SUBORDINATE LEGISLATION

2013 No. 8

THE NATIONAL HEALTH SERVICE (WALES) ACT 2006

Directions to Local Health Boards as to the Statement of Financial Entitlements Directions 2013

Made	*10 June 2013*
Coming into force	*11 June 2013*

Introduction

1.1. The Welsh Ministers give these Directions as to payments to be made under general medical services contracts in exercise of the powers conferred on them by sections 45, 203(9) and (10) and 204(1) of the National Health Service (Wales) Act 2006(**a**).

1.2 The Welsh Ministers have consulted in accordance with section 45(4) of that Act both with the bodies appearing to the Welsh Ministers to be representative of persons to whose remuneration these Directions relate and with such other persons as the Welsh Ministers think appropriate.

1.3 The title of these Directions is the Directions to Local Health Boards as to the Statement of Financial Entitlement Directions 2013.

1.4 The Directions include the attached Document SFE/April/2013 and its Annexes and are referred to collectively as "this SFE". Any reference in this SFE to an Annex means one of those Annexes.

1.5 This SFE replaces the Statement of Financial Entitlements, which came into force on 30 April 2005 as amended by the Directions listed in Annex J, but the Statement of Financial Entitlements 2005 as amended continues to have effect in relation to the matters set out in section 21 of Part 6 of this SFE.

1.6 This SFE is divided into Parts, Sections, paragraphs, sub-paragraphs and heads. A Glossary of some of the words and expressions and definitions of words used in this SFE is provided in Annex A.

1.7 This SFE applies in relation to Wales.

1.8 This SFE may be revised at any time, in certain circumstances with retrospective effect(**b**).

Application and commencement

2.1 The directions in this SFE are given to the LHBs. This SFE relates to the payments to be made by LHBs to a contractor under a general medical services contract.

(**a**) 2006 (c.42);
(**b**) See section 45(3)(e) of the 2006 Act.

2.2 Except as provided in directions 2.3 and 2.4**, t**his SFE comes into force on 11 June 2013 but has effect from 1 April 2013;

2.3 Section 8 (Rotavirus vaccine) and Annex I (routine childhood vaccines and immunisation) in so far as it relates to section 8, comes into force on and has effect from 1 July 2013.

2.4 Section 10 (Shingles immunisation programme) comes into force on and has effect from 1 September 2013.

Signed by Lisa Dunsford, Deputy Director Primary Care, Medical Directorate, Department for Health, Social Services and Children, under the authority of the Minister for Health and Social Services, one of the Welsh Ministers

Date: 10 June 2013

NATIONAL HEALTH SERVICE, WALES

The Directions to Local Health Boards as to the Statement of Financial Entitlements Directions 2013

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Global Sum Payments: General

2.1. Global Sum Payments are a contribution towards the contractor's costs in delivering essential and additional services, including its staff costs. Although the Global Sum Payment is notionally an annual amount, it is to be revised quarterly and a proportion paid monthly.

Calculation of a contractor's first Initial Global Sum Monthly Payment

2.2. At the start of each financial year or, if a GMS contract starts after the start of the financial year, from the date on which the GMS contract takes effect, LHBs must calculate for each contractor its first Initial Global Sum Monthly Payment ("Initial GSMP") value for the financial year. This calculation is to be made by first establishing the contractor's Contractor Registered Population (CRP)—

(a) at the start of the financial year; or

(b) if the contract takes effect after the start of the financial year, on the date on which the GMS contract takes effect.

2.3. Once the contractor's CRP has been established, this number is to be adjusted by the Global Sum Allocation Formula, a summary of which is included in Annex B of this SFE. The resulting figure, which is the contractor's Contractor Weighted Population for the Quarter, is then to be multiplied by £68.28.

2.4. Then, the LHB will need to add the total produced by paragraph 2.3 to the annual amount of the contractor's Temporary Patients Adjustment. The method of calculating contractors' Temporary Patients Adjustments is set out in Annex C. The resulting amount is then to be divided by twelve, and the resulting amount from that calculation is the contractor's first Initial GSMP for the financial year.

Calculation of Adjusted Global Sum Monthly Payments

2.5. If, where a first Initial GSMP for the financial year has been calculated, the relevant GMS contract stipulates that the contractor is not to provide one or more of the Additional or Out of Hours Services listed in column 1 of the Table in this paragraph, the LHB is to calculate an Adjusted GSMP for that contractor as follows. If the contractor is not going to provide—

(a) one of the Additional or Out of Hours Services listed in column 1 of the Table, the contractor's Adjusted GSMP will be its Initial GSMP reduced by the percentage listed opposite the service it is not going to provide in column 2 of the Table;

(b) more than one of the Additional or Out of Hours Services listed in column 1 of the Table, an amount is to be deducted in respect of each service it is not going to provide. The value of the deduction for each service is to be calculated by reducing the contractor's Initial GSMP by the percentage listed opposite that service in column 2 of the Table, without any other deductions from the Initial GSMP first being taken into account. The total of all the deductions in respect of each service is then deducted from Initial GSMP to produce the Adjusted GSMP.

Table 1

Additional or Out of Hours Services	*Percentage of Initial GSMP*
Cervical Screening Services	1.1
Child Health Surveillance	0.7
Minor Surgery	0.6
Maternity Medical Services	2.1
Contraceptive Services	2.4
Childhood vaccines and immunisations	1.0
Vaccines and immunisations	2.0
Out of Hours Services	6.0

First Payable Global Sum Monthly Payments

2.6. Once the first value of a contractor's Initial GSMP, and where appropriate Adjusted GSMP have been calculated, the LHB must determine the gross amount of the contractor's Payable GSMP. This is its Initial GSMP or, if it has one, its Adjusted GSMP. The net amount of a contractor's Payable GSMP, i.e. the amount actually to be paid each month, is the gross amount of its Payable GSMP minus any monthly deductions in respect of superannuation determined in accordance with Section 20 (superannuation contributions – see paragraphs 20.6 and 20.7 and 20.13).

2.7. The LHB must pay the contractor its Payable GSMP, thus calculated, monthly (until it is next revised). The Payable GSMP is to fall due on the last day of each month. However, if the contract took effect on a day other than the first day of a month, the contractor's Payable GSMP in respect of the first part-month of its contract is to be adjusted by the fraction produced by dividing—

(a) the number of days during the month in which the contractor was under an obligation under its GMS contract to provide the Essential Services; by

(b) the total number of days in that month.

Revision of Payable Global Sum Monthly Payments

2.8. The amount of the contractor's Payable GSMP is thereafter to be reviewed—

(a) at the start of each quarter;

(b) if there are to be new Additional or Out of Hours Services opt-outs (whether temporary or permanent);

(c) if the contractor is to start or resume providing specific Additional Services that it has not been providing; or

(d) if the amount specified in paragraph 2.3 is changed.

2.9. Whenever the Payable GSMP needs to be revised, the LHB will first need to calculate a new Initial GSMP for the contractor (unless this has not changed). This is to be calculated in the same way as the contractor's first Initial GSMP (as outlined in paragraphs 2.2 and 2.4 above), but using the most recently established CRP of the contractor (the number is to be established quarterly).

2.10. Any deductions for Additional or Out of Hours Services opt-outs are then to be calculated in the manner described in paragraph 2.5. If the contractor starts or resumes providing specific Additional Services under its GMS contract to patients to whom it is required to provide essential services, then any deduction that had been made in respect of those services will need to be reversed. The resulting amount (if there are to be any deductions in respect of Additional or Out of Hours Services) is the contractor's new (or possibly first) Adjusted GSMP.

2.11. Once any new values of the contractor's Initial GSMP and Adjusted GSMP have been calculated, the LHB must determine the gross amount of the contractor's new Payable GSMP. This is its (new) Initial GSMP or, if it has one, its (new or possibly first) Adjusted GSMP. The net amount of a contractor's Payable GSMP, i.e. the amount actually to be paid each month, is the

gross amount of its Payable GSMP minus any monthly deductions in respect of superannuation determined in accordance with section 20 (see paragraphs 20.6 and 20.13).

2.12. Payment of the new Payable GSMP must (until it is next revised) be made monthly, and it is to fall due on the last day of each month. However, if a change is made to the Additional or Out of Hours Services that a contractor is under an obligation to provide and that change takes effect on any day other than the first day of the month, the contractor's Payable GSMP for that month is to be adjusted accordingly. Its amount for that month is to be the total of —

(a) the appropriate proportion of its previous Payable GSMP. This is to be calculated by multiplying its previous Payable GSMP by the fraction produced by dividing—

  (i) the number of days in the month during which it was providing the level of services based upon which its previous Payable GSMP was calculated, by

  (ii) the total number of days in the month; and

(b) the appropriate proportion of its new Payable GSMP. This is to be calculated by multiplying its new Payable GSMP by the fraction produced by dividing—

  (i) the number of days left in the month after the change to which the new Payable GSMP relates takes effect, by

  (ii) the total number of days in the month.

2.13. Any overpayment of Payable GSMP in that month as a result of the LHB paying the previous Payable GSMP before the new Payable GSMP has been calculated is to be deducted from the first payment in respect of a complete month of the new Payable GSMP. If there is an underpayment for the same reason, the shortfall is to be added to the first payment in respect of a complete month of the new Payable GSMP.

Conditions attached to Payable Global Sum Monthly Payments

2.14. Payable GSMPs, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's Payable GSMP;

(b) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully;

(c) the contractor must immediately notify the LHB if for any reason it is not providing (albeit temporarily) any of the services it is under an obligation to provide under its GMS contract; and

(d) all information supplied to the LHB pursuant to or in accordance with this paragraph must be accurate.

2.15. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of any or any part of a Payable GSMP that is otherwise payable.

Deduction for not achieving 150 points under the Quality and Outcomes Framework

2.16. It is also a condition of every contractor's Payable GSMPs that it achieves, in relation to each financial year in which it receives Payable GSMPs, an Achievement Points Total of at least 150, whether or not it participated in the Quality and Outcomes Framework. If it breaches this condition, the LHB must withhold from the contractor the amount produced by multiplying—

(a) 150; by

(b) the amount specified in paragraph 6.8 as the value of each Achievement Point in a calculation of an Achievement Payment for the financial year to which the Achievement Points Total relates; by

(c) the contractor's Contractor Population Index that is, or would be, used for the calculation of any Achievement Payment due to the contractor in respect of that financial year (the contractor will, in any event, receive an Achievement Payment in respect of the points it does score for that financial year, pursuant to Section 6).

2.17. However, if the contractor's GMS contract either takes effect during or is terminated before the end of, that financial year, the amount to be withheld pursuant to paragraph 2.16 is to be adjusted by the fraction produced by dividing the number of days during which the financial year for which its GMS contract had effect by 365 (or 366 where the financial year includes 29th February).

Contractor Population Index

2.18. The Contractor Population Index (CPI) of a contractor, mentioned in paragraph 2.16(c), is the contractor's most recently established CRP divided by the national average for Wales of the number of registered patients of contractors on the 1st January in the year immediately before the commencement of the financial year to which the achievement payment relates as calculated using the registered lists of contractors held on the Exeter Registration System.

Section 3: MINIMUM PRACTICE INCOME GUARANTEE

Minimum Practice Income Guarantee: General

3.1. The Minimum Practice Income Guarantee (MPIG) is based on the historic revenue of General Practitioners (GPs) comprising the contractor from the list in Annex D of the Directions to Local Health Boards as to the Statement of Financial Entitlements for 2004/5 which came into force on 19 April 2004 ("2004/5 SFE)"(essentially the Red Book fees and allowances) and was essentially designed to protect those income levels (**a**).

3.2. MPIG calculations are one-off calculations made in respect of contractors whose GMS contracts took effect, or which were treated as taking effect for payment purposes, on 1st April 2004. Nevertheless, an explanation of how MPIG calculations were originally undertaken has been retained in this SFE for reference purposes. The basis of an MPIG calculation was one year aggregate of the protected income amounts mentioned in paragraph 3.1, which produced the contractor's Initial Global Sum Equivalent (GSE), which was then adjusted to produce first its Adjusted GSE and then its Final GSE.

Calculation of Global Sum Equivalent

3.3. In respect of contracts which took effect, or which were treated as taking effect for payment purposes, on 1st April 2004, in order to calculate a contractor's GSE, a calculation was first made of its Initial and Adjusted GSE. This was done by the LHB—

(a) on the basis of information obtained by it from the contractor about payments to the contractor (or GPs comprising the contractor) under the Red Book, and in particular in the year preceding 1st July 2003; and

(b) in accordance with the Welsh Government guidance reproduced in Annex D of the SFE 2004/5.

3.4. Whether any adjustments were in fact necessary to the Initial GSE, the final total produced as a result of the calculation in accordance with Annex D of the 2004/5 SFE was known as the contractor's Adjusted GSE. That amount was then subject to three further adjustments—

(a) the amount was increased by 2.85% to bring prices in respect of the year ending 30th June 2003 up to 31st March 2004 levels (i.e. rebasing for the financial year 2003 to 2004); then

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(**a**) The Directions to Local Health Boards as to the Statement of Financial Entitlements 2004/5 was replaced by the Directions to Local Health Boards as to the Statement of Financial Entitlements which came into force on 30 April 2005.

(b) the sub-paragraph (a) amount was increased by 1.47% to take account of projected price increases in respect of the financial year 2004 to 2005 (i.e. rebasing for the financial year 2004 to 2005); then

(c) the sub-paragraph (b) amount was added to the contractor's GSE Superannuation Adjustment. This was an adjustment to take account of an additional 7% employer's superannuation contributions in respect of practice staff as a result of a Treasury transfer. The contractor's GSE Superannuation Adjustment was its weighted population for the first quarter of the financial year 2004 to 2005 multiplied by £1.46.

The resulting amount *was* the contractor's Final GSE.

Calculation of Correction Factor Monthly Payments

3.5. The contractor's Final GSE was then compared to the paragraph 2.3 total (paragraph 2.3 of the 2005 SFE) in respect of the contractor. In the financial year 2004 to 2005, a contractor's paragraph 2.3 total was the annual amount of its first Initial Global Sum Payment, minus its Temporary Patients Adjustments and minus two adjustments in that financial year which have since been discontinued: a Superannuation Premium and an Appraisal Premium. From that paragraph 2.3 total was subtracted any Historic Opt-Outs Adjustment to which the contractor was entitled.

3.6. A contractor was entitled to the Historic Opt-Outs Adjustment if—

(a) between 1st July 2002 and 1st April 2004, the GPs comprising the contractor had not been providing, within GMS services, services which as far as possible were equivalent to one or more of the Additional or Out of Hours Services listed in the Table in paragraph 2.5 of the 2005 SFE; and

(b) the contractor would not be providing those services in the financial year 2004 to 2005.

3.7. The amount of the contractor's Historic Opt-Outs Adjustment was calculated as follows. If the contractor was claiming an Historic Opt-Outs Adjustment in respect of —

(a) one of the Additional or Out of Hours Services listed in column 1 of the Table in paragraph 2.5 of the 2005 SFE, the value of the contractor's Historic Opt-Outs Adjustment was the amount by which its paragraph 2.3 total would be reduced if it was reduced by the percentage listed opposite that service in column 2 of the Table; and

(b) more than one of the Additional or Out of Hours Services listed in column 1 of the Table in paragraph 2.5 of the 2005 SFE, the value of the contractor's Historic Opt-Outs Adjustment was to include an amount in respect of each service. The value of the amount for each service was the amount by which the contractor's paragraph 2.3 total would be reduced if it was reduced by the percentage listed opposite that service in column 2 of the Table, without any other deductions from the paragraph 2.3 total first being taken into account. The total of all the amounts in respect of each service was then aggregated to produce the final amount of the contractor's Historic Opt-Outs Adjustment.

3.8. Accordingly, a contractor's paragraph 2.3 total, minus any Historic Opt-Outs Adjustment to which it was entitled, was its Global Sum Comparator.

3.9. If the contractor's Final GSE was less than its Global Sum Comparator, a Correction Factor was not payable in respect of that contractor. However, if its Final GSE was greater than its Global Sum Comparator, Correction Factor Monthly Payments ("CFMPs") had to be paid by the LHB to the contractor under its GMS contract. The amount of the CFMPs payable was the difference between the contractor's Final GSE and its Global Sum Comparator, divided by twelve.

Continuing obligation to pay Correction Factor Monthly Payments in respect of the period ending on 31st March 2013

3.10. At the start of each financial year, LHBs determined which of their contractors were entitled to CFMPs. Generally these were—

(a) the contractors to which CFMPs were payable at the end of the previous financial year and which are still in existence at the start of the new financial year; and

(b) any contractors affected by a partnership merger or split whose contract takes effect at the start of the financial year and who, by virtue of paragraphs 3.16 to 3.19 of the 2005 SFE as in force on 31 March 2013 were entitled to receive CFMPs calculated in accordance with those paragraphs.

3.11. The baseline monthly figure amount for the calculation of a contractor's CFMP for a new financial year was established as follows—

(a) in the case of a contractor affected by a partnership merger or split that takes effect at the start of the financial year, if, by virtue of paragraphs 3.16 to 3.19 of the 2005 SFE as in force on 31st March 2013, the contractor becomes entitled to CFMPs, or the amount of its CFMPs is to change, a calculation must first be made of the amount to which it would have been entitled as a CFMP in the previous financial year, had the merger or split taken effect then, and that amount is to be the baseline monthly figure amount for the calculation of its CFMPs for the new financial year; or

(b) in all other cases, the baseline monthly figure amount for the calculation of a contractor's CFMPs for the new financial year is the monthly figure for any CFMP that was payable at the end of the previous financial year.

Review and revision of the baseline monthly figure amount for Correction Factor Monthly Payments in respect of the period 1st April 2008 and ending 31st March 2009

3.12. The baseline monthly figure amount of CFMP payable, as calculated in accordance with the provisions set out in paragraphs 3.5 to 3.9 of the 2005 SFE, was revised during the financial year commencing on 1st April 2008 and ending on 31st March 2009 in accordance with amending directions which came into force on 1st October 2008. Following such revision, in some cases CFMP ceased to be payable with effect from 1st October 2008. In some cases, a revised CFMP was established which became the CFMP payable with effect from 1st October 2008.

Review and revision of the baseline monthly figure amount for Correction Factor Monthly Payments in respect of the period 1st April 2009 and ending 31st March 2010

3.13. The baseline monthly figure amount of CFMP payable, as calculated in accordance with the provisions set out in paragraphs 3.5 to 3.9 of the 2005 SFE, was revised during the period commencing on 1st April 2009 and ending on 31st March 2010 in accordance with the Statement of Financial Entitlements (Amendment (No.4) and Specification of National Minimum Uplift) Directions 2009, which came into force on 30th June 2009 but had effect from 1st April 2009.

Review and revision of the baseline monthly figure amount for Correction Factor Monthly Payments in respect of the period 1st April 2010 and ending 31st March 2011

3.14. Once the existing baseline monthly figure amount of a contractor's CFMPs had been established, that amount was reviewed and, if necessary, revised for the period commencing on 1st April 2010 and ending on 31st March 2011, in accordance with the provisions of paragraph 3.12A to 3.12C of the 2005 SFE as in force on 31st March 2011.

Review and revision of the baseline monthly figure amount for Correction Factor Monthly Payments in respect of the period 1st April 2011 and ending 31st March 2012

3.15. Once the existing baseline monthly figure amount of a contractor's CFMPs had been established, that amount was reviewed and, if necessary, revised for the period commencing on 1st April 2011 and ending on 31st March 2012, in accordance with the provisions of paragraph 3.13 of the 2005 SFE as in force on 31st March 2012.

Review and revision of the baseline monthly figure amount for Correction Factor Monthly Payments in respect of the period 1st April 2012 and ending 31st March 2013

3.16. Once the existing baseline monthly figure amount of a contractor's CFMPs had been established, that amount was reviewed and, if necessary, revised for the period commencing on 1st April 2012 and ending on 31st March 2013, in accordance with the provisions of paragraph 3.13 as in force on 31st March 2013.

Review and revision of the baseline monthly figure amount for Correction Factor Monthly Payments in respect of the period 1st April 2013 and ending 31st March 2014

3.17. In respect of the period commencing on 1st April 2013 and ending on 31st March 2014, the LHB must review the baseline monthly figure amount in respect of a contractor's CFMP (which is the monthly figure for any CFMP that was payable at the end of the previous financial year) and uprate that amount by 3.55% which is the percentage by which the first amount specified in paragraph 2.3 is uprated at or for the start of the financial year.

CFMP of a value of £10 or less

3.18. No CFMP must be paid in the case where the value of the CFMP payable to the contractor, as calculated in accordance with paragraph 3.17, is equal to or less than £10.

Amount of CFMP and due date for payment

3.19. Except where paragraph 3.18 applies, in respect of the period commencing on 1st April 2013 and ending on 31st March 2014, the amount of a contractor's CFMP is to be the revised baseline monthly figure as calculated in accordance with paragraph 3.17.

3.20. CFMPs fall due on the last day of each month.

3.21. Thereafter throughout the new financial year, unless the contractor is subject to a partnership merger or split, the amount of the contractor's CFMPs is to remain unchanged, even if the amount of the contractor's Payable GSMP changes.

Practice mergers or splits

3.22. Except as provided for in paragraphs 3.23 to 3.27, a contractor with a GMS contract which takes effect, or is treated as taking effect for payment purposes, after 1st April 2004 will not be entitled to CFMPs.

3.23. If—

(a) a new contractor comes into existence as the result of a merger between one or more other contractors; and

(b) that merger led to the termination of GMS contracts and the agreement of a new GMS contract,

the new contractor is to be entitled to a CFMP that is the total of any CFMPs payable under the terminated GMS contracts.

3.24. If—

(a) a new contractor comes into existence as the result of a partnership split of a previous contractor (including a split in order to reconstitute as a company limited by shares);

(b) at least some of the members of the new contractor were members of the previous contractor; and

(c) the split led to the termination of the previous contractor's GMS contract,

the new contractor will be entitled to a proportion of any CFMP payable under the terminated contract. The proportions are to be worked out on a pro rata basis, based upon the number of

patients registered with the previous contractor (i.e. immediately before its contract is terminated) who will be registered with the new contractor when its new contract takes effect.

3.25. However, where a contractor that is a company limited by shares becomes entitled to CFMPs as a consequence of a partnership split in order to reconstitute as a company limited by shares, entitlement is conferred exclusively on that company and is extinguished if that company is dissolved. Following such dissolution, discretionary payments under section 53 of the 2006 Act, equivalent to correction factor payments, could be made by the LHB to a new contractor to whom the extinguished company's patients are transferred. Such payments may be appropriate, for example, where a group of providers in a partnership become a company limited by shares and then again a partnership, but all the while they continue to provide essentially the same services to essentially the same number of patients.

3.26. If —

(a) a new GMS contract is agreed by a contractor which has split from a previously established contractor; but

(b) the split did not lead to the termination of the previously established contractor's GMS contract,

the new contractor will not be entitled to any of the previously established contractor's CFMP unless, as a result of the split, an agreed number, or a number ascertainable by the LHB for the contractors, of patients have transferred to the new contractor at or before the end of the first full quarter after the new GMS contract takes effect.

3.27. If such a transfer has taken place, the previously established contractor and the new contractor are each to be entitled to a proportion of the CFMP that has been payable under the previously established contractor's GMS contract. The proportions are to be worked out on a *pro rata* basis. The new contractor's fraction of the CFMP will be –

(a) the number of patients transferred to it from the previously established contractor; divided by

(b) the number of patients registered with the previously established contractor immediately before the split that gave rise to the transfer.

And the previously established contractor's CFMP is to be reduced accordingly.

Conditions attached to payment of Correction Factor Monthly Payments

3.28. CFMPs, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must make available any information which the LHB does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's CFMP; and

(b) all information supplied pursuant to or in accordance with this paragraph must be accurate.

3.29. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of any or any part of a CFMP that is otherwise payable.

PART 2

QUALITY AND OUTCOMES FRAMEWORK

Section 4: GENERAL PROVISIONS RELATING TO THE QUALITY AND OUTCOMES FRAMEWORK

Background

4.1. The Quality and Outcomes Framework (QOF) is set out in Annex D to this SFE.

4.2. Participation in the QOF is voluntary. Information on what is required to accomplish the task or achieve the outcome included in each indicator is set out in Annex D. Additional Guidance on the rationale for indicators, best practice, establishing evidence and verification is published by Welsh Government and can be obtained on www.wales.nhs.uk/GMS.

4.3. This Section explains the types of payments in relation to the QOF and sets out the mechanism for measuring achievement payments in respect of indicators for the period commencing on 1st April 2013 – see paragraphs 4.7 to 4.20.

Types of payments in relation to the QOF

4.4. Essentially, there are two types of payments that are made in relation to the QOF: Aspiration Payments (see also section 5) and Achievement Payments (see also section 6).

Aspiration Payments

4.5. Aspiration payments are, in effect, a part payment in advance in respect of achievement under the QOF, and may be calculated using one of two different methods—

(a) a calculation based on 70% of the contractor's previous year's Unadjusted Achievement Payment; or

(b) a calculation based on the total number of points that a contractor has agreed with the LHB that it is aspiring towards under the QOF during the financial year in respect of which the Aspiration Payment is made. This total is the contractor's Aspiration Points Total. The points available are set out in the QOF indicators in Annex D, which have numbers of points attached to particular indicators.

4.6. If a contractor is to have an Aspiration Points Total, this is to be agreed between the contractor and the LHB–

(a) at the start of the financial year; or

(b) if the contractor's GMS contract takes effect after the start of the financial year, no later than the date the contractor's GMS contract takes effect.

Achievement Payments

4.7. Achievement Payments are payments based on the points total that the contractor achieves under the QOF – as calculated, generally speaking (see paragraph 6.2), on the last day of the financial year or the date on which its contract terminates (see paragraph 6.3) – this points total is its Achievement Points Total. The payments are to be made in respect of all Achievement points actually achieved, whether or not the contractor was seeking to achieve those points, but the final amount also takes into account the deduction of the Aspiration Payments that the contractor has received in respect of the same financial year.

The five principal domains of the QOF

4.8. The QOF is divided into five principal domains, which are—

(a) the clinical domain;

(b) the public health domain which includes an additional services sub-domain;

(c) the organisational domain;

(d) the quality and productivity domain which will apply only for the period commencing on 1st April 2013 and ending on 31st March 2014; and

(e) the patient experience domain.

Calculation of points in respect of the domains

4.9. Each domain contains areas for which there are a number of indicators set out in tables in Section 2 (summary of QOF indicators) of Annex D. These indicators contain standards (tasks or thresholds) against which the performance of a contractor will be assessed. An explanation of these standards and the calculation relating to these standards are set out in paragraph 4.10 to 4.20.

Calculation common to all domains

4.10. Some of the indicators simply require particular tasks to be accomplished (e.g. the production of disease registers), and the standards contained in those indicators do not have, opposite them in the table of indicators, percentage figures for Achievement Thresholds. The points available in relation to these indicators which require tasks to be undertaken are only obtainable (and then in full) if the task is accomplished. What is required to accomplish these tasks is set out in Section 2 of Annex D.

Calculations in respect of the clinical domain and the public health domain including additional services sub-domain

4.11. Other indicators relating to the clinical and public health domain have designated Achievement Thresholds. The contractor's performance against the standards set out in these indicators is assessed by a percentage – generally of the patients suffering from a particular disease in respect of whom a specific task is to be performed or a specific outcome recorded (referred to as "Fraction" indicators – see for example paragraph D.9 of Section 1 of Annex D). Two percentages are set in relation to each indicator—

(a) a minimum percentage of patients, which represents the start of the scale (i.e. with a value of zero points); and

(b) a maximum percentage of patients, which is the lowest percentage of eligible patients in respect of whom the task must be performed or outcome recorded in order to qualify for all the points available in respect of that indicator.

