Implementation Guidance for Providers of General Medical Services

March 2025

Introduction:

This guidance has been produced with the aim of supporting a consistent Wales wide understanding of the operational aspects relating to the delivery of general medical services (GMS) following the recent tripartite GMS contract agreement between Welsh Government, NHS Wales and GPC Wales. There are a number of contractual amendments which have been agreed during the recent negotiations which have not yet been reflected in the Regulatory framework. It is intended to incorporate these items within revised contract legislation.

Context

The GMS Contract is a legal contract between the respective Health Board and the GMS Contractor. The GMS Contract Implementation Group (CIG) includes representatives from the Welsh Government, GPC Wales, NHS Wales and other key stakeholders, and was formed to help transpose the recently agreed negotiated outcomes within the annual contract and underlying legislation.

Purpose

This guidance has been specifically produced to assist practitioners and practices in respect of implementing the new contractual requirements, illustrating how the contractual changes and/or additional aspects are intended to work in practice, at an operational level.

The guidance exclusively applies to the following areas:

- Application of staff pay uplift;
- Learning Disabilities;
- Covid antivirals;
- Frailty indexing;
- Ethnicity recording;
- Repeat Prescribing via the NHS App;
- Welsh Identity Verification Service (WIVS);
- Requirements for practices on the Access Standards for 2025/26.

The guidance will be particularly relevant to health boards, persons who provide or may wish to apply to provide general medical services, persons who assist in the provision of general medical services or may wish to apply to assist in the provision of such services, and representative bodies.

The guidance provides clarity on aspects for immediate service implementation and on service changes that will be brought into being via modifications to the General Medical Services Contracts (Wales) Regulations 2023. In this respect a lead-in time has been intentionally factored in which the practice guidance summarised within this paper is intended as a forward look, enabling practices and practitioners to

prepare and make the necessary adjustments, in a timely manner in advance of the legislative changes coming into force.

1. Staff Uplift

In terms of investment, the DDRB recommendation of a 6% pay uplift to GP pay, and to extend this pay uplift to all practice staff for 2024/25 has been met.

To clarify, the staff uplift element of funding should be applied in full after any statutory pay uplifts have been applied. Recognising the vital role all practice staff play in the delivery of services and the desire for a fair and equitable pay uplift to be made to those existing staff, funding will be made available, mandated to ensure all relevant practice staff receive a 6% uplift to their gross pay.

1.1 Requirement:

All staff that were in post at 1st April 2024 should receive a pay increase of 6% for 2024/25, backdated to 1st April 2024. The staff uplift element of funding should be applied in full after any statutory pay uplifts have been applied.

Where practices have already awarded staff an in-year pay increase, they must now uplift that increase to 6%, if it was previously a lower figure (e.g staff already awarded 3% must now also get the additional 3% backdated to 1st April and applied to the rate payable on 1st April - not the uplifted rate).

This will include any staff that may have left practice employment since 1st April 2024 and practices should make reasonable attempts to contact those staff that have left.

Whilst the SFE does not mandate an uplift to new staff, any staff that started in post after 1st April 2024 may be subject to specific clauses in their practice employment contracts in their first year of employment. Practices will need to make a judgement on these on an individual basis.

Practices will be required to complete a self-declaration, as in previous years, to confirm that they have paid all eligible staff a 6% pay rise. A practice declaration form and associated guidance communicating the requirement was issued to all Wales GP Practice Managers on 21 February 2025.

1.2 Additional Practice Expenses

Alongside the 6% pay uplift for GPs and their staff, an additional £1.8 million of annual recurrent funding has been made available for other practice expenses.

1.3 In year non-recurrent funding

The total investment into General Medical Services for 2024/25 is £52.1m, made up of £25.1m recurrent monies, £23m of non-recurrent monies, and the current year's Additional Capacity Fund allocation of £4m. In addition, there is a commitment to continue the £4m of Additional Capacity Funding through 2025/26 as part of this overall settlement. A short life working group will address the Additional Capacity Fund and options for the future.

For information purposes a financial breakdown of the new investment for 2024/25 is provided as follows:

1.4

New Investment:

Recurrent funding 24/25	
DDRB recommended 6% pay uplift for GP partners	£10.6 million
DDRB recommended 6% pay uplift applied to practice staff	£12.7 million
Practice expenses	£1.8 million
In year non-recurrent funding for 24/25	
Non-recurrent practice stabilisation payment	£23 million
Additional Capacity Fund investment in 24/25 (with commitment to continue at same level for 25/26)	
Additional Capacity Fund	£4 million

Here is a link to the additional capacity fund guidance.

1.5 Legislative process and financial aspects

The Directions to Local Health Boards as to the Statement of Financial Entitlements (Wales) 2013 ("the SFE") will take into account the uplifts noted above. This will be applied to the 2024/25 financial year and apply going forward (for all recurring elements).

