

Focus On: Welsh GP Contract 2021/22

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Introduction

Welsh Government, NHS Wales and GPC Wales have agreed the Welsh GP contract for 2021/2022.

During this protracted period of negotiations, we have fought hard to ensure the best deal possible for GPs in Wales.

We are pleased that hard-working practice staff are finally able to receive a pay uplift, however, we have stated throughout negotiations that it is inappropriate to link the DDRB's recommended pay award to wider contractual change. This is a clear point of principle for us as an Association and we are deeply frustrated that the Welsh Government has taken this approach.

Subsequent to the completion of formal negotiations a GMS Contract Implementation Group was established to take forward the agreed negotiation outcomes and facilitate their implementation into the GMS contract. This group has now concluded its work.

The group included representatives from the Welsh Government, GPC Wales, NHS Wales, the NHS Wales Shared Service Partnership, Digital Health and Care Wales and Practice Managers.

Work is ongoing in Welsh Government to develop a webpage specifically for resources relating to the GMS Contract including the statement of financial entitlement, guidance and relevant directions. Relevant contractual guidance has been hosted on the [Welsh Government site](#) in the interim, and links feature within this document. Additionally, documents are hosted on the BMA website¹ and also the Primary Care portal under the resources section.

¹ <https://www.bma.org.uk/pay-and-contracts/contracts/gp-contract/gp-contract-wales-202122>



1. Key changes

a) Financial

The following funding arrangements having been reached for 2021-22:

- DDRB pay uplift of 3% for independent contractor GPs and salaried GPs
- An uplift of 3% to the Staff pay expenses element of the contract to ensure that 'all existing practice staff receive a 3% uplift to their gross pay'
- GP uplift at 3% equates to £4.7m. Staff pay at 3% equates to £4.8m.
- Continued Investment of £9.2 million for the implementation of the 'Access to In-hours GP Services' standards.
- An in-year investment of up to £2 million towards Capacity funding. Recognising the winter pressures that are being experienced across the system and GPC's concerns around capacity, £2m will be made available in year for 2021-22 for capacity to support access over the remaining period of this year and in readiness for the new arrangements from 1 April 2022.
- A new funded Partnership Premium Scheme for non-GP partners will be introduced. No changes to Seniority and no uplift of Partnership Premium rates.
- Enhanced Shared Parental leave arrangements will be enabled for all salaried GPs in Wales. The SFE will be extended to enable the reimbursement of costs, up to an agreed limit, where Independent Prescribers are providing cover for GPs on parental leave.

Historically, uplifts to the global sum have been applied using the average EER (expenses to earnings ratio) calculated from NHS Digital average GP earnings estimates. In recent years the adopted ratio has been GP pay at 40% and practice expenses (including staff costs) at 60% of the contract value.

However, the EER has gradually increased over last 10 years, away from this traditional split. Using most recent Technical Steering Committee (TSC) evidence the uplift has been calculated in a ratio of 36.6/63.4.

The staffing expenses element of the TSC figures is the total gross cost of staff pay. Therefore, the 3% uplift to the quantum includes an uplift covering the employers on-cost contributions.

Without a 'ring-fenced' staff pay award uplift, any pay increase given to staff would be funded from the DDRB uplift. This means that GP partners would not see any pay increase as the DDRB intended.

With these elements considered, the new Global Sum payments will be made at a value of £98.51 per weighted patient and backdated to 1 April 2021 (in comparison to £95.65 for 2020/21.)