4.12. If a contractor has achieved a percentage score in relation to a particular indicator that is the minimum set for that indicator, or is below that minimum, it achieves no points in relation to that indicator. If a contractor has achieved a percentage score in relation to a particular indicator that is between the minimum and the maximum set for that indicator, it achieves a proportion of the points available in relation to that indicator. The proportion is calculated as follows.

4.13. First, a calculation will have to be made of the percentage the contractor actually scores (D). This is calculated from the following fraction: divide—

(a) the number of patients registered with the contractor in respect of whom the task has been performed or outcome achieved (A); by

(b) the number produced by subtracting from the total number of patients registered with the contractor with the relevant medical condition (B), the total number of patients who fall within the meaning of excepted patients and the total number of patients who fall within the meaning of excluded patients (C).

4.14. For the purposes of paragraph 4.13—

(a) "excepted patients" means patients who fall within the criteria for exception reporting as set out in paragraph D.9 – D.15 of Section 1 of Annex D; and

(b) "excluded patients" means patients who are on the relevant disease register or target group and are referred to in paragraph D10 of Section 1 of Annex D but are not included in an indicator denominator for the clinical area concerned.

4.15. The fraction derived from the calculation in paragraph 4.11 is then multiplied by 100 for the percentage score. The calculation can be expressed as—

$\frac{A}{} \times 100 = D$

(B-C)

4.16. Once the percentage the contractor actually scores has been calculated (D), subtract from this the minimum percentage score set for that indicator (E), then divide the result by the difference between the maximum (F) and minimum (E) percentage scores set for that indicator, and multiply the result of that calculation by the total number of points available in relation to that indicator (G). This can be expressed as—

$$\frac{(D-E)}{(F-E)} \times G$$

4.17. The result is the number of points to which the contractor is entitled in relation to that indicator.

Section 5: ASPIRATION PAYMENTS : CALCULATION, PAYMENT ARRANGEMENTS AND CONDITIONS OF PAYMENTS

Calculation of Monthly Aspiration Payments: General

5.1. At the start of each financial year (or if a GMS contract starts after the start of the financial year, the date on which the GMS contract takes effect) subject to paragraph 5.2(b), the LHB must calculate for each contractor that has agreed to participate in the QOF the amount of the contractor's Monthly Aspiration Payments for that, or for the rest of that, financial year.

5.2. As indicated in paragraph 4.5 above, there are two methods by which a contractor's Monthly Aspiration Payments may be calculated. Each contractor may choose the method by which its Monthly Aspiration Payments are calculated, if it is possible to calculate Monthly Aspiration Payments in respect of the contractor by both methods. However—

(a) if it is only possible to calculate a Monthly Aspiration Payment in respect of the contractor by basing the calculation on an Aspiration Points Total, that is the method which is to be used; and

(b) if the contractor's GMS contract is to take effect on or after 2nd February but before 1st April, no Aspiration Points Total is to be agreed for the financial year into which that 2nd February falls, so the contractor will not be able to claim Monthly Aspiration Payments in that financial year. However, the contractor will nevertheless be entitled to Achievement Payments under the QOF if that contractor participates in the QOF.

Calculation of Monthly Aspiration Payments: the 70% method

5.3. Where—

(a) the contractor's GMS contract took effect before the start of the financial year in respect of which the claim for Monthly Aspiration Payments is made; and

(b) in respect of the previous financial year the contractor was entitled to an Achievement Payment under this SFE,

that contractor's Monthly Aspiration Payments may be calculated using the 70% method.

5.4. To calculate a contractor's Monthly Aspiration Payments by the 70% method, the contractor's Unadjusted Achievement Payment for the previous year needs to be established (that is, the total established under paragraph 6.7 of the 2005 SFE as in force on 31st March 2013 or paragraph 6.9 (calculation of achievement payments) of this SFE). Generally, this will not be possible in the first quarter of the financial year, and so a Provisional Unadjusted Achievement Payment will need to be established by the LHB. The amount of this payment is to be based on the contractor's return submitted in accordance with paragraph 6.3 of the 2005 SFE as in force on 31st March 2013 or paragraph 6.4 (returns in respect of Achievement Payments) of this SFE.

5.5. In practice, therefore, the amount of the contractor's Provisional Unadjusted Achievement Payment will be a provisional value for the contractor's Unadjusted Achievement Payment.

5.6. Once an annual amount for the contractor's Provisional Unadjusted Achievement Payment has been determined, this is to be multiplied by the QOF Uprating Index for the financial year. The QOF Uprating Index is to be determined by dividing—

(a) the amount set out in paragraph 6.8 as the value of each Achievement Point for the financial year in respect of which the claim for Monthly Aspiration Payments is being made; by

(b) the amount set out in paragraph 6.8 or, as the case may be in accordance with paragraph 6.6 of the 2005 SFE, as the value of each Achievement Points for the previous financial year,

and the resultant figure is to be multiplied by the CPI.

5.7. The total produced by paragraph 5.6 is then to be multiplied by 70%. This figure is then further multiplied by the figure which is the product of the maximum number of points available under the QOF for the financial year in respect of which the calculation is being made divided by the maximum number of points available under the QOF in the previous financial year.

By way of example, the figures used for this element of the calculation in the financial year commencing on 1st April 2013 and ending on 31st March 2014 are 969 and 1000 respectively, 969 points being the maximum number of points available under the QOF for that financial year and 1000 being the maximum number of points available under the QOF for the financial year commencing on 1st April 2012 and ending on 31st March 2013. The resulting figure is the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to **paragraphs 5.8, 5.9 and 5.10**, is to be the contractor's Monthly Aspiration Payment as calculated by the 70% method.

5.8. Once the correct amount of the contractor's Achievement Payment in respect of the previous financial year has been established, the amount of the Monthly Aspiration Payments of a contractor whose payments were calculated using a Provisional Unadjusted Achievement Payment is to be revised. First, the difference between the contractor's Total Aspiration Payment for the financial year using the Unadjusted Achievement Payment and Total Aspiration Payment for the financial year calculated using the contractor's Provisional Unadjusted Achievement Payment is to be established. If this figure is zero, there is to be no change to the contractor's Monthly Aspiration Payments for the rest of the financial year.

5.9. If contractor's Total Aspiration Payment for the financial year using the Unadjusted Achievement Payment is lower than the Total Aspiration Payment for the financial year calculated using the contractor's Provisional Unadjusted Achievement Payment, the difference between the two is to be divided by the number of complete months left in the financial year after the actual Achievement Payment is paid. The amount produced by that calculation is to be deducted from each of the contractor's Monthly Aspiration Payments in respect of those complete months, thus producing the revised amount of that contractor's Monthly Aspiration Payments for the rest of the financial year.

5.10. If the contractor's Total Aspiration Payment for the financial year using the Unadjusted Achievement Payment is higher than the Total Aspiration Payment for the financial year calculated using the contractor's Provisional Unadjusted Achievement Payment, the difference between the two is to be divided by the number of complete months left in the financial year after the actual Achievement Payment is paid. The amount produced by that calculation is to be added to each of the contractor's Monthly Aspiration Payments in respect of those complete months, thus producing the revised amount of that contractor's Monthly Aspiration Payments for the rest of the financial year.

Calculation of Monthly Aspiration Payments: the Aspiration Points Total method

5.11. Any contractor who is participating in the QOF may instead have their Monthly Aspiration Payments calculated by the Aspiration Points Total method, provided that the contractor's GMS contract takes effect before 2nd February in the financial year in respect of which the claim for Monthly Aspiration Payments is made.

5.12. If the contractor is to have its Monthly Aspiration Payments calculated by this method, at the start of each financial year – or if a GMS contract starts after the start of the financial year, on the date on which the GMS contract takes effect – an Aspiration Points Total is to be agreed between the contractor and the LHB. As indicated in paragraph 4.5(b) above, an Aspiration Points Total is the total number of points that the contractor has agreed with the LHB that it is aspiring towards under the QOF during the financial year in respect of which the Aspiration Payment is made.

5.13. If the LHB and the contractor have agreed an Aspiration Points Total for the contractor, that total is to be divided by three. The resulting figure is to be multiplied by £153.14 and then by the contractor's CPI, which produces the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to paragraph 6.12 (recovery where Aspiration Payments have been too high), is to be the contractor's Monthly Aspiration Payment, as calculated by the Aspiration Points Total method.

Payment arrangements for Monthly Aspiration Payments

5.14. If, as regards any financial year, a contractor could have its Monthly Aspiration Payments calculated by either the 70% method or the Aspiration Points Total method, it must choose the method by which it wishes its Monthly Aspiration Payments to be calculated. Once the contractor has made that choice, the contractor cannot change that choice during that financial year.

5.15. The LHB must pay the contractor under the contractor's GMS contract its Monthly Aspiration Payment monthly. The Monthly Aspiration Payment is to fall due on the last day of each month. However, if the contractor's contract took effect on a day other than the first day of a month, the contractor's Monthly Aspiration Payment in respect of that first part month (which will have been calculated by the Aspiration Points Total method) is to be adjusted by the fraction produced by dividing—

(a) the number of days during the month in which the contractor was participating in the QOF; by

(b) the total number of days in that month.

5.16. The amount of a contractor's Monthly Aspiration Payments is thereafter to remain unchanged throughout the financial year, even when the contractor's CPI changes or if the contractor ceases to provide an Additional Service and as a consequence is less likely to achieve the Aspiration Points Total that has been agreed.

Conditions attached to Monthly Aspiration Payments

5.17. Monthly Aspiration Payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) as regards Monthly Aspiration Payments which are, or are to be, calculated by the Aspiration Points Total method—

  (i) the contractor's Aspiration Points Total on which the Payments are based must be realistic and agreed with the LHB, and

  (ii) the contractor must make any returns required of it (whether computerized or otherwise) to the LHB in such manner as the LHB may reasonably require, and do so promptly and fully;

(b) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's Monthly Aspiration Payments;

(c) a contractor utilising computer systems approved by the LHB must make available to the LHB aggregated monthly returns relating to the contractor's achievement of the standards contained in the indicators in the QOF, and in the standard form provided for by such systems;

(d) a contractor not utilising computer systems approved by the LHB must make available to the LHB similar monthly returns, in such form as the LHB may reasonably request (for example, the LHB may reasonably request that a contractor fill in manually a printout of the standard spreadsheet in a form specified by the LHB); and

(e) all information supplied pursuant to or in accordance with this paragraph must be accurate.

5.18. If the contractor breaches any of the conditions referred to in paragraph 5.17, the LHB may, in appropriate circumstances, withhold payment of any or any part of a Monthly Aspiration Payment that is otherwise payable.

Section 6: ACHIEVEMENT PAYMENTS: CALCULATION, PAYMENT ARRANGEMENTS AND CONDITIONS OF PAYMENTS

Basis of Achievement Payments

6.1. Achievement Payments are to be based on the Achievement Points to which a contractor is entitled each financial year, as calculated in accordance with this Section and Section 4.

Assessment of Achievement Payments

6.2. Subject to paragraph 6.3, the date in respect of which the assessment of achievement points is to be made is the last day of the financial year.

Assessment of Achievement Payments where a GMS contract terminates during the financial year

6.3. In a case where a GMS contract terminates before the end of the financial year, the assessment of the Achievement Points to which the contractor is entitled is to be made in respect of the last date in the financial year on which that contractor is required under the contractor's GMS contract to provide essential services.

Returns in respect of Achievement Payments

6.4. In order to make a claim for an Achievement Payment, a contractor must make a return in respect of the information required by the LHB in order for the LHB to calculate the contractor's Achievement Payment. Where a GMS contract terminates before the end of the financial year, a contractor may make a return at the time the contract terminates in respect of the information necessary to calculate the Achievement Payment to which the contractor is entitled in respect of that financial year.

6.5. On the basis of that return but subject to any revision of the Achievement Points Totals that the LHB may reasonably see fit to make to correct the accuracy of any points total, the LHB must calculate the contractor's Achievement Payment as follows.

Calculation of Achievement Payments

6.6. The parts of the Achievement Payment that relate to the domains referred in paragraph 4.8(a) and (b) (other than the parts referred to in paragraph 6.7) are calculated in a different way from the parts relating to the other domains. As regards—

(a) the additional services sub-domain of the public health domain, the Achievement Points Total in respect of each additional service is to be assessed in accordance with Annex E, and a calculation is to be made of the cash total in respect of that domain in the manner set out in that Annex; and

(b) the clinical domain and the public health domain in a case where there is a disease register (other than the areas and indicators referred to in paragraph 6.7), first a calculation needs to be made of an Adjusted Practice Disease Factor for each disease area. The sum from this

calculation is then multiplied by £153.14 and by the contractor's Achievement Points Total in respect of the disease area to produce a cash amount for that disease area. Then the cash totals in respect of all the individual disease areas in the domain are to be added together to give the cash total in respect of the domain.

A fuller explanation of the calculation of Adjusted Practice Disease Factors, and of the provisions that apply in the case of a GMS contract that only has effect for part of a financial year, is given in Annex F (Adjusted Practice Disease Factor Calculations).

6.7. The part of the Achievement Payment that relates to—

(a) the palliative care area of the clinical domain;

(b) indicators 001W, 003, 004W in the smoking area of the public health domains; and

(c) indicator BP001 in the blood pressure area of the public health domain,

must be calculated by multiplying the total number of Achievement Points gained by the contractor in respect of the palliative care area referred to in sub-paragraph (a) or, as the case may be, in respect of the indicators referred to in sub-paragraphs (b) and (c) by £153.14.

6.8. As regards all the other Achievement Points gained by the contractor, the total number of Achievement Points is to be multiplied by £153.14.

6.9. The cash totals produced under paragraphs 6.6 and 6.8 are then added together and multiplied by the contractor's CPI, calculated in accordance with the provisions of paragraph 2.18—

(a) at the start of the final quarter of the financial year to which the Achievement Payment relates;

(b) if its GMS contract takes effect after the start of the final quarter of the financial year to which the Achievement Payment relates, on the date its GMS contract takes effect; or

(c) if its GMS contract has been terminated, its CPI at the start of the quarter during which its GMS contract was terminated.

The cash total produced as a consequence of this paragraph is the Unadjusted Achievement Payment for the purposes of calculating aspiration payments for the following financial year.

6.10. If the contractor's GMS contract had effect—

(a) throughout the financial year, the resulting amount is the interim total for the contractor's Achievement Payment for the financial year; or

(b) for only part of the financial year, the resulting amount is to be adjusted by the fraction produced by dividing the number of days during the financial year for which the contractor's GMS contract had effect by 365 (or 366 where the financial year includes 29th February), and the result of that calculation is the interim total for the contractor's Achievement Payment for the financial year.

6.11. From these interim totals, the LHB needs to subtract the total value of all the Monthly Aspiration Payments made to the contractor under its GMS contract in the financial year to which the Achievement Payment relates. The resulting amount (unless it is a negative amount or zero, in which case no Achievement Payment is payable) is the contractor's Achievement Payment for that financial year.

Recovery where Aspiration Payments have been too high

6.12. If the resulting amount from the calculation under paragraph 6.11 is a negative amount, that negative amount, expressed as a positive amount ("the paragraph 6.11 amount"), is to be recovered by the LHB from the contractor in one of two ways—

(a) to the extent that it is possible to do so, the paragraph 6.11 amount is to be recovered by deducting one twelfth of that amount from each of the contractor's Monthly Aspiration Payments for the financial year after the financial year to which the paragraph 6.10 amount relates. In these circumstances—

(i) the gross amount of its Monthly Aspiration Payments for accounting and superannuation purposes in the financial year after the financial year to which the paragraph 6.11 amount relates is to be the amount to which the contractor is otherwise entitled under paragraphs 5.3 to 5.10 or paragraph 5.11 to 5.13, and

(ii) the paragraph 6.11 amount is to be treated for accounting and superannuation purposes as an overpayment in respect of the contractor's Monthly Aspiration Payments for the financial year to which the paragraph 6.10 amount relates; or

(b) if it is not possible to recover all or part of the paragraph 6.11 amount by the method described in sub paragraph (a) (for example, because of the termination of the GMS contract after a partnership split), the amount that cannot be so recovered is to be treated as an overpayment in respect of the contractor's Monthly Aspiration Payments for the year to which the paragraph 6.10 amount relates, and is to be recovered accordingly (i.e. in accordance with paragraph 19.1).

Accounting arrangements and due date for Achievement Payments

6.13. The contractor's Achievement Payment, as calculated in accordance with paragraph 6.11 is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year into which the date in respect of which the assessment of Achievement Points on which the Achievement Payment is based ("the relevant date") falls and the Achievement Payment is to fall due –

(a) where the GMS contract terminates before the end of the financial year into which the relevant date falls (see paragraph 6.3), at the end of the quarter after the quarter during which the GMS contract was terminated, and

(b) in all other cases, at the end of the first quarter of the financial year after the financial year into which the relevant date falls (see paragraph 6.2).

Conditions attached to Achievement Payments

6.14. Achievement Payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must make the return required of it under paragraph 6.4;

(b) the contactor must ensure that all the information that it makes available to the LHB in respect of the calculation of its Achievement Payment is based on accurate and reliable information, and that any calculations it makes are carried out correctly;

(c) the contractor must ensure that it is able to provide any information that the LHB may reasonably request of it to demonstrate that it is entitled to each Achievement Point to which it says it is entitled, and the contractor must make that information available to the LHB on request;

(d) the contractor must make any returns required of it (whether computerized or otherwise) to the LHB in such manner as the LHB may reasonably require, and do so promptly and fully;

(e) the contractor must co-operate fully with any reasonable inspection or review that the LHB or another relevant statutory authority wishes to undertake in respect of the Achievement Points to which it says it is entitled; and

(f) all information supplied pursuant to or in accordance with this paragraph must be accurate.

6.15. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of all or part of an Achievement Payment that is otherwise payable.

PART 3

SECTION 7: CHILDHOOD IMMUNISATIONS

General: Childhood vaccines and immunisations

7.1. Childhood vaccines and immunisations are classified as Additional Services. If the contractor is providing these additional services to registered patients, the LHB must seek to agree a Childhood Immunisation Scheme. As part of the Childhood Immunisation Scheme, the Childhood Immunisation Scheme plan as specified in direction 5(2)(a) to (g) of the DES Directions forms part of the contractor's GMS contract. This Section sets out the mechanism under which the payments will be payable only in respect of that part of the Childhood Immunisation Scheme referred to in direction 5 of the DES Directions. Contractors which provide childhood vaccines and immunisations as part of additional services under a GMS contract are required to offer to provide the vaccines and immunisations of the type and in the circumstances which are set out in Annex I.

Childhood Immunisation Scheme plans

7.2. Paragraphs 7.3 to 7.24 set out the payment mechanism in respect of Childhood Immunisation plans.

Target payments in respect of two-year-olds

7.3. The LHB must pay to a contractor under that contractor's GMS contract a Quarterly Two-Year-Olds Immunisation Payment ("Quarterly TYOIP") if it qualifies for that payment. A contractor qualifies for that payment if, on the first day of a quarter—

(a) the contractor has, as part of its GMS contract, a Childhood Immunisations Scheme plan which has been agreed with the LHB; and

(b) subject to paragraph 7.4 as regards the cohort of children, established on that day, who are registered with the contractor and who are aged two (i.e. who have passed their second birthday but not yet their third), by the end of that quarter at least 70%, for the lower payment, or at least 90%, for the higher payment, have completed the recommended immunisation courses (i.e. those that have been recommended nationally and by the World Health Organisation) for protection against—

(i) diphtheria, tetanus, poliomyelitis, pertussis and Haemophilus influenza type B (HiB);

(ii) measles/mumps/rubella; and

(iii) Meningitis C.

7.4. In establishing whether the required percentage of the cohort of children referred to in paragraph 7.3 have completed the recommended immunisation courses referred to in that paragraph, the LHB is not required to determine whether any of that cohort have received the Hib/MenC booster vaccine recommended in the provisions set out in Annex I for the administration around the age of 12 months. The administration of that Hib/MenC booster vaccine is not a requirement for payment under this Section.

Calculation of Quarterly Two-Year-Olds Immunisation Payment

7.5. The LHB will first need to determine the number of completed immunisation courses that are required over the three disease groups in paragraph 7.3 (b) in order to meet either the 70% or 90% target. To do this the contractor will need to provide the LHB with the number of two-year-olds (A) whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which the contractor is seeking payment (this is the cohort of children in respect of whom the calculation is to be made), and then the LHB must make the following calculations –

(a) $(0.7 \times A \times 4) = B^1$ (the number of completed immunisation courses needed to meet the 70% target); and

(b) $(0.9 \times A \times 4) = B^2$ (the number of completed immunisation courses needed to meet the 90% target).

7.6. The LHB will then need to calculate which, if any, target was achieved. To do this, the LHB will also need from the contractor the number of children in the cohort of children in respect of whom the calculation is to be made who, by the end of the quarter to which the calculation relates, have completed immunisation courses in each of the three disease groups (C1 + C2 + C3). In this section, C1 is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 7.3(b)(ii); C2 is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 7.3(b)(ii) and C3 is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 7.3(b)(iii). Only completed immunisation courses (whether or not carried out by the contractor) are to count towards the determination of whether or not the targets are achieved. No adjustment is to be made for exception reporting. A calculation (which provides for an additional weighting factor of 2 to be given to immunisation courses in respect of the diseases referred to in paragraph 7.3(b)(i)) is then to be made of whether or not the targets are achieved –

(a) if $(C1 \times 2) + C2 + C3 \geq B^1$, then the 70% target is achieved; and

(b) if $(C1 \times 2) + C2 + C3 \geq B^2$, then the 90% target is achieved.

7.7. Next the LHB will need to calculate the number of the completed immunisation courses, notified under paragraph 7.13(b)(ii), that the contractor can use to count towards achievement of the targets (D). To do this, the contractor will need to provide the LHB with a breakdown of how many immunisation courses in each disease group were completed before the end of the quarter to which the calculation relates by a completing immunisation administered, within the National Health Service (and not necessarily during the quarter to which the calculation relates), by—

(a) the Contractor;

(b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term "GMS contractor" includes a contractor providing services under section 42 of the 2006 Act, section 84 of the National Health Service Act 2006, a contractor providing services under a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);

(c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term "PMS Contractor" includes a contractor providing services under section 50 of the 2006 Act, a contractor providing services under section 92 of the National Health Service Act 2006, a contractor providing services under section 17C of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);

(d) an Alternative Provider Medical Services contractor ("APMS contractor") as part of primary medical services to a patient who was at that time registered with that contractor (where the term "APMS contractor" includes a contractor providing services under arrangements made under section 41 of the 2006 Act, section 83(2) of the National Health Service Act 2006, a contractor providing services under arrangements made under a contractor providing services under section 2C(2) of the National Health Services (Scotland) Act 1978 or a contractor providing services under arrangements made under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or

(e) a Local Health Board Medical Services practice as part of primary medical services to a patient who was at that time registered with such a practice which provided services under arrangements made under section 41(2) of the 2006 Act, section 83(2)(a) of the National Health Service Act 2006 (before the coming into force of section 34 (abolition of Primary

Care Trusts) of the Health and Social Care Act 2012) or Article 56(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 (such arrangements in Northern Ireland being referred to as Health and Social Services Board Medical Services)).

7.8. For the purpose of paragraph 7.7 and paragraph 7.9, an immunisation course is considered as being completed when the final immunisation needed to complete the immunisation course ("the completing immunisation") is administered.

7.9. Once the LHB has that information, (D) is to be calculated as follows –

C1 x 2 minus E1 x 2

+ C2 minus E2

+ C3 minus E3

= D

For these purposes –

(a) $\underline{(E^X)}$ is the number of completed immunisation courses in each disease group where the completing immunisation was carried out other than by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 7.7(a) to (e) (e.g. for the diseases referred to in paragraph 7.3(b)(i), E1);

(b) (C^X) is the number of children in the cohort of children in respect of whom the calculation is to be made who have completed the immunisation course in respect of a particular disease group (e.g. for the diseases referred to in paragraph 7.3(b)(i), (C1);

(c) in the case of the disease group referred to in paragraph 7.3(b)(i), the value of (C1 x 2) – (E1 x 2) can never be greater than (A x 2) x 0.7 or 0.9 (depending on which target achieved); where it is, it is treated as the result of: A x 0.7 or, as the case may be, 0.9.

7.10. The maximum amounts payable to a contractor will depend on the number of children aged two whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 63. The maximum amounts payable to the contractor (F) are therefore to be calculated as follows –

(a) where the 70% target is achieved: $(F^1) = \frac{A}{63} \times £722.68$; or

(b) where the 90% target is achieved: $(F^2) = \frac{A}{63} \times £2{,}168.04$

7.11. The Quarterly TYOIP payable to the contractor is thereafter calculated as a proportion of the maximum amounts payable as follows –

$$F^1 \text{ or } F^2 \times \frac{D}{B^1 \text{ or } B^2} = \text{Quarterly TYOIP}$$

7.12. The amount payable as a Quarterly TYOIP is to fall due on the last day of the quarter after the quarter in respect of which the contractor is seeking payment (i.e. at the end of the quarter after the last quarter in which immunisations were carried out that could count towards the targets). However, if the contractor delays providing the information the LHB needs to calculate its Quarterly TYOIP beyond the LHB's cut-off date for calculating quarterly payments, the amount is to fall due at the end of the next quarter (that is, just under nine months after the cohort was established). No Quarterly TYOIP is payable if the contractor provides the necessary information more than four months after the final date for immunisations which could count towards the payment.

Conditions attached to Quarterly Two-Year-Olds Immunisation Payments

7.13. Quarterly TYOIPs, or any part thereof, are only payable if the contractor satisfies the following conditions–

(a) the contractor must meet its obligations under its Childhood Immunisations Scheme plan;

(b) the contractor must make available to the LHB sufficient information to enable it to calculate the contractor's Quarterly TYOIP. In particular, the contractor must supply the following figures–

(i) the number of two-year-olds whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which a payment is claimed;

(ii) how many of those two-year-olds have completed each of the recommended immunisation courses (i.e. that have been recommended nationally and by the World Health Organisation) for protection against the disease groups referred to in paragraph 7.3(b) by the end of the quarter in respect of which a payment is claimed; and

(iii) of those completed immunisation courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 7.7(a) to (e); and

(c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

7.14. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of all or part of a Quarterly TYOIP that is otherwise payable.

Target payments in respect of five-year-olds

7.15. The LHB must pay to a contractor under its GMS contract a Quarterly Five-Year-Olds Immunisation Payment ("Quarterly FYOIP") if it qualifies for that payment. A contractor qualifies for that payment if, on the first day of a quarter–

(a) the contractor has, as part of its GMS contract, a Childhood Immunisations Scheme plan which has been agreed with the LHB; and

(b) as regards the cohort of children, established on that day, who are registered with the contractor and who are aged five (i.e. who have passed their fifth birthday but not yet their sixth), by the end of that quarter at least 70%, for the lower payment, or at least 90%, for the higher payment, have received all the recommended reinforcing doses (i.e. those that have been recommended nationally and by the World Health Organisation) for protection against diphtheria, tetanus, pertussis and poliomyelitis.

