General Medical Services (GMS) Contract Agreement 2025-26

Final Outcomes

This document summarises the changes which have been considered and agreed through the course of formal negotiations to date, setting out a full picture of the final overall contract package offer.

Proposal

1. Pay and Expenses

For 2025-26:

- **4%** DDRB recommended uplift for GP partners and their staff:
  - GP partner pay will be uplifted in line with the recommendations of the DDRB, applying the same principles and methodology as have been used in previous years.
  - Wider practice staff pay will be uplifted in line with the DDRB rate, applying the same sequential SFE methodology as have been used in previous years. This ensures a consistent and fair approach to pay awards for all eligible staff.
- **1.77%** in practice expenses,
- A recurrent **£20m** to support immediate stabilisation and deliver this year's agreed mandate in preparation for the next phase of reform.
- A continuation of **£4m** Additional Capacity Funding in its current form for 2025-26 year (as agreed previously).
- The total investment into GMS for 2025-26 is **£41.9 million** *(comprised of £37.90m new investment and continuation of the £4m Additional Capacity Funding)*

For 2026-27:

- A guaranteed **5.8% recurrent funding uplift of the GMS contract from the outset of the financial year**. This funding uplift from 2026-27, will comprise three funds (namely the Workforce Fund, Change Fund and Resilience Fund) that provide practices with financial certainty to invest in resources needed for the next phase of reform, including workforce expansion, service redesign and administrative support. This uplift underpins the Community-by-Design transformation programme led by the Welsh Government Chief Medical Officer, enabling GPs to play a central role in integrated care models. This uplift is additional and unrelated to any DDRB pay award in 2026-27.

- Additionally, from 2026-27, the **£4m** funding previously defined as Additional Capacity Funding will be added on a recurrent basis to the Workforce Fund of the 2026-27 5.8% uplift.

2025-26 Uplift:

Recurrent funding 2025-26	
Element	**2025-26 uplift value (£m)**
DDRB recommended 4% pay uplift for GP partners	£6.9 million
4% pay uplift applied to practice staff , equivalent to DDRB recommended uplift (inclusive of DDRB Salaried GP recommendation)	£9.0 million
Practice expenses 1.77%	£2.0 million
Recurrent Additional	£20.0 million
Additional Capacity Fund investment in 2025-26 *(NB: this £4m funding will be moved and added to Workforce Fund from April 2026 onwards)*	£4.0 million
Total	**£41.9 million**

Apportionment of funding:

Element	**25-26 uplift (£m)**
GSUM	36.60*
QIF	0.72
Supplementary services	0.00
HB managed funds	1.16*
Total £m	**37.90**
Additional Capacity Fund	*4.00*

* For 2025-26, a six-month apportionment of £0.58m will be applied to SFE claims for absences after 1 October 2025. For 2026-27, a full twelve month apportionment will be applied, with an additional £0.58m added to HB managed funds, drawn from the Global Sum, reducing the Global Sum for 2026-27 by £0.58m.

2. Staff pay uplifts

The staff uplift element of funding will be applied in full after any statutory pay uplifts have been applied. Practices are required to report to Health Boards that this has been implemented correctly (as in previous years).

3. Mandate Items and agreed outcomes:

SFE Reimbursement

Mandate proposal: uplift SFE entitlements, ensuring that reforms support workforce sustainability and incentivise professional development

Agreement outcome: The tripartite agreed to adopt the recommendations of the short life working group for SFE reimbursements.

- Apply a 24.1% uplift to the SFE for all GP reimbursement ceilings and equalising the suspended doctors ceiling to other entitlements.
- Extend SFE parental leave cover to Independent Prescribers (IPs) at 62.2% of the GP rate.
- Reduce the sickness absence cover rate for IPs to the same 62.2% level.
- Claims for absences from 1st October 2025 will be at the new Welsh rates, with guidance to be issued for practices. Claims submitted after 1 October 2025 for absences between 1 April 2025 and 30 September 2025 will be paid at the previous Welsh rates.

