07 November 2022

BMA

Cymru Wales

Focus On: Welsh GP Contract 2022/23

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1. Introduction

Following extensive tripartite negotiations, we have reached a GMS contract deal with Welsh Government.

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.

This year's set of negotiations, and resulting package, was unique in the sense that it encompasses in-year changes for 2022-23 (both financial and non-financial) and lays the groundwork for the proposed Unified Contract reforms, set to begin next year. The agreement is about more than pay alone: the pay uplift, which is sub-inflationary, is mitigated by reduced bureaucracy in the contract, lightening the administrative burden and freeing up GPs to do what they are trained to do, namely, to see and treat patients

Subsequent to the completion of formal negotiations and following last year's successful introduction, a GMS Contract Implementation Group will again be established to take forward the agreed negotiation outcomes and facilitate their implementation into the GMS contract.

The group will include representatives from the Welsh Government, GPC Wales, NHS Wales, NHS Wales Shared Service Partnership, DHCW and have Practice Manager representation.

The full directions, statement of financial entitlement and guidance will, in due course, be found on the Welsh Government GMS Contract website.

A list of key resources relating to the contract can be found at Appendix A.

2. Key changes

a) Financial

The following funding arrangements having been reached for 2022-23:

- Contractor GP pay uplift of 4.5% backdated to April 2022. This equates to £7.4m overall
- An uplift of 4.5% to the Staff pay expenses element of the contract ensuring '*all existing practice staff receive a 4.5% uplift to their gross pay'* backdated to April 2022. This includes the salaried GP pay award of 4.5% as recommended by DDRB. This equates to £7.5m overall.
- A General Expenses uplift of £2.718m.
- Clinical domains of current QAIF will transfer into Core contract from 1 October 2022, resulting in a transfer of £9m into Global Sum (GSUM). This quantum represents full achievement in all indicators for all practices moving into total GSUM and then distributed to practices via the Carr-Hill formula. The removal of Assurance indicators from the framework means that QAIF will become QIF (Quality Improvement Framework).
- Continued investment of £7.2m for the implementation of the 'Access to In-hours GP Services' standards with Access QIF.
- As agreed in 2020-21, the £4m Capacity Fund will continue for a further two financial years.
- Completion of CGSAT & IG Toolkit to transfer to Core contract from 1 October 2022, with achievement funding for completion of these (80 points total) at £5.7m to transfer into GSUM. Practices will be required to complete the next toolkit activity by 31 March 2024 and annually from 1 April 2024 onwards.
- The current cluster domain indicators in QAIF will be moved into the contract and mandated for all practices as of 1 October 2022. The respective 100 points, equating to £7.2m, will be transferred into GSUM.
- The current QI project in relation to activity data will, in part, move into the contract from 1 October 2022, supported by a transfer of £2.5m (35 points) into GSUM.
- There have been no changes to the Direct Enhanced Services during this round.

The agreement represents a total financial uplift to the GMS contract of **£17.618m** as well as a transfer of 340 QAIF points, valued at **£24.4m**, consolidated into Global Sum.

Pay uplift calculation methodology

Historically, uplifts to the global sum have been applied using the average EER (expenses to earnings ratio) calculated from the NHS Digital Technical Steering Committee[1] (TSC) 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 total contract value.

Whilst the EER has gradually increased over last 10 years, away from this traditional split. Using the most recent TSC evidence, published September 2022, the uplift has been calculated in a ratio of 38.6/61.4. This provides the most accurate up to date evidence-based representation of GP expense modelling.

The staffing expenses element (staff expenses accounting for 64.1% of total practice expenses according to the 20/21 TSC figures) represents the total gross cost of staff pay. Therefore, the 4.5% 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 contractor GP pay uplift. This means that GP partners would not see any pay increase as the DDRB intended.

Expenses and cost of living pressures

During the course of negotiations there have been many pressures on GMS expenses identified & discussed, such as rising inflation, NI contribution increases and energy costs.

We have been absolutely clear with Welsh Government how sub-inflationary pay uplifts and general expense awards will have a detrimental effect on the sustainability and indeed viability of some practices. We would also acknowledge that the negotiations have taken place under the backdrop of significant challenges in the national economic climate. Concurrent to our negotiations there has been a constantly shifting political backdrop with mitigations made by UK Government with regard to reversal of National Insurance increases and the temporary cap on energy prices for businesses.