Queries relating to the funding and any claiming process should be directed to NWSSP at nwssp-primarycareservices@wales.nhs.uk

2. Learning Disability

The requirements of the Directed Supplementary Service will transfer into 'unified' services, with existing DSS spend moving into Global Sum.

To clarify, this will form part of core GMS Contract Regulations. The existing Directed Supplementary Service (DSS) will come to an end, and the current £500k DSS funding will move from supplementary services into global sum on a recurrent basis.

The guidance relating to this provision is attached at annex A, and was developed on a collaborative basis by CIG, upon agreement on the definition of learning disabilities (LD) that qualifies a person to be on the GP LD register and to describe in the GMS contract regulations the primary medical services that all people with LD should

expect to receive under the unified contract. This includes, as part of unified services an offer of an annual patient care review that should be conducted by the contractor. Please also find attached at annex B a health check document that accompanies the guidance (annex A) together with advice on clinical coding at annex C.

3. Covid Anti-viral treatments

Agreement was reached to introduce a change to the treatment pathway that will enable eligible patients to contact their GP practice (or the GP Out of Hours Service) when/if they test positive for Covid and to be clinically assessed inclusive of covid antiviral treatment i.e. Paxlovid to be prescribed and dispensed from within primary care if deemed appropriate. This requirement will form part of the core contract in which the operational detail will be attached to this guidance as a standalone document, at annex D, when finalised. In the meantime, the following advice is included in lieu of the final guidance, to be circulated in due course:

3.1 Introduction of the pathway, supported by supplementary guidance, during the contractual year will be dependent on finalisation of the supply chain arrangements for Paxlovid and will be introduced with an agreed period of notice and support for necessary training opportunities by Health Boards. Patients who are deemed unsuitable for oral Paxlovid but suitable for parenteral therapy will continue to be managed by Health Board services and the pathway within each Health Board area will be reaffirmed with the supplementary guidance.

4. Collection of data via GP systems on frailty & ethnicity.

Going forward there will be a contractual requirement for GPs to include agreed equalities data questions (using consistent ethnic group categories) within their new patient questionnaires, and to record this information on the patient record.

Practices will also be required to proactively identify people who are living with severe or moderate frailty using an evidenced based tool.

To clarify, both elements will form part of core GMS Contract Regulations with the operational detail provided below.

4.1 Frailty indexing - GMS Contract requirements for the identification and management of people with frailty:

Background

Frailty is the most problematic expression of ageing we are facing in modern healthcare. While relatively easy to recognise when advanced, distinguishing older people with less advanced frailty from fit older people is challenging. However, it is important to identify patients who may be living with frailty by stratifying populations of older people by risk of future health and care utilisation to ensure health interventions are appropriately targeted.

Purpose

The identification and coding of frailty will support early identification and allow for targeted support from health and care services as appropriate for older people living with frailty to help them stay well for as long as possible.

Aim

Is improve the care of patients who are frail, by increasing identification and awareness, to promote clinically appropriate clinical care and advice.

What do practices have to do?

The contractual requirement is to proactively identify people who are living with severe or moderate frailty using an evidenced based tool.

This may be done by:

- using an evidenced based tool practices should proactively identify older people (aged 65 and older) who are living with severe or moderate frailty, and
- confirm diagnosis by clinical assessment of the patient,
- add appropriate coding to the patient medical record once diagnosis has been confirmed

The minimum requirement is that practices undertake a frailty assessment as part of chronic disease annual review, on appropriate patients, utilising the Rockwood assessment tool. Use of the Rockwood tool is mandated to ensure consistency across all practices.

Practices may also take the opportunity to assess patient frailty during other interactions during the year.

In order to identify suitable patients, practices may wish to utilise the electronic frailty index within their clinical system which can flag those at risk of frailty, but this should only be used as a risk stratification tool and in itself does not meet the minimum requirement. Batch coding should not be utilised.

Further guidance regarding practice requirements are included at annex E.

4.2 Ethnicity recording:

The contractual requirement is for GPs to include agreed equalities data questions (using consistent ethnic group categories) within their new patient questionnaires, and to record this information on the patient record. In alignment with this requirement practices must take action to ensure that the categories as listed below are captured within patient questionnaires.

Asian, Asian Welsh or Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background

Black, Black Welsh, Black British, Caribbean or African

- Caribbean
- African
- Any other Black, Black British, or Caribbean background

Mixed or multiple ethnic groups

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed or multiple ethnic background

White

- Welsh, English, Scottish, Northern Irish or British
- Irish
- Gypsy or Irish Traveller
- Any other White background

Other ethnic group

- Arab
- Any other ethnic group

5. Practices to enable the repeat prescribing functionality of NHS Wales App.

Going forward there will be a contractual requirement for GMS contractors to ensure they use the NHS Wales App to allow patients to order repeat prescriptions. Digital Health and Care Wales (DHCW) have been working to 'onboard' all practices to the NHS Wales App which is offered as the recommended supported digital tool enabling practices to discharge the contractual requirements, enabling patients to order repeat prescriptions via the approved app. This function is therefore already available to providers of general medical services included in the "onboarding exercise" which commenced in 2024 enabling practices to utilise the NHS Wales App to order repeat prescriptions.