The table below sets out the specific GP reimbursement rates:

SFE Entitlement	Previous Welsh Rate £	New Welsh rate £
Parental / Adoption / Shared-parental leave – weeks 1-2	1,131.74	1,418.43
Parental / Adoption / Shared-parental leave – week 3 +	1,734.18	2,151.96
Long-term sickness – week 3 + (same ceiling as parental week 3 +)	1,734.18	2,151.96
Suspension from practice	1,131.74	2,151.96

The table below sets out the specific Independent Prescriber reimbursement rates:

SFE Entitlement	New Welsh GP Rate £	New Welsh IP Rate (62.2% of GP rate) £
Parental / Adoption / Shared-parental leave – weeks 1-2	1,418.43	882.08

Parental / Adoption / Shared-parental leave – week 3 +	2,151.96	1,338.24
Long-term sickness – week 3 + (same ceiling as parental week 3 +)	2,151.96	1,338.24

Partnership Premium

Mandate proposal: uplift partnership premium by the equivalent of the GP pay uplift and a mechanism agreed for doing this in future years

Agreement outcome: the tripartite agreed to adopt the recommendations of the Partnership Premium short life working group for SFE reimbursements:

- Uplift the Partnership Premium for the current year, backdated to 1 April 2025, with a 10.5% session rate increase as recommended by the short life working group.
- The future of seniority payments will be reviewed annually, with no formal change at this stage.
- The existing short life working group will be tasked with designing experience tier options and reviewing the future of the Seniority scheme.

The table that follows sets out the revised rates for the scheme.

GP Rates	**Previous rate**	**New rate (10.5% uplift)**
Base session	£1,000	£1,105
Senior session (16+ yrs)	£1,200	£1,326

Population adjustment factor within the SFE entitlements

Mandate proposal: consider introduction of a population adjustment factor within the Statement of Financial Entitlements.

Agreement outcome: as agreed in Contract Reform Group, annual uplifts to the total national contract value will be calculated and uplifted as per the population data from latest available point prior to agreement, up to 1 April each year.

Review of Access Standards

Mandate proposal: review Access Standards and agree on what becomes part of the core contract and what further access requirements are needed

Agreement outcome: a tripartite 2025-26 Working Group will consider, agree and implement improvements to Access Standards, for which draft Terms of Reference were developed by the preparatory SLWG and signed off by Contract Reform Group. The group will be stood up to identify changes of reporting and standards to be implementable from **1 April 2026**.

GMS funding allocation formula

Mandate proposal: review the appropriateness of the funding allocation formula for Welsh general practice.

Agreement outcome: a short life working group (SLWG) will undertake a scoping exercise to determine the mechanism for a robust review of the current global sum allocation formula for GMS The group will assess options, and recommend the best long-term approach to reviewing and potentially changing the current process.

This work will follow a two-phase approach:

- Phase 1: The group will scope and define the remit and methodology of the longer-term review, and make recommendations for commissioning. This may require upfront investment to procure specialist input (including population health and financial modelling expertise).
- Phase 2: The group will review the evidence, assess options and develop recommendations for the best long-term funding approach, including how any changes would be implemented. These recommendations will go to the Minister/Cabinet Secretary and may inform future negotiations.

Quality Improvement (QI)

Mandate proposal: augment the QI approach with additional investment.

Agreement outcome: a value preservation 4% uplift to QI point value in 2025-26. This is on the basis that this does not set a precedent for future years and the uplift is contingent on a robust review of the QI approach being undertaken by the Quality Committee. Future uplifts will be subject to rigorous evidence of value and impact.

The Quality and Improvement Framework (QIF) is made up of two domains, Access and Quality Improvement. The QIF points value has always applied to both access and quality improvement. We have agreed to uplift the points value for quality improvement and apply the same points value to access. The QIF points value will therefore increase from £199 to £206.96 backdated to 1 April 2025.

It will be for the tripartite Quality Committee to recommend and implement specific projects for future years, subject to approval by Contract Reform Group, acknowledging that the projects for 2025-26 have already been approved and are underway.