The planned changes to QIF contractual payment structures, whilst not necessarily introducing new money into the contract, will in effect provide a consolidated cash injection into the global sum on a monthly basis, rather than awaiting achievement payments next year.

Global sum and QIF point values

With these elements considered, the new Global Sum payments will be made at a value of **£103.91 per weighted patient for the period beginning with 1 April 2022** and ending with 30 September and **£111.40 from 1 October 2022** (in comparison to £98.51 for 2021/22.) This represents a 13.1% consolidated increase in the GSUM value compared to the 21/22 value.

[1] https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2020-21/wales

The points that are remaining in the Quality Improvement domains, namely Access (100 pts) and the newly drafted mandatory QI projects (170 pts), will be revalued **at £189 per point for 2022/23**. The revaluation of the point value (via the NARP process[2] in the SFE) reflects an increase in the National Average of Registered Patients i.e., average practice list size to 8494 as of 30 September 2022.

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:

Workforce and sustainability

- Agreement to a tripartite meeting taking place within 24 hours at the request of the Minister for Health, in an emergency situation. This meeting will identify possible responsive measures within GMS which may include temporary contractual amendments.
- Agreement to extending the notice period for single handed GP contracts to six months, bringing them into line with usual arrangements and in support of alternative arrangements being put in place for the patient list. A reasonability factor will also be included to mitigate impact on single-handed GPs in extenuating circumstances. This cannot be legally enforced until brought in with the proposed Unified Contract regulations (from October 2023), however, we would encourage any members in this situation to have early discussions with their health board in the interests of patients and the wider local health system.
- Agreement reached to mandate the undertaking of pre-employment checks for new practice staff with minimum requirements as mandatory.
- Recognising the importance and value Protected Learning Time brings, this provision will continue at six sessions per year on a 2:2:2 ratio (2 x health board or locality wide with cover arranged by LHB, 2 x GP Collaborative/Cluster, 2 x practice) running on an October to September cycle. Whilst current arrangements will be continued for now, we will reinforce the importance and benefit PLT brings and through the Implementation Group seek to identify how best to facilitate this. A sustainable and perhaps national solution (e.g., through 111) will be a focus to provide longer term assurance with a clearly stated expectation that all six sessions are delivered to all areas by the end of the annual cycle.
- The following two areas are not contractual commitments, but are matters that we *strongly advise* all practices to have in place:

[2] "National Average of Registered Patients" means the aggregate CRP of contractors in Wales, as calculated using the number of patients recorded on the Primary Care Registration System administered by NHS Digital as being registered with contractors on the 1 July, divided by the number of contractors on 30 September, in the QAIF (QA and QI) year immediately before the commencement of the QAIF year (QA and QI) to which the relevant payment relates.

  - Reinforcement of the need for a partnership agreement that meets minimum requirements to be in place. BMA guidance[3] sets out the core elements of an agreement.
  - Reinforcement of the need for practices to have in place a business continuity plan, with consideration given to GP Collaborative solutions, noting that this does *not* impose any duty or contractual responsibility on individual practices for other practices in the Collaborative.

Embedding previous agreements in regulations

- Mandating of data recording and submission to Wales National Workforce Reporting System (WNWRS) through the contract.
- Mandating of completion of the GP Escalation Tool through the contract.
- The removal of the patient charge for completion of the Mental Health and Debt Evidence Form.

Access to and from primary care

- Core and normal service opening hours will be clarified to prohibit half day/lunch time closures Mon-Fri (with the exception of branch surgeries). The requirement for patients to be able to physically access the reception at a minimum of one practice site between 08:30 and 18:00 will be reinforced through the Regulations. This allows 30 minutes either side of the day to support set-up/close down of the practice although practices must be contactable by telephone in that time.
- Practices who offer private services, unrelated to GMS and not available through the NHS, must delineate and advertise those services clearly and separately to those available through the NHS.
- Regulations will be amended to enable the digital authorisation of prescriptions where directed by the health board which will support the future rollout of E-Prescribing.
- Practices should reasonably take steps to ensure patients who contact the practice during the out of hours period are provided with information about how to obtain services during that period (e.g., how to access 111) including how those services should be used.
- Practices should ensure the clinical details of all out of hours consultations received from the out of hours provider are appropriately care navigated within the practice on the same working day as those details are received, or exceptionally, on the next working day.
- Practices should ensure that any information requests that upload a special note are responded to appropriately in the practices on the same working day as received, or exceptionally, on the next working day.