Calculation of Quarterly Five-Year-Olds Immunisation Payments

7.16. The LHB will first need to determine the number of completed immunisation courses that are required over the three disease groups in paragraph 7.3(b) in order to meet either the 70% or 90% target. To do this the contractor will need to provide the LHB with the number of five-year-olds (A) whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which the contractor is seeking payment (this is the cohort of children in respect of whom the calculation is to be made), and then the LHB must make the following calculations –

(a) $(0.7 \times A) = B^1$ (the number of completed booster courses needed to meet the 70% target); and

(b) $(0.9 \times A) = B^2$ (the number of completed booster courses needed to meet the 90% target).

7.17. The LHB will then need to calculate which, if any, target was achieved. To do this, the LHB will also need from the contractor the number of children in the cohort of children in respect of whom the calculation is to be made who, by the end of the quarter to which the calculation relates, have completed the booster courses required (C). Only completed booster courses (whether or not carried out by the contractor) are to count towards the determination of whether or not the targets are achieved. No adjustment is to be made for exception reporting. A calculation is then to be made of whether or not the targets are achieved–

(a) if $C \geq B^1$, then the 70% target is achieved; and

(b) if $C \geq B^2$, then the 90% target is achieved.

7.18. Next the LHB will need to calculate the number of the completed courses, notified under paragraph 7.23(b)(ii), that the contractor can use to count towards achievement of the targets (D) the initial value of which is (C) minus the number of children whose completed courses were not carried out by a contractor or practice of a type specified in, or under the circumstances specified in, any of the paragraphs (a) to (e) below. To do this, the contractor will need to provide the LHB with a breakdown of how many of the completed courses were carried out before the end of the quarter to which the calculation relates by a completing course administered, within the National Health Service (and not necessarily during the quarter to which the calculation relates), by—

(a) the Contractor;

(b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term "GMS contractor" includes a contractor providing services under section 42 of the 2006 Act, a contractor providing services under section 84 of the National Health Service Act 2006, a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);

(c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term "PMS Contractor" includes a contractor providing services under section 50 of the 2006 Act, a contractor providing services under section 92 of the National Health Service Act 2006, a contractor providing services under section 17C of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);

(d) an Alternative Provider Medical Services contractor ("APMS contractor") as part of primary medical services to a patient who was at that time registered with that contractor (where the term "APMS contractor" includes a contractor providing services under arrangements made under section 41(2)(b) of the 2006 Act, a contractor providing services under arrangements made under section 83(2) of the National Health Service Act 2006, a contractor providing services under section 2C(2) of the National Health Services (Scotland) Act 1978 or a contractor providing services under arrangements made under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or

(e) a Local Health Board Medical Services practice as part of primary medical services to a patient who was at that time registered with such a practice which provided services under arrangements made under section 41(2)(a) of the 2006 Act (such arrangements in Wales being referred to as Local Health Board Medical Services), a Primary Care Trust Medical Services practice under section 83(2)(a) of the National Health Service Act 2006 (before the coming into force of section 34 (abolition of Primary Care Trusts) of the Health and Social Care Act 2012), or Article 56(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 (such arrangements in Northern Ireland being referred to as Health and Social Services Board Medical Services).

7.19. If $D > B^1$ or B^2 (depending on the target achieved), then D is adjusted to equal the value of (B^1) or (B^2) as appropriate.

7.20. The maximum amounts payable to a contractor will depend on the number of children aged five whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 58. The maximum amounts payable to the contractor (E) are therefore to be calculated as follows –

(a) where the 70% target is achieved: $E^1 = \frac{A}{58} \times £223.85$; or

(b) where the 90% target is achieved: $E^2 = \frac{A}{58} \times £671.55$

7.21. The Quarterly FYOIP payable to the contractor is thereafter calculated as a proportion of the maximum amounts payable as follows—

$$E^1 \text{ or } E^2 \quad x \quad \frac{D}{B^1 \text{ or } B^2} = \text{Quarterly FYOIP}$$

7.22. The amount payable as a Quarterly FYOIP is to fall due on the last day of the quarter after the quarter in respect of which the contractor is seeking payment (i.e. at the end of the quarter after the last quarter in which completed courses were carried out that could count towards the targets). However, if the contractor delays providing the information the LHB needs to calculate its Quarterly FYOIP beyond the LHB's cut-off date for calculating quarterly payments, the amount is to fall due at the end of the next quarter (that is, just under nine months after the cohort was established). No Quarterly FYOIP is payable if the contractor provides the necessary information more than four months after the final date for immunisations which could count towards the payment.

Conditions attached to Quarterly Five-Year-Olds Immunisation Payments

7.23. Quarterly FYOIPs, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must meet its obligations under its Childhood Immunisations Scheme plan;

(b) the contractor must make available to the LHB sufficient information to enable the LHB to calculate the contractor's Quarterly FYOIP. In particular, the contractor must supply the following figures—

(i) the number of five-year-olds whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter in respect of which a payment is claimed;

(ii) how many of those five-year-olds have received the complete course of recommended reinforcing doses (i.e. that have been recommended nationally and by the World Health Organisation) for protection against the diphtheria, tetanus, pertussis and poliomyelitis by the end of the quarter in respect of which a payment is claimed; and

(iii) of those completed courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 7.18(a) to (e); and

(c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

7.24. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of all or any part of any Quarterly FYOIP that is otherwise payable.

PART 4

PAYMENTS FOR SPECIFIC PURPOSES

Section 8: ROTAVIRUS VACCINE

General

8.1. Section 8 makes provision in respect of payments to be made in respect of the administration of the rotavirus vaccine by a contractor. A contractor may be contracted to provide the childhood vaccines and immunisations which are classified as Additional Services. The

rotavirus vaccine is part of the routine childhood immunisation schedule (see Annex I) and therefore falls within the childhood vaccines and immunisations which are classified as Additional Services.

8.2. References in Section 8 to the age of a child expressed in months are references to calendar months. A reference made to a vaccine being administered at or around a certain age in this Section, is an indication of the recommended schedule for administration of the vaccine (**a**). The specific timing of the administration of the vaccine, which should be within the parameters of the recommended childhood immunisation schedule, is a matter for the clinical judgement of the relevant health care professional.

Payment for administration of rotavirus vaccine

8.3. The LHB must pay a contractor who qualifies for the payment, a payment of £7.67 in respect of each child registered with the contractor who receives a completed course of immunisation (as set out below) as part of their routine childhood immunisation schedule.

8.4. A payment is to be made only where the course of immunisation is complete and where the contractor has administered the second and final vaccine in accordance with the Table—

When to immunise	*How vaccine is given*
2 months	One oral dose
3 months	One oral dose

8.5. Where the vaccine status of the child is incomplete and the contractor vaccinates the child by giving—

(a) the final completing dose at least one month following the administration of the first dose; and

(b) the second dose of the vaccine to the child before the child reaches the age of 24 weeks,

the LHB must pay a contractor in accordance with paragraph 8.3.

8.6. Where the vaccine status of a child is unknown (**b**) and the contractor vaccinates the child by giving—

(c) the final completing dose of the vaccine at least one month following the administration of the first dose (which must have been given before the child reaches the age of 15 weeks); and

(d) the second dose of the vaccine to the child before that child reaches the age of 24 weeks,

the LHB must pay contractor in accordance with paragraph 8.3.

8.7. Where the vaccine status of the child is unknown and the child is unable to receive the first dose before the age of 15 weeks, no vaccine should be given and a contractor is not eligible for any payment under this Section.

Eligibility for payment

8.8. A contractor is only eligible for a payment under Section 8 in circumstances where the following conditions are met—

(e) the contractor is contracted to provide the childhood vaccines and immunisations as part of Additional Services;

(f) the child in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the final completing course of the vaccine was administered;

(**a**) *See* "Immunisation against infectious diseases – The Green Book".
(**b**) *See* recommendation in "Immunisation against infectious diseases – The Green Book".

(g) the contractor administers the final completing course of the vaccine to the child in respect of whom the payment is claimed;

(h) the contractor does not receive any payment from any other source in respect of the vaccine (if the contractor does receive any such payment in respect of any child from any other source, the LHB must give serious consideration to recovering any payment made under this Section in respect of that patient pursuant to paragraphs 19.1 and 19.2 (overpayments and withheld amounts); and

(i) the contractor submits the claim within 6 months of administering the final completing course of the vaccine.

Claims for payment

8.9. The contractor is to submit claims in respect of the final completing course of the vaccine after they have been administered at a frequency to be agreed between the LHB and the contractor (which must be a frequency which provides for the claim to be submitted within 6 months of administering the final completing vaccination), or if agreement cannot be reached, within 14 days of the end of the month during which the final completing course of the vaccine was administered. Any amount payable falls due on the next date, following the expiry of 14 days after the claim is submitted, when the contractor's Payable GSMP falls due.

8.10. The LHB must ensure that the receipt and payment in respect of any claims are properly recorded and that each such claim has a clear audit trail.

Conditions attached to payment

8.11. A payment under the provisions of this Section is only payable if the contractor satisfies the following conditions—

(j) the contractor must supply the LHB with the following information in respect of each child for which a payment is claimed—

(i) the name of the child;

(ii) the date of birth of the child;

(iii) the NHS number, where known, of the child;

(iv) except where paragraph (v) applies, confirmation that the child has received two doses of the rotavirus vaccine in accordance with the table at paragraph 8.4;

(v) if the claim is made in the circumstances set out in paragraph 8.5, confirmation that all required vaccines have been administered; and

(vi) the date of the final completing course of the vaccine, which must have been administered by the contractor,

but where a parent or carer objects to details of the child's name or date of birth being supplied to the LHB, the contractor need not supply such information to the LHB but must supply the child's NHS number;

(k) the contractor must provide appropriate information and advice to the parent or carer of the child;

(l) the contractor must record in the child's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, any refusal of an offer of the rotavirus vaccine;

(m) where the rotavirus vaccine is administered, the contractor must record in the child's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004 Regulations;

(n) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable him to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;

(o) the contract must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;

(p) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully; and

(q) all information provided pursuant to or in accordance with this paragraph must be accurate.

8.12. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of any, or any part of, the payment due under this Section.

Section 9: PNEUMOCOCCAL VACCINE AND HIB/MENC BOOSTER VACCINE

General

9.1. Section 9 make provision in respect of payments to be made in respect of the administration by a contractor, which is contracted to provide childhood vaccines and immunisations as part of Additional Services (such vaccines are classified as an Additional Service), of the pneumococcal conjugate vaccine (PCV) and the combined Hib and Men C booster vaccine (Hib/MenC) as part of the routine childhood immunisation schedule and in certain non-routine cases.

9.2. References in Section 9 to the age of a child expressed in months are references to calendar months. Where reference is made to a vaccine being administered at or around a certain age, this is an indication of the recommended schedule for administration of the vaccine contained Immunisation against Infectious Diseases – The Green Book which is published by the Department of Health. The specific timing of the administration of the vaccine, which should be within the parameters of the recommended schedule, is a matter for the clinical judgement of the relevant health care professional.

Payment for administration of PCV vaccine and Hib/MenC vaccine as part of the routine childhood immunisation schedule

9.3. The LHB must pay to a contractor who qualifies for the payment, a payment of £15.02 in respect of each child registered with the contractor—

(a) who has received, as part of their routine childhood immunisation schedule, all four of the vaccines set out in the table at paragraph 9.5, namely the series of three PCV vaccines to be administered at two months, four months and around 13 months, and the Hib/MenC booster vaccination which is to be administered at around 12 months; and

(b) in respect of whom the contractor administered the final completing course of the vaccine.

9.4. For the purpose of paragraph 9.3(b), the final completing course of the vaccine means the third in the series of three PCV vaccines which is scheduled, in the table at paragraph 9.5, to be administered at around 13 months.

9.5. The table below sets out the schedule for the administration of the PCV and the Hib/MenC vaccines as part of the routine childhood immunisation schedule.

When to immunize	*What is given*	*How vaccine is given*
Two months old	Pneumococcal (PCV)	One injection
Four months old	Pneumococcal (PCV)	One injection
Around 12 months	Haemophilus influenzae type B, Meningitis C (Hib/MenC)	One injection
Around 13 months	Pneumococcal (PCV)	One injection

Payment for administration of PCV vaccine other than as part of the routine childhood immunisation schedule

9.6. The LHB must pay to a contractor who qualifies for the payment, a payment of £15.02 in respect of each child registered with the contractor who has received the PCV vaccine in any of the circumstances set out in paragraphs 9.8 to 9.14 and in respect of whom the contractor administered the final completing course of the vaccine.

Children at increased risk of pneumococcal infection

9.7. The table below sets out what are, for the purposes of this Section the specific pneumococcal clinical risk groups for children.

Clinical risk group	*Examples (decision based on clinical judgement*
Asplenia or dysfunction of the spleen	This includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction
Chronic respiratory disease	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neuromuscular disease (e.g. cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below) is needed.
Chronic heart disease	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
Chronic renal disease	This includes nephrotic syndrome, chronic renal failure, renal transplantation.
Chronic liver disease	This includes cirrhosis, biliary atresia, chronic hepatitis.
Diabetes (requiring insulin or oral hypoglycaemic drugs)	This includes type I diabetes requiring insulin or type 2 diabetes requiring oral hypoglycaemic drugs. It does not include diabetes that is diet controlled.
Immunosuppression	Due to disease or treatment, including asplenia or splenic dysfunction and HIV infection at all stages. Patients undergoing chemotherapy leading to immunosuppression. Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone 20mg or more per day (any age), or for children under 20Kg a does of $\geq$ 1mg/kg/day. Some immunocompromised patients may have a suboptimal immunological response to the vaccine.
Individuals with cochlear implants	It is important that immunisation does not delay the cochlear implantation. Where possible, pneumococcal vaccine should be completed at least 2 weeks prior to surgery to allow a protective immune response to develop. In some cases, it will not be possible to complete the course prior to surgery. In this instance, the course should be started at any time prior to or following surgery and completed according to the immunisation schedule.
Individuals with Cerebrospinal fluid leaks	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery.

9.8. Where a child who is in any of the pneumococcal clinical risk groups set out in the table in paragraph 9.7 presents late for a vaccine (that is, not in accordance with the routine schedule set out in paragraph 9.5), and–

(a) consequently cannot receive, and has not received the four vaccines referred to in paragraph 9.3(a) in accordance with the routine schedule set out in the table in paragraph 9.5; but

(b) who nevertheless still presents in time to enable the child to receive, and did receive two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months,

the LHB must pay to the contractor administering the final completing course of the vaccine a payment of £15.02 in respect of that child. The third dose of PCV is considered the final completing course of the vaccine for this purpose.

9.9. Where a child over the age of 12 months but under the age of 5 years and who is in any of the clinical risk groups set out in the table in paragraph 9.7 presents late for vaccine (that is, not in accordance with the routine schedule set out in paragraph 9.5), and

(a) consequently cannot receive, and has not received, two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months; but

(b) nevertheless receives either a single dose of PCV or, if the child has asplenia, splenic dysfunction or is immunocompromised, two doses of PCV, the second of which is administered two months after the first dose,

the LHB must pay to the contractor administering the final completing course of the vaccine a payment of £15.02 in respect of that child. The singe dose of PCV or, in the case of a child where a second dose of PCV is required, the second dose of PCV is considered the final completing course of the vaccine for this purpose.

Children over the age of 13 months but under the age of 5 years who have previously had invasive pneumococcal disease

9.10. Where a child who is over the age of 13 months but under the age of 5 years and who has previously had invasive pneumococcal disease receives a single dose of PCV in accordance with the recommendation contained in Immunisation against infectious diseases – The Green Book, the LHB must pay to the contractor administering the final completing course of the vaccine a payment of £15.02 in respect of that child unless a payment is otherwise payable for that same final completing course of the vaccine under paragraph 9.9 or 9.12. The single dose of PCV is considered the final completing course of the vaccine for this purpose.

Children with an unknown or incomplete immunisation status

9.11. Where a child who has an unknown or incomplete immunisation status receives vaccines sufficient to ensure that he has received two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months, the LHB must pay to the contractor administering the final completing course of the vaccine a payment of £15.02 in respect of that child. The third dose of PCV is considered the final completing course of the vaccine for this purpose.

9.12. Where a child who has an unknown or incomplete immunisation status and is too old to be able to receive two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months, receives a single dose of PCV prior to the age of 24 months, the LHB must pay to the contractor who administers the final completing course of the vaccine a payment of £15.02 in respect of that child. The single dose of PCV is considered the final completing course of the vaccine for this purpose.

Eligibility for payment

9.13. A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met—

(a) the contractor is contracted to provide the childhood vaccines and immunisations as part of Additional Services;

(b) the child in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the final completing course of the vaccine was administered;

(c) the contractor administers the final completing course of the vaccine to the child in respect of whom the payment is claimed;

(d) subject to sub-paragraph (e), the child in respect of whom the payment is claimed is aged around 13 months when the final completing course of the vaccine is administered;

(e) in the case of payments in respect of the vaccines administered in accordance with paragraphs 9.9 or 9.10, the child must be under the age of 5 years when the final completing course of the vaccine is administered and in the case of the vaccines administered in accordance with paragraph 9.14, the child must be under the age 2 years when the final completing course of the vaccine is administered;

(f) the contractor does not receive any payment from any other source in respect of any of the series of three PCV vaccines and the Hib/MenC booster vaccine set out in the table at paragraph 9.5 or in respect of any vaccine administered under any of the circumstances set out in paragraphs 9.8 to 9.12 of this Section (if the contractor does receive any such payment in respect of any child from any other source, the LHB must give serious consideration to recovering any payment made under this Section in respect of that child pursuant to paragraph 19.1(a) (overpayments and withheld amounts); and

(g) the contractor submits the claim within 6 months of administering the final completing course of the vaccine.

9.14. The LHB may specify a requirement that the contractor submit the claim within 6 months of administering the final completing course of the vaccine if it considers it is reasonable to do so.

9.15. The contractor is not entitled to payment of more than £15.02 in respect of any child under this Section, other than where –

(a) the contractor claims for payment for a final completing course of the vaccine administered under the circumstances set out in paragraph 9.10; and

(b) by virtue of that paragraph, the contractor is entitled to a payment under that paragraph, irrespective of any previous payment made in respect of that child under the provisions of this Section.

Claims for payment

9.16. The contractor is to submit claims in respect of the final completing course of the vaccine after they have been administered at a frequency to be agreed between the LHB and the contractor (which must be a frequency which provides for the claim to be submitted within 6 months of administering the final completing vaccine), or if agreement cannot be reached, within 14 days of the end of the month during which the final completing course of the vaccine was administered. Any amount payable falls due on the next date, following the expiry of 14 days after the claim is submitted, when the contractor's Payable GSMP falls due.

9.17. The LHB must ensure that the receipt and payment in respect of any claims are properly recorded and that each such claim has a clear audit trail.

Conditions attached to payment

9.18. A payment under the provisions of this Section is only payable if the contractor satisfies the following conditions—

(a) the contractor must supply the LHB with the following information in respect of each child for which a payment is claimed—

(i) the name of the child;

(ii) the date of birth of the child;

(iii) the NHS number, where known, of the child;

(iv) except where paragraph (v) applies, confirmation that the child has received three doses of PCV and one dose of Hib/MenC in accordance with the table at paragraph 9.5;

(v) if the claim is made in the circumstances set out in paragraph 9.9, 9.10 or 9.12, confirmation that all required vaccines have been administered; and

(vi) the date of the final completing course of the vaccine, which must have been administered by the contractor,

but where a parent or carer objects to details of the child's name or date of birth being supplied to the LHB, the contractor need not supply such information to the LHB but must supply the child's NHS number;

(b) the contractor must provide appropriate information and advice to the parent or carer of the child, and where appropriate, also to the child, about pneumococcal vaccine and the Hib/MenC booster vaccine;

(c) the contractor must record in the child's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, any refusal of an offer of a pneumococcal vaccine or a Hib/MenC booster vaccine;

(d) where a pneumococcal vaccine or a Hib/MenC booster vaccine is administered, the contractor must record in the child's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004 Regulations;

(e) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable that health care professional to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;

(f) the contract must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;

(g) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully; and

(h) all information provided pursuant to or in accordance with this paragraph must be accurate.

9.19. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of any, or any part of, the payment due under this Section.

Section 10: SHINGLES IMMUNISATION PROGRAMME

General

10.1. Vaccines and immunisations are classified as an Additional Service. Section 10 makes provision in respect of payments to be made in respect of the administration by a contractor to provide the Shingles vaccines as part of the Shingles Immunisation Programme.

Payment for administration of the Shingles vaccine

10.2. The LHB must pay to the contractor who qualifies for the payment, a payment of £7.67 in respect of each registered patient of the contractor who has received the Shingles vaccine during the financial year ending on 31st March 2014 and who, on 1st September 2013 has attained the age of 70 years but has not yet attained the age of 71 years ("Target Age Group").

Eligibility for payment

10.3. A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met—

(i) the contractor is contracted to provide vaccine and immunisations as part of Additional Services;

(j) the patient in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the vaccine was administered;

(k) the contractor administers the vaccine to the patient in respect of whom the payment is claimed;

(l) the patient in respect of whom the payment is claimed falls within the Target Age Group referred to in Section 10.2 when the vaccine is administered.

(m) the contractor does not receive any payment from any other source in respect of the vaccine (if the contractor does receive any such payment in respect of any patient from any other source, the LHB must give serious consideration to recovering any payment made under this Section in respect of that patient pursuant to paragraphs 19.1 and 19.2 (overpayments and withheld amounts); and

(n) the contractor submits the claim within 6 months of administering the vaccine.

10.4. The LHB may set aside the requirement that the contractor submit the claim within 6 months of administering the vaccine if it considers it is reasonable to do so.

10.5. The contractor is not entitled to payment of more than £7.67 in respect of any patient under this Section, other than where the contractor claims for payment for the vaccine administered under the circumstances set out in paragraph 10.2.

Claims for payment

10.6. The contractor is to submit claims in respect of the final completing course of the vaccine after they have been administered at a frequency to be agreed between the LHB and the contractor (which must be a frequency which provides for the claim to be submitted within 6 months of administering the final completing vaccination), or if agreement cannot be reached, within 14 days of the end of the month during which the final completing course of the vaccine was administered. Any amount payable falls due on the next date, following the expiry of 14 days after the claim is submitted, when the contractor's Payable GSMP falls due.

10.7. The LHB must ensure that the receipt and payment in respect of any claims are properly recorded and that each such claim has a clear audit trail.

Conditions attached to payment

10.8. A payment under the provisions of this Section is only payable if the contractor satisfies the following conditions—

(o) the contractor must supply the LHB with the following information in respect of each patient for which a payment is claimed—

(i) the name of the patient;

(ii) the date of birth of the patient;

(iii) the NHS number, where known, of the patient;

(iv) confirmation that the patient has received the vaccine in accordance with Section 10.2; and

(v) the date on which the vaccine was administered by the contractor,

but where the patient objects to details of that patient's name or date of birth being supplied to the LHB, the contractor need not supply such information to the LHB but must supply the patient's NHS number;

(p) the contractor must provide appropriate information and advice to the patient about the vaccine and immunisation;

(q) the contractor must record in the patient's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, any refusal of an offer of the Shingles vaccine;

(r) where the Shingles vaccine is administered, the contractor must record in the patients records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 4(2)(d) of Schedule 2 to the 2004 Regulations;

(s) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable that health care professional to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;

(t) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;

(u) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully; and

(v) all information provided pursuant to or in accordance with this paragraph must be accurate.

10.9. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of all or any part of any payment due under this Section.

Section 11 PAYMENTS FOR LOCUMS COVERING MATERNITY, PATERNITY AND ADOPTION LEAVE

General

11.1. Employees of contractors will have rights to time off for ante-natal care, maternity leave, paternity leave, adoption leave and parental leave, if they satisfy the relevant entitlement conditions under employment legislation for those types of leave. The rights of partners in partnerships to these types of leave are a matter for their partnership agreement.

11.2. If an employee or partner who takes any such leave is a performer under a GMS contract, the contractor may need to employ a locum to maintain the level of services that it normally provides. Even if the LHB is not directed in this SFE to pay for such cover, it may do so as a matter of discretion. However, if—

(a) the performer is a GP performer; and

(b) the leave is ordinary or additional maternity, paternity leave or ordinary or additional adoption leave,

the contractor may be entitled to payment of, or a contribution towards, the costs of locum cover under this SFE.

Entitlement to payments for covering ordinary or additional maternity, paternity and ordinary or additional adoption leave

11.3. In any case where a contractor actually and necessarily engages a locum (or more than one such person) to cover for the absence of a GP performer on ordinary or additional maternity leave, paternity leave or ordinary or additional adoption leave, and—

(a) the leave of absence is for more than one week ;

(b) the performer on leave is entitled to that leave either under—

(i) statute;

(ii) a partnership agreement or other agreement between the partners of a partnership; or

(iii) a contract of employment, provided that the performer on leave is entitled under their contract of employment to be paid their full salary by the contractor during their leave of absence;

(c) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer; and

(d) the contractor is not also claiming another payment for locum cover in respect of the performer on leave pursuant to this Part,

then subject to the following provisions of this Section, the LHB must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 11.5).

11.4. The LHB must consider whether or not it is or was in fact necessary for the contractor to engage the locum, or to continue to engage the locum and have regard to the following principles—

(a) it should not normally be considered necessary for the contractor to employ a locum if the performer on leave had a right to return but that right has been extinguished; and

(b) it should not normally be considered necessary for the contractor to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on his return.

Ceilings on the amounts payable

11.5. The maximum amount payable under this Section by the LHB in respect of locum cover for a GP performer is—

(a) in respect of the first two weeks for which the LHB provides reimbursement in respect of locum cover, £1,131.74 per week; and

(b) in respect of any week thereafter for which the LHB provides reimbursement in respect of locum cover, £1,734.18 per week.

Payment arrangements

11.6. The contactor is to submit claims for costs actually incurred after they have been incurred, at a frequency to be agreed between the LHB and the contractor, or if agreement cannot be reached, within 14 days of the end of the month during which the costs were incurred. Any amount payable falls due 14 days after the claim is submitted.

Conditions attached to the amounts payable

11.7. Payments or any part of a payment under this Section are only payable if the contractor satisfies the following conditions—

(a) if the leave of absence is maternity leave, the contractor must supply the LHB with a certificate of expected confinement as used for the purposes of obtaining statutory maternity pay, or a private certificate providing comparable information;

(b) if the leave of absence is for paternity leave, the contractor must supply the LHB with a letter written by the GP performer confirming prospective fatherhood and giving the date of expected confinement;

(c) if the leave of absence is for adoption leave, the contractor must supply the LHB with a letter written by the GP performer confirming the date of the adoption and the name of the main care provider, countersigned by the appropriate adoption agency;

(d) the contractor must, on request, provide the LHB with written records demonstrating the actual cost to it of the locum cover; and

(e) once the locum arrangements are in place, the contractor must inform the LHB—

(i) if there is to be any change to the locum arrangements; or

(ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the performer on leave,

at which point the LHB is to determine whether it still considers the locum cover necessary.

11.8. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of any sum otherwise payable under this Section.

Section 12: PAYMENTS FOR LOCUMS COVERING SICKNESS LEAVE

General

12.1. Employees of contractors will, if they qualify for it, be entitled to statutory sick pay for 28 weeks of absence on account of sickness in any three years. The rights of partners in partnership agreements to paid sickness leave is a matter for their partnership agreement.

