and to adhere to locally agreed pathways. These changes are expected to strengthen integration between primary and secondary care, support timely decision-making and improve patient experience.

5.30 Parliamentarians have queried these changes in PQs and UQs. On 22 April, NHSE wrote to the profession with important clarifications on the changes. The purpose of Elective SPoA is to ensure patients and practices receive rapid specialist assessment and a clear next step, using modern referral and triage approaches. GPs should continue to make a clinical decision to refer for specialist care where that is in the patient's best interests, and to request specialist advice where it is needed. Under the specialist advice model, practices should expect timely responses to referrals and advice requests, with clear standards for turnaround times. Requests will receive senior, accountable specialist input, typically from a named consultant, ensuring appropriate oversight and continuity. Where there is clear clinical evidence, the intention is to avoid adding patients to outpatient waiting lists when they can receive timely diagnosis, advice or management in a more appropriate setting. There is no national target for specialists, trusts or general practice to divert a fixed proportion of referrals away from hospital care. The objective is simply to identify the most appropriate next step for each patient, based on specialist assessment and triage at speciality or sub-specialty level.

What was the previous policy, how is this different?

Information relating to the Lung Cancer Screening Programme

5.31 There are no previous provisions in the GMS and PMS regulations that explicitly require practices to facilitate the sharing of cohort data with the LCSP. The new provision will require practices, in their capacity as data controllers, to allow NHSE or authorised persons, to extract the data reasonably required for the LCSP. This change strengthens the policy framework by embedding clear, enforceable expectations on data provision to support timely identification and screening of eligible patients

Information relating to NHS staff surveys

5.32 There are no previous provisions in the GMS and PMS regulations to facilitate the GPSS. The GPSS has been rolled out, but only on a voluntary basis; this resulted in inconsistent uptake across ICBs and limited comparability with the NHS Staff Survey, where participation is mandatory for all trusts. The new provision now requires contracts to contain provision requiring GP practices to make available the information needed for NHS staff surveys within the timeframe specified by NHSE. In practice, this means providing staff emails to their local ICB to allow all eligible staff to receive the GPSS.

GP Registration

5.33 There are no previous provisions in the GMS and PMS regulations requiring practices to enter paper registrations into the online registration system. Practices have continued to process paper forms in their clinical systems. The new provision requires contracts to contain provision requiring all registration activity to be completed through the online registration service, including entering paper forms into the system, ensuring a single, standardised digital process and removing inconsistencies in how registrations are handled.

Digital practice area map

5.34 There is an existing provision in the GMS and PMS regulations requiring practices to submit a digital practice area map as part of their annual return, but practices have been able to amend this map without agreeing changes with their ICB. The amended provision will require contracts to contain provision requiring practices to ensure their digital practice area map is agreed with the ICB and matches the contractual practice boundary.

Patient Choice: Pharmaceutical Services

5.35 Previously, the regulations required contractual terms reflecting that GP practices must not to influence a patient's choice of nominated pharmacy and to provide a list of Electronic Prescription Service pharmacies if asked, but they did not prevent practices from referring patients to preferred pharmacies, nor from using triage tools that showed only a limited set of providers. Reports continued of practices directing patients, whether through recommendations, referrals or digital tools, towards a particular chemist - limiting genuine patient choice. The new provisions in the GMS and PMS regulations will require contracts to contain provision requiring practices to support full patient choice of pharmaceutical service. GPs must direct patients to the full list of chemists who can provide the relevant service if they are being referred for pharmaceutical services and/or they do not have a nominated dispenser, and they should re-confirm a patient's choice of chemist for each new prescription if they already have a nominated dispenser.

Directory of Services

5.36 The new provisions in the GMS and PMS regulations will require contracts to contain provision requiring practices to maintain, monitor and publish a dedicated generic email address for communications with health service providers and to ensure it is recorded in the DoS, establishing a consistent and reliable route for timely transfer of information between health service providers and practices. Previously, there was no requirement in the GMS and PMS Regulations to reflect that contracts must require GP practices to maintain a dedicated email address for communication with health service providers, meaning pharmacies relied on inconsistent or outdated contact details when GP Connect Update Record was unavailable, increasing the risk of mis-directed or delayed clinical information.