Practices who have not yet "onboarded" to the app will be contractually required to use the app from the point at which they "onboard" to uphold the contract requirement.

6. Welsh Identity Verification Service (WIVS).

Agreement relates to practices assisting patients with the WIVS. This is essentially onboarding for patients for the NHS Wales app, akin to the previous *"My Health Online"* in which GP practices are required to support patients requiring assistance with the process to enable patients to access the NHS Wales App. This requirement will form part of the core contract and included within the GMS Contract Regulations. **DHCW guidance, inclusive of the respective technical process, will be circulated to practices as soon as the guidance is completed to accompany the WIVS rollout scheduled for May - June 2025.** In the meantime, the link below

is provided as a forward look to providers of General Medical Services, demonstrating the patient's journey in respect of the WIVS process. The aforementioned and overarching DHCW guidance will be added to this guidance as annex F, in alignment when it becomes available by DHCW.

WIVSVideo://nhswales365.sharepoint.com

7. Access

To embed the positive progress achieved to date in respect of GMS Access Standards and to ensure there is consistency in patients accessing their GP practice, the pre-qualifier access standards (previously Phase 1) have been mandated through the core contract since 1 April 2023 and comprise an integral part of Unified Services. Mandating the phase 1 elements was required to deliver against the following objectives:

- strengthening evidence to support achievement;
- meaningful demonstration of achievement over the full year;
- more frequent reporting intervals and;
- sharing of data by practice to support a better understanding of demand and capacity.

In terms of the current requirements, operational since April 2023, all practices are required to continue to achieve all Phase I (pre-qualifier) Access standards on a permanent basis. To further clarify, since 1 April 2023, any practices that have not previously engaged in, or achieved these standards, are now required to participate and achieve all Phase 1 standards. Furthermore, a requirement was placed on all practices that had not previously achieved the required standards, to upload supporting evidence on 1 April 2023. Confirmation of achievement of the pre-qualifiers is demonstrated through practice self-declaration.

Going forward, and to build on the progress made to date in terms of embedding a consistent approach in respect of access requirements, it has been agreed, through the tripartite negotiations to review and amend the practice requirements under the GMS Access Standards for 2025-26. The revised guidance relating to this provision has been developed on a collaborative basis by CIG, and is appended to this guidance in template form as annex G and annex H. The revised practice requirements outlined within the guidance at annexes G and H are aligned with the tripartite agreement in respect of strengthening evidence to support achievement; and enabling a meaningful demonstration of achievement over the full year, with more frequent reporting intervals and sharing of data by practices to support a better understanding of demand and capacity.

A further substantive review of the Access Standards will follow and in terms of the arrangements, the review will be commissioned by the Quality Committee with the requirements forming part of 2025/26 mandate for further discussion and/or ratification, subject to final Ministerial approval.

7.1 Legislative process and financial aspects

Again, the Directions to Local Health Boards as to the Statement of Financial Entitlements (Wales) 2013 (“the SFE”) will take account of the amended guidance and underpinning funding. This will be applied to the 2025/26 financial year and will apply going forward.

Queries relating to the funding and claiming process should be directed to NWSSP at nwssp-primarycareservices@wales.nhs.uk

Annex A

Practice guidance for the transfer of enhanced care of adults with learning disabilities to unified contract

Background

The guidance outlines the agreed definition of adults (18 years +) learning disabilities (LD) that qualifies a person to be included on the primary care LD register and describes the services that all people with LD should expect to receive under the unified contract, previously offered through the Directed Supplementary Service (DSS).

The DSS will cease and the current DSS funding moved from supplementary services into global sum on a recurrent basis from 1st April 2025.

All GP contractors are expected to deliver this provision as part of the unified contract.

Public Health Wales (PHW) identify 15,600 adults registered with the General Practices in Wales with a LD. (PHW 2024). A strong consensus from LD advocacy organisations such as Mencap a charitable organisation has estimated that there is between 54,000 and 60,000 people living in Wales with an LD including 16,000 children, which is not reflected in any published data. Source: Learning disability explained. https://mencap.org.uk/learning-disability-explained/research-and-statistics

Evidence shows that:

- People with learning disabilities, as a group, have much greater health needs than the general population. They are more likely to have general health problems, sensory impairments, mental health problems, epilepsy, cerebral palsy and other physical disabilities;
- the uptake of breast and cervical screening by women with learning disabilities is poor;
- people with learning disabilities tend to access primary care much less than they need to;
- many people with learning disabilities have undetected conditions that cause unnecessary suffering or reduce the quality or length of their lives.