12.2. If an employee or partner who takes any sickness leave is a performer under a GMS contract, the contractor may need to employ a locum to maintain the level of services that it normally provides. Even if the LHB is not directed in this SFE to pay for such cover, it may do so as a matter of discretion and it may also provide support in order for the contractor to employ a locum for performers who are returning from sickness leave or for those who are at risk of needing to go on sickness leave. It should in particular consider exercising its discretion—

(a) where there is an unusually high rate of sickness in the area where the performer performs services; or

(b) to support contractors in rural areas where the distances involved in making home visits make it impracticable for a GP performer returning from sickness leave to assume responsibility for the same number of patients for which that performer previously had responsibility.

Entitlement to payments for covering sickness leave

12.3. In any case where a contractor actually and necessarily engages a locum (or more than one such person) to cover for the absence of a GP performer on sickness leave, and—

(a) the leave of absence is for more than one week;

(b) if the performer on leave is employed by the contractor, the contractor must—

(i) be required to pay statutory sick pay to that performer; or

(ii) be required to pay the performer on leave his full salary during absences on sick leave under his contract of employment;

(c) if the GP performer's absence is as a result of an accident, the contractor must be unable to claim any compensation from whoever caused the accident towards meeting the cost of engaging a locum to cover for the GP performer during the performer's absence. But if such compensation is payable, the LHB may loan the contractor the cost of the locum, on the condition that the loan is repaid when the compensation is paid unless—

(i) no part of the compensation paid is referable to the cost of the locum, in which case the loan is to be considered a reimbursement by the LHB of the costs of the locum which is subject to the following provisions of this Section; or

(ii) only part of the compensation paid is referable to the cost of the locum, in which case the liability to repay shall be proportionate to the extent to which the claim for full reimbursement of the costs of the locum was successful;

(d) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer; and

(e) the contractor is not already claiming another payment for locum cover in respect of the performer on leave pursuant to Part 4,

then subject to the following provisions of this Section, the LHB must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 12.5).

12.4. It is for the LHB to determine whether or not it was in fact necessary for the contractor to engage the locum, or to continue to engage the locum, but it is to have regard to the following principles—

(a) it should not normally be considered necessary to employ a locum if the performer on leave had a right to return but that right has been extinguished;

(b) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on return;

(c) it should not normally be considered necessary for a contractor with two or more GP performers to engage a locum to replace the GP performer, unless the absence of the performer on leave leaves each of the other GP performers (not including members of the Doctor's Retainer Scheme) with average numbers of patients as follows—

Absences lasting or expected to last	*Full-time GP*	*Three-quarters time GP*	*Half-time GP*
Not more than 2 weeks	3600+ patients	2700+ patients	1800+ patients
Not more than 6 weeks	3100+ patients	2325+ patients	1550+ patients
Longer than 6 weeks	2700+ patients	2025+ patients	1350+ patients

(d) it should normally be considered necessary that a single-handed GP performer or a job-sharer fulfilling the role of a single-handed GP performer will need to be replaced, if they are on sickness leave, by a locum.

Ceilings on the amounts payable

12.5. The maximum amount payable under this Section by the LHB in respect of locum cover for a GP performer is £1,131.74 per week.

12.6. However, the maximum periods in respect of which payments under this Section are payable in relation to a particular GP performer are—

(a) 26 weeks for the full amount of the sum that the LHB has determined is payable; and

(b) a further 26 weeks for half the full amount of the sum the LHB initially determined was payable.

12.7. In order to calculate these periods, a determination is to be made in respect of the first day of the GP performer's absence as to whether in the previous 52 weeks, any amounts have been payable in respect of that performer under this Section. If any amounts have been payable in those 52 weeks, the periods in respect of which they were payable are to be aggregated together. That aggregate period (whether or not it in fact relates to more than one period of absence)—

(a) if it is 26 weeks or less, is then to be deducted from the period referred to in paragraph 12.6(a); or

(b) if it more than 26 weeks, then 26 weeks of it is to be deducted from the period referred to in paragraph 12.6(a) and the balance is to be deducted from the period referred to in paragraph 12.6(b).

12.8. Accordingly, if payments have been made in respect of locum cover for the GP performer for 32 weeks out of the previous 52 weeks, the remaining entitlement in respect of that performer is for a maximum of 20 weeks, and at half the full amount that the LHB initially determined was payable.

Payment arrangements

12.9. The contractor is to submit to the LHB claims for costs actually incurred during a month at the end of that month, and any amount payable is to fall due on the same day of the following month that the contractor's Payable GSMP falls due.

Condition attached to the amounts payable

12.10. Payments or any part of a payment under this Section are only payable if the following conditions are satisfied—

(a) the contractor must obtain the prior agreement of the LHB to the engagement of the locum (but its request to do so must be determined as quickly as possible by the LHB), including agreement as to the amount that is to be paid for the locum cover;

(b) the contractor must, without delay, supply the LHB with medical certificates in respect of each period of absence for which a request for assistance with payment for locum cover is being made;

(c) the contractor must, on request, provide the LHB with written records demonstrating the actual cost to it of the locum cover;

(d) once the locum arrangements are in place, the contractor must inform the LHB—

(i) if there is to be any change to the locum arrangements; or

(ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the GP performer on leave,

at which point the LHB is to determine whether it still considers the locum cover necessary;

(e) if the locum arrangements are in respect of a performer on leave who is or was entitled to statutory sick pay, the contractor must inform the LHB immediately if it stops paying statutory sick pay to that employee;

(f) the GP performer on leave must not engage in conduct that is prejudicial to that performer's his recovery; and

(g) the GP performer on leave must not be performing clinical services for any other person, unless under medical direction and with the approval of the LHB.

12.11. If any of these conditions are breached, the LHB may, in appropriate circumstances, withhold payment of any sum otherwise payable under this Section.

Section 13: PAYMENTS FOR LOCUMS TO COVER SUSPENDED DOCTORS

General

13.1. The LHB has powers to suspend GP performers from the medical performers list.

13.2. A GP performer who is suspended from the medical performers list may be entitled to payments directly from the LHB. This is covered by a separate determination made under regulation 13(17) of the Performers Lists Regulations.

Eligible cases

13.3. In any case where a contractor—

(a) either –

(i) is a sole practitioner who is suspended from the LHB's medical performers list and is not in receipt of any financial assistance from the LHB under section 53 of the 2006 Act as a contribution towards the cost of the arrangements to provide primary medical services under the contractor's GMS contract during the contractor's suspension;

(ii) is paying a suspended GP performer –

(aa) who is a partner of the contractor, at least 90% of that performer's normal monthly drawings (or a pro rata amount in the case of part months) from the partnership account; or

(bb) who is an employee of the contractor, at least 90% of that performer's normal salary (or a pro rata amount in the case of part months); or

(iii) paid a suspended GP performer the amount mentioned in paragraph (ii)(aa) or (bb) for at least six months of that performer's suspension, and the suspended GP performer is still a partner or employee of the contractor;

(b) actually and necessarily engages a locum (or more than one such person) to cover for the absence of the suspended GP performer;

(c) the locum is not a partner in a partnership or shareholder in a company limited by shares where that partnership or company is the contractor, or already an employee of the contractor, unless the absent performer is a job-sharer; and

(d) the contractor is not also claiming any other payment for locum cover in respect of the absent performer under Part 4,

then subject to the provisions in this Section, the LHB must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 13.5).

13.4. It is for the LHB to determine whether or not it is or was in fact necessary to engage the locum, or to continue to engage the locum, but it is to have regard to the following principles—

(a) it should not normally be considered necessary to employ a locum if the performer on leave had a right to return but that right has been extinguished; and

(b) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on that performer's return.

Ceilings on the amounts payable

13.5. The maximum amount payable under this Section by the LHB in respect of locum cover for a GP performer is £1,131.74 per week.

Payment arrangements

13.6. The contractor is to submit claims for costs actually incurred after they have been incurred, at a frequency to be agreed between the LHB and the contractor, or if agreement cannot be reached, within 14 days of the end of the month during which the costs were incurred. Any amount payable falls due 14 days after the date on which the claim is submitted.

Conditions attached to the amounts payable

13.7. Payments or any part of a payment under this Section are only payable if the contractor satisfies the following conditions—

(a) the contractor must, on request, provide the LHB with written records demonstrating—

(i) the actual cost to it of the locum cover; and

(ii) that it is continuing to pay the suspended GP performer at least 90% of that performer's normal income before the suspension (i.e. the normal monthly drawings from the partnership account, that performer's normal salary or a pro rata amount in the case of part months); and

(b) once the locum arrangements are in place, the contractor must inform the LHB—

(i) if there is to be any change to the locum arrangements, or

(ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the absent performer,

at which point the LHB is to determine whether it still considers the locum cover necessary.

13.8. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of any such sum otherwise payable under this Section.

Section 14: PAYMENTS IN RESPECT OF PROLONGED STUDY LEAVE

General

14.1. GP performers may be entitled to take Prolonged Study Leave, and in these circumstances, the contractor for whom they have been providing services under its GMS contract may be entitled to two payments—

(a) an educational allowance, to be forwarded to the GP performer taking Prolonged Study Leave; and

(b) the cost of, or a contribution towards the cost of, locum cover.

Types of study in respect of which prolonged study leave may be taken

14.2. Payments may only be made under this Section in respect of Prolonged Study Leave taken by a GP performer where –

(a) the study leave is for at least 10 weeks but not more than 12 months;

(b) the educational aspects of the study leave have been approved by the Dean of General Practice, University Wales College of Medicine, having regard to any guidance on Prolonged Study Leave that the Dean of General Practice, University Wales College of Medicine has been agreed nationally; and

(c) the LHB has determined that the payments to the contractor under this Section in respect of the Prolonged Study Leave are affordable, having regard to the budgetary targets it has set itself.

Educational allowance payment

14.3. Where the criteria set out in paragraph 14.2 are met, in respect of each week for which the GP performer is on Prolonged Study Leave, the LHB must pay the contractor an Educational Allowance Payment of £133.68, subject to the condition that where the contractor is aware of any change in circumstances that may affect its entitlement to the Educational Allowance Payment, it notifies the LHB of that change in circumstances.

14.4. If the contractor breaches the condition set out in paragraph 14.3, the LHB may, in appropriate circumstances, withhold payment of all or any part of any Educational Allowance Payment that is otherwise payable.

Locum cover in respect of doctors on Prolonged Study Leave

14.5. In any case where a contractor actually and necessarily engages a locum (or more than one such person) to cover for the absence of a GP performer on Prolonged Study Leave, then subject to the following provisions of this Section, the LHB must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 14.7).

14.6. It is for the LHB to determine whether or not it was in fact necessary to engage the locum, or to continue to engage the locum, but it is to have regard to the following principles—

(a) it should not normally be considered necessary to employ a locum if the GP performer on leave had a right to return but that right has been extinguished; and

(b) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on that performer's return.

14.7. The maximum amount payable under this Section by the LHB in respect of locum cover for a GP performer is £1,131.74 per week.

Payment arrangements

14.8. The contractor is to submit to the LHB claims for costs actually incurred during a month at the end of that month, and any amount payable is to fall due on the same day of the following month that the contractor's Payable GSMP falls due.

Conditions attached to the amounts payable

14.9. Payments or any part of a payment in respect of locum cover under this Section are only payable if the following conditions are satisfied—

(a) the contractor must obtain the prior agreement of the LHB to the engagement of the locum (but its request to do so must be determined as quickly as possible by the LHB), including agreement as to the amount that is to be paid for the locum cover;

(b) the locum must not be a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer;

(c) the contractor must, on request, provide the LHB with written records demonstrating the actual cost to it of the locum cover; and

(d) once the locum arrangements are in place, the contractor must inform the LHB—

(i) if there is to be any change to the locum arrangements; or

(ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the performer on leave,

at which point the LHB is to determine whether it still considers the locum cover necessary.

14.10. If any of these conditions are breached, the LHB may, in appropriate circumstances, withhold payment of any sum in respect of locum cover otherwise payable under this Section.

Section 15: SENIORITY PAYMENTS

General

15.1. Seniority payments are payments to a contractor in respect of individual GP providers in eligible posts. They reward experience, based on years of Reckonable Service.

Eligible posts

15.2. Contractors will only be entitled to a Seniority Payment in respect of a GP provider if the GP provider has served for at least two years in an eligible post, or for an aggregate of two years in more than one eligible post – part-time and full-time posts counting the same. The first date after the end of this two year period is the GP provider's qualifying date. For the purposes of this Section, a post is an eligible post—

(a) in case of posts held prior to 1st April 2004, if the post-holder provided unrestricted general medical services and was eligible for a basic practice allowance under the Statement of Fees and Allowance made under section 34 of the National Health Service (General Medical Services) Regulations 1992 (**a**) as in force on 31st March 2004; and

(b) in the case of posts held on or after 1st April 2004, if the post-holder performs primary medical services and—

(i) that post-holder is a GMS contractor (i.e. a sole practitioner);

(ii) is a partner in a partnership that is a GMS contractor, or

(iii) is a shareholder in a company limited by shares that is a GMS contractor.

Service that is Reckonable Service

15.3. Work shall be counted as Reckonable Service if—

(a) it is clinical service as a doctor within the NHS or service as a doctor in the public service health care system of another EEA Member State (including service in that system pre-Accession);

(b) it is clinical service as a doctor or service as a medical officer within the prison service or the civil administration (which includes the Home Civil Service) of the United Kingdom, or within the prison service or the civil administration of another EEA Member State (including service in that prison service or civil administration pre-Accession);

(c) it is service as a medical officer—

(i) in the armed forces of an EEA Member State (including the United Kingdom) or providing clinical services to those forces in a civilian capacity (including service pre-Accession); or

(ii) in the armed forces under the Crown other than the United Kingdom armed forces or providing clinical services to those forces in a civilian capacity,

if accepted by the LHB or endorsed by the Welsh Ministers as Reckonable Service;

(d) it is service with the Foreign and Commonwealth office as a medical officer in a diplomatic mission abroad, if accepted by the LHB or endorsed by the Welsh Ministers as Reckonable Service; or

(e) it comprises up to a maximum of four years clinical service in a country or territory outside the United Kingdom—

(i) which followed the date of first registration of the GP provider in that country or territory; and

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(**a**)

(ii) in circumstances where –

(aa) on 31st March 2003, that period of clinical service had been counted by the LHB as a period of registration for the purposes of a calculation of the annual rate of the GP Provider's Seniority Payment under the Statement of Fees and Allowance made under regulation 34 of the National Health Service (General Medical Services) Regulations 1992; and

(bb) that period of clinical service is not counted as reckonable service by virtue of any preceding sub-paragraphs in this paragraph.

Calculation of years of Reckonable Service

15.4. Claims in respect of years of service are to be made to the LHB, and should be accompanied by appropriate details, including dates, of relevant clinical service. Where possible, claims should be authenticated from appropriate records, which may in appropriate circumstances include superannuation records. If the LHB is unable to obtain authentication of the service itself, the onus is on the GP provider to provide documentary evidence to support his claim (although payments may be made while verification issues are being resolved). The LHB should only count periods of service in a calculation of a GP provider's Reckonable Service if satisfied that there is sufficient evidence to include that period of service in the calculation.

15.5. In determining a GP provider's length of Reckonable Service—

(a) only clinical service is to count towards Reckonable Service;

(b) only clinical service since the date on which the GP provider first became registered (be it temporarily, provisionally, fully or with limited registration) with the General Medical Council, or an equivalent authority in another EEA Member State, is to count towards Reckonable Service, with the exception of Reckonable Service prior to registration that is taken into account by virtue of paragraph 15.3(e);

(c) periods of part-time and full-time working count the same; and

(d) generally, 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.

15.6. Claims in respect of service in or on behalf of armed forces pursuant to paragraph 15.3(c) are to be considered in the first instance by the LHB, and should be accompanied by appropriate details, including dates and relevant postings. If the LHB is not satisfied that the service should count towards the GP provider's Reckonable Service as a doctor, it is to put the matter to the Welsh Ministers, together with any comments it wishes to make.

15.7. Before taking a decision on whether or not to endorse the claim, the Welsh Ministers will then consult the Ministry of Defence. Generally, the only service that will be endorsed is service where the GP provider undertook clinical or medical duties (whether on military service or in a civilian capacity), and the Welsh Ministers have received acceptable confirmation of the nature and scope of the duties performed by the GP provider from the relevant authorities.

15.8. Claims in respect of clinical service for or on behalf of diplomatic missions abroad pursuant to paragraph 15.3(d) are to be considered in the first instance by the LHB, and should be accompanied by appropriate details, including dates and relevant postings. If the LHB is not satisfied that the service should count towards the GP provider's Reckonable Service as a doctor, it is to put the matter to the Welsh Ministers, together with any comments it wishes to make.

15.9. Before taking a decision on whether or not to endorse the claim, the Welsh Ministers will consult the Foreign and Commonwealth Office. Generally the only service that will be endorsed is service where the GP provider undertook clinical duties for—

(a) members of the Foreign and Commonwealth Office and their families;

(b) members of the Department for International Development and their families;

(c) members of the British Council and their families;

(d) British residents, official visitors and aid workers;

(e) Commonwealth and EEA Member State official visitors; or

(f) staff and their families of other Commonwealth, EEA, Member State or, in the opinion of the Foreign and Commonwealth Office, friendly State diplomatic missions,

and the Welsh Ministers have received acceptable confirmation of the nature and scope of the clinical duties performed by the GP provider from the relevant authorities.

Determination of the relevant dates

15.10. Once a GP provider's years of Reckonable Service have been determined, a determination has to be made of two dates—

(a) the date a GP provider's Reckonable Service began, which is the date on which that GP's first period of Reckonable Service started (referred to in this Section as "the Seniority Date"); and

(b) the GP provider's qualifying date (see paragraph 15.2).

Calculation of the full annual rate of Seniority Payments

15.11. Once a GP provider has reached the qualifying date that GP is entitled to a Seniority Payment in respect of service as a GP provider thereafter. The amount of the Seniority Payment will depend on two factors: that GP's Superannuable Income Fraction and the number of years of Reckonable Service.

15.12. At the end of each quarter, the LHB is to make an assessment of the Seniority Payments to be made in respect of individual GP providers working for or on behalf of its GMS contractors. If—

(a) a GP provider's Seniority Date is on the first date of that quarter, or falls outside that quarter, that GP's Years of Reckonable Service are the number of complete years since the first Seniority Date, and the full annual rate of the Seniority Payment payable in respect of that GP is the full annual rate opposite the GP's Years of Reckonable Service in the Table below; and

(b) if the GP provider's Seniority Date falls in that quarter on any date other than the first date of that quarter, the full annual rate of the Seniority Payment in respect of that GP changes on the Seniority Date – and so in respect of that quarter, the full annual rate of the Seniority Payment payable in respect of that GP is to be calculated as follows—

(i) calculate the daily rate of the full annual rate of payment for the first total of Years of Reckonable Service relevant to him (i.e. divide the annual rate by 365 (or 366 where the relevant year includes 29th February), and multiply that daily rate by the number of days in that quarter before the Seniority Date; and

(ii) calculate the daily date of the full annual rate of payment for the second total of Years of Reckonable Service relevant to that GP (i.e. divide the annual rate by 365 (or 366 where the relevant year includes 29th February), and multiply that daily rate by the number of days in that quarter after and including the Seniority Date,

then add the totals produced by the calculations in heads (i) and (ii) together, and multiply by four.

TABLE

Years of Reckonable Service	*Full annual rate of payment per practitioner*
0	0
1	0
2	0
3	0
4	0
5	0
6	600
7	672
8	753
9	843
10	944
11	1,057
12	1,184
13	1,326
14	1,486
15	1,664
16	3,185
17	3,504
18	3,854
19	4,239
20	4,663
21	5,129
22	6,785
23	6,989
24	7,198
25	7,414
26	7,637
27	7,866
28	8,225
29	8,455
30	8,692
31	8,935
32	9,186
33	9,433
34	9,707
35	9,979
36	10,258
37	10,546
38	10,841
39	11,144
40	11,457
41	11,777
42	12,107
43	12,446
44	12,795
45	13,153

Years of Reckonable Service	*Full annual rate of payment per practitioner*
46	13,521
47	13,900

15.13. If immediately before 1st April 2013, any GP provider—

(a) would have been entitled to an amount calculated in accordance with paragraph 15.13 of the 2005 SFE; or

(b) received a Seniority Payment, an amount of which is calculated in accordance with paragraph 15.13 of the 2005 SFE,

that GP provider remains entitled to, and is to continue to receive a Seniority Payment, an amount which is the full annual rate of the Seniority Payment calculated in accordance with paragraph 15.13 of the 2005 SFE as in force on 31st March 2013.

Superannuable Income Fractions

15.14. In all cases, the full annual rate of a Seniority Payment for a GP provider is only payable under this SFE in respect of a GP provider who has a Superannuable Income Fraction of at least two thirds.

15.15. For these purposes, a GP provider's Superannuable Income Fraction is the fraction produced by dividing—

(a) that GP provider's NHS profits from all sources for the financial year to which the Seniority Payment relates, excluding—

(i) superannuable income which does not appear on that GP provider's certificate submitted to the LHB in accordance with paragraph 20.11 (superannaution contribution: end-year adjustments) (i.e. NHS income already superannuated elsewhere); and

(ii) any amount in respect of Seniority Payments; by

(b) the Average Adjusted Superannuable Income.

15.16. The Average Adjusted Superannuable Income is to be calculated as follows—

(a) all the NHS profits of the type mentioned in paragraph 15.15(a) of all the GP providers in Wales who have submitted certificates to the LHB in accordance with paragraph 20.11, by the required date, are to be aggregated; then

(b) this aggregate is then to be divided by the number of GP providers in respect of which the aggregate was calculated; then

(c) the total produced by sub-paragraph (b) is to be adjusted to take account of the shift towards less than full-time working. The index by which the amount is to be adjusted is to be the same as the index for the financial year to which the calculation of Average Adjusted Superannuable Income relates by which the uprating factor for pensions is to be adjusted to take account of the shift towards less than full-time working(**a**),

and the total produced by sub-paragraph (c) is the Average Adjusted Superannuable Income amount for the calculation in paragraph 15.15.

15.17. If the GP provider has a Superannuable Income Fraction of one third or between one third and two thirds, only 60% of the full annual amount payable in respect of a GP provider with Reckonable Service is payable under this SFE in respect of that GP provider. If the GP provider has a Superannuable Income Fraction of less than one third, no Seniority Payment is payable under this SFE in respect of that GP provider.

(**a**) It is anticipated that the amounts mentioned in this paragraph will be calculated by the Technical Steering Committee (TSC).

Amounts payable

15.18. Once a GP provider's full annual rate in respect of a quarter has been determined, and any reduction to be made in respect of that GP provider's Superannuable Income Fraction has been made, the result amount is to be divided by four, and that quarterly amount is the Quarterly Superannuation Payment that the LHB must pay to the contractor under the GMS contract in respect of the GP provider.

15.19. If, however, the GP provider's—

(a) qualifying date fall in that quarter, the quarterly amount is instead to be calculated as follows: the annual amount (taking account of any reduction in accordance with the GP provider's Superannuable Income Fraction) is to be divided by 365 (or 366 where the relevant year includes 29th February), and then multiplied by the number of days in the quarter after and including that GP provider's qualifying date; and

(b) retirement date falls in that quarter, the quarterly amount is instead to be calculated as follows: the annual amount (taking account of any reduction in accordance with the GP provider's Superannuable Income Fraction) is to be divided by 365 (or 366 where the relevant year includes 29th February), and then multiplied by the number of days in the quarter prior to the GP provider's retirement date.

15.20. Payment of the Quarterly Seniority Payment is to fall due on the last day of the quarter to which it relates (but see paragraph 19.6 (payments on account)).

Condition attached to payment of Quarterly Seniority Payments

15.21. A Quarterly Seniority Payment, or any part thereof, is only payable to a contractor if the following conditions are satisfied—

(a) if a GP provider receives a Quarterly Seniority Payment from more than one contractor, those payments taken together must not amount to more than one quarter of the full annual rate of Seniority Payment in respect of that GP provider;

(b) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the payment;

(c) all information provided pursuant to or in accordance with sub-paragraph (b) must be accurate; and

(d) a contractor who receives a Seniority Payment in respect of a GP provider must give that payment to that doctor—

(i) within one calendar month of it receiving that payment, and

(ii) as an element of the personal income of that GP provider subject (in the case of a GP provider who is a shareholder in a contractor that is a company limited by shares) to any lawful deduction of income tax and national insurance.

15.22. If the conditions set out in paragraph 15.21(a) to (c) are breached, the LHB may in appropriate circumstances withhold payment of all or any part of any payment to which the conditions relate that is otherwise payable.

15.23. If a contractor breaches the condition in paragraph 15.21(d), the LHB may require repayment of any payment to which the condition relates, or may withhold payment of any other payment payable to the contractor under this SFE, to the value of the payment to which the condition relates.

Section 16: DOCTORS' RETAINER SCHEME

General

16.1. This is an established Scheme designed to keep doctors who are not working in general practice in touch with general practice.

Payments in respect of sessions undertaken by members of the Scheme

16.2. Subject to paragraph 16.3, where—

(a) a contractor who is considered as a suitable employer of members of the Doctors' Retainer Scheme by the Dean of General Practice, University Wales College of Medicine employs or engages a member of the Doctors' Retainer Scheme; and

(b) the service sessions for which the member of the Doctors' Retainer Scheme is employed or engaged by that contractor are arranged or approved by the Dean of General Practice, University Wales College of Medicine Health,

the LHB must pay to that contractor under its GMS contract £59.18 in respect of each full session that the member of the Doctors' Retainer Scheme undertakes for the contractor in any week, up to a maximum of four sessions per week.

Provisions in respect of leave arrangement

16.3. The LHB must pay to the contractor under its GMS contract any payment payable under paragraph 16.2 in respect of any session which the member of the Doctors' Retainer Scheme is employed or engaged to undertake but which that member does not undertake because they are absent due to leave related to—

(a) annual holiday up to a maximum number of sessions annually equivalent to 6 weeks' worth of arranged sessions for the member of the Doctors' Retainer Scheme;

(b) maternity, paternity or adoption, in accordance with the circumstances and for the periods referred to in Section 9 (payments for locums covering maternity, paternity and adoption leave);

(c) parental leave, in accordance with statutory entitlements (except that the normal statutory qualifying period of one year's service with the contractor does not apply);

(d) sickness, for a reasonable period as agreed by the contractor and the LHB;

(e) an emergency involving a dependent, in accordance with employment law and any guidance issued by the Department for Business, Innovation and Skills; and

(f) other pressing personal or family reasons where the contractor and the LHB agree that the absence of the member of the Doctors' Retainer Scheme is necessary and unavoidable.

Payment conditions

16.4. Payments under this section are to fall due at the end of the month in which the session to which the payment relates takes place. However, the payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must inform the LHB of any change to the member of the Doctors' Retainer Scheme's working arrangements that may affect the contractor's entitlement to a payment under this section;

(b) the contractor must inform the LHB of any absence on leave of the member of the Doctors' Retainer Scheme and the reason for such absence;

(c) in the case of any absence on leave in respect of which there are any matters to be agreed between the contractor and the LHB in accordance with paragraph 16.3 above, the contractor must make available to the LHB any information which the LHB does not have but needs, and which the contractor either has or could be reasonably expected to obtain, in order to form an opinion in respect of any of the matters which are to be agreed between the contractor and the LHB;

(d) the contractor must inform the LHB if the doctor in respect of whom the payment is made ceases to be a member of the Doctors' Retainer Scheme, or if it ceases to be considered a suitable employer of members of the Doctors' Retainer Scheme by the Dean of General Practice, University Wales College.

