General Medical Services (GMS) Contract Revisions 2019-20
Frequently Asked Questions (FAQs)

What are the key changes under the 2019-20 GMS Contract Agreement?

The GMS Contract agreement for 2019-20 introduces several new changes with a clear focus on:

- incentivisation of partner working through the introduction of the new Partnership Premium Scheme;
- a clear emphasis on working at scale and a mandatory requirement for cluster membership;
- a new Quality Assurance and Improvement Framework with a new QI domain and project activity to be planned and delivered on a cluster basis; and
- new standards in relation to access to GMS services in the general practice setting.

The contract agreement also involves a commitment from all parties to undertake further work through 2019-20 on a premises review, enhanced services review and legislative changes in relation to data sharing.

PARTNERSHIP PREMIUM

When will the Partnership Premium Scheme commence?

The scheme was introduced on 1 October 2019.

Why has a new Partnership Premium been introduced?

The new Partnership Premium Scheme has been introduced as part of our commitment to the partnership model as the preferred model for delivery of GMS and to incentivise GPs to take up the key partner roles across GMS.

The Partnership Premium Scheme provides payments to GP Partners based on the number of clinical sessions undertaken. In addition, in recognition of the need to reward and retain our most experienced GP Partners a senior element has been included.

How will the payments under the scheme be calculated?

The guidance and Statement of Financial Entitlement (SFE) sets out the payment structure for the new scheme. Data on the number of clinical sessions undertaken will be collated by Shared Services Partnership (SSP) on a quarterly basis. In the long term, we envisage that this information will be taken from the Wales National Workforce Reporting System (WNWRS) but as an interim measure a claim form has been developed to capture the necessary data.

Is the scheme a long term commitment? What are the implications for the existing Seniority Scheme?

We have committed to the new scheme being a long term element of the GMS contract with significant investment having been made into the contract to support this. The amount payable is set out in the guidance and SFE. Any future changes will be considered as part of the overall investment package in future negotiations.

As part of the contract agreement we gave assurance that there were no immediate plans to change or withdraw the existing Seniority Scheme. This scheme will continue in its current form with the exception that no new applications to join this scheme will be accepted after 30 September 2019.

Can GPs stay on the existing Seniority Scheme if they are already in it?

Yes, GPs who are already in receipt of payments under the existing Seniority Scheme are able to continue on that scheme. No changes have been made to the existing scheme. However, GPs can opt to migrate to the new Partnership Premium Scheme after which they will not be able to migrate back to Seniority.

Can GPs still join the Seniority Scheme?

No new applications to join the Seniority Scheme will be accepted after 30 September 2019. However, GPs can choose to join the new Partnership Premium Scheme.

How do GPs join the new scheme?

An application form, developed in conjunction with SSP, has been made available. GPs wishing to join the new scheme should complete this form and return to SSP and complete the necessary data collection fields of the WNWRS.

What is the definition of “reckonable service” under the new scheme?

Reckonable service should only be counted as clinical service under the new scheme. Clinical service since the date on which the GP provider first became registered with the General Medical Council, or an equivalent authority is to count towards Reckonable Service. Breaks in service are not to count towards Reckonable Service but periods when doctors were taking leave of absence (i.e. they were absent from a post but had a right of return) due to compulsory national service, maternity leave, paternity leave, adoption leave, parental leave, holiday leave, sick leave or study leave, or because of a secondment elective or similar temporary attachment to a post requiring the provision of clinical services, are to count towards Reckonable Service. Paragraphs 15.3 to 15.9 of the Statement of Financial Entitlements provides the full details.

What is defined as “a clinical session” and what is and isn’t included for this purpose?

The SFE sets out the definition of a clinical session in detail. However, a clinical session is defined as 4 hours 10 minutes and will usually consist of patient contact (which may be via the phone at the premises) plus time for correspondence, test follow up and other administrative tasks associated with patient care. There is a maximum limit of two sessions per day with a typical full time working week consisting of eight sessions.

A session may also include time spent on Undergraduate or Postgraduate medical teaching and attendance at coroners courts.

Clinical sessions *do not* include time spent on locum work, Cluster Lead sessions, working in a community hospital or any work undertaken outside of the normal business of the practice.

Annual leave up to a maximum of six weeks pro rata per annum (excluding bank holidays) qualifies for payment. In these circumstances, clinical sessions will be based on the average number of clinical sessions undertaken by the GP in the previous quarter.