Aims

- People with learning disabilities have an equal right of access to primary health care services.
- Improve the quality of care provided through general medical services to patients with learning disabilities. As a result, it will enhance the life and independence of those patients.

Definition

A learning disability is defined by the Department of Health and Social Care (DHSC) (2001) as:

a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood.

A learning disability is different for everyone. The degree of disability can vary greatly, being classified as mild, moderate, severe or profound. In all cases, a learning disability is a lifelong condition and cannot be cured. A learning disability is not a physical disability.

A learning disability is different to a learning difficulty, which is a reduced ability for a specific form of learning and includes conditions such as dyslexia (reading), dyspraxia (affecting physical co-ordination) and attention deficit hyperactivity disorder (ADHD). A person with a learning disability may also have one or more learning difficulties.

Additionally, there are a number of conditions and neurological disorders that often involve or cause some type of learning disability, including Down's syndrome, autism, meningitis, epilepsy or cerebral palsy.

A learning disability is caused by something which affects the development of the brain either before birth, during birth or in early childhood.

Possible causes may include:

- an inherited condition – for example, Fragile X syndrome
- abnormal chromosomes – for example, Down's syndrome or Turner syndrome
- exposure to environmental toxins or infections and illness during pregnancy
- a very premature birth
- complications during birth, resulting in a lack of oxygen to the baby's brain
- illness – for example, meningitis or measles; or injury or trauma to the brain in early childhood

Sometimes the cause of a learning disability remains unknown

Source: GOV.UK

Practice Requirements

Practices are required to

1. Develop and maintain a register of those individuals with learning disabilities in line with the agreed definition.
2. Demonstrate systematic recall system for patients on the register
3. To provide an offer of an annual health check. The health check will include the minimum requirements set out in the attached annex.
4. Integrate the health check as part of the patient's personal health record.
5. Involve carers and support workers. Where family or paid carers are involved, they can play a vital role in the patient's health care. With the consent of the patient where possible, they should be fully informed of the patient's health care needs and supported as necessary.
6. Liaise with relevant local support services. Liaison with community and learning disability health professionals, social services and educational support services is necessary to provide seamless care for their patients and their carers. GPs should also, where appropriate, inform patients and their carers of local and national voluntary support groups for vital information and support.

Monitoring

All practices will be required to provide:

1. The total number of patients on the LD register;
2. number of health checks offered and;
3. number of health checks completed.

Resources

Improvement Cymru provides guidance and resource to support best practice and an education Framework to support staff who undertake the annual reviews.

The resource pack available is for health care staff in Wales who deliver health care to people with a learning disability. It contains useful information and easy read resources on health and well-being.

Learning Disability | Improvement Cymru - NHS Wales Executive

Any available resources or templates do not replace the contractual requirements or minimum requirements for the annual health check outlined within the Annex.

Annex B

Welsh Health Check for Adults with a Learning Disability and on the Social Services Register

Date:	
Name:	
Marital status:	Ethnic origin:
Date of Birth:	Sex:
Address: Tel	
Next of Kin Tel	
Principal Carer: Tel	

Key Health and Social Care Contacts:		
Consent to share the review with Carer**?**	**Yes**	**No**
Consent to share the review with other named relevant professionals**?**	**Yes**	**No**
Names of other individuals to whom the review should be sent:		

This is a good time to ask the carer, person with a learning disability if they have any specific concerns or issues they wish to cover whilst performing the health check

Weight (kg/stone)	Height (meters /feet)
Blood Pressure	Urine Analysis
Smoke (per day)	Alcohol (units per week)
Body Mass Index (weight in kg / height in m^2)	Cholesterol has been performed if indicated
& random Blood glucose if indicated	

Immunisation People with learning disability should have the same regimes as others and the same contraindications apply. A high risk of hepatitis 'b' has been seen in population of individuals with learning disability		
Has the patient completed a full course of currently recommended vaccinations?	**Yes**	**No**
If No, has the patient been offered the recommended top up vaccinations?	**Yes**	**No**
Is the patient included in the annual influenza vaccination programme?	**Yes**	**No**
Patient declined / contraindicated	**Yes**	
Screening uptake Where screening cannot be performed due to refusal it can be helpful to support from the community learning disability teams to support the individual through the procedures **Cervical Cytology** People with a learning disability have same indications for cervical cytology as others. **Note:** Smear could be declined by patient		
Is a smear indicated?	**Yes**	**No**
If yes when was last smear?		
When is next due?	**Date:**	
Patient declined	**Yes**	
Mammography uptake This should be arranged in line with national screening programme and as per local practice.		
Is mammography indicated and has it been offered?	**Yes**	**No**
Performed?	**Yes**	**No**
Declined	**Yes**	**No**
Bowel Cancer uptake This should be arranged in line with national screening programme and as per local practice.		
Indicated and offered?	**Yes**	**No**
Performed?	**Yes**	**No**
Declined	**Yes**	**No**
Aortic aneurysm uptake This should be arranged in line with national screening programme and as per local practice.		
Indicated and offered?	**Yes**	**No**
Performed?	**Yes**	**No**
Declined	**Yes**	**No**