The SFE amendment directions came into force as of 30 March 2022 and are available here: gov.wales/sites/default/files/publications/2022-03/directions-to-local-health-boards-as-to-the-statement-of-financial-entitlements-amendment-directions-2022.pdf

b) Non-financial changes

Coupled with the financial changes, we have reached agreement on a number of activities as part of the reformed contract. The changes this year include:

- A renewed focus on the role of clusters, working collaboratively to plan and deliver services locally. GP cluster networks will be redefined as GP Collaboratives. Practices are now automatically members of a GP collaborative through the terms of the core contract.
- The cluster domain in QAIF will be revised. Points in QAIF domains have been redistributed. However, the total points will remain at 510, which will each continue to be paid at £179 per point.
- The QI domain structure will be restructured and expanded to include projects to improve standardised data quality.
- Reactivation of inactive QAIF clinical indicators.
- Data Legislative reform to de-risk GP - Contractual and legislative change needed to underpin data sharing for creation of NDR, particularly if pseudonymised patient-linked data is desired. Otherwise, personal risk sits with GP.
- Protected Learning time - Six funded protected learning time sessions per annum will be made available and targeted at all staff within the practice.
- Funding of ongoing training to upskill practice staff as care navigators via HEIW.
- GPC Wales has agreed to engage with national developments in the 'Prevention Agenda' to focus on GMS response to prevention of obesity and pre-diabetes.
- GPCW will work jointly with colleagues in NHS Wales and Welsh Government to explore and establish the GMS role in supporting the wider system and patients, particularly GMS role in referrals management plus GMS input into national pathway development.

2. Quality Assurance and Improvement Framework – QAIF

The Quality Assurance and Improvement Framework (QAIF) has been evolved and modified.

An updated [Quality Assurance and Improvement Framework Guidance for the GMS Contract Wales](#) has been published by Welsh Government, concerning the detailed changes to the various domains within QAIF.

The QAIF will still consist of three domains, remunerated via a points system. There is a total of 510 pts for the two core QAIF domains, together with 200 pts for Access. The indicator points for clinical disease registers & Atrial Fibrillation were previously moved into core working & Global Sum in the 2019/20 agreement.

According to the revised SFE effective from 30 March 2022, QAIF points now have a value of **£184.²**.

The three domains of QAIF are described below:

- a) Quality Assurance – Active Clinical Indicators – 125pts
- b) GP Collaborative – 100 pts
- c) Quality Improvement- QI Projects & Cluster - 285 pts

The annual QAIF cycle for the Quality Assurance and Quality Improvement domains is **1st October to 30th September**.

The practice achievement payment for QA and QI is to be calculated in accordance with the provisions set out in the Statement of Financial Entitlement (SFE), adjusted by the practice registered patient list against the average practice registered patient list for Wales, taken at 1 July, and rebased each subsequent year.

This achievement payment will be made at quarter end following the QAIF cycle i.e. December 31st.

The average practice list size as of 1st July 2021 was 8248. This figure is rising and expected to continue to rise, with practice closures and mergers continuing to decrease the denominator.

² As described at p2 of the [SFE Amending Directions](#), on and from 1 October 2021, the value of a QAIF point for QA and QI is recalculated each year after the NARP has been established and will apply to the current QAIF (QA and QI) year for QA and QI.

a) Quality Assurance Clinical Domain

Clinical QAIF domains will be reactivated for the 2021/22 QAIF cycle (October 2021 to September 22).

Our aim, in line with views from recent BMA Surveys, is that remaining QA indicators and funding resource are be transferred into the core contract with appropriate assurance mechanisms.

This was impossible to deliver in this contract round. While Health Boards and Welsh Government agreed this with direction of travel for the unified contract, due to concerns over the (what we consider flawed) data during the pandemic plus limited legislative time, for 21-22 they wish to see assurance by:

- Continuation of active clinical indicators (flu at 20pts and dementia at28pts)
- Re-activation of inactive clinical indicators including Diabetes, COPD, MH and Palliative Care (77 points).

GPCW expressed concern that reactivation of clinical QAIF would be unpopular with the GP profession and will continue to negotiate for the withdrawal of clinical QAIF measures through ongoing Unified Contract discussions.

Given the blood bottle shortages of late 2021 and protracted nature of discussions this year, it is our view that a proportionate reduction in the thresholds should be implemented for certain indicators. We have raised this with Welsh Government and will update this document in due course subject to the outcome.

b) GP Collaborative Domain

In line with the wider strategic context and work to accelerate cluster development with clearly defined and separated functions, GP cluster networks will be redefined as GP Collaboratives. [Full guidance on GP collaboratives has been published.](#)

All practices will be mandated, via the core contract, to be members of a GP Collaborative.