Data and digital

Mandate proposal: make patient data available in the NHS Wales app, and form a tripartite digital working group to consider e-triage for GP appointment booking through the NHS Wales App.

Agreement outcome:

- Patient record data – Patients will have access to agreed coded elements of their record, by default, from 1 January 2026, excluding free text and test results, via the NHS Wales App (once the functionality has been enabled) - rollout will be as soon as practically possible, **between 1 January 2026 and 31 March 2026**). As a minimum, a summary patient record will be available to the individual user in a secured view, including documented allergies, immunisations and health conditions. This will be a workstream of the NHS Wales App work, linking into the overall DDaT governance.
- Appointments, e-triage and test results – GPCW, WG and NHS agree to be part of a rapidly convened working group with Digital colleagues and DHCW as part of the NHS Wales App work to work through e-triage and appointment booking development on the NHS Wales App, as well as how test results are released on the NHS Wales App and what developments need to be made to the NHS Wales app and EMIS systems in order to facilitate this as soon as possible. Expected outputs of the group would be a collective roadmap and plan on development, testing and implementation of e-triage, appointment booking post-care navigation, and inclusion of test results as part of the summary patient record through the NHS Wales App.
- In addition, as a further enhancement to WIVS, the working group will explore authorised access controls (proxy) extension of the WIVS process for carers and parents, with the intention of this being rolled out to EMIS practices by **March 2026.**

Additional capacity funding (ACF)

Mandate proposal: agree on the best ways to utilise, deploy and monitor the effectiveness of the Additional Capacity Fund (£4m) to ensure it aligns with the needs of the population and supports GPs in delivering those needs.

Agreement outcome: the tripartite had previously agreed a continuation of ACF in its current form for the 2025-26 year. The ACF short life working group (SLWG) will stand back up to undertake a lessons learned reflection.

The tripartite agreed that from 2026-27, the £4m is added to the workforce portion of the 2026-27 5.8% uplift ("Directed Collaborative Services model"). This means that £4m is added to the additional Workforce Fund earmarked for 2026-27 of approx. £10m, creating a total of approx. £14m. Matched-funding requirements for ACF in its current format would therefore come to an end at the end of March 2026.

The workforce portion of the 5.8% uplift would require clear timelines, objectives, eligible uses, allocation method and a Monitoring and Evaluation Framework (Key Performance Indicators, simple reporting, etc.), involving the full tripartite and signed off by Contract Reform Group. As such, the tripartite agreed that the current ACF SLWG is also assigned the task of agreeing what the reporting expectations will be

for the Workforce Fund in order to demonstrate the value of the investment. The survey to be undertaken after negotiations have concluded will inform this work.

Routine management of high risk and rising risk patients in the community

Mandate proposal: fully embed a consistent approach to the identification of the patient cohort and proactive management of the identified 0.5% high risk population group. Practices are already required to maintain frailty registers; this proposal is to add patients meeting DSS criteria in order to gather data for future planning.

Agreement outcome:

The Tripartite have agreed the following actions to be taken by GP teams to continue to support the identification of the High-Risk Frailty and Complex Multimorbidity group[1] in order to assist with the servicing of their preventative needs. Proposed actions:

- Maintain "High Risk Frailty and Complex Comorbidity Cohort" Register - maintenance and quarterly validation of registers of individuals in the defined cohort using recommended SNOMED codes and descriptions.
- Cluster-Level Service Mapping and Planning - practices to share prevalence data and their professional assessment of unmet needs in Collaborative and Cluster service reviews.
- Categorise and Support Individuals - assess and support individuals when they see them according to existing professional responsibilities and contractual requirements

Inclusion health service models

Mandate proposal: support the goal of delivering inclusion health service access aligned to the guidance for the development of local inclusion service models and opportunity for cluster level access models

Agreement outcome: the tripartite have agreed the following actions to be taken by GP teams to identify vulnerable individuals who experience multiple severe and overlapping disadvantages that significantly increase their risk of poor health, and connect them with appropriate care:

- Maintenance and annual review and validation of Inclusion Health Registers. Practices will be expected to maintain registers of individuals using recommended SNOMED codes and descriptions.