Sickness absence is included as qualifying for payment. In these circumstances, clinical sessions will be based on the average number of clinical sessions undertaken by the GP in the previous quarter.

Maternity, paternity, adoption and shared parental leave are included as qualifying for payment. Clinical sessions, for these purposes, will be based on the average number of clinical sessions undertaken by the GP in the previous quarter.

Compassionate Leave is included as qualifying for payment. In these circumstances, clinical sessions will be based on the average number of clinical sessions undertaken by the GP in the previous quarter.

What about GPs who are working more than 8 sessions per week? Will these additional hours or sessions be payable?

The current payment structure allows for payments for up to 8 clinical sessions per week. Where additional sessions are undertaken, no additional payment will be made in relation to these.

What allowances are made for undertaking mandatory training or CPD under the scheme? Will there be a list made available?

Up two weeks pro rata per annum for CPD/mandatory training related to the individuals role as a GP will be eligible for payment under the scheme. Given the range of training and development that this could cover, no list will be provided.

What allowances are made for attendance at meetings on behalf of the practice?

For the purposes of partnership premium, a clinical session will usually consist of patient contact (which may be via the phone at the premises) plus time for

correspondence, test follow up and other administrative task associated with patient care. Attendance at meetings on behalf of the practice would be eligible under a clinical session for partnership premium.

Can a GP apply for two partnership premiums if they hold two GMS contracts, under two separate W codes?

Yes, a partner can claim for two partnership premium payments for sessions worked at more than one partnership up to a maximum of eight clinical sessions in total.

Will the scheme recognise previous years of service (e.g. as a GP in England) in order for GPs to be eligible for the £200 senior premium under the scheme?

Yes, previous service will be recognised for the purpose of eligibility for the senior premium element of the scheme. More details are outlined within the SFE.

Are there plans to expand the scheme to include non-GP partners?

The scheme is open to GP partners only. The scheme has been introduced to address GP contract sustainability issues caused by a lack of appetite from newly qualified doctors to enter into partnership arrangements. There is substantial evidence of a shift towards sessional GP locum working as a career choice by younger doctors, the consequences of this are an issue for the future sustainability of partnership arrangements. Any changes or expansion to the scheme including widening eligibility to non-GP partners would need to be considered in the context of evidence of a contractual issue and a full business case to justify a policy action through contract investment.

Are courses contributing to continuous professional development (required by the GMC) included?

Training for Continuous Professional Development can be included.

Illustrative examples – calculating a clinical session

1. **A GP undertakes a 5 hour session from 8:00-13:00 with 3.5 hours spent seeing patients and the remaining time undertaking patient related admin work (e.g. signing prescriptions and checking test results).**

   For the purpose of Partnership Premium, given the nature of the work is directly related to patient care and usual course of business for the practice, the whole 5 hour session will be eligible as a single session.

2. **A GP working 6 sessions may actually work 6 x 6hour sessions – being 36 hours, which is equivalent to 8.6 sessions based on the 4 hour 10 minute definition – so can we assume this GP would be receiving the full £8,000 partnership premium payment?**

The SFE sets out the definition of a clinical session in detail. However, broadly a clinical session is normally defined as 4 hours 10 minutes and will usually consist of patient contact.

There is a maximum limit of two sessions per day with a maximum of 8 sessions per week.

In this scenario, the GP would not receive the full £8000 but payment for 6 clinical sessions.

3. **A GP works a proportion of their sessions on an "on call basis".**

   A clinical session is defined as 4 hours 10 minutes and will usually consist of patient contact (which may be via the phone at the premises) plus time for correspondence, test follow up and other administrative task associated with patient care.

   "On call" activity whilst operating from the practice or home visits (i.e. undertaking other duties such as patient admin) will be eligible for payment.

   "On call" activity whilst operating from elsewhere (i.e. from home) will not be eligible for payment under the scheme.

4. **A GP spends some session time during the week teaching medical students.**
   A clinical session under the partnership premium may also include time spent on Undergraduate or Postgraduate medical teaching

5. **A GP partner attends a cluster meeting on behalf of their practice in lieu of undertaking a session.**

   Time spent attending cluster meetings on behalf of their practice will be eligible for payment under the Partnership Premium Scheme. Time spent as a Cluster Lead is not eligible for payment under the scheme as this is separate employment and not undertaken on behalf of a specific practice.