GP Collaboratives **will not** place any legal or contractual requirement on practices to take on responsibility for contracts held by other practices within the collaborative. These arrangements in no way alter or replace the role of the statutory negotiating committees and the duty for Health Boards to consult with those bodies.

The existing cluster domain will be revised as follows:

Redefined Cluster Domain – to be called GP Collaborative domain	Points
CND014W – The GP Collaborative will meet on a minimum of 4 occasions during the year; the timing of meetings should be agreed around the planning of	

<p>the HB and Cluster Planning Group ideally, to avoid the period of winter pressure.</p> <p>In addition, a lead from the GP collaborative will engage and work with other collaborative leads to inform the Pan Cluster Planning Group, via lead representatives identified by the Health Board and Pan Cluster Planning Group.</p>	40
<p>CND015W Contribute relevant information to the Primary Care Cluster IMTP via the Cluster Planning Group.</p> <p>The contribution must include information on demand and capacity planning undertaken via the QI domain.</p> <p>Practices will need to demonstrate how they have engaged in planning & delivery of local services agreed within the cluster plan – This will need to include evidence of wide partnership/ multi-professional / multi-agency working and development of integrated services.</p>	40
<p>CND016W Delivering specific cluster determined outcomes which includes: -</p> <p>Engagement in planning of local initiatives through engagement with the Cluster Planning Group and via the Collaborative Lead. (E.g., contribution to population needs assessment).</p>	20
Total	100

c) Quality Improvement Domain

The QI domain will be revised, for the 2021-22 QAIF cycle, with 100 points in total transferred from the previous cluster domain (20 to the Project Basket and 80 to new QI Collaborative Domain).

Project	Points Value
Data & Patient Safety QI Domain	
Mandatory Project 1 – Activity/Appointment Data	70 points
Mandatory Project 2 – Patient Safety Clinical Data	35 points
Legacy Project	
Patient Medicines Safety Project from previous QI Basket	30points
QI Basket	(For 2021-22 cycle - up to a maximum of 70 points)
<ul style="list-style-type: none"> • Previous Basket Choices (project not previously done) <p style="text-align: center;"><i>or</i></p> <ul style="list-style-type: none"> • Collaborative freestyle project in agreement with Health Board <p style="text-align: center;"><i>And</i></p> <ul style="list-style-type: none"> • Green Inhaler project 	70 Points
	35 points
	35 points
TOTAL POINTS	205 Points
Quality Improvement – GP Collaborative	
<ul style="list-style-type: none"> • Demand and Capacity 	40 points
<ul style="list-style-type: none"> • Completion of CGSAT and IG Toolkit 	40 points
TOTAL POINTS	80 Points

i. Data & Patient Safety QI Domain

Two new one-off patient safety and data projects will be introduced this year, replacing the Covid-19 Learning Project and the previously mandatory Patient Safety project, both of which will be retired.

These projects will be a mandatory within the QAIF framework for all practices this year with 105 points:

- 70 Points – Mandatory Project 1 Activity/Appointment data.
- 35 Points – Mandatory Project 2 Patient Safety Clinical Data.

These projects will be a one-year addition to the QI basket for the 21/22 cycle but with a clear expectation that all practices will complete these projects within the QAIF framework. GPC Wales publicly support and encourage all practices to participate in these initiatives.

To highlight the priority of the Activity/Appointment data and Patient Safety Clinical Data projects these have been designated as '*Mandatory*'.

These QI projects sit within QAIF, which itself is optional. However, to be able to claim any points for achievement of projects in the QI projects sub domain, the practice must complete the '*mandatory*' data and patient safety projects.