Co-operation with NHSE: performance management

5.37 Previously, GP practices were only required to engage with their ICB when applying to close their patient list, and ICB relied on guidance and local assurance processes to encourage practices to seek support where performance concerns arose. This reflected the earlier policy context in which engagement with ICB was expected but not enforceable, resulting in inconsistent engagement and limited ability to intervene early when practices were struggling. The new provisions in the GMS and PMS regulations requires contracts to contain provision requiring practices to engage with ICB support where performance concerns and/or risks of contractual breach are identified, ensuring that improvement activity takes place promptly and consistently and strengthening ICB's ability to secure better performance and patient outcomes.

Contact with the Practice

5.38 Previously, the regulations contained contractual requirements for practices to provide an "appropriate response" to requests during the day on which the core hours fell if received within core hours, and if a request was made outside core hours, practices were asked to provide a response during the following core hours. This amendment

introduces new provisions that require practices to provide a same-day response for clinically urgent issues, while allowing routine matters to be handled by the end of the next working day. Furthermore, the regulations did not explicitly prevent practices from asking patients to call back on another day prior to this change. This ambiguity meant that, despite the policy intent set in 2023, some practices continued directing patients to re-contact the practice later, leading to variability in access. This amendment introduces new provisions in the GMS and PMS regulations that make it clear that practices must not ask patients to call back on a different day. These changes strengthen and clarify expectations, ensuring patients receive timely and consistent responses across all practices.

Sub-contracting of clinical matters and out of hours service

5.39 Previously, the PMS Regulations did not give NHSE the same ability as under the GMS Regulations to object to sub-contracting arrangements where patient safety, financial risk or a sub-contractor's capability were in doubt. This meant NHSE had weaker safeguards over PMS sub-contracted clinical services. The amended provisions now align the PMS Regulations with the GMS framework by giving NHSE equivalent grounds to object to proposed sub-contracts, ensuring consistent protections across contract types and strengthening oversight where sub-contracting may pose risks to service quality or patient safety.

Online consultation tool

5.40 The new provisions in the GMS and PMS regulations make it explicit that GP practices must not place caps on the number of online consultation requests submitted during core hours, ensuring parity of digital access routes with walk in and phone access. Previously, although practices were required to keep online consultation systems switched on throughout core hours, some limited the volume of requests they accepted, meaning that patients were re-directed to telephone or in-person contact. This created inconsistency and reduced the effectiveness of online access. The updated provision closes this gap by ensuring online consultation tools remain fully available throughout the day, strengthening fairness, accessibility and the reliability of digital contact for patients.

Information to be included in practice leaflets

5.41 The new provisions in the GMS and PMS regulations introduce a requirement for contracts to contain provision requiring practices to display, both on their website and within practice premises, the opening hours of the practice and all methods of obtaining access to services throughout core hours. Practices must also include this information in the patient leaflet, which is already required to be reflected on the website. Previously, while practices had to publish opening hours and general access information, the requirement did not explicitly cover all modes of access. This amendment improves clarity and transparency by ensuring patients can easily see how to access services, whether by walking in, telephoning or using online routes, throughout core hours, strengthening the consistency and visibility of access information.

Collection of data relating to the use of the online consultation tool and video consultations

5.42 Previously, Government policy required GP practices to provide CBT and OC/VC data, but only the CBT requirement explicitly mandated that information be supplied within a reasonable timeframe. This reflected an earlier policy position in which timely provision was emphasised for CBT but not for OC/VC data, leading to inconsistent expectations and delayed OC/VC data flows. The amended provisions in

the GMS and PMS regulations now align the OC/VC requirement with the established CBT wording, ensuring both datasets must be provided within the timeframe specified by NHSE. This creates a consistent policy framework and strengthens the reliability and timeliness of data needed for oversight, system monitoring and improvement.

Referral Pathways

5.43 Previously, Government policy encouraged the use of A&G and locally agreed referral pathways but did not require GP practices to follow these pathways in relation to planned care referrals. This reflected an earlier position in which A&G usage was promoted through an Enhanced Service meaning it was explicitly incentivised and GPs were paid per use of A&G through the GP contract. This change embeds A&G contractually, removing the need for annual sign-up and treats A&G as routine clinical practice with predictable, recurrent funding. The amended provisions in the GMS and PMS regulations now require contracts to contain provision requiring practices to use A&G where clinically appropriate and to comply with locally agreed referral pathways, including future single-point-of-access arrangements. This shifts A&G from a voluntary, service-led expectation to a core contractual requirement, strengthening consistency in referral practice and supporting more efficient patient flows between primary and secondary care.

6. Legislative and Legal Context

How has the law changed?