16.5. If a contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of all or any part of any payment otherwise payable under this Section.

Section 17: DISPENSING

Dispensing: General

17.1. Some contractors are authorised or required to provide dispensing services to specific patients. The arrangements for this are set out in Part 3 (dispensing doctors) of the National Health Service (Pharmaceutical Services) Regulations 1992 ("the 1992 Regulations") and paragraph 51 (provision of drugs, medicines and appliances for immediate treatment or personal administration) of Part 3 of Schedule 6 to the 2004 Regulations. The 1992 Regulations are to be revoked with effect from 10 May 2013 by the National Health Service (Pharmaceutical Services)(Wales) Regulations 2013 ("the 2013 Regulations").

Costs in respect of which reimbursement is payable

17.2. Where drugs and appliances are provided by a medical practitioner—

(a) in accordance with the arrangements under which a dispensing doctor undertakes to provide pharmaceutical services referred to in regulation 20 (Arrangements for the provision of pharmaceutical services by doctors) of the 1992 Regulations or (after the 2013 Regulations come into force) regulation 20 (Arrangements for the provision of pharmaceutical services by doctors) of the 2013 Regulations;

(b) for personal administration, in accordance with paragraph 51(1)(b) in Part 3 of Schedule 6 to the 2004 Regulations,

then subject to the following provisions of this Section, the LHB must pay to the contractor under its GMS contract the payments listed in paragraph 17.3, as calculated in accordance with this Section.

17.3. The amounts payable in relation to the provision of drugs and appliances are—

(a) the basic price of the drug or appliance, which is the price as calculated in accordance with Part II Clause 8 (Basic Price), clause 10 (A and B) (Quantity to be Supplied), clause 11 (Broken Bulk), clause 13 (Reconstitution of Certain Oral Liquids) and Part VIIA Basic Prices of Drugs) of the Drug Tariff, less a discount calculated in accordance with Part 1 of Annex G;

(b) the appropriate dispensing fee, as set out in Part 2 of Annex G (in respect of contractors authorised or required to provide dispensing services in accordance with Part 8 of the Pharmaceutical Regulations 2013) or Part 3 of Annex G (in respect of all other contractors);

(c) an allowance to cover the VAT payable on the purchase of any products listed in paragraph 17.4(a) to (e) and which are provided in accordance with paragraph 51(1)(b) in Part 3 of Schedule 6 to the 2004 Regulations. The allowance is to be calculated by applying the rate of VAT applying at the time of a claim to the basic price of the product after the discount has been calculated in accordance with Part 1 of Annex G has been deducted;

(d) exceptional expenses, as provided for in Part II, clause 12 (Out of Pocket Expenses), of the Drug Tariff; and

(e) professional fees, as provided for in Part IIIA, clause 2A (additional fees for unlicensed medicines), of the Drug Tariff.

Personally administered drugs and appliances and those used for diagnosis

17.4. A contractor who is providing services under a GMS contract may, whether or not the contractor is authorised or required to provide dispensing services to specific patients, be entitled to the payments listed in paragraph 17.3. This applies only in relation to the following products—

(a) vaccines, anaesthetics and injections;

(b) the following diagnostic reagents: Dick Test; Schick Test; Protein Sensitisation Test Solutions; and Tuberculin Tests (i.e. Koch Test, Mantoux Test, Patch Test and Diagnostic Jelly);

(c) intrauterine contraceptive devices (including drug-releasing IUCDs, contraceptive caps and diaphragms);

(d) pessaries which are appliances; and

(e) sutures (including skin closing strips).

17.5. In respect of these products, subject to the provisions of this Section, the LHB must pay to all contractors under their GMS contracts the payments listed in paragraph 17.3, as calculated in accordance with this Section – if the products are provided in accordance with paragraph 51(1)(b) in Part 3 of Schedule 6 to the 2004 Regulations.

Products not covered by this Section

17.6. No payments are payable under this Section in respect of the products listed in this paragraph, which are centrally supplied as part of the Childhood Immunisation Programme—

(a) MMR (Measles, Mumps and Rubella);

(b) BCG (Bacillus Calmette-Guerin);

(c) Tuberculin Purified Protein Derivative;

(d) Meningococcal C conjugate vaccine (for children under 5 and persons entering the first year of higher education);

(e) DTaP/IPV/HiB (Diphtheria/Tetanus/Pertussis/Inactivated Polio/Haemophilus influenzae type B);

(f) dTaP/IPV (low dose Diphtheria/Tetanus/Pertussis/Inactivated Polio);

(g) DTaP/IPV (Diphtheria/Tetanus/Pertussis/Inactivated Polio);

(h) Td/IPV(Diphtheria/Tetanus/Inactivated Polio);

(i) Hib/MenC (Haemophilus influenzae type B/meningitis C), PCV (pneumococcal); and

(j) HPV (human papillomavirus types 16 and 18) in the case where the course of immunisation has commenced and is not complete before 19th October 2012;

(k) HPV (human papillomavirus types 6, 11, 16 and 18) in the case where the course of immunisation commences on or after 19th October 2012; or

17.7. No payments are payable under this Section in respect of any other product which may be centrally supplied by the Welsh Government.

17.8. Payments are payable under this Section—

(a) in respect of Td/IPV Diphtheria/Tetanus/Inactivated Polio) where that product is used for the treatment of adults; or

(b) supplied to patients who require such products prior to travelling outside the United Kingdom and in either case where the Td/IPV product has been purchased by the contractor directly from the manufacturer.

17.9. If a medical practitioner issues a prescription for a drug or appliance and that medical practitioner does not supply it, no payments are payable in respect of that drug or appliance under this Section.

Deductions in respect of charges

17.10. Payment in respect of prescriptions shall be subject to any deduction required to be made under the National Health Service (Free Prescriptions and Charges for Drugs and

Appliances)(Wales)Regulations 2007(**a**) in respect of charges required to be made and recovered by the dispensing practitioner.

Contractors unable to obtain discounts

17.11. If a contractor satisfies the LHB, by reason of remoteness of the contractor's practice premises, the contractor is unable to obtain any discount on the basic price of drugs and appliances for which a payment is payable by the LHB under this Section (and the LHB must consult the Local Medical Committee for the area in which the contractor provides primary medical services, if there is one, before being so satisfied), the LHB must approve an exemption for that contractor from the application of the discount scale. The exemption shall be granted for a period of up to one year, and may be renewed thereafter for further periods, each not exceeding one year, if the contractor is able to satisfy the LHB that it is still unable to obtain any discount on the basic price of drugs and appliances for which a payment is payable under this Section.

17.12. Where the LHB approves such an exemption, it must inform the NHS Wales Shared Services Partnership – Primary Care Services of the exemption and of the period for which it is to apply.

Contractors that are to receive special payments

17.13. If a contractor satisfies the LHB that—

(a) by reason of the remoteness of the contractor's practice premises or the small quantities of drugs and appliances that the contractor needs to buy, the contractor has had to pay more than the basic price for drugs and appliances it orders; and

(b) its payments under paragraph 17.3(a) should be calculated at special payment levels rather than basic price levels,

(and the LHB must consult the Local Medical Committee for the area in which the contractor provides primary medical services, if there is one, before being so satisfied), the LHB must agree to reimburse the contractor on the basis of the special payment levels, instead of the basic price levels, of the drugs and appliances it supplies, as set out in the table below.

Where on average the price paid by the contractor (excluding VAT) has been:	*Special payment price level*
In excess of 5% and up to 10% over the basic price	5% over the basic price
In excess of 10% and up to 15% over the basic price	10% over the basic price
In excess of 15% and up to 20% over the basic price	15% over the basic price
In excess of 20% over the basic price	20% over the basic price

17.14. Where a contractor is reimbursed on the basis of special payment levels (see paragraph 17.13) any VAT allowance payable (see paragraph 17.3(c)) shall be calculated as a percentage of the special payment level.

17.15. Agreement to reimburse on the basis of special payment levels shall be granted for a period of up to one year, and may be renewed thereafter if the contractor is still able to satisfy the LHB that its payments under paragraph 17.3(a) should be calculated at special payment levels rather than basic price levels.

Preconditions before payments under this Section are payable

17.16. The payments listed in paragraph 17.3 are only payable if the contractor has—

(**a**) S.I. 2007/ 121 (W.11) as amended by S.I. 2007/1112 (W.117), S.I. 2009/1175 (W.102), S.I. 2009/2607 (W.210), S.I. 2010/1647 (W.155), S.I. 2012/1479, and S.I. 2012/1916.

(a) noted, counted and sent all the prescriptions in respect of drugs or appliances in respect of which it wishes to claim reimbursement to the NHS Wales Shared Services Partnership – Primary Care Services, 12th Floor, Brunel House, 2 Fitzalan Road, Cardiff, CF24 0HA, not later than the 5th of the month following the month to which the prescriptions relate; and

(b) included all the claims under cover of a single claim form, and if the claim is in respect of the following high-volume personally administered vaccines – influenza, typhoid, hepatitis

A, hepatitis B, Pneumococcal, and Meningococcal – it must be made in the form of bulk entries on the claim form.

Payment arrangements

17.17. Where a contractor has satisfied the conditions in paragraph 17.16, the LHB must pay to the contractor under its GMS contract—

(a) on the first day of the month after the month on which the contractor submitted its claim to the NHS Wales Shared Services Partnership – Primary Care Services, an amount that represents 80% of the amount that the LHB reasonably estimates is likely to be due to the contractor in respect of the claim, once the NHS Wales Shared Services Partnership – Primary Care Services has certified the amount due in respect of the claim (having taken into account the charges that are required to be made and recovered), although the LHB may pay less than 80% if the contractor's claims each month in respect of prescriptions vary significantly; and

(b) on the first day of the second month after the month on which the contractor submitted its claim to the NHS Wales Shared Services Partnership – Primary Care Services, the balance of the amount due in respect of the claim, having had that amount certified by NHS Wales Shared Services Partnership – Primary Care Services and taking into account—

(i) the charges that are required to be made and recovered; and

(ii) the amount already paid out in respect of the claim pursuant to sub-paragraph (a).

Accounting obligations

17.18. It is a condition of the payments payable under this Section that the payments are only payable under this Section if the contractor ensures that—

(a) its actual expenditure on drugs and appliances (i.e. the amount it pays its suppliers) is shown "gross" on its practice accounts; and

(b) its payments from the LHB pursuant to this Section, and collected from patients in accordance with the National Health Service (Free Prescriptions and Charges for Drugs and Appliances)(Wales) Regulations 2007, are brought "gross" into its contractor accounts as "income".

Section 18: DISPENSARY SERVICES QUALITY SCHEME

Dispensary Services Quality Scheme: General

18.1. Contractors who are authorised or required to provide dispensing services to specific patients either in accordance with the provisions of Part 3 (dispensing doctors) of the National Health Service (Pharmaceutical Services) Regulations 1992, or after the National Health Service (Pharmaceutical Services)(Wales) Regulations 2013come into force, Part 5 of the National Health Service (Pharmaceutical Services)(Wales) Regulations 2013, and paragraph 51 (provision of drugs, medicines and appliances for immediate treatment or personal administration) of Part 3 of Schedule 6 to the 2004 Regulations (the provision of such dispensing services being referred to in this Section as having "consent to dispense"), may choose to participate in the Dispensary Services Quality Scheme.

18.2. The obligations under the Dispensary Services Quality Scheme are set out in Annex H to this SFE. Participation in the Dispensary Services Quality Scheme is voluntary.

Eligibility for Dispensary Services Quality Payments

18.3. A contractor that has consent to dispense will be eligible for an annual Dispensary Services Quality Payment, calculated in accordance with the provisions of this Section, if—

(a) the contractor participates in the Dispensary Services Quality Scheme;

(b) the contractor satisfies the eligibility conditions set out in paragraph 18.4 (read with paragraphs 18.5 and 18.6); and

(c) the LHB is satisfied, following review of the contractor's arrangements (which the LHB is to undertake between 1st January and 31st March inclusive of the financial year to which the payment relates or, where the provision of the service terminates before 1st January for any reason, on such other date as the LHB may, in consultation with the contractor, consider reasonable) that the contractor is providing the required level of service and is achieving the required standards, as set out in Annex H. This eligibility condition will only be satisfied if the contractor—

(i) complies with any reasonable requirement imposed on it, as part of that review, to provide documentary evidence of matters the LHB needs to consider in order to satisfy itself as to compliance with the standards and levels of service set out in Annex H; and

(ii) co-operates with a practice inspection, if the LHB considers it necessary to undertake one.

18.4. A contractor will only qualify for a Dispensary Services Quality Payment if it meets the following eligibility conditions—

(a) it must provide the LHB, in respect of each financial year during which it proposes to participate in the Dispensary Services Quality Scheme, with a written undertaking, within the time limits set out in paragraph 18.5, that it will, during the financial year to which the written undertaking relates—

(i) perform the services identified in Annex H; and

(ii) achieve the standards identified in Annex H;

(b) it must indicate in the written undertaking provided in accordance with sub-paragraph (a) the date during the financial year to which the written undertaking relates (that is, 1st April at the start of that financial year or a later date) with effect from which it either has been carrying out or proposes to carry out the services identified in Annex H;

(c) it must provide the LHB, in respect of each financial year during which it proposes to participate in the Dispensary Services Quality Scheme, with the name of a partner or salaried GP within the contractor's practice who will be responsible for the Dispensary Services Quality Scheme and if the identity of the nominated responsible person changes, the contractor must notify the LHB in writing of the details of the new responsible person within 28 calendar days of the change; and

(d) it must, in respect of each financial year during which it proposes to participate in the Dispensary Services Quality Scheme, co-operate with the LHB in reviewing its Dispensary Services Quality Scheme arrangements.

18.5. The contractor must provide the written undertaking referred to in paragraph 18.4(a) within the following timescales—

(a) in the case of a GMS contract which is in existence on 1st April in the financial year and in respect of which the contractor has consent to dispense on that date, the contractor must provide the written undertaking before 1st July of that financial year;

(b) in the case of a GMS contract which is in existence on 1st April in the financial year but in respect of which the contractor does not have consent to dispense on that date, the contractor

must provide the written undertaking within 3 months of obtaining consent to dispense, but in any event before 1st February of that financial year;

(c) in the case of a GMS contract which takes effect between 2nd April and 31st January inclusive in the financial year and in respect of which the contractor has, on the date the contract takes effect, consent to dispense, the contractor must provide the written undertaking within 3 months of the date the contract takes effect, but in any event before 1st February of the financial year; and

(d) in the case of a GMS contract which takes effect between 2nd April and 31st January inclusive of that financial year and in respect of which the contractor does not have, on the date the contract takes effect, consent to dispense, the contractor must provide the written undertaking within 3 months of the date of obtaining consent to dispense is obtained, but in any event before 1st February of that financial year.

18.6. A contractor is not eligible for a Dispensary Services Quality Payment in respect of any financial year as regards which its participation in the Dispensary Services Quality Scheme starts on or after 1st February.

Calculation of Dispensary Services Quality Payments

18.7. If, as regards a GMS contract which is in existence on 1st April in any financial year, the contractor—

(a) had consent to dispense on 1st April of that financial year;

(b) had been participating in the Dispensary Services Quality Scheme immediately prior to 1st April of that financial year; and

(c) satisfies the eligibility conditions set out in paragraph 18.3,

the LHB must pay to the contractor under its GMS contract a Dispensary Services Quality Payment in respect of that financial year. That payment is to be calculated as follows—

£2.58 multiplied by the number of patients on the contractor's list (as measured by the Exeter system) on 1st January of that financial year in respect of whom the contractor has consent to dispense.

18.8. If, as regards a GMS contract which is in existence on 1st April but to which paragraph 18.7(b) does not apply, or which is entered into between 2nd April and 31st January inclusive, the contractor—

(a) either had consent to dispense on 1st April of that financial year or has, on the date the contract takes effect, consent to dispense; and

(b) satisfies the eligibility conditions set out in paragraph 18.3,

the LHB must pay to the contractor under its GMS contract a Dispensary Services Quality Payment in respect of that financial year.

18.9. The Dispensary Services Quality Payment payable under paragraph 18.8 above is calculated as follows—

£2.58 multiplied by–

the number of patients on the contractor's list (as measured by the Exeter system) on 1st January of that financial year in respect of whom the contractor has consent to dispense on–

(a) 1st January of that financial year; or

(b) where the contract takes effect between 2nd January and 31st January inclusive of that financial year, the date upon which the contract takes effect,

then multiplied by X/365 (or X/366 where the financial year includes 29th February), where X is either the number of days left in the financial year from when the contract took effect or the number of days left in the financial year starting from (and including)

the date specified by the contractor in his written undertaking pursuant to paragraph 18.4(b), whichever is the shorter period.

18.10. If, as regards a GMS contract which is in existence on 1st April, or which is entered into between 2nd April and 31st January inclusive, the contractor—

(a) either did not have consent to dispense on 1st April of that financial year or, on the date the contract takes effect, did not have consent to dispense;

(b) obtains consent to dispense between 2nd April and 31st January inclusive of that financial year; and

(c) satisfies the eligibility conditions set out in paragraph 18.3,

the LHB must pay to the contractor under its GMS contract a Dispensary Services Quality Payment in respect of that financial year.

18.11. The Dispensary Services Quality Payment payable under paragraph 18.10 above is calculated as follows—

£2.58 multiplied by–

the number of patients on the contractor's list (as measured by the Exeter system) in respect of whom the contractor has consent to dispense on—

(a) 1st January of that financial year; or

(b) where the consent to dispense is obtained between 2nd January and 31st January inclusive of that financial year, the date upon which the consent to dispense is obtained,

then multiplied by X/365 (or X/366 where the financial year includes 29th February), where X is either the number of days left in the financial year from when the contract took effect or the number of days left in the financial year starting from (and including) the date specified by the contractor in his written undertaking pursuant to paragraph 18.4(b), whichever is the shorter period.

Conditions attached to Dispensary Services Quality Payments

18.12. A Dispensary Services Quality Payment, or any part thereof, is only payable if the contractor satisfies the following conditions—

(a) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor has fulfilled its obligations under the Dispensary Services Quality Scheme;

(b) the contractor must make any returns required of it (whether computerized or otherwise) to the Exeter Registration System, and do so promptly and fully; and

(c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

18.13. If the contractor breaches any of the conditions referred to in paragraph 18.12, the LHB may, in appropriate circumstances, withhold payment of any, or any part of, a Dispensary Services Quality Payment that is otherwise payable.

Accounting arrangements and date payment is due

18.14. Dispensary Services Quality Payments are to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year to which the payment relates. The Dispensary Services Quality Payment is to fall due—

(a) subject to sub-paragraph (b), at the end of the first month of the financial year after the financial year to which the payment relates or, in the case of a contract that terminates prior to the end of the financial year or in respect of which the contractor cease to have consent to dispense or to provide the service in Annex H prior to the end of the financial year, on the date the contract terminates or the consent to dispense ceases or the provisions of the service in Annex H ceases, as the case may be; or

(b) if, on the due date provided for in sub-paragraph (a), the LHB does not have the information it needs in order to be satisfied that the contractor has met the eligibility criteria in paragraph 18.3 (all reasonable efforts to obtain the information having been undertaken), on the last day of the month during which the LHB obtains the information it needs in order to be so satisfied.

18.15. In the case of a contract merger or split of a type described in paragraphs 18.18 to 18.23 below, the due date is the date that the payment would have fallen due if the contracts that are treated as terminated had in fact terminated.

Part payment of Dispensary Services Quality Payments in special circumstances

18.16. Where a contractor is participating in the Dispensary Services Quality Scheme during any financial year and during that financial year—

(a) the contract terminates;

(b) the contractor ceases to have consent to dispense; or

(c) the contractor ceases to provide the services in Annex H,

the contractor may nevertheless be entitled to payment of a Dispensary Services Quality Payment, calculated in accordance with the provisions of paragraph 18.17 of this Section.

18.17. The calculation of the payment—

(a) will be on the basis of the number of patients in respect of whom the contractor has consent to dispense at the start of the quarter in which the contract terminates, the contractor ceases to have consent to dispense or the contractor ceases to provide the service in Annex H, as the case may be; and

(b) will be on the basis that in any calculation involving X/365, or X/366, "X" will be the number of days during the relevant financial year starting on the date when the contractor's participation during that financial year in the Dispensary Services Quality Scheme began and ending on the date on which the contract terminates, the contractor ceases to have consent to dispense or the contractor ceases to provide the services in Annex H, as the case may be.

Provisions relating to contactors whose practices merge

18.18. Paragraphs 18.19 and 18.20 apply where two or more contractors merge ("a contractual merger") and as a result two or more patient lists are combined, resulting in either a new GMS contract or a varied GMS contract.

18.19. If any of the contractors in a contractual merger which takes place before 1st February in any financial year were participating in the Dispensary Services Quality Scheme during that financial year, any Dispensary Services Quality Payment relating to that participation is to be calculated on the basis that their original GMS contract terminated on the date of the merger. The merged contract is to be treated for the purposes of this Section as a new contract coming into force on the date of the merger. If the new contractor (for these purposes) wants to participate in the Dispensary Services Quality Scheme it should seek to do so in accordance with the provisions of this Section.

18.20. If any of the contractors in a contractual merger which takes place on or after 1st February in any financial year were participating in the Dispensary Services Quality Scheme during that financial year, any Dispensary Services Quality Payment is to be calculated on the basis that its original GMS contract terminated on 31st March of that year. The merged contract is to be treated for the purposes of this Section as a new contract coming into force on the date of the merger. If the new contractor (for these purposes) wants to participate in the Dispensary Services Quality Scheme it should seek to do so in accordance with the provisions of this Section. The new contractor will have no entitlement to any Dispensary Services Quality Payment for the period between 1st February and 31st March of that financial year but may participate in the Dispensary

Services Quality Scheme in accordance with the provisions of this Section in future financial years.

Provisions relating to contractors whose practices split

18.21. Paragraphs 18.22 and 18.23 apply where a GMS contract splits ("a contractual split") and as a result the contractor's patient list is divided between two or more contractors, resulting in either new GMS contracts or varied GMS contracts or a combination of both.

18.22. If the original contractor in a contractual split which takes place before 1st February in any financial year was participating in the Dispensary Services Quality Scheme during that financial year, any Dispensary Services Quality Payment is to be calculated on the basis that the original GMS contract terminated on the date of the split. The GMS contracts that emerge from the split are to be treated for the purposes of this Section as new contracts coming into force on the date of the split. If the new contractors (for these purposes) want to participate in the Dispensary Services Quality Scheme they should seek to do so in accordance with the provisions of this Section.

18.23. If the original contractor in a contractual split which takes place on or after 1st February in any financial year was participating in the Dispensary Services Quality Scheme during that financial year, any Dispensary Services Quality Payment is to be calculated on the basis that the original GMS contract terminated on 31st March of that year. The GMS contracts that emerge from the split are to be treated for the purposes of this Section as new contracts coming into force on the date of the split. If any of the new contractors (for these purposes) want to participate in the Dispensary Services Quality Scheme they should seek to do so in accordance with the provisions of this Section. The new contractors will have no entitlement to any Dispensary Services Quality Payment for the period between 1st February and 31st March of that financial year but may participate in the Dispensary Services Quality Scheme in accordance with the provisions of this Section in future financial years.

Discretionary matters

18.24. Where the GMS contract of a contractor who is participating in the Dispensary Services Quality Scheme is subject to a split or a merger and—

(a) the application of the provisions set out in this Section in respect of splits or mergers would, in the reasonable opinion of the LHB, lead to an inequitable result; or

(b) the circumstances of the split or merger are such that the provisions set out in this Section cannot be applied,

the LHB should consider, in consultation with the contractor or contractors concerned, making payments under section 53 of the 2006 Act.

18.25. It may be that the circumstances of a contract termination, or of a split or merger as described in paragraphs 18.18 to 18.23, have rendered it practicably speaking impossible for a contractor to have complied with all of the entitlement conditions in paragraph 18.3. In these circumstances, the LHB may, where it is equitable to do so, set aside the considerations with which the contractor is no longer able to comply.

PART 5

SUPPLEMENTARY PROVISIONS

Section 19: ADMINISTRATIVE PROVISIONS

Overpayments and withheld amounts

19.1. Without prejudice to the specific provisions elsewhere in this SFE, if the LHB makes a payment to a contractor under its GMS contract pursuant to this SFE and—

(a) the contractor was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment or because the payment was calculated incorrectly (including where a payment on account overestimates the amount that is to fall due);

(b) the LHB was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money has already been paid; or

(c) the LHB is entitled to repayment of all or part of the money paid,

the LHB may recover the money paid by deducting an equivalent amount from any payment payable pursuant to this SFE, and where no such deduction can be made, it is a condition of the payments made pursuant to this SFE that the contractor must pay to the LHB that equivalent amount.

19.2. Where the LHB is entitled pursuant to this SFE to withhold all or part of a payment because of a breach of a payment condition, and the LHB does so or recovers the money by deducting an equivalent amount from another payment in accordance with paragraph 19.1, it may, where it sees fit to do so, reimburse the contractor the amount withheld or recovered, if the breach is cured.

Underpayments and late payments

19.3. Without prejudice to the specific provisions elsewhere in this SFE relating to underpayments of particular payments, if the full amount of a payment that is payable pursuant to this SFE has not been paid before the date on which the payment falls due, then unless—

(a) this is with the consent of the contractor; or

(b) the amount of, or entitlement to, the payment, or any part thereof, is in dispute (once the payment falls due) it must be paid promptly (see regulation 22 of the 2004 Regulations).

19.4. If the contractor's entitlement to the payment is not in dispute but the amount of the payment is in dispute, then once the payment falls due, pending the resolution of the dispute, the LHB must—

(a) pay to the contractor, promptly, an amount representing the amount that the LHB accepts that the contractor is at least entitled to; and

(b) thereafter pay any shortfall promptly, once the dispute is finally resolved.

19.5. However, if a contractor has—

(a) not claimed a payment to which it would be entitled pursuant to this SFE if it claimed the payment; or

(b) claimed a payment to which it is entitled pursuant to this SFE but the LHB is unable to calculate the payment until after the payment is due to fall due because it does not have the information or computer software it needs in order to calculate that payment (all reasonable efforts to obtain the information, or make the calculation, having been undertaken),

that payment is (instead) to fall due at the end of the month during which the LHB obtains the information or computer software it needs in order to calculate the payment.

Payments on account

19.6. Where the LHB and the contractor agree (but the LHB's agreement may be withdrawn where it is reasonable to do so and if it has given the contractor reasonable notice thereof), the LHB must pay to a contractor on account any amount that is—

(a) the amount of, or a reasonable approximation of the amount of, a payment that is due to fall due pursuant to this SFE; or

(b) an agreed percentage of the amount of, or a reasonable approximation of the amount of, a payment that is due to fall due pursuant to this SFE,

and if that payment results in an overpayment in respect of the payment, paragraph 19.1 applies.

19.7. The LHB will not be able to calculate the correct amount of GP providers' Seniority Payments during the financial year to which they relate because it will not be possible to calculate the correct value of the GP provider's Superannuable Income Fraction until—

(a) the Average Adjusted Superannuable Income for that financial year has been established; and

(b) the GP provider's pensionable earnings from all sources for that financial year, excluding—

(i) pensionable earnings which do not appear on that provider's certificate submitted to the LHB in accordance with paragraph 20.10; and

(ii) any amount in respect of Seniority Payments,

have been established.