6. **A GP works 8 sessions per week but for 2 of these he is released by the practice as a GPwSI to do cardiology work in secondary care.**
   Time spent as a GPwSI within secondary care is not eligible for payment under the scheme as this is separate employment/contractual arrangement outside of the GMS contract.

ACCESS TO IN-HOURS GMS SERVICES STANDARDS

Who do the standards apply to?

The standards apply to all GMS practices including those under Health Board management. Whilst in the context of QAIF they are voluntary, a clear expectation has been set by the Minister for Health and Social Services that all practices should be compliant with the standards by end of March 2021.

What happens if a practice doesn't achieve the access standards? Will they still receive payment?

No. Payment will be made under the Quality Assurance and Improvement Framework (QAIF) and will be paid on an achievement basis only. Further information on payment arrangements can be found in the guidance and the Statement of Financial Entitlements. In recognition of some practices needing to invest in new infrastructure/systems to support them meeting the standards, a significant investment was made into GSUM as part of the 2019-20 contract agreement directly linked to access.

Why is there such a focus on digital solutions to access?

An improved digital offering is a key focus of the introduction of the standards. In order to meet the varying and sometimes complex demands of patients and to reduce the demand on front desk service. The digital solution can include systems such as "Ask My GP" and there are excellent examples of these systems in operation across Wales.

Some practices operate an open access appointment system, why do they need to invest in digital solutions?

Open access appointment systems can be a beneficial method of operating, but not in isolation. Open access is not, in itself, an appropriate single access method and is a difficult fit with the triaging and primary care model. Patients have varied needs and demands and appointment systems need to offer a range of contact options including through digital methods for routine advance appointments.

What are the requirements for a new telephone system? Will practices be supported with a national specification?

The guidance sets out the minimum requirements we would expect to see for telephone systems in practices. For some practices, this will require procurement of a new system and funding has been made available through GSUM to support this. Practices should consider the requirements of the standards such as the ability to record incoming and outgoing calls, call stacking and the number of lines required when procuring any new system to ensure that it will enable them to achieve the standards.

Does the requirement to be able to record incoming and outgoing calls apply to the calls themselves?

Yes, the recording function is in relation to the conversation and for specific purposes such as training or monitoring purposes. Patients should be made aware of this beforehand and standard wording is included in the introductory bilingual message which will be made available to practices.

Will there be any financial reimbursement for practices who are tied into existing telephony contracts and want to enter in to a new one?

No, practices will not be reimbursed any early exit fees with regards to their existing telephony contact. This should be funded (whether partly or wholly) from the investment made into GSUM relating to access infrastructure. Practices should also consider discussing their requirements with their existing providers as upgrade options may be available.

How does the push to offer patients the ability to book appointments digitally fit with the drive in appropriately triaging patients and signposting to alterative services?

The option of booking an appointment through a digital method applies to pre-bookable advance appointments only and should be across the range of professionals in the practice. Some digital programmes also offer a triaging function, whether virtually through an agreed methodology or through a suitably trained person (e.g. call handler at the practice) reviewing the information submitted. Practices should consider the functionality and offering of any system they procure.

On the day urgent appointments should continue to be accessed appropriately (e.g. via the telephone) with triaging playing a critical role in the management of patient needs, practice capacity and in educating patients around the wider services available based on their needs.

What tools/templates will be made available nationally to support the standards?

Wherever possible we want work to happen in a consistent way across Wales. In support of this, we are developing a nationally agreed reporting template and framework which will be made available prior to the first reporting period in March 2020.

A national approach to Demand and Capacity auditing is also being scoped out and will play a significant role in workforce planning. We are looking to rollout a toolkit later in 2020.

The standards require all practices to have in place a bilingual introductory message for in-hours which includes information on the role of triaging and appropriate signposting to other local services.

A bilingual standard introduction message has been made available for use by all practices and can be adapted at a local level to add additional information such as cluster based services.

We are working with NWIS to establish a national governance framework around the use of email for the booking of routine/advance appointments.

What are the reporting arrangements for the standards?

The progress of all practices will be assessed at 31 March by means of practice achievement claim in accordance with the Statement of Financial Entitlement.