6.1 Part 4 of the NHS Act 2006 requires NHSE to secure the provision of primary medical services in England. It makes provision for regulations to be made to govern the terms of contracts and arrangements under which primary medical services are provided. This instrument is being made to amend existing regulations to reflect the terms which will form part of the GP contract.

Why was this approach taken to change the law?

6.2 This is the only possible approach to make the necessary changes.

7. Consultation

Summary of consultation outcome and methodology

7.1 DHSC and NHSE has consulted multiple stakeholders on this instrument. These included: the England General Practitioners Committee (GPC England) of the British Medical Association (BMA), Royal College of General Practitioners (RCGP), Institute of General Practice Management (IGPM), National Association of Primary Care (NAPC), NHS Confederation (now NHS Alliance following its merger with NHS Providers), Healthwatch England and National Voices. Drafts of the proposed amendments were shared with the GPC England - as the representative body of the profession - for consultation. GPC England raised several points for clarification. These included concerns about the practical application of the requirement to reconfirm a patient's nominated pharmacy, queries as to whether certain information-sharing requirements would be more appropriately delivered through data directions, and requests for clarity on the scope of data to be shared for NHS staff surveys and the operational impact of changes to GP registration requirements. GPC England also expressed concerns about the drafting of the referral pathways provisions, including the need for pathways to be developed through established NHS England processes with appropriate engagement of local representative structures.

7.2 In response, DHSC and NHS England clarified that the obligation to reconfirm a nominated pharmacy applies at the point a prescription is first issued and does not re-apply to subsequent repeats; that the amendments relating to online consultation data are intended to align and strengthen existing contractual requirements rather than introduce new data directions; that the contractual approach to information sharing supports consistent participation in the LCSP; that staff survey participation remains voluntary; and that changes to GP registration are intended to streamline and standardise processes rather than increase administrative burden. It was further confirmed that referral pathway requirements apply only where clinically appropriate, do not override clinical judgement, and sit within established NHS England processes for pathway development, which involve engagement with local clinicians and representative structures.

8. Applicable Guidance

8.1 NHSE have issued guidance to support the implementation of the Regulatory amendments:

- NHS England » Advice and guidance – operational delivery framework for integrated care boards for 2025/26 https://www.england.nhs.uk/publication/advice-and-guidance-operational-delivery-framework-for-integrated-care-boards/
- Recording same day appointments for all clinically urgent patients https://www.england.nhs.uk/long-read/recording-same-day-appointments-for-all-clinically-urgent-patients/
- https://www.england.nhs.uk/long-read/online-consultation-tools/

Part Two: Impact and the Better Regulation Framework

9. Impact Assessment

9.1 We were not required to complete a full impact assessment as it is considered that this legislation does not meet the requirements for an Impact Assessment under the Better Regulation Framework, where they are required for all regulations where impacts are greater than ± £10 million Equivalent Annual Net Direct Cost to Business (EANDCB). Further, primary care contractors are outside of the scope of "business" for the purpose of "business activities" under the Framework. This is due to the exemption relating to businesses acting on behalf of a public authority when carrying out its activities. We consider that this captures GPs providing NHS services. DHSC have completed an impact assessment for our internal records, as is usual practice, where we considered the effects on staff and patients, and across all protected characteristics.

Impact on businesses, charities and voluntary bodies

9.2 There is no, or no significant, impact on business, charities or voluntary bodies because, as outlined in 9.1, primary care contractors are outside the scope of "business".

9.3 The legislation does not impact small or micro businesses.

9.4 There is no, or no significant, impact on the public sector.

10. Monitoring and review

What is the approach to monitoring and reviewing this legislation?

10.1 NHSE (on behalf of the Secretary of State for Health and Social Care) are responsible for monitoring the implementation of, and compliance with, this instrument. However, the Secretary of State is ultimately responsible for this instrument and the policies it implements.

10.2 The instrument does not include a statutory review clause.

Part Three: Statements and Matters of Particular Interest to Parliament

11. Matters of special interest to Parliament

11.1 None.

12. European Convention on Human Rights

12.1 As the instrument is subject to negative procedure and does not amend primary legislation, no statement is required.

13. The Relevant European Union Acts

13.1 This instrument is not made under the European Union (Withdrawal) Act 2018, the European Union (Future Relationship) Act 2020 or the Retained EU Law (Revocation and Reform) Act 2023 ("relevant European Union Acts").