[1] The tripartite agreed that the definition of High-Risk Frailty and Complex Multimorbidity groups refers to individuals with increased vulnerability resulting from age-related decline in physiological systems identified with the use of validated frailty assessment tools such as the Rockwood Frailty Scale, along with individuals that suffer with the coexistence of multiple long-term health conditions that interact in ways that complicate clinical management. Both groups of individuals often experience challenges across physical, mental and social domains and typically require coordinated, multidisciplinary care.

- Cluster Service Mapping and Planning - practices to share prevalence data and their professional assessment of unmet needs in Collaborative and Cluster service reviews.
- Categorise and Support Individuals - assess and support individuals when they see them according to existing professional responsibilities and contractual requirements

Structured medication reviews

Mandate proposal: practices to undertake structured medication reviews for people on multiple medications to improve patient outcomes and consistency of repeat prescribing processes, and to reduce polypharmacy and waste.

Agreement outcome. The tripartite agreed additional questions to the Clinical Governance Practice Self-Assessment Toolkit (CGP-SAT) 5.1: Prescription Administration System to enable better understanding of the adoption of the Welsh National Standards for Medication Review by practices. Practices will not be asked to change clinical practice at this time.

These questions are:

- 1. Does the practice have a medication review policy? [Yes/No]
- 1b. If yes, date of last review
- 2. Has the practice adopted the Welsh National Standards for Medication Review? [Yes/No]
- 2b. If yes, are the Standards reflected in the practice medication review policy and process [Yes/No]
- 3. Does the practice have a specific additional medication review process for medication review in patients or patient groups deemed to be at greater risk of harm from higher-risk repeat medicines (such as those with a history of substance abuse, the very old, patients with 'frailty', those prescribed ten or more medicines, those with learning difficulties and those who are reliant on others to order and collect their medicines). [Yes/No]
- 3b. [if yes to 3] Are structured medication reviews undertaken when reviewing high risk medicines/situations [always/sometimes/never]
- 4. Number of reviews documented as SMR as a percentage of total reviews undertaken by the practice. [x%]

GMS Quality Committee, which has oversight of the CAF, will approve these additional questions and then obtain sign-off from Contract Reform Group. Data collected may inform future negotiations.

Diabetes eight care processes

Mandate proposal: practices to allow health boards access to contemporaneous data on the completion of the Eight Essential Care Processes in its population of diabetic

patients. This will provide assurance that all patients living with diabetes have equitable access to high-quality care. The assessment of the Eight Essential Care Processes for all patients with diabetes is recommended via various national guideline.

Agreement outcome: automatic sharing of the eight diabetes care processes aggregate practice level data for all patients with diabetes (already captured and reported monthly) at individual practice level will be enabled via the same digital mechanism used for cluster information. There was consensus that the data flow should be universal (not requiring individual practice consent), with only standard GDPR opt-outs at the patient level. There are no significant information governance issues since the data is not patient identifiable.

Mainstreaming the All-Wales Diabetes Prevention Programme (AWDPP) pre-diabetes service

Mandate proposal: support the goal of mainstreaming the All-Wales Diabetes Prevention Programme pre-diabetes service.

Agreement outcome: conduct a deeper dive into the diabetes prevention programme and discuss data collation requirements, including standing up a tripartite short life working group to explore mainstreaming specific aspects of the AWDPP (or health board equivalent) into Unified Services from **April 2026**.

Protected Learning Time (PLT)

Mandate proposal: continue the Protected Learning Time arrangements and formalise this in 2025-26.

Agreement outcome: the tripartite recognise that PLT is currently implemented differently across health boards, leading to inconsistency in practice. There is a need for a review of current practices and data to understand how PLT is being delivered. The tripartite have agreed to establish a tripartite short life working group to map existing PLT arrangements, identify inconsistencies and recommend a sensible, consistent approach for the future. This group will also determine an appropriate timeframe for implementing any changes.