19.8. If the LHB cannot reach agreement with a contractor on a payment on account in respect of a Quarterly Seniority Payment pursuant to paragraph 19.6, it must nevertheless pay to the contractor on account a reasonable approximation for the Quarterly Seniority Payment, on or before the unrevised due date for payment of that payment (i.e. before it is revised in accordance with paragraph 19.5). If that payment results in an overpayment in respect of the Quarterly Seniority Payment, paragraph 19.1 applies.

Payments to or in respect of suspended doctors whose suspension ceases

19.9. If the suspension of a GP from the medical performers list ceases, and a contractor is entitled to any payments in respect of that GP pursuant to this SFE and payment was made to the GP pursuant to a determination made under regulation 13(17) of the Performers Lists Regulations but the GP was not entitled to receive all or any part of that payment, the amount to which the GP was not entitled may be set off, equitably, against any payment in respect of that GP pursuant to this SFE.

Effect on periodic payments of termination of a GMS contract

19.10. If a GMS contract under which a periodic payment is payable pursuant to this SFE is terminated before the date on which the payment falls due, a proportion of that payment is to fall due on that last day on which the contractor is under an obligation under its GMS contract to provide essential services. The amount of the periodic payment payable is to be adjusted by the fraction produced by dividing—

(a) the number of days during the period in respect of which the payment is payable for which the contractor was under an obligation under its GMS contract to provide essential services; by

(b) the total number of days in that period.

19.11. Paragraph 19.10 is without prejudice to any arrangements for the recovery of money paid under the GMS contract that is recoverable as a result of the contract terminating or any breach thereof.

Time limitation for claiming payments

19.12. Payments under this SFE are only payable if claimed within six years of the date on which they could first have fallen due (albeit that the due date has changed pursuant to paragraph 19.5).

Dispute resolution procedures

19.13. Any dispute arising out of or in connection with this SFE between the LHB and a contractor is to be resolved as a dispute arising out of or in connection with the contractor's GMS

contract, i.e. in accordance with the NHS dispute resolution procedures or by the courts (see Part 7 of Schedule 6 to the 2004 Regulations).

19.14. The procedures require the contractor and the LHB to make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute between themselves before referring it for determination. Either the contractor or the LHB may, if it wishes to do so, invite the Local Medical Committee for the area in which the contractor provides primary medical services under the GMS contract to participate in these discussions.

Protocol in respect of locum cover payments

19.15. Part 4 sets out a number of circumstances in which the LHB is obliged to pay a maximum amount per week for locum cover in respect of an absent performer. However, even where the LHB is not directed pursuant to this SFE to make payments in respect of such cover, it has powers to do so as a matter of discretion – and may also decide, as a matter of discretion, to make top-up payments in a case where the maximum directed amount is payable.

19.16. As a supplementary measure, the LHB is directed to adopt and keep up-to-date a protocol, which they must take all reasonable steps to agree with The General Practitioners Committee which is part of the British Medical Association, setting out in reasonable detail—

(a) how they are likely to exercise their discretionary powers to make payments (including top-up payments) in respect of locum cover, having regard to the budgetary targets they have set for themselves, where they are not obliged to make such payments;

(b) where they are obliged to make payments in respect of locum cover pursuant to Part 4, the circumstances in which they are likely to make payments in respect of locum cover of less that the maximum amount payable (for example where the locum cover is in respect of a part-time GP performer who normally works three days per week);

(c) how they are likely to exercise their discretionary powers to make payments in respect of cover for absent GP performers which is provided by nurses or other health care professionals;

(d) how they are likely to exercise their discretionary powers to make payments to a partner or shareholder in a contractor, or an employee of a contractor, who is providing locum cover for an absent GP performer who is also a partner or shareholder in, or an employee of, the contractor;

(e) how they are likely to exercise their discretionary powers to make payments in respect of a GP performer who is on a long term sickness leave, where locum cover payments are no longer payable in respect of that performer under Section 12. In determining the amounts that may be appropriate in these circumstances, the expectation of the Welsh Government is that they would not exceed the half rate payable in the second period of 26 weeks under paragraph 12.6(b), or the amount that would be payable under the NHS Pension Scheme Regulations if the performer retired on ground of permanent incapacity, whichever is the lower; and

(f) where they are not obliged to make payment in respect of locum cover pursuant to Part 4, how they are likely to exercise their discretionary powers to make payments in respect of a sole practitioner who is absent for the purposes of attending an accredited postgraduate educational course, in circumstances where, because of the nature of the locality in which the contractor's premises are situated, locum cover arrangements (i.e. arrangements other than cover provided by a neighbouring practice) are essential to meet the needs of patients in that locality for primary medical services.

19.17. Where the LHB—

(a) intends to depart from that protocol in any individual case, it must consult the Local Medical Committee (if any) for the area in which the applicant affected by the departure from that protocol provides primary medical services; and

(b) departs from that protocol in any individual case and refuses an application for funding in respect of locum cover, this must be duly justified to the unsuccessful applicant.

Adjustment of Contractor Registered Populations

19.18. The starting point for the determination of a contractor's Contractor Registered Population is the number of patients recorded in the Exeter Registration System as being registered with the contractor, initially when its GMS contract takes effect and thereafter at the start of each quarter, when a new number must be established.

19.19. However, in respect of any quarter, this number may be adjusted as follows—

(a) if a contractor satisfies the LHB that a patient who registered with it before the start of a quarter was not included in the number of patients recorded in the Exeter Registration System as being registered with it at the start of that quarter, and the LHB received notification of a new registration within 48 hours of the start of that quarter, that patient—

(i) is to be treated as part of that contractor's Contractor Registered Population at the start of that quarter; and

(ii) if that patient was registered with another contractor at the start of that quarter, is not to be counted as part of that other contractor's Contractor Registered Population for that quarter;

(b) if, included in the number of patients recorded in the Exeter Registration System as being registered with a contractor at the start of a quarter, there are patients who—

(i) transferred to another contractor in the quarter before the previous quarter (or earlier); but

(ii) notification of that fact was not received by the LHB until after the second day of the previous quarter,

those patients are not treated as part of the contractor's Contractor Registered Population at the start of that quarter; or

(c) if a patient is not recorded in the Exeter Registration System as being registered with a contractor at the start of a quarter, but that patient—

(i) had been removed from a contractor's patient list in error; and

(ii) was reinstated in the quarter before the previous quarter (or earlier),

that patient is to be treated as part of the contractor's Contractor Registered Population at the start of that quarter.

19.20. If a contractor wishes its Contractor Registered Population to be adjusted in accordance with paragraph 19.19, it must—

(a) within 10 days of receiving from the LHB a statement of its patient list size for a quarter, request in writing that the LHB makes the adjustment; and

(b) within 21 days of receiving that statement, provide the LHB with the evidence upon which it wishes to rely in order to obtain the adjustment,

and the LHB must seek to resolve the matter as soon as is practicable. If there is a dispute in connection with the adjustments, paragraphs 19.13 and 19.14 apply.

Section 20: SUPERANNUATION CONTRIBUTIONS

The LHB's responsibilities in respect of contractors' employer's and employee's superannuation contributions

20.1. Employer's superannuation contributions in respect of GP Registrars in general practice – who are subject to separate funding arrangements from those in respect of other GP performers – are the responsibility of the LHB, which act as their employer for superannuation purposes. In this section, a reference to a "specialist trainee" means a GP Registrar.

20.2. Under the NHS Pension Scheme Regulations, contractors continue to be responsible for paying the employer's superannuation contributions of practice staff who are members of the NHS

Pension Scheme, and for collecting and forwarding to the NHS Pensions Division which is part of the NHS Business Services Authority (NHSPD) both employer's and employee's superannuation contributions in respect of their practice staff. Contractors are responsible, as the "employing authority" and are required to pay the LHB both the employer's and employee's superannuation contributions for—

(a) non-GP providers; and

(b) GP performers who are not specialist trainees in general practice,

who are members of the NHS Pension Scheme. The LHB must thereafter forward these contributions to the NHSPD. The detail of all these arrangements is set out in the NHS Pension Scheme Regulations.

20.3. In this Section—

(a) non-GP providers and GP performers who are not specialist trainees in general practice are together referred to as "Pension Scheme Contributors"; and

(b) the "LHB" is the "host LHB", as defined in the NHS Pension Scheme Regulations(**a**).

20.4. The cost of paying Pension Scheme Contributors' employer's and employee's superannuation contributions relating to the income of Pension Scheme Contributors which is derived from the revenue of a GMS contract has been or will be included in the national calculations of the levels of the payments in respect of services set out in this SFE. It is also to be assumed that—

(a) any other arrangements that the contractor has entered into to provide services which give rise to pensionable earnings for the purposes of the NHS Pension Scheme Regulations will have included provision for all the payable superannuation contributions in respect of its Pension Scheme Contributors in the contract price; and

(b) the payments from the LHB to the contractor in respect of services under the GMS contract, together with the contract price of any other contract to provide services which gives rise to pensionable earnings for the purposes of the NHS Pension Scheme Regulations that the contractor has entered into, also cover the cost of any additional voluntary contributions that the LHB is obliged to forward to the NHSPD or an Additional Voluntary Contributions Provider on the contract's, or its Pension Scheme Contributors' behalf.

20.5. Accordingly, the costs of paying the employer's and employee's superannuation contributions of a contractor's Pension Scheme Contributors under the NHS Pensions Scheme in respect of their pensionable earnings from all sources – unless superannuated for the purposes of the NHS Pension Scheme elsewhere – are all to be deducted by the LHB from any money the LHB pays, pursuant to this SFE, to the contractor that is the employing authority of the Pension Scheme Contributor.

Monthly deduction in respect of superannuation contributions

20.6. The deductions are to be made in two stages. First, the LHB, as part of the calculation of the net amount (as opposed to the gross amount) of a contractor's payable GSMPs, deduct an amount that represents a reasonable approximation of a monthly proportion of—

(a) the contractor's liability in the financial year to which the Payable GSMPs relate in respect of the employer's superannuation costs under the NHS Pension Scheme relating to any of the contractor's Pension Scheme Contributors (i.e. a reasonable approximation in respect of their total NHS Pension Scheme pensionable earnings which are not superannuated elsewhere)who are members of the NHS Pension Scheme;

(b) those Pension Scheme Contributors' related employee's superannuation contributions; and

(c) any payable additional voluntary contributions in respect of those Pension Scheme Contributors.

(**a**) "Host Board" is defined in regulation 2.A.1 of the National Health Service Pension Scheme Regulations 2008 (S.I. 2008/653).

20.7. Before determining the monthly amount to be deducted, the LHB must take all reasonable steps to agree with the contractor what that amount should be, and it must duly justify to the contractor the amount that it does determine as the monthly deduction.

20.8. Superannuation contributions in respect of payments for specific purposes which are paid after the start of the financial year will, for practical reasons, need to be handled slightly differently. The LHB and the contractor may agree that the payment is to be made net of any superannuation contributions that the LHB is responsible for collecting on behalf of the NHSPD or an Additional Voluntary Contributions Provider. In the absence of such an agreement, the default position is that a reasonable proportion of the total amount of those contributions will need to be deducted from the remaining Payable GSMPs that are due to the contractor before the end of the financial year.

20.9. An amount equal to the monthly amount that the LHB deducts must be remitted to the NHSPD and any relevant Money Purchase Additional Voluntary Contributions Providers no later than—

(a) the 19th day of the month in respect of which the amount was deducted; or

(b) in the case of Money Purchase Additional Voluntary Contributions, 7 days after an amount in respect of them is deducted pursuant to paragraph 20.6.

End-year adjustments

20.10. After the end of any financial year, the final amount of each Pension Scheme Contributor's superannuable income in respect of the financial year will need to be determined. For these purposes, the superannuable income of a Pension Scheme Contributor is the contractor's total pensionable earnings, as determined in accordance with the NHS Pension Scheme Regulations, which are not superannnuated elsewhere.

20.11. As regards contractors that are partnerships, sole practitioners or companies limited by shares, it is a condition of all the payments payable pursuant to Parts 1 to 3 of this SFE – if any of the contractor's Pension Scheme Contributors are members of the NHS Pension Scheme – that the contractor ensures that its Pension Scheme Contributors (other than those who are neither members of the NHS Pension Scheme nor due Seniority Payments) prepare, sign and forward to the LHB—

(a) an accurately completed certificate, the General Medical Practitioner's Annual Certificate of Pensionable Profits, in the standard format provided nationally; and

(b) no later than one month from the date on which the GP was required to submit the HM Revenue & Customs return on which the certificates must be based.

20.12. Seniority payments have to be separately identifiable in the certificate for the purposes of the calculation of Average Adjusted Superannuable Income, which is necessary for the determination of the amount of GP providers' Seniority payments. Seniority Payment figures in the certificates forwarded to the LHB will necessarily be provisional (unless they are submitted too late for the information they contain to be included in the national calculation of Average Adjusted Superannuable Income), but the forwarding of certificates must not be delayed simply because of this. Pension Scheme Contributors who are not members of the NHS Pension Scheme but in respect of whom a claim for a Quarterly Seniority Payment is to be made must nevertheless prepare, sign and forward the certificate to the LHB so that the correct amount of their Seniority Payments may be determined.

20.13. Once a contractor's Pension Scheme Contributor's superannuable earnings in respect of a financial year have been agreed, the LHB must—

(a) if its deductions from the contractor's Payable GSMPs during that financial year relating to the superannuation contributions in respect of those earnings—

(i) did not cover the cost of all the employer's and employee's superannuation contribution that are payable by the contractor or the Pension Scheme Contributors in respect of those earnings—

(aa) deduct the amount outstanding from any payment payable to the contractor under its GMS contract pursuant to this SFE (and for all purposes the amount that is payable in respect of that payment is to be reduced accordingly); or

(bb) obtain payment (where no such deduction can be made) from the contractor of the amount outstanding, and it is a condition of the payments made pursuant to this SFE that a contractor that is an employing authority of a Pension Scheme Contributor must pay to the LHB the amount outstanding; or

(ii) were in excess of the amount payable by the contractor and the Pension Scheme Contributor to the NHSPD or a relevant Money Purchase Additional Voluntary Contributions Provider in respect of those earnings, repay the excess amount to the contractor promptly (unless, in the case of an excess amount in respect of Money Purchase Additional Voluntary Contributions, the Contributor elects for that amount to be a further contribution and he is entitled to so elect); and

(b) forward any outstanding employer's and employee's superannuation contributions due in respect of those earnings to the NHSPD or any relevant Additional Voluntary Contributions Provider (having regard to the payments it has already made on account in respect of those Pension Scheme Contributors for that financial year).

Locum practitioners

20.14. Under the NHS Pensions Schemes Regulations, locum practitioners must pay employee's superannuation contributions to the LHB in respect of pensionable locum work undertaken.

20.15. Where contributions are payable by a locum practitioner under paragraph 20.14 in respect of pensionable locum work carried out for an employing authority, that employing authority (within the meaning of the Pension Schemes Regulations) must pay employer's superannuation contributions in respect of that work.

20.16. Where employer's superannuation contributions are payable in respect of a locum practitioner under paragraph 20.15, those contributions must be paid to the LHB.

20.17. It is to be assumed that a GMS contractor who enters into an arrangement with a locum practitioner which give rise to pensionable earnings for the purposes of the NHS Pension Scheme Regulations will have included provision in that arrangement for all the payable superannuation contributions in respect of that locum practitioner in the contract price.

Recovery of unpaid contributions

20.18. Paragraph 20.19 applies where, despite the provisions of this section—

(a) a Pension Scheme Contributor or locum practitioner has failed to pay employee's superannuation contributions;

(b) a Pension Scheme Contributor has failed to pay employer's superannuation contributions; or

(c) an employing authority has failed to deduct employee's superannuation contributions.

20.19. The LHB may recover the amount of any unpaid contributions referred to in paragraph 20.18—

(a) where an employing authority has ceased to exist and paragraph 20.18(a) applies, by adding the amount of those unpaid contributions to the amount of employee's superannuation contributions the Pension Scheme Contributor or locum practitioner in question is due to pay the LHB: that Pension Scheme Contributor is to record that amount of those unpaid contributions in a certificate referred to in paragraph 23 of Schedule 2 to the National Health Service Pension Scheme Regulations 1995 or regulation 2.J.14 of the National Health Service Pension Scheme Regulations 2008; or

(b) by deduction from any payment of a benefit to, or in respect of, the member entitled to that benefit, such a deduction must be to the member's advantage and is subject to the member's consent.

20.20. The provisions of paragraph 20.19 are without prejudice to any other method of recovery the Secretary of State may have.

PART 6

TRANSITIONAL, REVOCATION AND SAVING PROVISIONS

Transitional provisions

21.1 Where it is necessary for the contractor or the LHB—

(a) to take account of a period of time; or

(b) to calculate a period of time which is required in accordance with this SFE,

any period of time that occurred before 1st April 2013 and which is relevant to the matter under consideration is to be taken into account or used in order to calculate any time period for the purposes of that consideration or applying provisions in this SFE on or after 1st April 2013 only if that period of time could have been taken into account or used in a calculation of a time period in respect of those mirror provisions as in force immediately before 1st April 2013.

Revocations

21.2 Subject to paragraph 21.3, the 2005 SFE and the amendments to the 2005 SFE, as listed in Annex J are revoked,

Savings

21.3 Notwithstanding the revocation provided for in paragraph 21.2, the 2005 SFE and the amendments to those Directions as in force immediately before 1st April 2013—

(a) continue to apply to the extent necessary in respect of establishing entitlement to a Seniority Payment and the calculation of the full annual rate of such a payment as provided for in paragraph 15.13 (calculation of seniority payments for the period until 31st March 2009);

(b) continue to apply to the extent necessary in respect of the application of Annex B; and

(c) continue to apply to the extent necessary to assess any entitlement to payment or recovery of payment arising under the terms of GMS contract.

21.4 For the purposes of paragraph 21.3 and for the resolution of any matter which is pending as at 31st March 2013 the LHB may do or continue to do anything which it could have done in relation to the 2005 SFE.

Annex A
GLOSSARY

PART 1
ACRONYMNS

The following acronyms are used in this document:

CFMP – Correction Factor Monthly Payment

CPI – Contractor Population Index

CRP – Contractor Registered Population

FYOIP – Five-Year-Olds Immunisation Payment

GMS – General Medical Services

GSE – Global Sum Equivalent

GSMP – Global Sum Monthly Payment

LHB – Local Health Board

LMC – Local Medical Committee

MPIG – Minimum Practice Income Guarantee

NHS – National Health Service

NHSPD – NHS Pensions Division which is part of the NHS Business Services Authority

QOF – Quality and Outcomes Framework

TYOIP – Two-Year-Olds Immunisation Payment

PART 2
DEFINITIONS

Unless the context otherwise requires, words and expressions used in this SFE and the 2004 Regulations bear the meaning they bear in the 2004 Regulations.

The following words and expressions used in this SFE have, unless the context otherwise requires, the following meaning—

"2006 Act" means the National Health Service (Wales) Act 2006(**a**);

"2004 Regulations" means the National Health Services (General Medical Services Contracts) (Wales) Regulations 2004(**b**);

"2005 SFE" means the Statement of Financial Entitlement made under section 45 of the 2006 Act which came into force on 30th April 2005;

"Achievement Payment" is to be construed in accordance with Section 6;

"Aspiration Payment" is to be construed in accordance with Section 5;

"Aspiration Points Total" is to be construed in accordance with paragraph 4.5(b) and 5.11;

(**a**) 2006 c. 42.
(**b**) S.I 2004/478 (W.48) as amended

"Additional Services", in the context of the additional services domain, means the following services: cervical screening services, child health surveillance, maternity medical services and contraceptive services. In other contexts, it also includes: minor surgery, childhood vaccines and immunisations including pre-school boosters, and vaccinate and immunisations;

"Additional or Out of Hours Services" means all the services listed in the definition of Additional Services above, together with out of hours services provided under arrangements made pursuant to regulation 30 of the 2004 Regulations;

"Adjusted Global Sum Equivalent" is to be construed in accordance with paragraphs 3.3 and 3.4;

"Adjusted Global Sum Monthly Payment" is to be construed in accordance with paragraph 2.5 and 2.10.

"Adjusted Practice Disease Factor" is to be construed in accordance with paragraph 6.6 and Annex F;

"the LHB" means the Local Health Board;

"Childhood Immunisations" is to be construed as a reference to the Childhood Vaccines and Immunisations additional service referred to in the 2004 Regulations;

"Contractor" means a person entering into, or who has entered into, a GMS contract with the LHB in accordance with section 42 of the 2006 Act;

"Contractor Population Index" is to be construed in accordance with paragraph 2.18.

"Contractor Registered Population", in relation to a contractor, means (subject to any adjustment made in accordance with paragraph 2.18) the number of patients recorded in the Exeter Registration System as being registered with the contractor, initially when its GMS contract takes effect and thereafter at the start of each quarter, when a new number must be established;

"Contractor Weighted Population for the Quarter" is a figure set for each contractor arrived at by the Global Sum Allocation Formula in Part 1 of Annex B;

"Correction Factor Monthly Payment" is to be construed in accordance with paragraph 3.9.

"DES Directions" means the Primary Medical Services (Directed Enhanced Services) Directions 2007 which came into force on 12th December 2007;

"Dispensary Services Quality Payment" is to be construed in accordance with the provisions of Section 16;

"Dispensary Services Quality Scheme" is to be construed in accordance with the provisions of Section 16 and Annex H;

"Drug Tariff" means the publication known as the Drug Tariff which is published by the Secretary of State and which is referred to in section 81(4) (arrangements for additional pharmaceutical services) of the 2006 Act;

"Employing authority" has the same meaning as in the NHS Pension Scheme Regulations.

"Employed or engaged", in relation to a general practitioner's relationship with a contractor, includes –

(a) a sole practitioner who is the contractor;

(b) a general practitioner who is a partner in a partnership and that partnership is the contractor; and

(c) general practitioner who is a shareholder in a company limited by shares and that company is the contractor;

"Final Global Sum Equivalent" is to be construed in accordance with paragraph 3.4;

"financial year" means the period of 12 months commencing on 1st April and ending on 31st March;

"Full-time" means, in relation to a performer of primary medical services with a contract of employment, a contractual obligation to work for at least 37 ½ hours per normal working week. The hours total may be made up of surgeries, clinics, administrative work in

connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services;

"General Practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"Global Sum Equivalent" is to be construed in accordance with paragraph 3.2.

"GMS Contract" means a general medical services contract entered into in accordance with section 42 of the 2006 Act;

"GMS contractor" means a contractor who provides primary medical services under a GMS contract;

"GP performer" means a general practitioner—

(a) whose name is included in the medical performers of a Local Health Board; and

(b) who performs primary medical services under a GMS contract, and who is—

(i) a contractor (i.e. a sole practitioner);

(ii) an employee of a contractor; or

(iii) a partner in a partnership or a shareholder in a company limited by shares and that partnership or, as the case may be, that company is the contractor;

"GP provider" means a GP who is—

(a) a contractor (i.e. a sole practitioner);

(b) a partner in a partnership and that partnership is the contractor; or

(c) a shareholder in a company limited by shares and that company is the contractor;

"GP Registrar" means a medical practitioner who is being trained in general practice by a medical practitioner who is approved under section 34I(1)(c) of the Medical Act 1983 for the purpose of providing training under that Act;

"Historic Opt-Outs Adjustment" is to be construed in accordance with paragraphs 3.6 and 3.7;

"Initial Global Sum Equivalent" is to be construed in accordance with paragraphs 3.1 and 3.2;

"Initial Global Sum Monthly Payment" is to be construed in accordance with paragraphs 2.4 and 2.9;

"LHB's cut-off date for calculating quarterly payments" means the date in the final month of a quarter, determined by the LHB, after which it is not in a position to accept new data in respect of payments to be made at the end of that quarter;

"Locum practitioner" means a general medical practitioner (other than a trainee practitioner)—

(a) who falls within the description of paragraph (a) of the definition of "GP Performer"; and

(b) who is engaged under a contract for services by a GMS contractor to deputise or assist temporarily in the provision of any one or a combination of any of the following—

(i) essential services;

(ii) additional services;

(iii) enhanced services;

(iv) dispensing services;

(v) out of hours services;

(vi) commissioned services; or

(vii) certification services;

"Medical Performers List" is to be construed in accordance with regulation 3(1) of the Performers Lists Wales Regulations;

"Minimum Practice Income Guarantee" is to be construed in accordance with paragraph 3.1;

"Money Purchase Additional Voluntary Contributions Provider" means an insurance company providing what, for the purposes of the National Health Service Pension Scheme (Additional Voluntary Contributions) Regulations 2000(**a**), is a free-standing additional voluntary contributions scheme;

"Money Purchase Additional Voluntary Contributions" means contributions to a Money Purchase Additional Voluntary Contributions Provider in respect of what, for the purposes of the National Health Service Pension Scheme (Additional Voluntary Contributions) Regulations 2000, is a free-standing additional voluntary contributions scheme;

"Monthly Aspiration Payment" is to be construed in accordance with paragraph 5.7 and 5.12;

"NHS Pension Scheme Regulations" means the National Health Service Pension Scheme Regulations 1995(**b**) and the National Health Service Pension Scheme Regulations 2008(**c**);

"Part-time" means, in relation to a performer of primary medical services with a contract of employment, a contractual obligation to work for less than 37 ½ hours per normal working week. The hours total may be made up of surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services.

"Performers Lists Regulations" means the National Health Service (Performers Lists) (Wales) Regulations 2004(**d**);

"PMS agreement" means an agreement entered into in accordance with section 50 of the 2006 Act;

"PMS contractor" means a person who has entered into a PMS agreement;

"Provisional Unadjusted Achievement Payment" is to be construed in accordance with paragraphs 5.4 and 5.5;

"Quality and Outcomes Framework" is the framework reproduced at Annex D;

"Quality and Outcomes Framework Uprating Index" is to be construed in accordance with paragraph 5.6;

"Quarter" means a quarter of the financial year and quarter period is to be construed as the period of 3 months ending on 31st March, 30th June, 30th September or 31st December;

"Reckonable Service" is to be construed in accordance with paragraph 15.3;

"Red Book" means the Statement of Fees and Allowances under regulation 34 of the National Health Service (General Medical Services) Regulations 1992, as it had effect on 31st March 2004;

"Sole practitioner" means an individual GP performer who is also a GMS contractor;

"Suspended", in relation to a GP performer, means suspended from the medical performers list;

"Target Population Factor is to be construed in accordance with paragraphs E3 and E4;

"Temporary Patients Adjustment" is to be construed in accordance with paragraph 2.4 and Annex C;

"Time Commitment Fraction" is the fraction produced by dividing a performer of primary medical services' actual working commitment by 37 ½ hours. The hours total may be made up of surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services; and

"Unadjusted Achievement Payment" is to be construed in accordance with paragraph 5.4.

(**a**) S.I 2000/619.
(**b**) S.I. 1995/ 300.
(**c**) S.I. 2008/653.
(**d**) S.I. 2004/1020 (W.117).

ANNEX B

GLOBAL SUM

PART 1

THE GLOBAL SUM ALLOCATION FORMULA

Introduction

B.1 The global sum will be allocated using the Global Sum Allocation Formula. This formula aims to ensure that resources reflect more accurately the contractor's workload and the unavoidable costs of delivering high quality care to the local population.

