18 September 2020

BMA

Cymru Wales

Focus On: Welsh GP Contract 2020/21

1. Introduction

Welsh Government, NHS Wales and GPC Wales have agreed the Welsh GP contract for 2020/2021.

Please see below for an overview of the contract changes and some useful guidance.

The full directions, statement of financial entitlement and guidance will be listed online in the near future when Welsh Government have completed their refresh of the Welsh GMS contract site.

2. Key changes

a) Financial

The following funding arrangements having been reached for 2020-21:

- DDRB recommendation of pay uplift of 2.8% for GPs
  - £4.5m to the pay element of GMS contract in Global Sum
- An uplift of £4.1m to the expenses element of the contract to fund a 2.8% pay uplift for all practice staff
  - Mandated as **a minimum uplift** to practice staff pay budget.
  - Agreed Health Board audit of implementation
  - Funds recovered from non-compliant practices.
- A £1.5m expenses investment to fund ongoing revenue telephony costs related to post COVID 'Telephone first' model
- A further £0.4m expense uplift towards inflationary pressures
- The inactive AF indicators and disease register indicators will be removed from QAIF, with disease registers becoming a core function
  - the associated funding of £4.125m is transferred into Global Sum.

For clarity, the £3.765m that was within the Global Sum in 19/20, specifically allocated towards Access standards infrastructure, has been 'redistributed' to the additional funding streams and therefore retained in the Global Sum, as per the 19/20 contract agreement.

With these elements taken into account, the new Global Sum payments will initially be uplifted to a value of £93.81 per weighted patient and backdated to 1 April 2020 (in comparison to £91.77 for 2019/20).

At 1st October 2020, the Global sum payment will be made at **£95.07 per weighted patient** to reflect the transfer of QAIF funds.

The payment systems will be updated by NHS Shared Service Partnership (with the new rates and arrears due from 1st April) and payment will be made to practices at the end of October.

Whilst we recognise that the transfer of QAIF funding to Global sum is exactly that - a transfer, not new investment - it is important to note the agreement reached this year that all the increases in Global Sum value as detailed above are consolidated funding and will be recurrent.

It has been historically recognised (using NHS Digital Technical Steering Committee reports on GP Earnings and Expenses Estimates[1], which are based upon HM Revenue & Customs Self-Assessment figures) that: -

- GP pay equates 40% of the total contract value
- Practice expenses reflect 60% of the contract value
- With 60% of expenses relating to Staff pay elements.

This is the basis of how the individual uplifts to Global sum are calculated.

[1] NHS Digital: GP Earnings and Expenses Estimates https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates

Due to a recognition that the ratio of expenses to earnings has gradually increased over last 10 years, diverging away from this traditional split, a working party will be established to consider methods of future expense analysis.

Therefore, when looking at this year's Global sum uplift it is important to note that without a 'ring-fenced' staff pay award uplift any pay increase given to staff would in reality be funded from the DDRB uplift, meaning that GP partners would not see any pay increase as the DDRB intended..

This element of this year's uplift does have a contractually enforceable element, which has been built into the Statements of Fees of Entitlements (SFE), allowing recovery of funds if the GMS contractor has not increased the remuneration of their practice staff budget by at least 2.8% for the financial year 2020/21.

There will be those of you who are still affected by the phasing out of correction factor payments. The phasing out of MPIG started at the beginning of the 2014-15 financial year with practice correction factor payments reduced by one seventh. This has happened every year until all GMS practices are receiving the same weighted funding per patient by the beginning of the 21-22 financial year.

The average practice list size as of 1st July 2020 was 7,945. This figure is rising and expected to continue to rise, with practice closures and mergers continuing to decrease the denominator.

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 are aligned to the Primary Care Strategic Program and include:

- An agreement to improve data quality & availability, helping to better demonstrate the rising activity levels and workload in general practice.
- Improving access to and from GMS services.
- Focusing on quality and prevention
- Strengthening the primary care workforce.

There is a continued commitment to undertake further work on Premises in the 2020-21 contract year, to seek to address the wider premises issues faced by practices which are known to affect sustainability. This work had commenced prior to the COVID pandemic outbreak but could not be completed. It will therefore resume as a priority.