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[3] BMA: 'The importance of an up-to-date GP partnership agreement' www.bma.org.uk/advice-and-support/gp-practices/gp-partners/the-importance-of-an-up-to-date-gp-partnership-agreement

c) Heads of Terms agreements

A number of contractual items have been prioritised for wider discussions in the forthcoming year. These have been identified by all parties as areas of interest and therefore have been included in the contract agreement as 'Heads of Terms Agreements' with indicative content for discussion. These commitments are outlined further in Section 6.

Task and finish groups according to the following themes will be established to consider the proposals.

- *Workforce and Sustainability*
- *Recovery and Transformation*
- *Data and digital*
- *Premises*
- *Vaccs and Imms*
- *Quality*

3. Quality Improvement Framework

a) Quality Assurance

Moving forwards, QAIF will be transformed to provide a greater focus on quality improvement. The removal of Assurance indicators from the framework means that QAIF will become the Quality Improvement Framework (QIF).

Through the course of negotiations this year, we have agreed:

- All remaining clinical indicators within QAIF will transfer into the core contract and be mandated for all practices from 1 October 2022. Monitoring will be supported through the Assurance Framework when introduced. Those indicators are:
    - Dementia (DEM002)
    - Diabetes (DM002,003,007,012,014)
    - COPD (CPD003)
    - Mental Health (MH011)
    - Palliative Care (PC002)
    - Flu (FLU001,002)
- The requirement for practices to provide data on the 21/22 clinical indicators will remain and will sit alongside other sources in the Assurance Framework.
- Dataset and business rules for data collection will be maintained with the requirement for annual reporting and set out in the revised GMS Contract Regulations.
- Aspiration and Achievement funding for these indicators will transfer into GSUM on 1 October 2022 totalling £9m.
- The requirement to undertake demand and capacity planning and evidencing of effective clinical governance (completion of CGSAT and IG Toolkit on an annual basis) will move into the contract as of 1 October 2022.
- Achievement funding for completion of these (80 points total) at £5.7m will transfer into GSUM at 1 October 2022 with practices required to complete the activity by 31 March 2024 and annually from 1 April 2024 onwards.

b) Quality Improvement

As part of the reconfiguration to the Quality Improvement Framework, there is a need to strengthen a number of areas, including:

- How QI projects are developed, valued and included in the QI domain
- Clarity on the scope and purpose of a QI project to ensure we maximise on learning and outcomes
- Removing delays in project rollouts to ensure practices are able to fully meet the requirements of the project within the QI cycle

Through a Heads of Terms approach, and a Task and Finish Group we will develop a clear framework which addresses those key issues and with a view to realigning QI delivery to a

financial year cycle from 1 April 2024. Transition funding arrangements for the next 18 months, which mitigates any negative financial impact on practices will also be agreed.

For the upcoming cycle, the QI basket will be revised to include:

- Mandatory prevention of unhealthy behaviours project
- Mandatory data project
- Mandatory phase 2 green inhaler project

Prevention and Health Promotion

GMS plays a key role in the prevention agenda and through the course of contract reform we will seek to continue to strengthen this further with a view to ensuring the contract itself enables and drives a focus on prevention and making every contact count.

For this year, we have focussed discussions on unhealthy behaviours, specifically obesity/high BMI, high risk alcohol intake and tobacco use and in particular those behaviours in patients with specific long-term or chronic conditions.