Mandatory Project 1 - Activity/Appointment Data

Activity in General Practice has been traditionally very difficult to accurately capture and reflect. This leaves Welsh Government and LHBs with minimal data or evidence of pressure on GMS contractors and is in stark contrast to source data available freely on WAST utilisation, ED attendance and Hospital admission. Trends cannot be monitored and interventions to increase capacity cannot be assessed for efficacy. There is a glaring gap in understanding real time activity and pressure on GMS as a result, with effectively only the WNWRS and self-reporting of GMS escalation status offering some insight into staffing and pressures.

Methods to capture GMS contractors recorded activity have traditionally relied on data recorded on appointment systems. Whilst these are valuable data, there are significant data quality issues in relying on homogeneous use of appointment books by nearly 400 independent GMS practices using two different clinical systems.

Without significant data quality improvements, this cannot truly reflect the breadth and complexity of GMS activity undertaken each day in General Practice and are clearly an under-representation of the activity and workload in Primary Care. Likewise, this method of data capture ignores a wave of hidden workload undertaken in GMS which cannot be captured by measuring appointments alone. It is widely estimated that this non-appointment work amounts to around a third of all work in general practice.

Non-GMS work is also a substantial extra workload that would not be captured in this data gathering exercise. It is nevertheless extremely important given its value to patients and is largely work that cannot be delivered elsewhere and also requires access to the full patient record.

This one-year QI project aims to:

1. Improve the validity of appointment book data which is already collected and analysed for purposes of tracking GMS activity by 'mapping' appointment slots to agreed categories.
2. Undertake regular data collection for those areas of activity not captured by appointment book data collection (prescribing, referral, results management, E-requests, administrative requests etc.) via pre-designed searches and audits, if not centrally collected by Audit+, with upload to the Primary Care Information Portal for collation and discussion.
3. Share the activity recorded at cluster level with partners and share/consider collaborative measures for managing demand and standardising good practice where applicable.

This data project is an important step in quantifying more accurately the volume and diversity of activity undertaken in GMS practices and clusters. It is expected that this data quality exercise will embed the accurate collection, discussion, and publication of activity data in primary care and that automated data collection methods will be developed and utilised at the fruition of this data quality project.

This should ensure that the Welsh NHS is better placed to assess the activity undertaken and support the needs of GMS and Primary Care in the coming year and extending into the future. The details of the implementation of this project are laid out in the QAIF guidance. Standardised data sets will be available to practices from March 2022 and the PCIP portal is being adapted to hold practice data and will be available for practices to start populating in April 2022.

Mandatory Project 2 – Patient Safety Clinical data

A standardised approach to coding will improve the ability to complete effective searches and audits of clinical encounters and ensure that all staff (including locums) are able to record their encounters in a consistent way.

The clinical areas of focus for this QI project are:

1. Sick Child
2. Suspected Deep Vein Thrombosis
3. Acute Mental Distress

The aim of this one-year QI project is to:

1. Standardise clinical coding within GP clinical systems.
2. Ensure properly coded consultation data is available to be shared across WGPR
3. Highlight the importance of accuracy and completeness in clinical recording.
4. Drive improvement in clinician adherence to standardised coding as best practice, promoting the avoidance of free text where suitable coding exists.
5. Promote an understanding of the whole system patient safety benefit of standardised coding for clinical data.

Further detailed guidance will then be made available to practices by end March 2022.

ii. Legacy Project

The 2020-21 Patient Safety QI project – Reducing medicines related harm, has been retained in the 2021-22 QI bundle, allowing a re-run for one further QI cycle in order to allow embedded learning of governance changes made within the practice and after conversations within the GP collaborative arena.

iii. Practice Choice QI project

The practice has a choice of selecting a 70-point QI basket project not previously undertaken (Reducing stroke, ceilings of care, urinary tract infection) **or** a collaborative freestyle mini project in agreement with Health Board (35 points) **and** the Green Inhaler mini project (35 points).

iv. Green Inhaler Project

The aim of the project is to reduce the carbon footprint of inhaler prescribing, in line with some specific objectives:

1. Optimise asthma and COPD care
2. Use dry powder inhalers or soft mist inhalers as first-line treatment options where clinically appropriate
3. If metered dose inhalers are needed, then chose a brand and dosage regime with care to minimise carbon footprint.