B.2 The formula consists of the following components—

(a) an adjustment for the age and sex structure of the population;

(b) an adjustment for the additional needs of the population, relating to morbidity and mortality;

(c) an adjustment for list turnover;

(d) a nursing and residential homes index; and

(e) adjustments for the unavoidable costs of delivering services to the population, including a Market Forces Factor and rurality index.

Age and sex adjustment

B.3 The analysis supporting the formula estimates the relative workload, weighted by staff input cost, of providing general medical services to males and females of a number of age groups. The table below, based on analysis of the General Practice Research Database, shows these indices (expressed relative to a male patient aged 5-14), including an adjustment for the higher workload of treating patients through home visits.

Table: Age-sex workload indices (males aged 5-14=1)

	0-4	*5-14*	*15-44*	*45-64*	*65-74*	*75-84*	*85+*
Male	3.97	1	1.02	2.15	4.19	5.81	6.27
Female	3.64	1.04	2.19	3.36	4.9	6.56	6.72

B.4 Therefore, each male patient on a contractor's list aged over 85 will attract 6.27 times the resources for a male patient aged 5-14.

Nursing and Residential Homes

B.5 Patients in nursing and residential homes generate more workload than patients with otherwise similar characteristics who are not in homes. A factor of 1.43 is applied in respect of each patient in a nursing or residential home.

Needs adjustment

B6. As well as the impact on contractors' workload generated by differing age and sex groups, the effect of indicators of mortality and morbidity on consultation frequency has been estimated, using the Health Survey for England.

B.7. Of all the variables tested by the supporting analysis, Standardised Limited Long-Standing Illness (SLLI) and the Standardised Mortality Ratio for those aged under 65 (SMR<65) were found to be best at explaining variations in workload.

B8. The Global Sum Allocation Formula relates these variables to workload by the following formula—

Practice list *(48.1198 + (0.26115 *SLLI) + (0.23676 * SMR<65)).

In this formula, as in all other formulae in this Annex B, the symbol "*" is used as the sign for multiplication.

List turnover adjustment

B.9. Areas with high list turnover often have higher workload, as patients in their first year of registration in a practice tend to have more consultations than other patients.

B.10. Analysis of the workload implications revealed 40 – 50% more workload, as measured by aggregate consultation times, within the first year of registration. An average uplift factor, of 1.46, will be applied through the formula in respect of all new registrants in their first year of registration.

Unavoidable costs adjustment

B.11. Contractors are also likely to face differing costs of delivering primary care, particularly caused by geographic location. The global sum allocation formula reflects these costs through an explicit adjustment for 'market forces' and rurality. There is also an 'off-formula' adjustment for contractors whose qualify for the London adjustment.

Staff Market Forces

B.12. The staff Market Forces Factor has been informed by analysis of the New Earnings Survey, and reflects the geographical variation in contractors' staff costs. The estimation methodology is the same as that used for general NHS allocations.

B.13. This element of the formula has been given a weighting of 48%, as this is the average proportion of the global sum accounted for by staff expenses.

Rurality

B.14. The cost of delivering services is likely to be affected by the rurality of the area the practice serves. Two measures designed to reflect rurality were used—

(a) population density (as measured by persons per hectare in the wards from which a contractor draws its patients); and

(b) population dispersion (as measured by the average distance from patients to practice). If a practice has more than one surgery, the average distance is assessed from the practice's principal surgery, which is defined as the surgery which the greatest number of the practice's patients could reasonably be expected to attend.

B.15. Using analysis of the HM Revenue & Customs information on GP expenses, rurality is linked to cost through the following adjustment to the formula—

Practice List *average distance $^{0.05}$ * population density $^{-0.06}$

B.16. This adjustment is applied only to the expenses element of GMS expenditure, and therefore given an overall weighting of 58%.

Normalising the adjustments

B.17. At each stage of the calculation, the weighted practice populations are normalized (scaled back) to the LHB normalized weighted population. This is done so that the impact of each of the adjustments is equal, and ensures that one adjustment does not dominate the others.

B.18. Using the age and sex adjustment as an example, the formula for normalising weighted practice populations, for the specific Global Sum Allocation Formula adjustments, is as follows:

$$\frac{\text{age and sex weighted practice population}}{\text{sum of LHB age and sex weighted practice populations}} \bullet \text{LHB normalized weighted population}$$

B.19. The LHB normalized weighted population used above is the LHB's registered population for the current quarter multiplied by its latest Quarterly LHB Normalising Index. The Quarterly LHB Normalising Index is a quarterly updated index derived by the Exeter System from the data used in the previous quarter's Global Sum Allocation Formula. Scaling back to this population ensures that the needs and costs of the LHB's population, relative to the LHB's in the country, are reflected in its practices' global sum payments.

B.20. The other five weighted practice populations produced by the other adjustments in the Global Sum Allocation formula are normalized in the same manner as outlined in B.18.

B.21. The normalised weighted practice populations for each adjustment are then divided by the practice's normalized list size to generate a practice index for each adjustment used in the Global Sum Allocation Formula. The formula for calculating the practice's normalized list size is as follows—

Practice normalized list size = CRP * Quarterly LHB Normalising Index

B.22. Using the age and sex adjustment as an example, the formula for then calculating the practice index for each adjustment is as follows—

$$\text{Practice age and sex index} - \frac{\text{Normalised age and sex weighted practice population}}{\text{Practice normalised list size}}$$

B.23. Indices are produced for each of the other five adjustments in the Global Sum Allocation Formula in the same manner as outlined in B.22.

Combining the adjustments

B.24 Each of the six indices are then applied simultaneously to the practice's normalised list size to calculate the overall weighted practice, as follows—

Overall weighted practice population =

Practice normalised list size *age and sex index* nursing and residential homes index* additional needs index *MFF index* rurality index

B.25. This overall weighted practice population is then normalised to the national registered population to calculate the Contractor Weighted Population for the Quarter as follows—

Contractors Weighted Population =

$$\frac{\text{overall weighted practice population}}{\text{sum of LHB overall weighted practice populations}} * \text{LHB normalised weighted population}$$

ANNEX C

TEMPORARY PATIENTS ADJUSTMENT

C.1 The need for this arises because of the contractors' obligations to provide emergency treatment to people who are not registered with their practice and to provide treatment to temporary residents. The Temporary Patients Adjustment will be calculated as follows.

C.2 All contractors are to receive a payment for unregistered patients as an element in their global sum allocation.

C.3 In the case of a contractor in respect of which a Temporary Patients Adjustment was calculated for the financial year prior to the current financial year in respect of which a calculation needs to be made, the Temporary Patients Adjustment for the current financial year will be the same amount as was calculated for the previous financial year.

C.4 However, there may be exceptional cases where a calculation pursuant to paragraph C.3 produces an amount that is clearly inappropriate as the basis for a payment in the financial year to which the payment relates. This may occur, for example, where the practice has faced a significant increase or decrease in the numbers of unregistered patients requiring treatment from it. In these cases, the LHB is instead to determine for the contractor, as the basis for its Temporary Patients Adjustment, a reasonable annual amount which is an appropriate rate for the area where the practice is located. Before making such a determination, the LHB must discuss the matter with the contractor.

C.5 In the case of a contractor in respect of which no Temporary Patients Adjustment was calculated for the financial year prior to the current financial year in respect of which a calculation needs to be made, the LHB is instead to determine for the contractor, as the basis for its Temporary Patients Adjustment for the current financial year, a reasonable annual amount which is an appropriate rate for the area where the practice is located. Before making such a determination, the LHB must discuss the matter with the contractor.

C.6 The amount calculated in accordance with paragraph C.3 to C.5 is the annual amount of the contractor's Temporary Patients Adjustment, which is the amount to be included in its Initial GSMP calculation.

C.7 Once a Temporary Patients Adjustment has been determined, it remains unchanged for the financial year to which the determination relates.

ANNEX D

QUALITY AND OUTCOMES FRAMEWORK

SECTION 1 : Introduction

General

D.1 The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary.

D.2 The percentages for the achievement threshold levels for the fraction indicators included in QOF for the financial year commencing on 1st April 2013 and ending on 31st March 2014 are set out in this Annex.

Glossary of terms used in Annex D

Abbreviation	*Definition*
ACE-Inhibitor or ACE-I	Angiotensin Converting Enzyme Inhibitor
AF	Atrial Fibrillation
ARB	Angiotensin Receptor Blocker
AST	Asthma
BMI	Body Mass Index

BP	Blood Pressure
CAN	Cancer
CHD	Coronary Heart Disease
CHS	Child Health Surveillance
$CHADS_2$	Congestive (HF) Hypertension Age (75 and over) Diabetes Stroke
CKD	Chronic Kidney Disease
CON	Contraception
COPD	Chronic Obstructive Pulmonary Disease
CS	Cervical Screening
CVD	Cardiovascular Disease
CVD-PP	CVD Primary Prevention
DEM	Dementia
DEP	Depression
DM	Diabetes Mellitus
DXA	Dual-energy X-ray Absorptiometry
EP	Epilepsy
FBC	Full Blood Count
FEV_1	Forced Expiratory Volume in One Second
GP	General Practitioner
GPPAQ	GP Physical Activity Questionnaire
HbA1c	Glycated Haemoglobin
HF	Heart Failure
HYP	Hypertension
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
IUS	Intrauterine System
LD	Learning Disabilities
LHB	Local Health Board
LVSD	Left Ventricular Systolic Dysfunction
MAT	Maternity
MH	Mental Health
mmHg	Millimetres of Mercury
mmol/l	Millimoles per Litre
NICE	National Institute for Health and Clinical Excellence
OB	Obesity
OST	Osteoporosis
PAD	Peripheral Arterial Disease
PC	Palliative Care
PE	Patient Experience
QP	Quality and Productivity
RA	Rheumatoid Arthritis
RCP	Royal College of Physicians
SMOK	Smoking
STIA	Stroke and Transient Ischemic Attack
THY	Hypothyroidism
TIA	Transient Ischemic Attack
TSH	Thyroid Stimulating Hormone

Interpretation of words and expressions used in Annex D

D.3 In this Annex, unless the context otherwise requires, words and expressions have the following meaning—

(a) "currently treated" in respect of a patient is to be construed as a patient who has been prescribed a specified medicine within a period of six months which ends on the last day of the financial year to which the achievement payment relates;

(b) "excepted patients" means persons who fall within the description of patients in paragraph D.11 (exception reporting);

(c) "exclusions" means person who fall within the description of patient in paragraph D.10; and

(d) "financial year" means the period of 12 months commencing on 1st April and ending on 31st March;

Indicators: general

D.4.1 For the purposes of calculating achievement payments, contractor achievement against QOF indicators is measured—

(a) on the last day of the financial year (31st March); or

(b) in the case where the contract terminates mid-year, on the last day on which the contract subsists.

D.4.2 For example, for payments relating to the financial year 1st April 2013 to 31st March 2014, unless the contract terminates mid-year, achievement is measured on 31st March 2014. If the GMS contract ends on 30th June 2013, achievement is measured on 30th June 2013.

D.4.3 Indicators generally set out the target, intervention or measurement to be recorded within a specified time period to establish eligibility for achievement payments. Unless otherwise stated, time periods referred to mean the period which ends on the last day of the financial year to which the achievement payment relates. For example—

(a) in indicator CHD002W, "the percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90mmHg or less", the phrase "preceding 15 months" means the period of 15 months which ends on 31st March in the financial year to which the achievement payments relate;

(b) in indicator CAN002W, "the percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 3 months of the contractor receiving confirmation of the diagnosis", the phrase "within the preceding 15 months" means the period of 15 months which ends on 31st March in the financial year to which the achievement payments relate;

(c) in indicator HYP002W, "the percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less", the phrase "in the preceding 9 months" means the period of 9 months which ends on 31st March in the financial year to which the achievement payments relate;

(d) in indicator CS002W, "the percentage of women (aged 25 or over and who have not attained the age of 65) whose notes record that a cervical screening test has been performed in the preceding 5 years", the phrase "in the preceding 5 years" means the period of 5 years which ends on 31st March in the financial year to which the achievement payments relate; and

(e) in indicator CHD004W, "the percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1st September to 31st March", the phrase " in the preceding 1st September to 31st March" means the period of 7 months which ends on 31st March in the financial year to which the achievement payments relate.

D.4.4 In the case of a contract that has come to an end before 31 March in any relevant financial year, the reference to periods of time must be calculated on the basis that the period ends on 31st March in the financial year to which the achievement payments relate.

Disease registers

D.5 An important feature of the QOF is the establishment of disease registers. These are lists of patients registered with the contractor who have been diagnosed with the disease or risk factor described in the register indicator. While it is recognised that these may not be completely

accurate, it is the responsibility of the contractor to demonstrate that it has systems in place to maintain a high-quality register. Verification may involve asking how the register is constructed and maintained. The LHB may compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations.

D.6 For some indicators, there is no disease register, but instead there is a target population group. For example, for cervical screening the target population group is women who have attained the age of 25 years or over and who have not attained the age of 65 years. Indicators in the Clinical and Public Health Domain are arranged in terms of clinical areas. Most of these areas either relate to a register or to a target population group.

D.7 Some areas in the clinical domain and the public health domain do not have a register indicator, or there may be more than one register to calculate the Adjusted Practice Disease Factor for different indicators within the area. For all relevant areas, the register population used to calculate the Adjusted Practice Disease Factor are set out in the summary of indicators.

D.8 Indicators in the Quality and Productivity Domain and the Patient Experience Domains have neither a disease register nor a target population. These are indicators which require a particular activity to be carried out and where the points available are awarded in full if it is carried out or not at all if it is not carried out.

Exception reporting and exclusions

D.9 Exception reporting applies to those indicators in any domain of the QOF where the achievement is determined by the percentage of patients receiving the specified level of care (fraction indicators).

D.10 Some indicators refer to a sub-set of patients on the relevant disease register, or in the target population group. Patients who are on the disease register or target group, but not included in an indicator denominator for the clinical area concerned for definitional reasons are called "exclusions".

D.11 "Exceptions" relate to registered patients who are in the relevant disease register or target group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria set out below. Patients are removed from the denominator if they have been excepted and also the care specified in the indicators has not been carried out. These patients are referred to as "excluded patients". If the patient has been excepted but subsequently the care has been carried out in the relevant time period the patient will be included in both the denominator and the numerator.

D.12 Patients may be excepted if they meet the following criteria for exception reporting—

(a) patients who have been recorded as refusing to attend review who have been invited on at least 3 occasions during the financial year to which the achievement payments relate (except in the case of indicator CS002W, where the patient should have been invited on at least 3 occasions during the period specified in the indicator during which the achievement is to be measured (i.e. the preceding 5 years ending on 31st March in the financial year to which achievement payments relate);

(b) patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail;

(c) patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels;

(d) patients who are on maximum tolerated doses of medication whose levels remain sub-optimal;

(e) patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, contraindication or have experienced an adverse reaction;

(f) where a patient has not tolerated medication;

(g) where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient;

(h) where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease; or

(i) where an investigative service or secondary care service is unavailable.

D.13 In the case of exception reporting on criteria (a) and (b) these patients are removed from the denominator for all indicators in that disease area where the care has not been delivered. For example, in a contractor with 100 patients on the Coronary Heart Disease (CHD) disease register, in which four patients have been recalled for follow-up on three occasions but have not attended and one patient has become terminally ill with metastatic breast carcinoma during the year, the denominator for reporting would be 95. However, all 100 patients with CHD would be included in the calculation of the Adjusted Practice Disease Factor. This would apply to all relevant indicators in the CHD set.

D.14 In addition, contractors may exception report patients from single indicators if they meet criteria in D12.(c)-(i), for example a patient who has heart failure due to left ventricular systolic dysfunction (LVSD) but who is intolerant of angiotensin receptor converting enzyme inhibitors (ACE inhibitors) and angiotensin receptor blocker (ARB) could be exception reported from Heart Failure (HF) indicator HF003W. This would result in the patient being removed from the denominator for that indicator only.

D.15 Contractors should report the number of exceptions for each indicator set and individual indicator. Contractors will not be expected to report why individual patients were exception reported. However, contractors may be called on to explain why they have excepted patients from an indicator and this should be identifiable in the patient record.

Additional guidance on exception reporting is included in the guidance referred to in paragraph 4.2 which is published by Welsh Government and can be obtained on www.wales.nhs.uk/GMS.

Verification

D.16 The contractor must ensure that it is able to provide any information that the LHB may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled, and the contractor must make that information available to the LHB on request. In verifying that an indicator has been achieved and information correctly recorded, the LHB may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator.

SECTION 2: Summary of QOF indicators

The clinical domain

2.1 This Section 2.1 (the Clinical domain) applies to all contractors participating in QOF.

Atrial fibrillation (AF)

Indicator	Points	Achievement thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	

Ongoing management		
AF002W. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the $CHADS_2$ risk stratification scoring system in the preceding 15 months (excluding those whose previous $CHADS_2$ score is greater than 1) *NICE 2011 menu ID: NM24*	10	54-94%
AF003W. In those patients with atrial fibrillation in whom there is a record of a $CHADS_2$ score of 1 (latest in the preceding 12 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy *NICE 2011 menu ID: NM45*	6	57-97%
AF004W. In those patients with atrial fibrillation whose latest record of a $CHADS_2$ score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy *NICE 2011 menu ID: NM46*	6	40-70%

Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Achievement thresholds
Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	4	
Ongoing management		
CHD002W. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	17	51-91%
CHD003W. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less	17	45–80%
CHD004W. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March	7	53-93%
CHD005W. The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	53-93%
CHD006W. The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin *NICE 2010 menu ID: NM07*	10	60-100%

Heart failure (HF)

Indicator	Points	Achievement thresholds
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	4	
Initial diagnosis		
HF002W. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register	6	50–90%
Ongoing management		
HF003W. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	10	50-90%
HF004W. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure	9	40–65%
HF100W.The percentage of patients with heart failure diagnosed within the preceding 15 months with a subsequent record of an offer of referral for an exercise-based rehabilitation programme within the preceding 15 months *Nice 2012 menu ID:NM48*	5	40-90%

Disease registers in relation to Heart Failure

(a) There are two disease registers used for the Heart Failure area for the purposes of calculating Adjusted Practice Disease Factor—

(i) a register of patients with heart failure which is used to calculate Adjusted Practice Disease Factor for HF001, HF002W and HF100W; and

(ii) a register of patients with heart failure due to left ventricular systolic dysfunction (LVSD) which is used to calculate Adjusted Practice Disease Factor for HF003W and HF004W.

(b) Register (i) is defined in indicator HF001. Register (ii) is a sub-set of register (i) and is composed of patients with a diagnostic code for LVSD as well as for heart failure.

Hypertension (HYP)

Indicator	Points	Achievement thresholds

Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	
Ongoing management		
HYP002W. The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	10	45-80%
HYP003W. The percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less *NICE 2012 menu ID: NM53*	45	45-80%

Peripheral arterial disease (PAD)

Indicator	Points	Achievement thresholds
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease *NICE 2011 menu ID: NM32*	2	
Ongoing management		
PAD002W. The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less *NICE 2011 menu ID: NM34*	2	40-90%
PAD003W. The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less *NICE 2011 menu ID: NM35*	3	40-90%
PAD004W. The percentage of patients with peripheral arterial disease with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken *NICE 2011 menu ID: NM33*	2	40-90%

Stroke and transient ischaemic attack (STIA)

Indicator	Points	Achievement thresholds
Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	

Initial diagnosis		
STIA002W. The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2008) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or TIA	2	45–80%
Ongoing management		
STIA003W. The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	5	40–75%
STIA004W. The percentage of patients with a history of a stroke or TIA who have a record of total cholesterol in the preceding 15 months	2	50–90%
STIA005W. The percentage of patients with a history of a stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less *NICE 2012 menu ID: NM60*	5	40–65%
STIA006W. The percentage of patients with a history of a stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March	2	50-90%
STIA007W. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken	4	54-94%

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Records		
DM001. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed *NICE 2011 menu ID: NM41*	6	
Ongoing management		
DM002W. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less *NICE 2010 menu ID: NM01*	8	51-91%
DM003W. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less *NICE 2010 menu ID: NM02*	10	40-72%

DM004W. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 15 months) is 5 mmol/l or less	6	40–75%
DM005W. The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 15 months *NICE 2012 menu ID: NM59*	3	50–90%
DM006W. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	51-91%
DM007W. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months *NICE 2010 menu ID: NM14*	17	40-72%
DM008W. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months	8	45-81%
DM009W. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months	10	51-91%
DM010W. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March	3	52-92%
DM011W. The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 15 months	5	50–90%
DM012W. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months *NICE 2010 menu ID: NM13*	4	50–90%
DM013W. The percentage of patients with diabetes, on the register, who have a record of a dietary review by a suitably competent professional in the preceding 15 months *NICE 2011 menu ID: NM28*	3	40-90%
DM014W. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register *NICE 2011 menu ID: NM27*	11	40-90%
DM015W. The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 15 months *NICE 2012 menu ID: NM51*	4	40-90%

DM016W. The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 15 months *NICE 2012 menu ID: NM52*	6	40-90%

Hypothyroidism (THY)

Indicator	Points	Achievement thresholds
Records		
THY001. The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine	1	
Ongoing management		
THY002W. The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 15 months	6	50–90%

Asthma (AST)

Indicator	Points	Achievement thresholds
Records		
AST001. The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	4	
Initial diagnosis		
AST002W. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis	15	45–80%
Ongoing management		
AST003W. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions *NICE 2011 menu ID: NM23*	20	45–70%
AST004W. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months	6	45–80%

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Achievement thresholds
Records		
COPD001. The contractor establishes and maintains a register of patients with COPD	3	
Initial diagnosis		
COPD002W. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	5	45–80%
Ongoing management		
COPD003W. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months	9	50–90%
COPD004W. The percentage of patients with COPD with a record of FEV_1 in the preceding 15 months	7	40–75%
COPD005W. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months *NICE 2012 menu ID: NM63*	5	40-90%
COPD006W. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	54-94%
COPD100W. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme within the preceding 15 months *NICE 2012 menu ID: NM47*	5	40-90%

Dementia (DEM)

Indicator	Points	Achievement thresholds
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	5	

Ongoing management		
DEM002W. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months	15	35–70%
DEM003W. The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register *NICE 2010 menu ID: NM09*	6	45–80%

Depression (DEP)

Indicator	Points	Achievement thresholds
Initial diagnosis		
DEP001W. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March who have had a bio-psychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded *NICE 2012 menu ID: NM49*	21	50-90%
Initial management		
DEP002W. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis *NICE 2012 menu ID: NM50*	10	45-80%

Disease register in relation to Depression

(c) There is no register indicator for the depression indicators. The disease register for the indicators in the Depression Area for the purposes of calculating the Adjusted Practice Disease Factor is defined as all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

Mental health (MH)

Indicator	Points	Achievement thresholds
Records		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4	

Ongoing management		
MH002W. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate	6	40-90%
MH003W. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months *NICE 2010 menu ID: NM17*	4	50–90%
MH004w. The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months *NICE 2010 menu ID: NM18*	5	45–80%
MH005W. The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months *NICE 2011 menu ID: NM42*	5	45–80%
MH006W. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months *NICE 2010 menu ID: NM16*	4	50–90%
MH007W. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months *NICE 2010 menu ID: NM15*	4	50–90%
MH008W. The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years *NICE 2010 menu ID: NM20*	5	45–80%
MH009W. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months *NICE 2010 menu ID: NM21*	1	50–90%
MH010W. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months *NICE 2010 menu ID: NM22*	2	50–90%

Disease register in relation to Mental Health

(d) Due to the way repeat prescribing works in general practice, patients on lithium therapy are defined as patients with a prescription of lithium within the preceding six months.

Remission from serious mental illness

(e) Making an accurate diagnosis of remission can be challenging. In the absence of strong evidence of what constitutes 'remission' from serious mental illness, clinicians should only consider using the remission codes if the patient has been in remission for at least five years, that is where there is—

(i) no record of antipsychotic medication

(ii) no mental health in-patient episodes; and

(iii) no secondary or community care mental health follow-up,

for at least five years.

(f) Where a patient is recorded as being 'in remission' they remain on the MH001 register (in case their condition relapses at a later date) but they are excluded from the denominators for mental health indicators MH002W-MH008W.

(g) The accuracy of this coding should be reviewed on an annual basis by a clinician. Should a patient who has been coded as 'in remission' experience a relapse then this should be recorded as such in their patient record.

(h) In the event that a patient experiences a relapse and is coded as such, they will once again be included in all the associated indicators for schizophrenia, bipolar affective disorder and other psychoses.

(i) Where a patient has relapsed after being recorded as being in remission, their care plan should be updated subsequent to the relapse. Care plans dated prior to the date of the relapse will not be acceptable for QOF purposes.

Cancer (CAN)

Indicator	Points	Achievement thresholds
Records		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5	
Ongoing management		
CAN002W. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 3 months of the contractor receiving confirmation of the diagnosis *NICE 2012 menu ID: NM62*	6	50–90%

Chronic kidney disease (CKD)

Indicator	Points	Achievement thresholds
Records		
CKD001. The contractor establishes and maintains a register of patients aged 18 or over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	

Ongoing management		
CKD002W. The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 15 months) is 140/85 mmHg or less	11	45-76%
CKD003W. The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with an ACE-I or ARB	9	45–80%
CKD004W. The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 15 months	6	45–80%

Epilepsy (EP)

Indicator	Points	Achievement thresholds
Records		
EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1	
Ongoing management		
EP002W. The percentage of patients aged 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 15 months	6	45–70%
EP003W. The percentage of women aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months *NICE 2010 menu ID: NM03*	3	50–90%

Learning disability (LD)

Indicator	Points	Achievement thresholds
Records		
LD001. The contractor establishes and maintains a register of patients aged 18 or over with learning disabilities	4	
Ongoing management		
LD002W. The percentage of patients on the learning disability register with Down's Syndrome aged 18 or over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register) *NICE 2010 menu ID: NM04*	3	45–70%

Osteoporosis: secondary prevention of fragility fractures

Indicator	Points	Achievement thresholds
Records		
OST001. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012 *NICE 2011 menu ID: NM29*	3	
Ongoing management		
OST002W. The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent *NICE 2011 menu ID: NM30*	3	30-60%
OST003W. The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent *NICE 2011 menu ID: NM31*	3	30-60%

Disease register in relation to Osteoporosis

(j) Although the register indicator OST001 defines two separate registers, the disease register for the purposes of calculating the Adjusted Practice Disease Factor is defined as the sum of the number of patients on both registers.

Rheumatoid arthritis (RA)

Indicator	Points	Achievement thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis *NICE 2012 menu ID: NM55*	1	
Ongoing management		
RA002W. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months *NICE 2012 menu ID: NM58*	5	40-90%

RA003W. The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 15 months *NICE 2012 menu ID: NM56*	7	40-90%
RA004W. The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 27 months *NICE 2012 menu ID: NM57*	5	40-90%

Palliative care (PC)

Indicator	Points	Achievement thresholds
Records		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	
Ongoing management		
PC002W. The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed	3	

Disease register in relations to palliative care

(k) There is no Adjusted Practice Disease Factor calculation in respect of the palliative care indicators. In the rare case of a nil register at year end, if a contractor can demonstrate that it established and maintained a register during the financial year then they will be eligible for payment for PC001.

The Public health domain

2.2.1 This Section 2.2.1 (the public health domain but does not include the additional services sub-domain which is set out in Section 2.2.2) applies to all contractors participating in QOF.