Delivery of a collaborative footprint for supplementary services

Mandate proposal: continue to collaborate and to work up the legal basis to operationalise the delivery of a collaborative footprint for supplementary services, which supports the Community-by-Design programme.

Agreement outcome: the existing CDSS tripartite group will expand its membership and conclude its work developing the proposed contractual model and investment approach, and agree how it migrates into the Community-by-Design programme. Once associated funding for the set-up is available, this group will work to achieve the contract model in operation, including timeframes for delivery.

Item of Service (IoS) Fee for Advice and Guidance

Mandate proposal: develop a Supplementary Service that entitles practices to an IoS fee for advice and guidance request made per episode of care

Agreement outcome: investment has already been agreed and released via Outpatients Waiting List Scheme – First Appointment (OWLS: FA). Acknowledging that OWLS: FA focuses on validation of lists rather on than providing advice and guidance prior to listing, the tripartite agreed to consider an IoS fee for advice and guidance as a potential future change as part of the Directed Supplementary Services review (see below).

Dispensing reform

Mandate proposal: tripartite group to explore dispensing doctor challenges and barriers.

Agreement outcome: the tripartite addressed the need to formalise and expedite the review of dispensing doctor remuneration. It agreed with GPC Wales's proposal to continue the existing group which already has the involvement of the Dispensing Doctors Association (DDA) and has produced helpful papers.

The group will scope, map and set a timeline for implementing a solution to resolve the issue around practices handing back dispensing contracts, aiming to produce recommendations to be presented to the Welsh Government Deputy Director of Primary Care during 2026, ideally for implementation from April 2027.

The tripartite recognises that, depending on the recommendations, a more comprehensive review with external input may be necessary. As such, it accepts the potential need for flexibility on the deadline to reflect the complexity involved.

Provision of services within branch / secondary sites

Mandate proposal: review the requirements for provision of services within branch / secondary sites identified within practice contracts

Agreement outcome: establish a short life working group (SLWG) to review the current position regarding the provision of services within branch / secondary sites. The purpose of this group is to scope out the existing arrangements, consider options and make recommendations subject to future negotiations before any decisions or contract changes are made. The SLWG's work will include consideration of opening hours and rent reimbursement.

Progress review of the All-Wales Communication Standards

Mandate proposal: review the All Wales Communication Standards between Primary and Secondary Care (WHC/2018/014), with any revision taking into account structural developments since the 2018 original such as the advent of the national

clinical pathways model, and the increased provision of multi-disciplinary services outside of the traditional hospital-based model.

Agreement outcome: a multi-professional team has been progressing its work on the All Wales Communications Standards alongside the main negotiations. This work will be delivered in two stages:

- Stage 1: Focus on the medical (GMS/health board) element, which will bring early improvements for primary and secondary care. The group is expected to deliver an outcome soon, and communications will follow.
- Stage 2: Broader multi-professional standards, requiring more time and effort.

The staged approach recognises the importance of implementing initial improvements without delay while acknowledging that wider work will follow.

Vaccinations and immunisations

Mandate proposal: simplify and align vaccination scales and embed inflationary uplifts into the contract.

Agreement outcome: existing tripartite short life working group (SLWG) will continue to operate but become a longer-term working group that takes forward and proposes an approach to Item of Service (IoS) fees for vaccination to come into operation at an agreed future date. This will include analysis of current and additional data.

Single Point of Access (SPoA)

Mandate proposal: ensure the needs of GMS are captured within the SPOA approach being implemented by heath boards.

Agreement outcome: GPC Wales will work with the Six Goals Programme to shape a national discussion on how General Medical Services can align with the Single Point of Access (SPOA) model being rolled out by health boards, ensuring that GMS requirements are fully considered and integrated.

4. Further agreed outcomes:

A summary of the 5.8% recurrent uplift to GMS contract from April 2026 is provided below. This funding will be separate to any negotiations relating to the consideration by Welsh Government of the recommendations of the DDRB.