Chronic Illness		
Does your patient suffer from any chronic illness**?**	**Yes**	**No**
If yes please specify:		

Systems Enquiry		
Respiratory **Be especially concerned if frequent chest infections as these can indicate that swallowing is impaired and referral needed**		
Persistent cough	**Yes**	**No**
Haemoptysis	**Yes**	**No**
Abnormal sputum	**Yes**	**No**
Wheeze	**Yes**	**No**
Dyspnoea	**Yes**	**No**

Cardiovascular system		
Chest pain	**Yes**	**No**
Swelling of ankles	**Yes**	**No**
Palpitations	**Yes**	**No**
Paroxysmal nocturnal dyspnoea	**Yes**	**No**
Cyanosis	**Yes**	**No**

Abdominal **Be aware of possibility of unrecognised reflux oesophagitis as a cause weight loss, sleep disturbance or dyspepsia**		
Constipation	**Yes**	**No**
Weight loss	**Yes**	**No**
Diarrhoea	**Yes**	**No**
Dyspepsia	**Yes**	**No**
Melaena	**Yes**	**No**
Rectal bleeding	**Yes**	**No**
Faecal incontinence	**Yes**	**No**
Feeding problems	**Yes**	**No**

C.N.S. – for epilepsy see below		
Faints	**Yes**	**No**
Parasthesia	**Yes**	**No**
Weakness	**Yes**	**No**

Genito-urinary		
Dysuria	**Yes**	**No**
Frequency	**Yes**	**No**
Haematuria	**Yes**	**No**
Urinary Incontinence	**Yes**	**No**

If Yes has M.S.U. been done	**Yes**	**No**
Have other investigations been considered**?**	**Yes**	**No**

Gynaecological		
Dysmenorrhoea	**Yes**	**No**
Inter menstrual bleeding	**Yes**	**No**
PV discharge	**Yes**	**No**
Is patient post menopausal**?**	**Yes**	**No**
Contraceptives		
Needed	**Yes**	**No**
Used Note: Oral, Intra-uterine device, Depot, Transdermal, Subcutaneous, Diaphragm, Contraceptive sponge, No contraception	**Yes**	**No**
Other **Note:** e.g. PMT, pregnancy		

Epilepsy Note: Consider specialist review if no review in last 3 years	**Yes**	**No**
Date of last specialist appointment: Less than 3 years	**Yes**	**No**
Greater than 3 years	**Yes**	**No**
Type of fit:		
Focal seizures: simple partial, complex partial or secondary generalised	**Yes**	**No**
Generalised seizures: absence seizures, myoclonic, clonic, tonic, tonic-clonic or atonic	**Yes**	**No**
Unclassified seizures	**Yes**	**No**

Frequency of seizures (fits/month)			
Over the last year have the fits	**Worsened**	**Remained the same**	**Improved**
Antiepileptic medication			
Name Dose/frequency Levels (if indicated)			
Side effects observed in the patient			

Presence of Behavioural disturbance
Note: Behavioural disturbance in people with a learning disability is often an indicator of other morbidity. For this reason it is important to record it as it can point to other morbidity. The presence of behavioural or emotional change when physical illness has been excluded warrants referral to learning disability services

Has there been a change in behaviour since the last review: eg aggression, self injury, over-activity.	**Yes**	**No**
Are you aware of any risk or change in the level of risk to the patient or others:	**Yes**	**No**
If yes, has this been communicated to key health and social care professionals	**Yes**	**No**

Physical Examination		
General appearance		
Are there any abnormal physical signs or key negative findings.	**Yes**	**No**
If yes please specify:		

Cardiovascular System		
Are there any abnormal physical signs or key negative findings	**Yes**	**No**
If yes please specify:		
Pulse (beats/min)		
Blood pressure		
Ankle Oedema	**Yes**	**No**
Heart sounds (describe)		
Patient declined	**Yes**	

Respiratory system		
Are there any abnormal physical signs or key negative findings	**Yes**	**No**
If yes please specify:		
Patient declined	**Yes**	

Abdomen		
Are there any abnormal physical signs or key negative findings	**Yes**	**No**
If yes please specify:		
Patient declined	**Yes**	**No**

