BMA

Cymru Wales

Focus on changes to the Welsh GMS Contract 2017/18

What has been agreed?

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

Overall changes to the value of the contract

We have agreed an overall uplift of 2.7% in the value of the GMS contract. This equates to an investment of approximately £12.7m, and comprises:

- a pay increase of 1%;
- a general expenses uplift of 1.4% to cover practice costs;
- a contribution towards the increased costs of the pensions administration;
- a contribution towards the rising costs of professional indemnity (whilst a longer-term solution is found);
- a contribution towards the business improvement levy (see below)

There is also an increase in funding for maternity, parental leave and sickness absence, similar to the situation in England but with some Welsh specific elements (further detail below). Whilst the uplift will not provide a universal reprieve to the sustainability and workload challenges, it will go some way in delivering much needed resources directly into practices.

We are in discussion with colleagues at NHS Shared Services Partnership in relation to a spreadsheet or other tools which can assist practices in calculating the breakdown of this uplift. Practices should also remember any salaried GPs that they employ when considering this contract uplift in terms of the contribution towards indemnity. Of course for salaried GPs, the terms of their contract are locally negotiated and the BMA has a number of online resources to help with this.

Changes to QOF

The Welsh Government's letter of 3 April 2017 outlines the changes to QOF. There are no changes to how aspiration and achievement payments are made, and of course, Contractor

Population Index (CPI, as of value on 1 Jan 2018) and Adjusted Disease Prevalence Factor (ADPF) will be applied as usual.

Revised guidance on the operation of QOF for 2017/18 has been published by Welsh Government, concerning changes to the various domains within QOF. The changes are summarised below:

Clinical domain

The Clinical QOF domain has been split into Active QOF (202 points), Inactive QOF (165 points) and retired QOF (40 points). As requested by many practices, IT pop-up prompts for inactive and retired indicators remain in place should they wish to use them.

Retired QOF indicators will not be monitored in any way, and the 40 retired QOF points have been transferred to the cluster network domain.

For the inactive QOF indicators, practices will be paid per indicator at the payment level applied at year end 16/17 after manual adjustment following the QOF relaxation. There will be no requirement for practices to formally demonstrate their achievement in these areas, but data will continue to be extracted on these areas for discussion at cluster level mid-way through the year and at year end. These discussions should focus on the inactive DM and COPD indicators, with outcomes captured in the minutes of the cluster meeting.

Active QOF points will continue to be paid according to achievement at year end – there have been no changes to thresholds or new indicators added in.

In terms of monitoring requirements, we will be able to use Audit +. There is an acknowledgement and agreement that overall achievement will go down where indicators are no longer relevant OR when managing individuals vs. diseases. Health Boards may seek assurance as appropriate on any performance related issues and the LMC will be involved where appropriate.

There were very good reasons as to why the QOF suspension was not continued into this year, and a hybrid QOF put in its place. The outcomes of this will form part of the discussions on the future of QOF in the remainder of the year.

Cluster network domain

Welsh Government, Health Boards and GPC Wales remain committed to the principle of cluster working. While many of you may not feel clusters are transforming General Practice or working well, there are many areas where clusters are beginning to make a difference and we need to release the obstacles inhibiting their potential in areas where they are working less well.

This domain now comprises 200 points and will help serve to reaffirm the role of clusters. Full guidance is available on the GMS contract website. Both the practice development plan and cluster development plan indicators remain the same but with an expectation that they should look to development over a three-year period rather than 12 months. There remain 5 cluster meetings in total where the following areas should be covered:

- Peer review of inactive QOF indicators (as above),
- Agreement of a cluster development plan
- Consideration of actions on 3 nationally prescribed areas of focus (access to wider primary care; winter preparedness planning; liaison with secondary care)
- Agreement to undertake 3 national clinical priority pathways across the cluster: 2 to be selected from a national basket (pathways for cancer, dementia, mental health & wellbeing, COPD and liver disease) and one to be decided by the network. Outcome of this work to be referenced in the cluster meeting minutes.

Points have been included again for completion of the Clinical Governance Self-Assessment Toolkit so that practices can evidence governance protocols in use and identify areas for development.

Also new this year are the QOF points for completing the information governance toolkit, and for reviewing the practice information on the revised sustainability framework, so that practices can proactively consider their own sustainability.

Cluster meeting attendance

The Cluster Network Domain section of the QOF guidance (Section 5) now takes into account the difficulties some single-handed or small practices may have in sending a partner to cluster network meetings. This guidance now makes explicit the capability for practices managers to attend meetings or for buddying arrangements with a larger practice, provided that the smaller practice engages electronically with cluster work. It also recognises that practices of all sizes may not find it possible to allow partners to attend cluster meetings, and thus allows for representation by senior employees (including administrative staff) with health board agreement.

National clinical priority pathways: Liver disease

In relation to the clinical national priority pathways, it has become apparent that not all health boards can deliver the Liver disease pathway as agreed, over concerns regarding cost and preference for established local pathways. This is unfortunate as these were not raised during the negotiation period by appropriate representatives. We would advise that clusters located in health boards who are unable to accommodate this pathway should choose an alternative from the national basket.

Secondary care initiated Phlebotomy

In light of the rising workload demand in this area, we have agreed a payment to practices to reflect the workload involved for phlebotomy tests which have specifically been requested by a secondary care provider. This includes administrative processes, professional oversight and/or providing a directly employed phlebotomist.