Details of the three funds under the 5.8% recurrent uplift of GMS contract from 2026-27 provided below:

- Outside of DRRB discussions.
- Recurrent from April 2026. Estimated at around £30 million.
- The exact uplift figure will be calculated based on the GMS allocation as of the end of March, with initial estimates provided in the Ministerial Announcement and final figures confirmed in January when finance sends out allocation tables.
- The precise allocation of the Resilience Fund will be confirmed once the list sizes are available (typically in January).

In 2026-27, the 5.8% uplift is to be split equally across three elements. This funding apportionment across funds may be flexed in future years (to be agreed in future negotiation cycles).

The new Directed Collaborative Services Model Group will lead an ongoing review of the 5.8% uplift introduced from April 2026, providing recommendations on how apportionment could be refined in future years.

Element 1: **Workforce Fund** (goes into LHB Managed Funds)

NB: From April 2026, the £4m ACF will be added to the Workforce Fund (with no matching requirement), and the Additional Capacity Fund as it currently operates will be closed down at the end of March 2026.

The Workforce Fund will be allocated to health boards on a raw population basis. Practices will be able to apply to utilise this funding from the health board on a raw list size basis. Practices must make initial applications by 31 January 2026 and draw down throughout the year (with a cut off for late applications or material changes being 31st December 2026) based on actual need and claims.

NB: In order to ensure consistent administration of the fund across health boards and robust data capture and reporting, the 5.8% Uplift Fund Implementation group will build on the learnings of the Additional Capacity Fund (ACF) group.

Element 2: **Change Fund** (goes into LHB Managed Funds)

The Change fund will be allocated to health boards on a raw population basis. Practices must make initial applications by 30 June 2026 and can draw down throughout the year after approval (with a cut off for late applications or material changes being 31st December 2026) based on actual need and claims.

NB: The detail of the services captured under the Change Fund will be discussed through the DCS workstream.

Any residual/underspend left in either the Workforce or Change Funds at year-end will be paid out by each HB to practices, as a one-off payment (*aka "**GMS Residual Payment**"*) calculated on a raw population basis. This approach keeps processes clean and avoids complications with the global sum.

The cutoff for applications or material changes relating to the Workforce and Change Funds is December 31 2026. The calculation with respect to any underspend in either the Workforce or Change Funds will be undertaken by Health Boards after 31 March 2027 and any remaining funding left at year-end will be retrospectively allocated as a one-off payment / "GMS Residual Payment" to practices in April 2027.

NB: The implemented failsafe will ensure that any underspend from the Workforce and Change Funds is ultimately allocated to GP practices. A reflective exercise will be undertaken by the tripartite to review the mechanisms governing how the funding is apportioned and utilised. The value of the three funds will be agreed each year during negotiations, including how the failsafe mechanism will work in each particular year.

Element 3: **Resilience Fund** (i.e. GSUM uplift from April 2026). Allocated to practices according to the Global Sum allocation formula.

5. Commitments to working groups:

GPCW, NHS and the WG have agreed to a series of working groups. The list below will be prioritised at an initial workshop, including consideration of which topics sit together and which topics require a one-topic rapidly delivered Short Life Working Group approach, before the working groups commence.

Working Groups, either in the form of Short Life Working Groups focused on one topic or Short Life Working Groups covering multiple prioritised topics to cover:

- **2025-26 Working Group to agree and implement improvements to Access Standards.** This group will be rapidly stood up, in line with agreed Terms of Reference to review and recommend changes to access standards and reporting within GMS, with potential implementation from **April 2026.**
- **Branch/Secondary Site Services**. There is currently insufficient clarity on the landscape of branch and secondary sites, which makes it difficult to articulate the current position or propose immediate contractual changes. Therefore, this SLWG will review and map the current arrangements for branch and secondary sites, then consider options and make recommendations for future negotiations regarding these sites. The SLWG's work will include consideration of opening hours and rent reimbursement.
- **All-Wales Diabetes Prevention Programme**. The All-Wales Diabetes Prevention Programme is not universally available across Wales. This SLWG will seek to address these complexities, including the involvement of Public Health Wales and will consider potential alternative delivery models and data collation requirements, with the aim of mainstreaming specific aspects of the AWDPP (or LHB equivalent) into Unified Services from **April 2026**.
- Options for further changes to **Partnership Premium**. This group will design experience tier options and make recommendations for plans for Seniority Payments in future years. This may include recommending incremental PP uplifts, to be financed by redeployments elsewhere in the GP contract envelope, for instance the shift from Seniority. Recommendations of the group will be reviewed and discussed in future negotiations.
- **Protected Learning Time (PLT).** As PLT is currently implemented differently across various locations, leading to inconsistency, this group will review current practices and data to understand how PLT is being delivered, identify inconsistencies and recommend a sensible, consistent approach for the future. This group will also determine an appropriate timeframe for implementing any changes.
- **Additional capacity funding (ACF).** The ACF short life working group will stand back up to complete a lessons-learned reflection. It will also make recommendations on the reporting expectations for the Workforce Fund element of the 5.8% uplift introduced from April 2026 to demonstrate the value of the investment.

- 'Longer life' working Groups to cover:
  - **Global Sum allocation formula.** Group to take forward a robust review of the current global sum allocation formula for GMS, assess options, and recommend the best long-term funding approach. This will include scoping the requirements and identifying a procured solution to deliver the initial report. This Group will develop the recommendations for consideration by Deputy Director of Primary and Community Care and in due course the Minister or Cabinet Secretary.
  - **2026-27 5.8% Uplift Fund Implementation Group.** This group will be aligned with the CMO Community-by-Design programme governance structure, will:
    i. *(Noting that a recurrent 5.8% uplift is agreed for 2026-27 as part of the 2025-26 agreement)*

       Formally implement the negotiated allocation quantum (with updated list sizes, etc.) and mechanism (payment dates from NWSSP, cut off dates, etc.) of the 5.8% uplift from April 2026, and agree the technical conditions for the release of funds.

    ii. Lead an ongoing review of the 5.8% uplift introduced from April 2026 (comprising Workforce Fund, Change Fund and Resilience Fund) and make recommendations on potential refinement of apportionment and operational arrangements across the funds in future years. In terms of the Workforce Fund, this group will take into consideration the learning from the Additional Capacity Fund (ACF) Short Life Working Group and its recommendations for improvements to ensure consistent administration of the fund across all health boards and robust data capture and reporting.
  - **Directed Collaborative Services Model Group (DCS).** This existing tripartite group will be renamed, have expanded membership and conclude its work developing the proposed contractual model and investment approach and agree how it migrates into the Community-by-Design programme.* The DCS group is expected to additionally take on the Directed Supplementary Services work detailed below, creating a single, broader workstream.

    ** With respect to the governance of the currently separate Community-By-Design programme, the Cabinet Secretary for Health and Social Care has stated that the GP voice must be central to this programme of work, and welcomes GPC Wales' involvement through the core Community-By-Design stakeholder group to provide input on a shared workplan, clear milestones, and regular joint reviews of progress across the range of headings for the programme.*

- **Directed Supplementary Services review.** A review of Directed Supplementary Services. The scope is complex and covers multiple areas such as diabetes, care homes and inclusion health. Supplementary services are central to the wider Community-by-Design programme, so the group's work will link to those goals. The group will consider potential future uplifts related to Directed Supplementary Services and review the commissioning process, and procurement challenges and uncertainties, consider options and make recommendations to be reviewed in future negotiations. Initial recommendations may be followed by detailed expert work and membership and approach will adapt as needed.