The following All Wales prescribing guidelines have been ratified and endorsed by AWMSG and should be considered when making decisions with patients

- [All Wales adult asthma management and prescribing guideline](#)
- [All Wales COPD management and prescribing guideline](#)

The contractor will need to complete a QI template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended and discussed the QI project in a GP collaborative meeting.

v. Freestyle QI project

In addition to the Green inhaler project, collaboratives may wish to design their own QI project. In doing so, we would remind them to be cognisant that this is valued at 35 points and thus would be expected to be a mini project when compared with the original basket of QI projects that were worth 70 pt. the expected workload of the project should reasonably reflect this difference.

vi. New GP Collaborative QI aspect to the QI domain

These indicators have been transferred from the previous 'cluster' domain.

<p>Demand and Capacity – to be evidenced in the Collaborative IMTP.</p> <p>The below should be taken into consideration;</p> <ul style="list-style-type: none"> • A population needs assessment • An analysis of current services available to the collaborative population and identifying any gaps in provision 	<p>40</p>
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<ul style="list-style-type: none"> • A consideration and analysis of current numbers and skills of workforce and its development needs • An analysis of current performance against the phase 2A primary care measures • Measurement of local health needs as determined by the collaborative. 	
<p>Evidence of operating an effective system of clinical governance (quality assurance) in the practice, through engagement in peer review and through discussion of clinical incidents that had occurred within the practice and local services.</p> <p>Contractors will need to evidence completion of CGSAT and IG toolkit.</p>	40

4. Access QAIF

a) Access Domain for 2021/22

The Access standards system, incentivised via QAIF points, were originally designed to end at 31 March 2021, but it has been agreed they will continue into a third year. The fundamentals of the domain remain although there are a number of in year changes to reflect COVID pressures. The total value of this domain is 125 points.

Details of the Access Standards, groupings, evidence, reporting, payment arrangements and achievement are set out in the [Access guidance published by the Welsh Government](#).

Achievement for the Access domain will be assessed at **31 March each year**, with **achievement payments paid at 30 June**.

There are no aspiration payments for Access Standards.

The practice achievement payment for access, as described in the Statement of Financial Entitlement (SFE) is calculated using the practice points achieved, adjusted by the practice registered patient list size against the average practice registered patient list for Wales.

There are two groups of standards, with each Access standard as its own QAIF indicator. Practices can receive full or partial payment depending on achievement:

a) Group 1

- Less than 3 standards = no payment (0 points)
 - 3 standards = 60% payment (30 points)
 - 4 standards = 80% payment (40 points)
 - All standards in Group 1 = 100% payment (50 points)
- (Standard 3 relating to bilingual introductory messaging must be one of the achieved standards in order to receive any payment outlined above. There are no Aspiration payments for the Access domain.)

b) Group 2

- Practices will be required to undertake all three standards in order to receive payment (50 pts)

c) Quality Payment

- A quality payment of 25 points will be awarded to a contractor for achievement of all Group 1 and Group 2 Standards.

Changes for 2021/22

- **Standard 2 – 2-minute response time**

- For the 2021-22 cycle (this year), practices will not be assessed on their achievement of Standard 2 with achievement assumed and counting towards Group 1 payments (min. of 3 in order for payment to be made).
- Retired from the access standards framework from 1 April 2022.

- **Standard 8 (demand and capacity and patient satisfaction)**

- For the 2021-22 cycle (this year) practices will not be assessed on their achievement of Standard 8, with achievement assumed and counting towards Group 2 payments.
- The demand and capacity element of this standard will, as part of our agreement on QAIF changes, be moved to the new cluster QI element of QAIF.
- The patient satisfaction element will be retained as a measure from 1 April 2022 as part of any agreed standards framework.

b) Access Commitment for 2022/23

Access Standards phase 1 remain as pre-qualifiers for phase 2 which will be introduced from 1 April 2022. All practices are expected to achieve phase 1 by end of March 2022 but will, as part of pre-qualifier status, then be required to maintain and embed those working practices in order to make any claim for achievement of phase 2 standards.