In order to strengthen both the data we have available to us in terms of new patients and to drive quality improvement in health promotion for at risk existing patients, we have agreed to:

- Standardise and provide a national “new patient questionnaire” template which will be utilised by all practices and offered to patients who register with the practice. The standardised questionnaire will ensure screening of patients aged 16 or over who:
    - are drinking alcohol at an increased or higher risk level
    - are users of tobacco products
    - have a high BMI
- Practices should continue with their current methods of signposting patients who are identified as at risk, to relevant support. Once the template is available it can further support practices, through consistent screening, to identify patients at high risk.
- As part of the ongoing engagement in the response to *Healthy Weight: Healthy Wales* and the All-Wales Weight Management Pathway, we have agreed to develop a QI approach which will ensure practices consider how they currently and will in future measure and record the height, weight and BMI of those patients with specific long-term or chronic conditions.
- Where appropriate and in line with NICE guidance, this QI approach will also support practices in ensuring HbA1C measurements are taken, and referrals made into the AWDPP where appropriate.

4. Access QIF

The existing Access Commitment guidance and Supplementary guidance 2022-23 remains in place for this financial year with no changes.

- *Access Commitment guidance for 2022-23* gov.wales/sites/default/files/publications/2022-09/guidance-for-the-gms-contract-access_1.pdf
- *Access Commitment supplementary guidance 2022-23* gov.wales/sites/default/files/publications/2022-06/supplementary-guidance-note-access-commitment-2022-2023.pdf

Future of Access in the Unified Contract

Building on the significant progress already seen in this area, which includes the Access Commitment and Phase 2 standards introduced on 1 April 2022, we have agreed a number of additional changes this year regarding the future of access in the contract.

We have continued to focus on strengthening the access to information and data within GMS to ensure there is a robust an accurate picture of the activity being undertaken.

- To embed the positive progress made to date and to ensure there is consistency in patients accessing their GP practice, the current pre-qualifier access standards (previously Phase 1) will be mandated through the contract as of 1 April 2023 and will form part of Unified Services (subject to Ministerial approval and the Senedd legislative procedures).
- To support this move, a heads of terms approach will be taken to identifying any possible national solution to the provision of digital tools in the longer term. This includes an agreement in principle to enhance the centrally funded My Health text bundles currently utilised by practices.
- The current Phase 2 Standards will remain in QAIF (100 QAIF points) for the 2023/24 cycle to allow for evaluation of achievement and impact during 2023.
- Subject to evaluation, the Phase 2 Standards are intended to be mandated through the contract forming part of Unified Services with 40 QAIF points transferred into GSUM as of 1 April 2024. The requirement for an annual access report will be retained in QAIF with 60 points payable upon achievement.
- The current QI project in relation to activity data will, in part, move into the contract from 1 October 2022. The collection and sharing of GMS activity/appointment data will be mandated through the contract supported by a transfer of £2.5m (35 points) into GSUM. The QI project will be refined and enhanced for 2022/23 cycle.

5. GP collaborative domain

We have agreed the transfer of the current cluster domain indicators in QAIF into the contract and therefore mandated for all practices as of 1 October 2022.

Those indicators, which will remain as is following their refinement in 2021-22[4], and which will be set out in GMS Contract Regulations, are:

- CND014

[4] https://gov.wales/sites/default/files/publications/2022-02/gp-collaborative-guidance-for-the-gms-contract-2021-2022.pdf

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- CND015
- CND016

The respective 100 points, equating to £7.2m, will be transferred into GSUM as of 1 October 2022.

6. Heads of Terms Agreements

A number of proposals have been agreed upon by all parties as areas of interest, but which require further development and exploration before they are considered to become contractual commitments. They therefore have been included in the contract agreement as 'Heads of Terms Agreements' with indicative content for discussion across themed Task and Finish Groups.

Each Task and Finish Group, through a clear remit, will put forward recommendations for change which will inform contract negotiations during 2023-24.

Workforce and Sustainability

- Review existing workforce schemes/initiatives including GP Partnership Premium Scheme, Non-GP Partnership Premium Scheme, Seniority, Recruitment and Retainer.
- Consider appropriate expectations of a clinical session and potential job role modelling for salaried GPs in Wales to support a blended employment model.
- Review the All-Wales Medical Performers List.
- Consider the decarbonisation agenda and Greener Primary Care Framework.

Recovery and Transformation

- Explore proposals to address the primary care backlog and the recovery of management of long-term conditions in the community.
- Improve utilisation of clinical pathways and smarter working across the primary secondary interface through GPC engagement, including the role LMCs play within that process.
- Define urgent care delivery through the GMS contract – at a practice level, cluster and pan-cluster level, including possible incentives to support.
- Explore levers to support and facilitate continuity of care in patient cohorts.
- Consider which services, currently delivered through an enhanced service approach, will benefit from scaled up commissioning and delivery through a multi-professional approach.