- **Digital health services group.** This group will oversee the implementation of patient data being made available in the NHS Wales App (Phase 1), and produce a roadmap and plan on development, testing and implementation of e-triage for GP appointment booking and release of test results through the NHS Wales App (Phase 2).
  In Phase One, the group will focus on:

  Patient record data: Patients will have access to agreed coded elements of their record, by default, from 1 January 2026, excluding free text and test results, via the NHS Wales App (once the functionality has been enabled) - rollout will be as soon as practically possible, between 1 January 2026 and 31 March 2026). As a minimum, a summary patient record will be available to the individual user in a secured view, including documented allergies, immunisations and health conditions. In Phase Two, the group will produce a roadmap and plan on development, testing and implementation of the features below:

  - authorised access - group to discuss authorised access controls (proxy) extension of the WIVS process for carers and parents, with the intention of this being rolled out to EMIS practices by March 2026.
  - test results/other aspects of record on a patient summary coded record - group to consider how test results are released on the NHS Wales App and what developments need to be made to the NHS Wales app and EMIS systems in order to facilitate this as soon as possible. As part of this, the group will consider how sensitive information will be clinically reviewed before release, ensuring there are mechanisms for clinicians to control access to certain elements.
  - e-triage for GP appointment booking - group to work through potential challenges associated with e-triage/care navigation and how this relates to appointment booking, and consider robust safety validation and workflow safeguards.

- **Dispensing reform.** This group will scope, map and set a timeline for implementing a solution to resolve the issue around practices handing back dispensing contracts, aiming to produce recommendations to be presented to the Welsh Government Deputy Director of Primary Care during 2026. Once recommendations are matured and approved, the

group may need to commission expert work as needed to deliver the proposed solution. The tripartite has agreed to aim to produce recommendations to be discussed in 2027-28 negotiations, but recognises the need for flexibility given the complexity of the task and the likelihood that its full scope will only become apparent over time, and may be impacted by external factors such as post-election changes.

- **Vaccinations and immunisations.** The timeline for the current Short Life Working Group (SLWG) needs to be extended because the work involves consideration of potentially significant policy changes, including alternative options to the current incentive-based payments approach and making other structural adjustments. Progress is also dependent on completing data analysis, which is still underway. The group will reconvene to review the current position and continue as an ongoing collaborative workstream rather than a short-term task. Expanding the membership is under consideration to ensure the right expertise is included for the next phase.

- **Contract Implementation Group** will stand up to develop the relevant guidance for the contract changes below, which fall into two phases.

  Phase One Implementation (for changes that will be implemented between 1 January 2026 and end of March 2026)

  - Patient access to structured coded records, excluding free text and test results by default. The implementation group will be responsible for finalising the go-live date (between 1 January and 31 March 2026), developing guidance, and managing the rollout process. The tripartite agreed to aim for the earliest practical rollout date with sufficient notice for practices to prepare.
  - Eight Care Processes Data Sharing - to be clearly defined and DHCW to enable monthly data sharing at the practice level for health boards to reduce manual reporting by practices. Data sharing will be standardised and apply universally across practices, without requiring individual practice-level consent as consent is provided centrally by GPC Wales. At the patient level, only the usual GDPR opt-out provisions will apply, safeguarding individual rights while enabling efficient data flow.
  - High-Risk Frailty and Complex Multimorbidity - quarterly maintenance and validation of registers, and data sharing with health boards.
  - Inclusion health services - annual maintenance and validation of registers, and data sharing with health boards.
  - Structured Medication Reviews - implementation group to operationalise additional questions being added to CGP-SAT. Implementation will be phased, with full-year data collection starting from April.

  Phase Two (for changes that will not be implemented before April 2026)

- NHS Wales App - authorised access controls (proxy) extension of the WIVS process.
- Output from 2025-26 Working Group to agree and implement improvements to Access Standards: potential recommendations or changes that need to be implemented from the start of the April 2026. Any proposed changes will be agreed by Contract Reform Group before being transferred to Contract Implementation Group.
- Output from All-Wales Diabetes Prevention Programme SLWG: potential recommendations or changes that need to be implemented from the start of the April 2026. Any proposed changes will be agreed by Contract Reform Group before being transferred to Contract Implementation Group
- Any guidance, templates, reporting requirements, etc. specific to the 5.8% uplift / DCS Fund which is being implemented from April 2026.