NHS England Introduces New £126 Proactive Care Payment for PCNs

Updated Network Contract DES creates an immediate winter opportunity for Primary Care Networks and GP practices

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£126 PER ELIGIBLE UNIQUE PATIENT

Manual monthly PCN claims through CQRS National, supported by the required SNOMED coding and evidence.

NHS England has updated the 2026/27 Network Contract DES, introducing additional funding for Primary Care Networks to deliver proactive, personalised care to patients at greatest risk of avoidable hospital admission this winter.

The new arrangement provides £126 per eligible patient where a qualifying Proactive Care Plan is developed and implemented, subject to the PCN's overall Proactive Care Allocation.

For PCNs and member practices, the key operational point is that payment will not happen automatically. Practices must identify appropriate patients, undertake and evidence the required proactive care, apply the correct SNOMED codes, and ensure that the PCN submits monthly manual claims through CQRS National.

What has changed?

The updated Network Contract DES requires PCNs to use appropriate risk-stratification approaches to identify patients at greatest risk of avoidable hospital admission. Potential cohorts include patients with:

- moderate or severe frailty;
- COPD;
- other severe respiratory disease;
- heart failure; and
- other conditions or circumstances where the PCN identifies a high risk of avoidable hospital admission.

For 0.5% of PCN patients identified as being at greatest risk, the PCN should undertake a proactive, holistic assessment of need and, following engagement with the patient, develop and implement a personalised Proactive Care Plan.

The plan should reflect the patient's individual needs, circumstances and preferences and identify interventions intended to support earlier intervention, improve coordination of care and reduce the likelihood of avoidable hospital admission.

How the payment works

PCNs can receive £126 for each eligible unique patient for whom the required Proactive Care Plan has been developed and implemented. Overall funding is capped by the PCN's Proactive Care Allocation, calculated using 0.5% of the PCN Adjusted Population as at 1 July 2026.

Worked example: PCN population	50,000
Indicative cohort at 0.5%	**250 patients**
Payment per eligible patient	**£126**
Indicative maximum activity value	**£31,500**

PCNs should confirm their actual Proactive Care Allocation before relying on indicative calculations.

Mandatory SNOMED coding

To support payment, qualifying activity must be recorded using both of the specified SNOMED codes:

SNOMED code	Required record entry
1239461000000102	Proactive care needs assessment (procedure)
802321000000106	Care plan agreed (finding)

The Care plan agreed code must be recorded within two working days of the proactive care needs assessment. This is a significant payment risk: clinically appropriate work may fail the scheme requirements if either code is absent or the second code is recorded outside the required timeframe.

Eligible activity and claims

- Eligible activity period: 1 October 2026 to 31 March 2027.
- Only one claim can be made for each individual PCN patient.
- The PCN must submit a manual claim through CQRS National.
- Claims should be submitted monthly and within 12 days of the end of the month in which the activity was delivered.
- Practices should review qualifying activity already completed since 1 October 2026.

Retrospective coding should only be undertaken where the contemporaneous clinical record demonstrates that the specified assessment, patient engagement, care planning and interventions genuinely occurred.

What might proactive care include?

Interventions should be personalised according to each patient's risks and needs. Depending on clinical need, activity may include:

- medication review and medicines optimisation;
- respiratory, COPD or heart failure review;
- inhaler technique and adherence support;
- frailty, falls-risk or home assessment;
- vaccination review;
- anticipatory care and escalation planning;
- social prescribing, community nursing or clinical pharmacy input;
- care-coordinator follow-up; and
- referral into appropriate community or neighbourhood services.

Evidence and post-payment verification

Commissioners may undertake post-payment verification and request Proactive Care Plans, evidence that identified interventions were completed, information supporting patient eligibility, and outputs from clinical-system searches used to identify patients.

PCNs should establish a clear audit trail before monthly claims begin. A controlled tracker should include the practice, patient identifier, assessment date, both SNOMED codes and coding dates, interventions, evidence status, claim month and duplicate-check status.