Health Boards will be required to report quarterly on progress against the standards in their area. Developments, issues and good practice should be discussed at the "Access Forum" meetings Health Boards are required to have as part of the standards. Health Boards will also be required to report against any delivery milestones set in relation to the standards and should continue to monitor practice achievement throughout the year to inform discussions at Board and Executive level.

In order to facilitate discussion at Health Board "Access Forum" and enable Health Boards to report on progress and offer support where needed, practices are expected to submit data on a quarterly basis.

The standards require all patients under 16 with an acute presentation and all patients with an urgent need to be seen the same day. Can we no longer advise patients to "ring back tomorrow"?

No. This standard has been introduced in line with patient safety guidance and best practice. A consultation should be offered on the same day for patients falling into these categories but this could be with an alternative healthcare professional other than the GP and could also include a telephone consultation.

What do you mean by "triaging" in the standards? Who is able to undertake "triaging"?

Triaging for the purpose of the access standards is defined as the process of care navigation. The guidance has been updated to clarify this point, Care navigation is a means of identifying patient needs prior to an appointment being made in order to appropriately direct patients to the right source of care and support. This plays a key role in helping patients understand their needs and directing them to the most appropriate professional to assist them. In some cases this will not be a GP and may be a member of the wider team or other healthcare professional. In turn, this will assist practices in managing the demand of patients to ensure the most urgent cases are seen first.

Care navigation should be undertaken at first point of contact and need not be undertaken by a GP. Suitably trained practice staff, including admin staff who have been appropriately trained are able to undertake this role.

What are the intentions in terms of developing My Health Online (MHOL)?

Development of My Health Online as a project has concluded. The Data & Digital workstream of the Strategic Programme will be responsible for considering the future of the digital platform for primary care including the functionality of MHOL.

What support will practices receive in relation to the Welsh Language Duties?

Health Boards can provide you with resources such as lanyards and training as well as translation of signs and notices in connection with services provided under the contract.

If practices are meeting demand using either walk in clinics or with a large volume of on the day bookable appointments, and can prove that they meet demand with their demand analysis data. Are they then expected to change their appointment system to meet this standard?

A single all Wales appointment system would not be appropriate or effective. Practices should design and implement an appointment system that meets the needs of their patients. However, research shows that there is a need for an increased digital access offering in order to improve the experience for patients. Practices are also expected to adopt the triaging model in order to manage patient needs and to enable better use of MDT skill mix thus reducing demand on GPs who can be freed up to see the most complex cases.

Whilst we do not expect practices to make significant changes to effective appointment systems, a focus on wider access initiatives such as digital and access to other healthcare professionals is required under the standards.

What does the "25% of all pre-bookable appointments bookable through a digital solution" requirement apply to? Is this 25% of all appointments for all clinician's individually or 25% of the total appointments available?

This applies to the overall total of pre-bookable appointments available across the whole practice and including wider healthcare professionals. Whilst the percentage is not being applied to each individual clinician, focus should be given to increasing the number of pre-bookable appointments available across the practice as a whole.

What are the arrangements around annual participation in Patient Surveys?

The guidance has been updated to reflect that the previous All Wales Patient Survey may no longer be fit for purpose. On that basis, practices will be required to undertake their own survey although it is expected that this will be developed and findings considered on a cluster basis. This will enable clusters and practices to target surveys on issues they specifically wish to get feedback on such as the design of appointment systems.

Are there exceptions to recording bilingual messages, if it is not deemed appropriate for a practice to provide such a message?

No, as part of the access standards, practices must have in place a bilingual introductory message which includes information on urgent need, triaging and

signposting to other services. A standard template will be provided that can then be adapted at local level.

We would expect standard 3 to be achieved by end of March 2020 as a bilingual transcript will be provided. As such, it is expected that standard 3 be one of the three, four or five standards achieved when making any claim for payment under Group 1.

Will the Welsh Government monitoring of practice opening hours continue?

Yes, data on practice opening hours will continue to be collected.

GP practices are required to give Care Homes access to repeat prescriptions through a digital method, does this need to be by individual patient or can multiple prescriptions be ordered in a single contact?

Under the standards, all practices should offer the option of repeat prescriptions through a digital method for Care Homes. How this is then used is at the discretion of, and agreement between, the practice and the Care Home as well as based on the functionality of the system in place.

QUALITY ASSURANCE AND IMPROVEMENT FRAMEWORK (QAIF)

When does the new Quality Assurance and Improvement Framework come in to effect?