This is a direct payment made from non-GMS funds *not* an enhanced service. There is a requirement to undertake an annual data collection (by recording these externally initiating tests using the READ code 9N7D), extracted at year end. Payments will be made twice-yearly based on list size not activity. Practices not directly employing a phlebotomist, or paying for the delivery of phlebotomy services will be entitled to a payment of £300/1000 patients per

year; while practices directly employing a phlebotomist will be paid according to £450/1000 patients per year.

Enhanced Services

Agreement has now been reached on a number of enhanced services which will increase GMS income by an additional £13m. This includes a new care homes DES, a new warfarin management DES. We are also in final stages of negotiations regarding a suite of enhanced services for type 2 diabetes.

The specifications and directions regarding three enhanced services have been published on the GMS contract website:

- ### Care homes Directed Enhanced Service
  This enhanced services applies to all residential care homes and nursing homes, as detailed in the specification. We have developed a FAQ specifically on this DES, available online and will periodically update this as new queries emerge.

- ### Warfarin Management Directed Enhanced Service
  There are two relevant reimbursement levels under this service, depending on the extend of a practice's dosing services, as detail in the specification. Two health boards (ABMU and Betsi Cadwaladr) requested a delayed start of this service and are unlikely to commence with any new practices ahead of 1st October 2017. Health Boards (other than ABMU) are undertaking a central procurement exercise for consumables and software. While this progresses, any costs borne by practices through the renewal of software licenses or purchase of consumables are to be reimbursed by Health Boards according to the agreed DES levels from 1st April 2017.

- ### Mental Health Directed Enhanced Service
  As before, this enhanced service funds the provision of annual practice education in mental health. This year's specification adds new topics for practices to consider.

- ### Type 2 Diabetes Enhanced Services
  Due to delays beyond the control of GPC Wales, negotiations regarding this enhanced service are in the process of being concluded. We have negotiated a specification for a suite of enhanced services for adult patients with type 2 diabetes, which will enable the delivery of a more comprehensive, structure package of care to patients in primary care. The suite of services has a modular structure, with a compulsory gateway module to be offered as a DES, with four optional modules (Monitoring of GLP1s, Initiation of GLP1s, Insulin monitoring, Insulin initiation) offered as NES agreements with a high expectation from WG that they should all be offered as an integrated package of care. which can only be offered provided the gateway one is undertaken.

  Payments for the gateway module are made for 100% of the patients in practice with Type 2 diabetes at the end of each quarter. All other modules are paid on a fee for service basis at a nationally negotiated rate; however existing local enhanced

services at a higher rate will continue. We anticipate that this service will be offered from 1 October 2017 and will produce more detailed guidance shortly.

Sickness and Maternity, Paternity and Adoption Leave payments

We have negotiated payments to cover sickness and maternity leave which are similar to the English GMS agreement. The SFE has been updated accordingly and published online (consolidated version August 2017), taking effect from 1 April 2017. We have created a separate Focus On… document on this topic.

For both sickness and parental leave, payments will no longer be made on a pro-rata basis, are not discretionary, and internal cover can be provided by partners (in excess of their usual commitment). The Welsh contract allows for practices to utilise any existing partners or salaried GPs to cover the absence of a GP performer, whereas the English deal states that this covering individual should "*not be employed full time*".

For sickness payments, the qualifying list size criteria has been removed ensuring that all practices will be eligible for this reimbursement once a GP has been absent as a result of sickness for 2 weeks, at a maximum of £1,734.18 per week. The duration will continue as it has been in terms of 26 weeks of full pay followed by 26 weeks reduced, with payments reimbursed on invoice.

Similarly, for maternity or adoption leave payments, the first 2 weeks will be paid at £1,131.74 with a further 24 weeks paid at the maximum of £1,734.18 per week.

We are actively pursuing health boards with regard to the reimbursement of payments for those who were underpaid in previous years due to what we believe was incorrect pro-rata calculations of sessions for less than full time partners.

Indemnity

The agreement includes a contribution towards the rising cost of indemnity into global sum based on capitation. This is an interim solution while we seek long-term solutions alongside Welsh Government and NHS Wales. We are also keenly monitoring the situation in England, as we seek to mitigate the impact of the Ogden ruling (the discount rate changes).

This year's contract contribution equates to £0.516 per registered patient, made directly to practices within the global sum. This is equivalent to the funding in the English contract, and it is expected that this payment should benefit partners *and* salaried doctors working within the practice (if indemnity cover is not already paid for by the partnership).

Other contract elements

- Seniority payments are maintained in Wales
- Any practice subject to a "*Business Improvement Levy*" can have full reimbursement from the Health Board. We are actively working on securing an outright GP exemption with Welsh Government.

BMA

2018 onwards

The fundamental review of the Welsh GMS contract for 2018 and beyond will commence in September, with a 'Future of general practice' meeting involving key players from NHS Wales and Welsh Government alongside GPC Wales representatives.

This meeting will set the shared vision for general practice in Wales, with several themed work streams then developing proposals for a contract which can enable this vision.

Work streams will include:

- Workforce;
- Minimising risks (business and individual);
- Cluster development;
- Funding;
- Demonstrating quality;
- Integration.

To get in touch with GPCW please email: **info.gpcwales@bma.org.uk**

Thank you for your continued support.

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