Data and Digital

- Support the development and rollout of the NHS App and to ensure appropriate patient access to their own records.
- Identifying a national solution to the provision of digital tools in the longer term.

Premises

- Explore the current reimbursement arrangements through the Premises Costs Directions.

Vaccs and Imms

- Consider the outcomes and impact of the national vaccination transformation programme.

Quality

- Improved concordance with national prescribing standards.
- Engagement with and reporting of performance against national prescribing indicators.
- Engagement with and reporting of performance against any local health board prescribing incentive schemes or other locally commission service.
- Explore how and if pharmacy roles could operate across a cluster footprint so as to influence prescribing practice and culture.

7. Unified Contract

(Subject to Ministerial approval and Senedd legislative procedures)

Tripartite work involving GPC Wales, Welsh Government and NHS Wales has been underway for the last twelve months, to take forward the development of a new streamlined and simplified GMS contract. Emphasis has been placed on clinical judgement with a focus on those things which only GMS can and should do at an individual practice level. It is proposed that the new contract takes effect from October 2023 subject to Ministerial approval and Senedd legislative procedures.

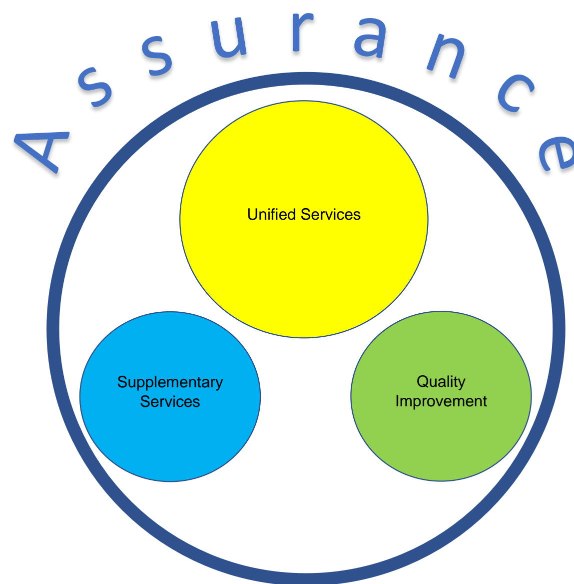
The following changes have been agreed and will be taken forward through amended Contract Regulations:

- All services currently identified as additional services will be re-classified as unified services (previously known as essential services).
- Some enhanced services (or elements of the enhanced service) will be re-classified as unified services.
- Those services which do not need to be provided by all GP practices and continue to be considered supplementary in nature will be redefined as supplementary services and delivered through commissioning by health boards. (Local Enhanced Service arrangements will remain the responsibility of health boards).
- Strengthened and holistic contract assurance measures, performance management and monitoring through a new Assurance Framework. Further work will be undertaken to finalise the Assurance Framework building on the principles which we have agreed.

As the Unified Contract will be underpinned by new legislation, there will be a formal consultation during 2023; we will lead upon engagement with the profession.

Unified contract strategic outline

The proposal in essence is for the structure the Unified contract to consist of three elements; Unified Services, Supplementary Services and Quality Improvement and wrapping around the contract will be the Assurance Framework.



Unified services will form most of the contract and are the key services all GP practices must provide. In simplifying the contract, all services under the 2004 contract which were classed as additional services or directed enhanced have been considered against what it is that every GP practice can be expected to provide. All of the enhanced services have been reviewed with the initial focus on 'what is it every GP can be expected to do' and what is more specialised. This key test has enabled us to consolidate and simplify the contract.

Unified Services

These are the basic services all GP contractors are responsible for delivering to all registered patients of the practice.

These cover the:

- (i) management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable;
- (ii) general management of patients who are terminally ill;
- (iii) management of chronic disease in accordance with national guidance and accepted best practice, in discussion with the patient;
- (iv) cervical screening;
- (v) contraceptive services;
- (vi) vaccinations and immunisations (that currently form part of Essential or Additional Services);
- (vii) child health surveillance;
- (viii) maternity services - excluding intra partum care;

(ix) the minor surgery procedures of curettage, cautery, cryocautery of warts and verrucae, and other skin lesions;

(x) learning disabilities annual health check.