Dermatology		
Any signs or symptoms	**Yes**	
Diagnosis		
Patient declined	**Yes**	

Breast		
Are you aware of any breast symptoms or signs	**Yes**	**No**
If yes, please indicate what action has been taken: **Note**: If no, please indicate why (e.g. consent issues)		
Patient declined	**Yes**	

Testis		
Has an examination of testis been performed	**Yes**	**No**
Patient declined	**Yes**	

Central Nervous System
Note: It is often difficult and not relevant to perform a full neurological examination, however, people with a learning disability are particularly prone to abnormalities in vision, hearing and communication – a change in function would suggest further investigation is necessary

Presence of vision difficulties		
Does the patient appear to have eyesight problems e.g. eye rubbing?	**Yes**	**No**
Normal vision? **Note:** include normal vision corrected with glasses/ contact lenses	**Yes**	**No**
Minor visual problem?	**Yes**	**No**
Major visual problems? **Note:** include registered blind	**Yes**	**No**
Is the carer/key worker concerned?	**Yes**	**No**
Recommend the carer takes the patient to an optometrist	**Yes**	**No**
Is there a cataract?	**Yes**	**No**

Presence of hearing difficulties		
Normal hearing?	**Yes**	**No**
Minor hearing problem?	**Yes**	**No**
Major hearing problem?	**Yes**	**No**

Is the carer/ key worker concerned?	**Yes**	**No**
Does he/she wear a hearing aid? **Note:** if no has he/she been fitted for a hearing aid?	**Yes**	**No**
Any wax?	**Yes**	**No**
Does your patient see an audiologist?	**Yes**	**No**
Other investigation		
• Has the patient ever had a hearing screen? • For those aged 40 and over, has the patient had a hearing screen within the past 3 years? • For those with Down's syndrome (regardless of age), has the patient had a hearing assessment with the past 3 years?		

Presence of communication difficulties		
Does your patient communicate normally?	**Yes**	**No**
Does your patient communicate with aids? **Note:** e.g. writing pad, signing	**Yes**	**No**
Does your patient have a severe communication problem?	**Yes**	**No**
Does your patient see a speech therapist?	**Yes**	**No**
Where communications problems exist have practice staff been made aware & medical record tagged?	**Yes**	**No**

Presence of mobility difficulties		
Is your patient fully mobile**?**	**Yes**	**No**
If no, please specify nature and severity of mobility loss such as presence of contractures e.g. uses a wheelchair, walking stick, walking frame, crutches, splints, surgical boots		
Has there been any change in mobility and dexterity of patient since the last review?	**Yes**	**No**
If yes, please specify:		

Other Investigations		
Are there any further investigations necessary?	**Yes**	**No**
If yes please indicate		

Syndrome Specific Check

Note: Certain syndromes causing learning disabilities are associated with increased morbidity for this reason it is important to record:		
Is the cause of learning disability known?	**Yes**	**No**
If yes, what is it?		
Has the patient had a genetic investigation?	**Yes**	**No**
Result?		
If your patient has Down's syndrome he/she should have a yearly thyroid profile		
Has this been done?	**Yes**	**No**

Medication Review

Drug	Dose	Side Effects	Levels (if indicated)

Please list the key findings from the medication review.

Actions

Please list the actions that have arisen as a result of the medication review and indicate how these have been dealt with.

Every year the patient should have a review by a dental practitioner – has this been done?	**Yes**	**No**
Every year the patient should have a review by an optometrist – has this been done?	**Yes**	**No**
Has a summary letter with appropriate responses been sent to the patient or carer?	**Yes**	**No**
Has a copy of the letter been sent to the community learning disability team if involved?	**Yes**	**No**

Annex C

Learning Disabilities

Practices should add one of the selected codes below to patients eligible for a health check, in addition to any appropriate syndrome specific or existing condition/diagnosis code in order to standardise their LD register. Replacing older codes for this limited newer set of codes is encouraged given the outdated nature of older codes.

QOF Read codes to place a person on the Learning Disabilities Register

Eu814 : [X]Moderate learning disability
Eu815 : [X]Severe learning disability
Eu816 : [X]Mild learning disability
Eu817 : [X]Profound learning disability
Eu81z : [X]Developmental disorder of scholastic skills, unspecified
Eu818 : [X]Specific learning disability
918e : On learning disability register

Learning Disability annual health check invitation – suggested Read codes

9mA.. Learning disability annual health check invitation
9mA0. Learning disability annual health check verbal invitation
9mA1. Learning disability annual health check telephone invitation
9mA2. Learning disability annual health check letter invitation

Learning disabilities annual health assessment – suggested Read code

9HB5. Learning disabilities annual health assessment

Annex D: This annex will include further guidance on Covid Anti-viral treatments, to be populated and circulated in due course.