A new Access Commitment forms the basis of new phase 2 standards for one year. Subject to review, and testing of the blended model of access, there is a joint commitment to establish future core contract access requirements, as part of the Unified Contract work stream.

From 1 April 2022, £2m will be transferred to QAIF access domain into Additional Capacity funding. This will be match funded by a further £2m new investment, meaning £4m total funding recurrently for 3 years.

This leaves £7.2m in Access QAIF to fund phase 2 standards for one year.

Throughout negotiations, we have discussed a renewed focus on improving access to triage/navigation and the changes that may be made in order to appropriately manage and meet the needs of patients in a more efficient way.

The emphasis must now be for practices to take a more forward planned approach, with contact supported throughout the day in order to address real concern around the '8am

bottleneck' and repeated attempts at contacting and or obtaining a consultation or other help and support.

From these discussions, there is broad alignment in terms of what we want to achieve – better access for patients. However, we are also cognisant of the need to balance demand with capacity as well as managing expectations, particularly those of the public. We have also discussed the likelihood of a gap in capacity as a risk, with investment into the workforce an option we would wish to explore, supported by robust and accurate data and evidence.

Last summer [we jointly issued a clear steer to the profession](#) on how the system should work in terms of access and this includes public messaging to build understanding of the role of all the different components (e.g., remote consultations).

We have sought to more clearly set out the strands to the '**Access Commitment**' below.

Public Facing Commitment

- All patients who contact the practice are treated equitably regardless of the method of contact used.
- Patients who telephone, have their calls answered care navigation is undertaken. Where clinically appropriate, patients may be signposted to another service – the reasons for this will be clearly explained.
- Where access to a service is clinically appropriate, patients will be triaged and offered an appropriate consultation, at an appropriate time, without the need to ring back. This may mean that an appointment is booked in advance for a date in the future but will be consistent with the patient's assessed clinical need.
- All patients can access the practice through a digital solution and that they receive a similar service to those who choose a telephony route.
- Practices are open and transparent about the services offered, how to access them and how to access additional or alternative services when required.

GMS Contract Requirements

- All patients telephoning the practice have their calls received by a standard recorded message, and subsequently calls are answered, and care navigation undertaken. Where clinically appropriate, patients may be signposted to another appropriate service.
- Where access to a service is clinically appropriate and patients require access to GMS services, they will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without the need for the patients to contact the practice again.
- Available appointments must be a mix of remote, face to face, urgent, on the day and pre-bookable to reflect the blended model of access, as determined by the practice in discussion with the patient. A more planned and forward-looking approach should be taken to the scheduling of appointments throughout the day, or for future dates, meaning it is no longer acceptable for all appointments to be released at 8am for that day.

- All practices must provide a telephony service (preferably Voice over Internet Protocol solutions or sufficient incoming and outgoing lines) that fully meets the needs of patients.
- The Health Board will be encouraged make digital tools available to practices long term. Practices must offer a digital means of access, in addition to telephone and in-person. The digital platform is for non-urgent access and only to be used during core hours.
- Practices will be required to take a more open and transparent approach, through an automated and standardised public facing dashboard, to the sharing of information and reporting, at a practice or cluster level, on GMS activity. The approach to this will be enabled via the Data Project with support from HBs and DHCW.

Health Board Requirements

- Health Boards will continue to have a responsibility to support struggling practices through the escalation tool and sustainability framework, and they should adopt a reasonable and supportive approach to access concerns.

Welsh Government Requirements

- WG will provide national public messaging to inform and support the blended model of access to GMS. Messaging will inform patients that priorities will be managed by the GP practice, which may, for less urgent cases, result in an appointment being booked for a time in the near future.
- The demand on appointments based upon clinical need, either via care navigation under the guidance of practice-based protocols or after clinically based triage, may in itself develop waits for appointments, which in themselves may highlight capacity gaps of service provision. This in itself may be insufficient and moving forward demand / capacity mismatches may still occur. To this end a revision of the escalation and sustainability processes will be undertaken by the tripartite contract implementation group.