Management of chronic disease includes the basic patient care for chronic conditions, delivered using clinical judgement in consultation with the patient, in accordance with national guidance issued by bodies such as National Institute for Clinical Excellence and All Wales Medicines Strategy Group, using national or local care pathways where available.

The Diabetes enhanced service gateway module is now considered to be basic patient care as part of chronic condition management and is to be included in Unified Services. The funding associated with the previous Diabetes enhanced service gateway module will be added to Global Sum when the Unified Contract is implemented on 1 April 2023.

Supplementary Services

These are GP services that do not need to be provided by all GP practices and are considered to be supplementary in nature. In most cases these would have been classed as enhanced services under the current contract. As part of the Unified Contract, Health Boards will be Directed to provide some services and Health Boards will retain the ability to commission Local Supplementary Services in line with the needs of local population.

The review of enhanced services that has been undertaken as part of the Unified Contract Task and Finish Group work has identified some service specifications that required amendment and some that are no longer required or fit for purpose. Work has commenced and is ongoing to update service specifications ahead of the Unified Contract. Health boards will be required to demonstrate future development of Supplementary Service specifications fit with care pathways whether national or health board specific.

Unified Services	Supplementary Services
2004 contract essential services	Warfarin DES
2004 contract additional services – Cervical screening Maternity Medical Services Contraceptive Services Child Health Surveillance Minor Surgery - Curettage and cautery of warts, verrucae and other skin lesions (where clinically appropriate)	Minor Surgery DES – Injections Minor Surgery DES – Minor Skin Surgery
2017 Diabetes DES gateway module	Extended Surgery Opening DES
Learning Disability DES (subject to clarity on service requirement at a practice vs collaborative/cluster level and date TBC)	Vaccinations & Immunisations: • Childhood Immunisation DES • Influenza & Pneumococcal Immunisations Scheme • Pertussis Immunisation for Pregnant & Post-natal Women DES (subject to review of V&I delivery policy)
	Shared Care Drug Monitoring NES
	IUCD NES
	Care Homes DES
	The following services are identified for delivery through ACD, they will continue to be delivered as supplementary services until new arrangements are developed.
	Services for Violent Patients DES
	Gender Identity DES
	Homeless DES
	Asylum Seekers & Refugees DES

Assurance Framework

The Assurance Framework draws on the work of the Contract Assurance Task and Finish Group and discussions on principles of assurance, sources of data and processes that exist. The Framework is to be applied across NHS Wales strengthening existing systems and instilling consistency of approach to assurance of the Unified Contract.

Principles of Assurance

- Open and transparent in process
- Proportionate and not bureaucratic in execution
- Makes use of existing sources of data
- Data analysed at a national level and provided to practices and Health Boards
- Uses national standards and measures
- Consistently applied across Wales
- Processes should be formative and supportive where possible
- Provides a clearly articulated stepped approach to escalation if concerns exist

To ensure assurance processes are proportionate and also formative, Health Boards will prioritise which contractors are to receive a governance review and consider what depth of review is necessary for assurance. A standard set of measures using existing data will be consistently applied across Wales.

Wherever possible, existing data, automatically collected and collated centrally, will be used to minimise bureaucracy for all parties. Health Boards may differ in weightings of individual measures according to local problems e.g., Antimicrobial Stewardship, National Diabetes Audit. Variation in performance is often related to features of the registered population, including health inequalities and vulnerable groups, or practice premises or workforce availability. These features will need to be recognised and taken into account.

Early engagement between the Health Board and contractor presents the best opportunity to support practices in making effective and sustainable changes to support service improvement should this be found to be appropriate and necessary.

Issues identified from governance review discussions should be incorporated into local population needs assessments, and ultimately into cluster, pan-cluster, and Health Board plans.

Contact us

To get in touch with GPC Wales please email: info.gpcwales@bma.org.uk

Appendix A: Key resources

- BMA GP contracts page: https://www.bma.org.uk/pay-and-contracts/contracts
- SFE Amending Directions and Contractual guidance can be found on the Welsh Government GMS management pages: https://gov.wales/general-practice-management