Recommended actions for PCNs and practices

1. **Confirm the funding envelope:** Obtain the PCN's Proactive Care Allocation and maximum funded patient number.
2. **Agree delivery across member practices:** Determine how the cohort will be distributed and set clear clinical, administrative and PCN-level responsibilities.
3. **Run risk-stratification searches:** Identify patients at greatest risk using clinical tools and professional judgement.
4. **Review activity from 1 October 2026:** Check whether qualifying assessments and care plans have already been completed and evidenced.
5. **Standardise templates and coding:** Include both mandatory SNOMED codes and make the two-working-day requirement highly visible.
6. **Adopt a consistent workflow:** Use: Identify > Assess > Engage > Agree Care Plan > Deliver or arrange interventions > Code > Validate > Claim.
7. **Validate monthly activity:** Check eligibility, coding, timing, intervention evidence and duplicate status before submission.
8. **Assign CQRS responsibility:** Nominate a PCN lead to consolidate returns and submit the manual monthly claim within 12 days of month end.

Avoiding double funding

Patients receiving proactive care through another funded arrangement are not automatically excluded. However, interventions claimed under this scheme must be additional to activity funded elsewhere. PCNs should flag these patients separately and seek commissioner clarification where eligibility is uncertain.

Our view

The new proactive care funding is welcome in principle. Supporting vulnerable patients to remain well at home, strengthening anticipatory care and reducing avoidable hospital admissions are aims that General Practice and PCNs will recognise as clinically important.

However, the announcement needs to be considered alongside the wider financial position of practices. There is a legitimate concern that time-limited, activity-based funding may not represent a genuine increase in overall investment if it coincides with reductions in core practice income. Core funding supports the fixed costs of delivering General Practice, including staffing, premises, clinical systems and day-to-day access. Replacing dependable core income with a short-term scheme that carries additional assessment, care-planning, coding, evidence and claiming requirements risks asking practices to undertake more work for a similar overall level of funding.

This distinction matters. A practice cannot readily reduce its workforce, premises costs or existing workload for four months and then rebuild capacity when a temporary scheme ends. Practices with limited headroom may also be unable to release the clinical and administrative capacity needed to deliver the new activity, meaning that some of the practices under greatest operational pressure could be least able to benefit. At PCN level, the £126 payment must therefore be assessed against the full cost of identifying patients, completing holistic assessments, agreeing and implementing care plans, coordinating interventions, applying the required SNOMED codes, validating evidence and submitting monthly manual CQRS claims.

The wider lesson is particularly relevant as neighbourhood working develops. Neighbourhood models will depend on resilient GP practices with sufficient core capacity to participate, lead clinical pathways and coordinate care. New collaborative services will not be sustainable if the underlying practices are financially or operationally weakened. Proactive care and additional investment are positive, but they should supplement stable core funding rather than substitute for it.

PCNs and practices should therefore treat the scheme as both a clinical opportunity and a business decision. Before committing delivery capacity, they should confirm the actual allocation, model the end-to-end cost of delivery, agree how funding and workload will be distributed, and assess whether participation can be achieved without destabilising essential services. A transparent local approach will help ensure that the programme delivers additional patient benefit rather than simply transferring further work and financial risk into already stretched practices.

HOW RM PRIMARY CARE CONSULTANCY CAN HELP

Practical support for General Practice, Primary Care Networks and neighbourhood working

- PCN implementation and mobilisation plans
- practice action plans and readiness reviews
- clinical coding and evidence protocols
- patient cohort and recall methodology
- CQRS claim assurance processes
- audit, governance and management dashboards

Richard McLeod | RM Primary Care Consultancy

Sources

NHS England: Network Contract DES Contract Specification 2026/27 (updated 9 November 2026)

National Health Executive: £40m GP Support Programme Aims to Keep 300,000 Vulnerable Patients Out of Hospital This Winter