The incentivised approach agreed is a balanced means of improving access whilst not having the unintended consequence of causing certain practices to fall foul of breach notices should they be unable to meet requirements.

We are confident that the agreement we have reached will not endanger the sustainability of our fragile Primary Care system and will go some way to improving patient experience.

The phase 2 Access Standards guidance has [now been published](#) and communicated to practices via Shared Services Partnership.

5. Enhanced Services

There have been no changes to the Direct Enhanced Services during this round.

6. Seniority & Partnership Premium

The existing GP Partnership Premium Scheme was established in October 2019 as a means of incentivising newer GPs to take up partner roles and support the sustainability of services.

A new funded Partnership Premium Scheme for non-GP partners will be introduced, in recognition of the vital role these staff play in the sustainability of GMS.

This scheme will be rolled out in phases, with phase 1 being open to those who had signed a Partnership Agreement prior to 31 March 2021.

[Guidance notes and claim forms](#) relating to the eligibility requirements and operation of this new extended scheme have now been published.

The substantive principles relating to the new scheme are analogous to the principles that underpin the GP Partnership Premium scheme.

The existing GP Partnership Premium and the Seniority schemes are unchanged.

7. Parental Leave

The SFE will be extended to enable the reimbursement of costs, up to an agreed limit, where Independent Prescribers are providing cover for **GPs on parental leave**. This will widen the available pool of professional cover to replace GP on parental leave or sick leave.

This proposal would be in line with new model of MDT working and provide practices with flexibility in how they manage a period of leave.

Enhanced Shared Parental leave arrangements will be enabled for all salaried GPs in Wales with the SFE amended to enable this to allow for the reimbursement of additional costs. Arrangements for GP Partners will continue to be a matter for the Partnership Agreement.

The Shared Parental Leave (SPL) scheme allows both parents and adopters more flexibility in how they care for their child during the first year after birth/adoption.

Shared Parental Leave took effect for parents of children born or placed for adoption on or after 5 April 2015 (having been included in the Children and Families Bill) and enables maternity pay and leave (and adoption pay and leave for adopters and intended parents through surrogacy) to be converted into shared parental leave, which either parent can then take. SPL is only created if the parent/adopter wishes to cut short their entitlement to maternity or adoption leave and convert the remaining part to SPL.

Any new leave rights should consider the diversity of families, in particular, the needs of lone parents, same-sex partners, adoptive parents and intended parents having children through surrogacy.

Practices will be entitled to claim back locum cover costs, as for parental leave cover, and this is reflected in the [Amendments to the Welsh SFE](#) which came into force on 30 March 2022 (see provisions listed on p15).

We will be issuing letters to practices and salaried GPs reflecting this change alongside updating the Salaried GP Handbook.

8. Additional Capacity

a) 2021/22 Scheme

£2m has been made available to support additional capacity within GMS over the winter period. The [guidance for 21/22](#) has now been published.

The funds were allocated to Health Boards and distributed to practices as an indicative spend, on a pro-rata basis, to enable 100% reimbursement of the total costs (salary / sessional fee & on-costs) of either additional posts upon appointment or additional hours worked by existing post holders.

b) 2022/23 Scheme

From 1 April 2022, capacity funding of £4m will be made available recurrently for three years, accessible to practices via Health Boards. [The guidance for 22/23 is now available.](#)

- This scheme from April 2022, will facilitate match funding of up to 50% of the cost of either additional posts upon appointment (including those in post from December 2021 under the 2021/22 scheme) or additional hours worked by existing post-holders, enabling GP practices to take on additional administrative and clinical resource.
- This money will be available to **all** practices based on evidence of additional hours worked at the practice.
- There are no pre-determined staffing ratios or other eligibility criteria

Contact us

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