Annex E / Frailty indexing

What do practices have to do

The contractual requirement is to identify populations at risk of being frail, by degree, using an evidence-based tool, supplemented by clinical judgement.

This may be done by:

- using an evidenced based tool practices should proactively identify older people (aged 65 and older) who are living with severe or moderate frailty, and
- confirm diagnosis by clinical assessment of the patient,
- add appropriate coding to the patient medical record once diagnosis has been confirmed.

Patients identified with moderate or severe frailty should be managed according to their individual needs taking account of appropriate national guidance. Practices are required to code clinical interventions for this group.

Using the electronic frailty index (eFI)

It is important to understand that eFI identifies people at risk of frailty, but cannot on its own be used to make a diagnosis of frailty. The diagnosis of frailty requires the judgement of a clinician, taking account an individual's complete clinical picture.

Currently in Wales the clinical systems of EMIS and Cegedim both use eFI to score frailty. The eFI score from both suppliers' literature classifies frailty as follows:

The eFI score

The eFI score is broken down in to three classifications: Mild, moderate and severe. The scores for each of these are classifications are:

Level of frailty	eFI score
Mild Frailty	Greater than 0.12 and less than or equal to 0.24
Moderate Frailty	Greater than 0.24 and less than or equal to 0.36
Severe Frailty	Greater than 0.36

With EMIS, the prompt protocol is released as **inactive:**

https://emisprod.service-now.com/csm?id=kb_article_view&table=kb_knowledge&sys_kb_id=9032463e3b4a9a50f9f2d32a85e45a60&searchTerm=efi&spa=1

With Cegedim there is a Vision+ template which aids the calculation with data being pre-populated where present, but this is undertaken on an individual patient basis and there are no automated prompts:

https://help.cegedim-healthcare.co.uk/Visionplus/Content/G_Full_Help_Topics/Data_Entry/Assessment_Forms_and_Calculators/Electronic_Frailty_Index.htm?Highlight=frailty

Batch-coding

Some GP clinical system tools are configured to convert the eFI index result directly into a diagnostic (Read) code for health record (EHR). Batch-coding is where this process is undertaken for cohorts of people, effectively automating clinical diagnosis without clinician judgement. To support appropriate follow up action, it is important that the eFI index result is subject to clinical review before entry into the EHR.

Automatic diagnostic coding of patients should not be done for the following reasons:

1. eFI is not a clinical diagnostic tool: it is a population risk stratification tool;

2. Automated diagnostic coding without clinical judgement will lead to inappropriate diagnosis of frailty with direct consequences for patient care;

3. Such practise does not meet the contractual requirement which includes clinician judgement to diagnose severe or moderate frailty;

4. Patients incorrectly diagnosed with frailty may be subject to inappropriate clinical interventions or future care planning based on a wrong diagnosis.

Welsh Government, NHS Wales and GPC advice on batch-coding is not to use eFI batch-coding for the reasons given above. Practices are advised of the need for clinician review and use of clinical judgement before converting a risk of frailty identified by the eFI to a coded clinical diagnosis of frailty.

Annex F: This annex will include further guidance on the Welsh Identity Verification Service (WIVS), to be populated and circulated in due course.

Annex G: Guidance on the practice requirements under the GMS Access Standards for 2025-26.

Access Standards 2025/26 – Reflective Report Template

Llywodraeth Cymru
Welsh Government

Introduction

This annex provides a template for practices to use in order to submit their reflective report.

Evidence required for the Reflective Report is outlined below.

Reflective Report

The reflective report must include all sub-headings as listed below. Practices will be expected to discuss the report at collaborative level. The report must be completed and uploaded to the PCIP Access Reporting Tool on or before 31 March 2026.

Practice Name	
W Code	
Date	

Equality Impact Assessment

- *The practice will need to evidence a review of population and access needs. Completion of the National Patient Experience Survey, reviewing patient digital requests and utilising telephone system intelligence will enable Practices to review population and access needs and undertake an Equality Impact Assessment to include any proposed changes to access. The Equality Impact Assessment needs to link in with the practice's patient survey action plan.*

Patient Engagement

The practice will need to evidence as a minimum:

- *How the public facing dashboard is available to patients which could include social media, websites, and other non-digital methods. (Standard 4)*
- *Confirmation of how often the dashboard is updated to ensure information is current and/or what processes are used to decide that an update is required (e.g. discussion at practice meeting etc.).*

- *How it communicates the access options and services available to patients and how it ensures that this information reaches the whole patient population*

National Patient Experience Survey

N.B. It is important that practices undertake the survey at a point which allows time to summarise the findings, create an action plan and evidence improvements. The report must be completed and uploaded to the PCIP Access Reporting Tool on or before 31 March 2026.

Practices are encouraged to discuss at collaborative level, and agree on a specific date to carry out the survey to ensure that all practices within the collaborative have comparative data to discuss and use towards their reflective report.