Cardiovascular disease – primary prevention (CVD-PP)

Indicator	Points	Achievement thresholds
Ongoing management		
CVD-PP001W. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the LHB) of ≥20% in the preceding 15 months: the percentage who are currently treated with statins *NICE 2011 menu ID: NM26*	10	40–90%
CVD-PP002W. The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet	5	40–75%

Disease register in relation to Cardiovascular Disease Primary Prevention

(a) The disease register for the purposes of calculating the Adjusted Practice Disease Factor for the indicators in the Cardiovascular Disease - Primary Prevention Area is defined as follows: patients diagnosed with a first episode of hypertension on or after 1 April 2009, excluding patients with the following conditions—

(i) CHD or angina;

(ii) stroke or TIA;

(iii) peripheral vascular disease;

(iv) familial hypercholesterolemia;

(v) diabetes; and

(vi) CKD (US National Kidney Foundation: Stage 3 to 5 CKD).

Blood pressure (BP)

Indicator	Points	Achievement thresholds
BP001. The percentage of patients aged 40 or over who have a record of blood pressure in the preceding 5 years *NICE 2012 menu ID: NM61*	15	50-90%

Obesity (OB)

Indicator	Points	Achievement thresholds
Records		
OB001W. The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 15 months	8	

Smoking (SMOK)

Indicator	Points	Achievement thresholds
Records		
SMOK001W. The percentage of patients aged 15 or over whose notes record smoking status in the preceding 27 months	11	50-90%
SMOK002W. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months *NICE 2011 menu ID: NM38*	25	50–90%
Ongoing management		
SMOK003W. The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy	2	
SMOK004W. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months *NICE 2011 menu ID: NM40*	12	40-90%
SMOK005W. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months	25	53-93%

NICE 2011 menu ID: NM39		

Disease register in relation to Smoking

(b) The disease register for the purposes of calculating the Adjusted Practice Disease Factor for SMOK002W and SMOK005W is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicators.

(c) Any patient who has one or more co-morbidities e.g. diabetes and coronary heart disease, is only counted once in the register for SMOK002W and SMOK005W.

(d) There is no Adjusted Practice Disease Factor calculation for SMOK001W, 003W and 004W.

Requirements for recording smoking status

Smokers

(e) For patients who smoke this recording should be made in the preceding 27 months for SMOK001W or in the preceding 15 months for SMOK002W.

Non-smokers

(f) It is recognised that lifelong non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 27 months (for SMOK001W) or in the preceding 15 months (for SMOK002W) until the end of the financial year in which the patient attains the age of 25.

(g) Once a patient is over the age of 25 years (i.e. in the financial year in which they attain the age of 26 or in any year following that financial year) to be classified as a non-smoker they require—

(i) SMOK001W, a recording of never smoked **after** their 25th birthday;

(ii) for SMOK002W, a recording of never smoked which is **both after** their 25th birthday **and after** the earliest diagnosis date of a disease which has led to their inclusion in the SMOK002W register (i.e. the register of patients on the disease registers for each of the conditions listed in SMOK002W).

Ex-smokers

(h) There are two ways in which a patient can be recorded as an ex-smoker—

(i) ex-smokers can be recorded as such in the preceding 27 months (for SMOK001W) or in the preceding 15 months (for SMOK002W); or

(ii) practices may choose to record ex-smoking status on an annual basis for three consecutive financial years, and after that smoking status need only be recorded if there is a change. This is in recognition of the fact it is recognised that once a patient has been an ex-smoker for more than three years they are unlikely to restart.

The Public health domain: additional services sub-domain

2.2.2 This sub-section 2.2.2 (the public health domain additional services sub-domain) applies to contractors who provide additional services under the terms of their GMS contract and participate in QOF.

Cervical screening (CS)

Indicator	Points	Achievement thresholds
CS001W. The contractor has a protocol that is in line with national guidance agreed with the LHB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates	7	
CS002W. The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years	11	45-80%
CS003W. The contractor ensures there is a system for informing all women of the results of cervical screening tests.	2	
CS004W. The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate screening tests in relation to individual sample-takers at least every 2 years	2	

Child health surveillance (CHS)

Indicator	Points	Achievement thresholds
CHS001W. Child development checks are offered at intervals that are consistent with national guidelines and policy agreed with the LHB	6	

Maternity services (MAT)

Indicator	Points	Achievement thresholds
MAT001W. Antenatal care and screening are offered according to current local guidelines agreed with the LHB	6	

Contraception (CON)

Indicator	Points	Achievement thresholds
CON001W. The contractor establishes and maintains a register of women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS	4	

CON002W. The percentage of women, on the register, prescribed an oral or patch contraceptive method in the preceding 15 months who have also received information from the contractor about long acting reversible methods of contraception in the preceding 15 months	3	50-90%
CON003W. The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception at the time of or within 1 month of the prescription	3	50-90%

The Organisational Domain

Section 2.3. applies to all contractors participating in QOF.

Records and information

Indicator	Points
REC001W. The contractor has a system for transferring and acting on information about patients seen by other doctors out of hours	1
REC002W. There is a system to alert the out of hours service or duty doctor to patients dying at home	2

Education and training

Indicator	Points
EDU001W. The contractor conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team	3
EDU002W. The contractor has undertaken a minimum of 12 significant event reviews in the preceding 3 years which could include: • Any death occurring on the practice premises • New cancer diagnoses • Deaths where terminal care has taken place at home • Any suicides • Admissions under the Mental Health Act • Child protection cases • Medication errors • A significant event occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss)	4
EDU003W. The contractor has undertaken a minimum of 3 significant event reviews within the preceding year	6

Practice management

Indicator	Points
MAN001W. Individual healthcare professionals have access to information on local procedures relating to Child Protection	1
MAN002W. The contractor offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments 5 mornings and 4 afternoons per week, except where	3

agreed with the LHB	
MAN003W. The contractor has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment	3

Medicines management

Indicator	Points
MED001W. The contractor possesses the equipment and in-date emergency drugs to treat anaphylaxis	2
MED002W. There is a system for checking the expiry dates of emergency drugs on at least an annual basis	2
MED003W. The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)	2
MED004W. The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)	6
MED005W. The contractor meets the LHB prescribing advisor at least annually and agrees up to three actions related to prescribing	4
MED006W. The contractor meets the LHB prescribing advisor at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change	10
MED007W. A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines Standard 80%	7
MED008W. A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines Standard 80%	8

The quality and productivity (QP) domain

2.4 This Section 2.4 (the quality and productivity domain) applies to all contractors participating in QOF.

Indicator	Points
QP001W. The contractor meets internally to review the data on secondary care outpatient referrals provided by the LHB.	5
QP002W. The contractor participates in an external peer review to compare its secondary care outpatient referral data with an agreed group of contractors in the LHB area, for the purpose of working with the LHB to identify service design and delivery improvements.	5
QP003W. The contractor engages with the development of and follows 3 agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) for improving the management of patients in the primary care setting to avoid inappropriate outpatient referrals and produces a report of the action taken to the LHB no later than 31 March 2014	11
QP004W. The contractor meets internally to review data on emergency admissions provided by the LHB.	5
QP005W. The contractor participates in an external peer review to compare its data on emergency admissions with an agreed group of contractors in the LHB area, for the purpose of working with the LHB to identify service design and delivery.	15
QP006W. The contractor engages with the development of and follows 3 agreed care pathways (unless in individual cases they justify clinical reasons for not doing this), in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the LHB no later than 31 March 2014.	27.5
QP100W The practice produces a list of 5% of patients in the practice who are predicted to be at significant risk of unscheduled care admission or community based alternatives	10
QP101W The practice identifies a minimum of 10% (with a maximum of 0.5% of the practice list) of those patients from the list produced in indicator QP100W who would most benefit from review and ensures there is an active management plan (see template attached) is in place for each patient. The active management plan must include an appropriate review date. The frequency of each patient's review should be determined in light of their clinical and care needs. The practice will be responsible for ensuring that an appropriate system is in place for monitoring and review of the patients identified.	10
QP102W The practice has at least four meetings during the year to review the needs of the patients identified as a result of developing the active	22.5

management plans, to identify opportunities for more effective systems of care and related changes in patient management. These meetings should be open to multi-disciplinary professionals who support the practice's patients.	
QP103W The practice reports annually to the Health Board on system changes that may benefit patients.	5

Requirements as to the composition of external review groups for indicators for QP002W and QP005W

The contractor will identify and agree with the LHB a group of contractors in the LHB area, with which it will carry out the external review. The group should contain a minimum of six practices unless the LHB agrees otherwise.

The patient experience (PE) domain

2.5 This Section 2.5 (the patient experience domain) applies to all contractors participating in QOF.

Indicator	Points
PE001 (Length of consultations) The contractor ensures that the length of routine booked appointments with doctors in the surgery is not less than 10 minutes. If the contractor routinely admits extra patients during booked surgeries, then the average booked consultation length should allow for the average number of extra patients seen in a surgery session such that the length of booked appointment is not less than 10 minutes. If the extra patients are seen at the end of surgery, then it is not necessary to make this adjustment. For contractors with only an open surgery system, the average face-to-face time spent by the GP with the patient is not less than 8 minutes. Contractors that routinely operate a mixed economy of booked and open surgeries should ensure that the length of booked appointments is not less than 10 minutes and the length of open surgery appointments is not less than 8 minutes.	33

ANNEX E

CALCULATION OF THE ADDITIONAL SERVICES SUB-DOMAIN OF THE PUBLIC HEALTH DOMAIN ACHIEVEMENT POINTS

CALCULATION OF THE SUB-DOMAIN ADDITIONAL SERVICES

Achievement points

E.1 The additional services indicators do not apply to all of the contractor's registered population. Assessment of achievement is carried out in relation to particular target populations. The relevant target populations are—

Additional services	*Target Population*
Cervical screening services	females who have attained the age of 25 years but not yet attained the age of 65 years
Child health surveillance	children who have attained the age of 4 years or are under that age
Maternity medical services	females who have not attained the age of 55 years
Contraceptive services	females who have not attained the age of 55 years

E.2. For example, to meet the requirements of the child health surveillance indicator, child health development checks will only need to be offered to the practice's registered population of children who have attained the age of 4 years or are under that age.

E.3. For each of the additional services mentioned in paragraph E.1, a Target Population Factor is to be calculated as follows—

(a) first the number of patients registered with the contractor in the relevant target population at the relevant date (A) is to be divided by the contractor's CRP at the relevant date (B);

(b) then the average number of patients registered with all contractors in Wales in the relevant target population at the relevant date (C) is to be divided by the average CRP for Wales (according to the Exeter Registration System) at the relevant date (D); and

(c) the number produced by the calculation in paragraph (a) is then to be divided by the number produced by the calculation in paragraph (b) to produce the Target Population Factor for the additional service in question.

E4. For the purposes of paragraph E.3, the "relevant date" is the date in respect of which the value of the contractors CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the financial year to which the Achievement Payment relates, but see paragraph 6.9.

E.5. The Target Population Factor for the additional service is to be multiplied by £153.14 and by the Achievement Points obtained in respect of the additional service (E) to produce the cash total in respect of the additional service (F).

E.6. This calculation could be expressed as –

$$\frac{(A \div B)}{(C \div D)} \times £153.14 \times E = F$$

E.7. If the contractor has not been under an obligation to provide an additional service for any period during the financial year to which the Achievement Payment relates, the adjusted total for that particular additional service is to be further adjusted by the fraction produced by dividing—

the number of days in the financial year during which its GMS contract had effect and the contractor was under no obligation to provide the additional service; by

the number of days in the financial year during which the contract had effect.

E.8 The resulting cash amounts, in respect of each additional service, are then to be added together for the total amount in respect of the additional services domain.

ANNEX F

ADJUSTED PRACTICE DISEASE FACTOR CALCULATIONS

ADJUSTED PRACTICE DISEASE FACTOR

Calculations

F.1 The calculation involves three steps—

(a) the calculation of the contractor's Raw Practice Disease Prevalence. There will be a Raw Practice Disease Prevalence in respect of each indicator in the clinical and public health domains (other than the additional services sub-domain where achievement is calculated in accordance with Annex E and the indicators in the palliative care area and indicators BP001, SMOK001W, 003 and 004W);

(b) making an adjustment to give an Adjusted Practice Disease Factor; and

(c) applying the factor to the pounds per point figure for each disease area (other than the area relating to palliative care).

F.2 The above three steps are explained below. The register to be used to calculate the Raw Practice Disease Prevalence is usually the register as defined in the first indicator for the indicator area concerned ("the register indicator") in the summary of indicators set out in Section 2 of Annex D, except in a case where there is no register indicator or where the register to be used is not the register indicator to be used to calculate the Raw Practice Disease Prevalence. In the case

where there is no register indicator or the register indicator is not the register to be used in respect of a specific disease area or indicator, the applicable register in respect of that specific disease area or indicator is specified in the relevant part of Section 2 relating to that disease.

F.3 The Raw Practice Disease Prevalence is calculated by dividing the number of patients on the relevant disease register at 31st March in the financial year to which the Achievement Payment relates by the contractor's CRP for the relevant date. For these purposes, the "relevant date" is the date in respect of which the value of the contractor's CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the financial year to which the Achievement Payment relates, but see paragraph 6.9 (calculation of Achievement Payments).

F.4.1 The Adjusted Practice Disease Factor is calculated by—

(a) calculating the national range of Raw Practice Disease Prevalence's in Wales (the LHB must use the national range established annually through the CMWeb System);

(b) re-basing the contractor figures around the new national Welsh mean (available at the end of each month) to give the Adjusted Practice Disease Factor (APDF). For example, an APDF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The re-basing ensures that in the relevant year, the average contractor (that is a contractor with an APDF of 1.00) would receive, after adjustment, an amount per point equal to the amount specified in paragraph 6.8 of this SFE as in force on the 1st April in that relevant year;

(c) thus, adjusting via the factor the contractor's average pounds per point for each disease, rather than the contractor's points score. For example, a contractor with an APDF of 1.2 for CHD in the period commencing on 1st April 2013 and ending on 31st March 2014 would receive £183.77 per point scored on the CHD indicators.

F.4.2 "Relevant year" in paragraph F.4.1(b) means the financial year to which the calculation of Achievement Payments relates.

F.5 As a result of the calculation in F.1, each contractor will have a different "pounds per point" figure for each indicator area with a disease register (other than the area relating to palliative care), or may have a different "pounds per point" for individual indicators within an area (if more than one register is used for the area). It will then be possible to use these figures to calculate a cash total in relation to the points scored for each area (other than the area relating to palliative care, smoking indicators 001W, 003 and 004W or BP001).

F.6 This national prevalence figure and range of practice prevalence will be calculated on an Wales-only basis.

F.7 If the contractor's GMS contract terminates before 1st January in the financial year to which the Achievement Payment relates, the Adjusted Practice Disease Factor to be used in calculating the contractor's Achievement Payment should be the Adjusted Practice Disease Factor calculated for the contractor for the previous financial year.

F.8 If the contractor did not have an Adjusted Practice Disease Factor calculation for the previous financial year, then no Adjusted Practice Disease Factor should be used in calculating the contractor's Achievement Payment for that year.

F.9 Unless paragraph F.10 applies, if the contractor's GMS contract terminates on or after 1st January and before the end of the financial year to which the Achievement Payment relates—

(a) the CRP to be used to calculate the Raw Practice Disease Prevalence is the CRP on 1st January; and

(b) the number of patients on the disease register is to be taken to be the number of patients on the register on the date nearest to the date on which the contract ends and on which there can be a calculation.

F.10 If the contractor's GMS contract commences after 1st January and terminates before the end of the financial year in which the GMS contract commences, no Adjusted Practice Disease

Factor is to be calculated for the contractor's Achievement Payment in respect of the period during which the contract subsisted.

ANNEX G
DISPENSING PAYMENTS

PART 1
DISCOUNT SCALE

Total basic price per month of the prescriptions submitted by the contractor - £ bandwidth	*New discount rate (%)*
1-2000	3.17
2001 – 4000	5.93
4001 – 6000	7.21
6001 – 8000	8.06
8001 – 10 000	8.68
10 001 – 12 000	9.19
12 001 – 14 000	9.60
14 001 – 16 000	9.97
16 001 – 18 000	10.29
18 001 – 20 000	10.57
20 001 – 22 000	10.82
22 001 – 24 000	11.03
24 001 and above	11.18

PART 2
DISPENSING FEESCALE FOR CONTRACTORS THAT ARE AUTHORISED OR REQUIRED TO PROVIDE DISPENSING SERVICES

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	*Prices per prescription in pence*
Up to 438	220.5
439 – 547	217.3
548 – 657	214.5
658 – 766	211.7
767 – 876	209.2
877 – 985	207.0
986 – 1368	204.8
1369 – 1915	202.9
1916 – 2189	201.1
2190 – 2736	199.5
2737 – 3283	198.2
3284 – 3830	197.0
3831 – 4377	196.0
4378 and over	195.2

PART 3

DISPENSING FEESCALE FOR CONTRACTORS THAT ARE NOT AUTHORISED OR REQUIRED TO PROVIDE DISPENSING SERVICES

Total prescriptions calculated separately for each individual practitioner, in bands	*Prices per prescription in pence*
Up to 438	229.7
439 – 547	226.6
548 – 657	223.7
658 – 766	221.0
767 – 876	218.6
877 – 985	216.3
986 – 1368	214.1
1369 – 1915	212.2
1916 – 2189	210.4
2190 – 2736	208.8
2737 – 3283	207.4
3284 – 3830	206.3
3831 – 4377	205.2
4378 and over	204.5

ANNEX H

DISPENSARY SERVICES QUALITY SCHEME

Governance of dispensary services

SOPs, clinical audit and risk management

H.1.1 The contractor must ensure that Standard Operating Procedures (SOPs) are in place and reflect both good professional practice, as well as the procedures that are actually performed by the practice. SOPs should be followed routinely for all dispensing related activities SOPs should be specific to the practice and should set out in writing what should be done, where, where and by whom.

H.1.2 Standard Operating Procedures must be reviewed and updated at least once every 12 months and whenever dispensing procedures are amended. A written audit trail of amendments should be maintained.

H.1.3 The contractor must participate in contractor lead clinical audit of dispensing services. Clinical audit seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and the implementation of change. Audit of dispensing services should include arrangements to assess the nature and quality of the advice provided to patients as part of the dispensing service.

H.1.4 The contractor must have a written policy for managing risks in providing dispensing services and must ensure that this policy is understood, and put into practice, by all staff involved in dispensing.

H.1.5 The contractor must ensure that all serious untoward incidents relating to dispensing are reported to the LHB for the purpose of reviewing and learning from incidents.

Information

H.2.1 The contractor must provide information to their patients on—

(a) the dispensing services provided by the contractor; and

(b) how to obtain medicines urgently.

H.2.2 The contractor must inform their LHB (who will inform NHS Direct as for pharmacies) of the hours of availability of dispensing services provided by the contractor. The contractor must ensure that opening times are displayed prominently on the premises from which they carry out dispensing and that they are legible from outside the premises when they are shut.

Dispensing Staff

H.3.1 The training and experience required in respect of dispensing staff is as follows.

H.3.2 The Standard Operating Procedures for each dispensary must indicate the level of competency expected for each function performed by dispensers or staff working as dispensary assistants.

H.3.3 For staff employed by the contractor who are not doctors and whose normal working patterns do not involve dispensing but who are involved in dispensing on an occasional or limited basis, a flexible approach to the minimum competence requirement for dispensing assistants can be adopted. The contractor must identify such staff to the LHB, which should agree that the staff member concerned only has an occasional or limited role in dispensing. However, the contractor also needs to demonstrates that all staff who are working in the dispensary have evidence that they have the knowledge and competencies to perform the tasks and roles assigned to them, and staff who only have an occasional or limited role in dispensing are still required to have a certificate of competency signed by the practice manager (if any) and accountable GP in respect of the roles they occasionally undertake.

H.3.4 The contractor must have a written record of the qualifications of all staff engaged in dispensing and ensure that staff engaged in dispensing undertake continuing professional development. The contractor must carry out and complete a written record of an appraisal of all dispensing staff, and assess their competence in performing dispensary tasks at least annually.

H.3.5 Regarding existing staff employed by the practice on the date of the practice's first written undertaking to provide the service trainee dispensers—;

(a) must be competent in the area in which they are working to a minimum standard equivalent to the Pharmacy Services Scottish/National Vocational Qualification (S/NVQ) level 2, or undertaking training towards this, or enrol in this training within three months of the practice's written undertaking towards this; and

(b) must not work unsupervised until they have completed 1,000 hours work experience in the dispensary and have a certificate of competency signed by the practice manager (if any) and accountable GP. (A trained dispenser should supervise dispensing assistants until they have completed the work experience).

H.3.6 Other existing dispensing staff that work independently in the practice dispensary—

(a) must have minimum work experience of 1,000 hours over the past five years in a GP dispensary or community pharmacy; and

(b) must be competent in the area in which they are working to a minimum standard equivalent to the Pharmacy Services S/NVQ level 2, or undertaking training towards this, or enrol in this training within three months of the practice's written undertaking to provide the service.

H.3.7 However where an experienced dispenser's residual term of employment is not commensurate with the timeframe requirement of the specified course, the dispenser must have their knowledge and competence assessed and hold a certificate of competency signed by the practice manager (if any) and the accountable GP.

H.3.8 New dispensing staff employed by the practice after the date of the practice's first written undertaking to provide the service:

(a) must be competent in the area which they are working, to a minimum standard equivalent to the Pharmacy Services S/NVQ level 2 qualification or enrol in training towards this within three months of the commencement of their employment; and

(b) must have completed 1,000 hours of work experience in a GP dispensary or community pharmacy within the past five years before being able to work unsupervised. (A trained dispensing staff member should supervise new staff until they have completed the work experience).

H.3.9 Where a dispenser is expected to enrol on a course, the relevant qualification should be completed within three years, although the LHB has discretion to allow for additional time in the case of absence due, for example, to sickness or maternity leave.

Minimum level of staff hours

H.4.1 The contractor must ensure that a minimum level of staff hours is dedicated to dispensary services to ensure that patients' needs for dispensing services, and the time required to complete the underpinning systems and processes, can reasonably be expected to safeguard patient safety.

H.4.2 The contractor must assure a level of staffing that reflects that practice's dispensary's configuration and hours of opening, as agreed with the LHB.

Duty of confidentiality

H.5 All employee contracts for dispensing staff must include a duty of patient confidentiality as a specific requirement, with disciplinary procedures set out for non-compliance.

Review with patients of compliance and concordance with use of medicines

H.6.1 A face-to-face review with patients (and, where appropriate, their carers) of compliance and concordance shall be carried out and recorded in the patient's medical record at least once in each financial year for at least 10% of the contractor's dispensing patients. Where the contractor is entitled to less than a full year's Dispensary Services Quality Payment in any financial year the figure of 10% shall be reduced by an appropriate percentage. The practice should agree with the LHB the types of patients that should be targeted for the review as part of their undertaking to carry out the services specified.

H.6.2 The review should normally be carried out by trained dispensing staff or by a registered health professional with appropriate competencies in review of medicines.

H.6.3 Arrangements must be in place to ensure that patients reviewed will be referred appropriately and in a timely manner to a doctor, nurse, pharmacist or other appropriate health professional working with the contractor, whenever clinically appropriate.

H.6.4 The reviewer should—

(a) establish the patient's actual use, understanding and experience of taking medicines: referring potential side effects or adverse effects reported by patients;

(b) identify discuss and resolve or refer poor or ineffective use of their medicines;

(c) improve the clinical and cost effectiveness of prescribed medicines, referring where appropriate, and initiating appropriate action by using information from patients to recommend improvements in repeat dispensing and so reduce medicine wastage.

Annex I

Routine childhood vaccines and immunisations

The Routine Childhood Immunisation Programme

Background

I.1 Guidance and information on routine childhood vaccines and immunisations are set out in "Immunisation against infectious diseases – The Green Book which is published by the Department of Health.

Routine Childhood Immunisation Schedule

I.2 All children starting the immunisation programme at 2 months of age will follow the schedule (often referred to as the "Childhood Immunisation Schedule") below as set out in the Table.

I.3 The latest information and guidance on vaccines and vaccine procedures for all the vaccines referred to in the Table, including completing the schedule of vaccines in the case of children with interrupted, incomplete or unknown immunisation status or in relation to premature infants is contained in the "Immunisations against infectious diseases – The Green Book".

Table

When to immunise	What vaccine is given	How it is given
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (DTaP/IPV/Hib)	One injection
	Pneumococcal (PCV)	One injection
(from July 2013)	Rotavirus (Rota)	One oral dose
Three months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (DTaP/IPV/Hib)	One injection
	Meningitis C (MenC)	One injection
(from July 2013)	Rotavirus (Rota)	One oral dose
Four months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (DTaP/IPV/Hib)	One injection
	Pneumococcal (PCV)	One injection
(until end May 2013 only)	Meningitis C (MenC)	One injection
Around 12 months	*Haemophilus influenzae* type b, Meningitis C (Hib/MenC)	One injection
Around 13 months	Measles, mumps and rubella (MMR)	One injection
	Pneumococcal (PCV)	One injection
Three years four months to five years old	Diphtheria, tetanus, pertussis (whooping cough) and polio (dTaP/IPV or DTaP/IPV)	One injection
	Measles, mumps and rubella (MMR)	One injection

Thirteen to 14 years old	Meningitis C (MenC)	One injection
(planned from September 2013)		
Thirteen to 18 years old	Tetanus, diphtheria and polio (Td/IPV)	One injection

Annex J

Amendments to the Statement of Financial Entitlements which came into force on 30 April 2005

(a) The Statement of Financial Entitlements (Amendment) (No.2) (Wales) Directions 2005 which were made on 21 July 2005;

(b) The Statement of Financial Entitlements (Amendment) (Wales) Directions 2006 (2006 No.3), which came into force on 1 February 2006;

(c) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2006 (2006 No. 20), which came into force on 1 April 2006;

(d) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.2) Directions 2006 (2006 No.76), which came into force on 16 November 2006;

(e) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.3) Directions 2006 (2006 No.93), which came into force on 20 December 2006;

(f) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2007(2007 No. 16), which came into force on 1 April 2007;

(g) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2008 (2008 No. 10), which came into force on 28 February 2008;

(h) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.2) Directions 2008 (2008 No.28), which came into force on 1 October 2008;

(i) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.3) Directions 2008 (2008 No. 45), which came into force on 7 November 2008;

(j) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2009 (2009 No. 13), which came into force on 1 April 2009;

(k) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.2) and Specification of National Minimum Percentage Uplift Directions 2009 (2009 No. 24), which came into force on 30 June 2009;

(l) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.3) Directions 2009 (2009 No. 32), which came into force on 1 October 2009;

(m) The Primary Medical Services (Directed Enhanced Services – Pandemic Influenza (H1N1) Vaccination Scheme and Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2009 (2009 No. 38), which came into force on 30 October 2009;

(n) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2010 (2010 No. 11), which came into force on 1 April 2010;

(o) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) and Specification of National Minimum Percentage Uplift Directions 2010 (2010 No. 32), which partly came into force on 28 July 2010 with the rest coming into force on 1 April 2010;

(p) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2010 (2010 No. 42), which came into force on 1 October 2010; and

(q) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2011, which came into force at 11.10am on 1 April 2011.

(r) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2011, which came into force on 6 May 2011.

(s) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2012, which came into force on 1 April 2012.

(t) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2012, which came into force on 1 October 2012.