The new framework, which replaces the previous QOF, came into effect as of 1 October 2019.

How is the value of QAIF points calculated?

The revised SFE sets out the calculation for the value of QAIF points. For 2019/20 the QAIF point value for QAIF QA, QI and Access is £179.00. On and from 1 October 2020, the value of a QAIF point for QA and QI will be recalculated each year after the National Average of Registered Patients (NARP) has been established and will apply to the current QAIF (QA and QI) year for QA and QI, subject to any uplift that may or may not be applied.

The revised QAIF point value is to be calculated by multiplying the previous QAIF point value by the fraction produced by dividing the newly established NARP that will apply for the forthcoming QAIF (QA and QI) year by the NARP that applied to the previous QAIF (QA and QI) year.

The QAIF point value for Access achievement at 31 March will be the value at the previous 1 October.

What are the timescales around clusters agreeing QI projects?

Under the new QAIF, clusters will be required to undertake QI projects as a cluster. This will include a choice from the basket of projects available. Health Boards have asked clusters to agree their projects by the end of October 2019 to allow sufficient time for the work involved to be undertaken and for individual practice plans to be agreed.

Will the QI projects be the same for 2020-21?

The existing projects under QAIF will remain with further QI projects being added in Year 2.

What QI training is available?

The guidance provides examples of relevant QI training that is available. 85% of registered health care professionals, and all practice managers within the practice are expected to complete the training at Bronze level. Administrative staff are not expected to need to do so, although this is up to individual practices to consider their own circumstances and practice requirements.

Will there be an agreed template for the audit or will practices/clusters be expected to develop their own?

The guidance sets out the expected outcomes of the QI projects and material on approaches to QI projects. Health Boards are developing a template for use by practices and will work with practices and clusters to support the delivery of Quality Improvement actions.

What resources are available to practices to support QI?

The current resources available to support practices are contained or referenced in the QAIF guidance. Additional resources may be developed through the year and will be publicised when made available. Discussions have been held with 1000 lives and NWIS around resource to support the patient safety project.

What effect will QAIF have on practice finances, e.g. the period of time in the reporting year that has already passed?

The QOF formally ended and was removed from the GMS contract in Wales on 1 April 2019. Contract negotiations were ongoing at the time, so as a measure of good faith and to maintain practice cash flow, Welsh Government amended the GMS contract SFE to require health boards to continue paying amounts equal to QOF aspiration payments in the belief agreement on the contract for 2019/20, including the introduction of QAIF, could be reached and the new scheme operate from October 2019 (the change of cycle had already been discussed in negotiations). This action has meant practices continued to receive amounts equal to what would have been expected under QOF during the six month period prior to the introduction of QAIF.

The QAIF cycle being October to September does mean QAIF QA and QI achievement payments will be paid in December, QOF achievement payments were

paid at June. This is not a financial loss but a delay of a small part of practice cash flow. However, practice cash flow will benefit from the investment made into QAIF Access achievement (payable at June) and the introduction of the partnership premium scheme. Whilst the benefit will vary according to individual practice circumstance, the quantum effect from all parts of the contract agreement will accrue in advance of June 2020.

Is there a difference between a GP Cluster and Primary Care Cluster?

Yes. Primary care clusters (clusters) are a mechanism to enable collaboration between health boards and their partners at a local level. Primary Care Cluster is the preferred term for the wider Cluster group including other Independent contractors, Local Authority and third sector. The GP Cluster network can be defined as the groupings of GP surgeries within the wider Primary Care Cluster (PCC).

Who can be an alternative representative at Cluster meetings?

Non-GP practice members can represent practices, however this will need to be discussed and approved with the Health Board on a case-by-case basis.

Are Clusters expected to meet the new IMTP standards immediately, how many IMTPS should each cluster produce and does the content need to cover the whole Cluster?

A new style and format for the cluster action plan template is required from October 2019 to September 2020 which should take the form of a cluster level IMTP, triangulating population health, planning of new services, workforce, activity and finance. More information can be found on the below links.

Cluster IMTP 2020-2023
http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/2019-07-025%20AG%20to%20CEs%20re%20Cluster%20IMTP.pdf

Cluster IMTP Guidance

http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/Cluster%20IMTP%20Template%20%20Guidance%20July%202019.pdf

Cluster IMTP Template

http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/Appendix%20I%20-%20Template%20for%20Cluster%20IMTP.pdf