Links to the National Patient Experience Survey are below for practices to use, the core questions have been validated and are to be used in all NHS Wales organisations to obtain real time feedback.
English Version:
Framework For Assuring Service User Experience (nhs.wales)
Framework For Assuring Service User Experience (Easy Read) *Welsh Version:*
Fframwaith profiad defnyddwyr gwasanaeth calonogol (GIG Cymru)
Fframwaith profiad defnyddwyr gwasanaeth calonogol (Hawdd ei Ddeall) The practice will need to evidence as a minimum:

Confirmation that National patient experience survey has been undertaken to include number of responses and distribution methods (25 completed questionnaires per 1000 registered patients from a range of practice population and captured through a range of methods) [Standard 5]

- *How the practice has considered / reflected on the results of the national patient survey (at practice and collaborative level) and demonstrate any resulting changes, including how they have been implemented and communicated to patients.*
- *Themes identified and actions taken as a result of patient feedback*
- *Numbers of concerns / complaints received in relation to Access issues and any learning from those concerns in the period 1st October 2025 – 30th March 2026*

- *Any good practice that can be shared with other practices and numbers of compliments received from patients in relation to Access 1st October 2025 – 30th March 2026*

Patient Survey Action Plan

- *The practice will need to evidence their action plan in this section of the report and provide an update from the position reported in the mid-year report showing any additional actions identified and progress against those and previous actions.*

Digital Requests

The practice will need to evidence as a minimum:

- *Care navigation is undertaken on digital requests in a similar and equitable fashion to telephone requests [Standard 6].*
- *Practices to reflect on the benefits of the Care Navigation training and its application – how many patients are re-directed to alternative appropriate services?*
- *Patients are able to access the practice digitally and that the practice has reflected on patient experience of using this method.*

- *Discussion on benchmarking administrative staffing levels available and necessary to respond to telephone calls / face to face and digital requests to take place as part of the collaborative discussion.*

Telephone System Intelligence

The practice will need to evidence as a minimum:

- *Appointments are available for advanced booking each day with declaration confirming that every patient contact is supported throughout the day. Confirmation required that patients are NOT required to call back and a description of any changes in how calls are dealt with since the mid-year report. (Patients will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without the need for the patients to contact the practice again) [Standard 2].*

- *How a regular assessment of the Practice scheduling appointment system is undertaken to ensure an appropriate mix of remote, face to face, urgent, on the day and pre-bookable. [Standard 3].*

- *Call demand comparisons, and a brief summary of intelligence taken from their telephone system. Practices should see changes in demand at 8am, as more people may ring throughout the day.*

***URGENT** is defined as those people who are clinically triaged as requiring an on-the-day assessment are offered a same day consultation (could be face to face, telephone, video call or a home visit).*

***PRE-BOOKABLE** is defined as an offer of an appointment which should routinely be within 2-3 weeks. However, it could be available up to 6 weeks in advance.*

Annex H: Guidance on the practice requirements under the GMS Access Standards for 2025-26.

ANNEX H Access Standards 2025/26

Mid-Year Reflective Report Template

Llywodraeth Cymru
Welsh Government

Introduction

This annex provides a template for practices to use in order to submit their mid-year reflective report.

Evidence required for the mid-year Reflective Report is outlined below.

Reflective Report

The reflective report must include all sub-headings as listed below. The report must be completed and uploaded to the PCIP Access Reporting Tool with the Quarter 2 achievement submission .

Practice Name	
W Code	
Date	

Service delivery and communication

Where access to a service is clinically appropriate and patients require access to GMS services, they will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without the need for the patients to contact the practice again.

On the two points below, Practices should reflect on the challenges in maintaining this position and any planned changes / actions to be taken in the second half of the year

- *Confirmation that patient contact is supported throughout the day and explanation of how this is done.*

- *Confirmation that patients are not required to call back - how are calls dealt with to avoid this occurring?*

The practice will need to detail:

- *Progress and what action it is taking to remove the 8am bottleneck or to retain a position where it does not exist*

N.B. Standard 2 - (Patients will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without the need for the patients to contact the practice again)

Patient Engagement

All practices have a clear understanding of patient needs and demands within their practices and how these can be met.

The practice will need to detail :

- *Progress made against their action plan and any new actions proposed and since the end of the previous year, including any revisions as a result of patient feedback*
- *Themes identified and actions taken as a result of patient feedback*
- *Numbers of concerns / complaints received in relation to Access issues and any learning from those concerns in the period 1st April 2025 – 30th September 2025*
- *Any good practice that can be shared with other practices and numbers of compliments received from patients in relation to Access. in the period 1st April 2025 – 30th September 2025*
- *How it communicates the access options and services available to patients and how it ensures that this reaches the whole patient population*