Similarly, the review of enhanced services will also be restarted in forthcoming months.

3. Quality Assurance and Improvement Framework

The Quality Assurance and Improvement Framework (QAIF) was introduced as part of last year's contract reform, replacing the Quality and Outcome Framework (QOF).

Details of the relaxation of QAIF for 2019/20 can be found in the BMA Focus on COVID Contract Changes document.

QAIF achievement at the end of the 19/20 cycle will be counted at a full 100% and paid in full at quarter end Dec 2020.

Given the temporary relaxations made to QAIF around reporting arrangements, and with the contractual uplift being preferentially applied through the consolidations in Global Sum, the current value of QAIF points will be retained at £179 per point.

In recognition of the ongoing maintenance of disease registers and the 90% practice coverage of the AF QI Project, the inactive AF indicators and disease register indicators will be removed from QAIF, with disease registers becoming a core function.

The introduction of a new QI project, worth 60 QAIF points, related to COVID learning with a focus on planning for urgent care across clusters under the new ways of working. This will replace the existing requirement to undertake QI training based on the assumption that most practices will have already undertaken this training in 2019.

- *Practices to implement standardised recording of clinical contacts as a means of reliably measuring clinical activity. The data will be used to better plan services related to acute conditions and long-term care, delivered by all clinicians.*

Full QI project guidance will be published as soon as available.

4. Improving Access to and from services

Following the introduction of the first two-year phase of Access Standards in March 2019, these standards will remain in place for the remainder of 2020- 21. There are a few minor modifications to the required standards: -

- the measure related to pre-bookable appointments will be removed from the framework.
- the Demand and Capacity planning requirement of the standards will be reactivated

A new phase of standards will be introduced for 2021 onwards, with the contract mechanism associated with the new standards discussed in future negotiations.

In line with the Primary Care Strategic Program 24/7 work stream we reached an agreement in principle to enable referrals from unscheduled care into GMS workloads, with GPs taking the ultimate decision how to treat the referred patient. Further work with all parties working together to support the integration of the Primary Care system on a 24/7 basis will be undertaken and detailed guidance issued at a later date.

The key aim of this work is in providing more streamlined and smoother access arrangements for patients **to and from** in-hour GMS services. However, we were very clear that direct booking by 111 into GP appointment books was not an option at present, and that GPs would retain the ultimate control of how any redirection would be handled. There is also agreement on robust quality assurance of any such mechanisms.

Removal of the patient charge for the completion of Mental Health and Debt Evidence Forms. This is a relatively simple and short form that states factually whether or not a patient in debt has a Mental Health problem. It consists of 2 pages, only the first of which is mandatory to complete.

To minimise the impact on practices, a digital form for integration into GP clinical systems is being created and will be available when the new form becomes contractual at the end of September.

5. Strengthening the primary care workforce

The Partnership Premium Scheme was introduced to rebalance the focus on partnership as an attractive career option.

The Seniority Payment Scheme, will remain in place but now closed to new applicants. The Seniority Scheme payment scales will be frozen at their current levels with no future uplifts applied. This will **not** prevent members moving up the scale as years of service increase.

An explanatory document for the Partnership Premium, published by Welsh Government, provides summary of both the existing Seniority Payment and the new partnership premium scheme, together with a selection of FAQs.

There is an agreement to scope out an extension of the partnership premium to Non-GP partners in practices, recognising the vital role and partnership risk these individuals absorb.

In line with a previous motion from Welsh LMC conference, an agreement was reached to widen the current SFE arrangements for reimbursement of sickness cover to include practice employed staff with Independent Prescriber status, which might include practice employed Pharmacists, Advanced Nurse practitioners and other Allied Health professionals. Given the difficulty in finding AHPs to act as *'like for like'* locums, it was agreed that backfill of these individuals can be undertaken by GP's on a locum basis, in a similar vein to GP sickness arrangements in the current SFE.

A review of available resources will be undertaken to allow all practice staff to access HB Occupational Health Services. Details of access to these services to be confirmed and circulated when available.

Contact us

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