
SUBORDINATE LEGISLATION

WG22-15

**THE NATIONAL HEALTH SERVICE (WALES) ACT
2006**

**Directions to Local Health Boards as to the Statement of
Financial Entitlements (Amendment) Directions 2022**

Made 29 March 2022

Coming into force 30 March 2022

The Welsh Ministers, in exercise of the powers conferred on them by sections 12(3), 45, 203(9) and (10) and 204(1) of the National Health Service (Wales) Act 2006^(a) and after consulting in accordance with section 45(4) of that Act with the bodies appearing to them to be representative of persons to whose remuneration these Directions relate, give the following Directions.

Title, application and commencement

1.—(1) The title of these Directions is the Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2022.

(2) These Directions are given to Local Health Boards. They relate to the payments to be made by Local Health Boards to a GMS contractor under a GMS contract.

(3) These Directions—

- (a) are made on 29 March 2022,
- (b) come into force on 30 March 2022, and
- (c) have effect from—
 - (i) 1 April 2021 for the purposes of direction 2(4)(a)(ii),
 - (ii) 1 October 2021 for the purposes of direction 2(4)(a)(i), (b) and (c), and
 - (iii) 30 March 2022 for all other purposes.

Amendment to the Statement of Financial Entitlements

2.—(1) The Directions to Local Health Boards as to the Statement of Financial Entitlements Directions 2013^(b) which came into force on 11 June 2013, as amended by the Directions listed in Annex J to those Directions, are further amended as follows.

(2) For the Table of Contents substitute the Table of Contents at Schedule 1.

(3) In **PART 1 – GLOBAL SUM AND MINIMUM PRACTICE INCOME GUARANTEE**—

(a) 2006 c.42.
(b) 2013 No. 8.

- (a) in the heading to PART 1 for “**MINIMUM PRACTICE INCOME GUARANTEE**” substitute “**PRACTICE SUPPORT MONTHLY PAYMENTS**”,
- (b) in *Section 2: GLOBAL SUM PAYMENTS* for paragraphs 2.17 and 2.18 substitute—

2.17. Beginning with 1 October 2021, the value of a QAIF point for QA, QI and the GP Collaborative must be recalculated each year after the NARP has been established and applies to the current QAIF (QA, QI and GP Collaborative) year for QA, QI and the GP Collaborative, subject to any uplift that may or may not be applied.

2.18. The revised QAIF point value is to be calculated by multiplying the previous QAIF point value by the fraction produced by dividing the newly established NARP that applies for the forthcoming QAIF (QA, QI and GP Collaborative) year by the NARP that applied to the previous QAIF (QA, QI and GP Collaborative) year. The calculation is expressed as—

Revised QAIF point value for the following QAIF (QA and QI) year =

$$\text{Previous QAIF point value} \times \frac{\text{Newly established NARP for the forthcoming QAIF (QA, QI and GP Collaborative) year}}{\text{NARP for the previous QAIF (QA, QI and GP Collaborative) year}}$$

”, and

- (c) for *Section 3: MINIMUM PRACTICE INCOME GUARANTEE* substitute—

“Section 3: PRACTICE SUPPORT PAYMENTS

Practice Support Monthly Payments

3.1. At 1 April 2015 LHBS were required to calculate contractors eligibility to receive practice support payments in accordance with the provisions of paragraphs 3.30–3.34 of the Directions to Local Health Boards as to the Statement of Financial Entitlements that were in force on that date. Where a contractor is entitled to a Practice Support Monthly Payment (“PSMP”), that contractor continue to receive payments, as calculated in accordance with paragraph 3.33 of the SFE in force on 1 April 2015, with any payment falling due on the last day of each month.

Practice mergers or splits and Practice Support Monthly Payments

3.2. A contractor with a GMS contract which takes effect, or is treated as taking effect for payment purposes, beginning with 1 April 2015 is not entitled to PSMPs, unless paragraphs 3.3 to 3.7 apply.

3.3. If—

- (a) a new contractor comes into existence as a result of a merger between one or more contractors, and
- (b) that merger led to the termination of GMS contracts and the agreement of a new GMS contract,

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

3.4. 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 PSMP 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 are to be registered with the new contractor when its new contract takes effect.

3.5. However, where a contractor that is a company limited by shares becomes entitled to PSMPs 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 PSMPs, 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.

3.6. If—

- (a) a new GMS contract is agreed by a contractor which has split from a previously established contractor, and
- (b) the split did not lead to the termination of the previously established contractor’s GMS contract,

the new contractor is not entitled to any of the previously established contractor’s PSMP 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 and in which case the PSMP is calculated in accordance with paragraph 3.7.

3.7. 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 PSMP 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 PSMP 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 PSMP is to be reduced accordingly.

Conditions attached to payment of Practice Support Monthly Payments

3.8. PSMPs, 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 have, but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor’s PSMP; and
- (b) all information supplied pursuant to, or in accordance with, this paragraph must be accurate.

3.9. If the contractor breaches any of the conditions relating to PSMP, the LHB may, in appropriate circumstances, withhold payment of a PSMP, or any part thereof, that is otherwise payable.”.

(4) In **PART 2 – QUALITY ASSURANCE AND IMPROVEMENT FRAMEWORK,**

- (a) in **Section 4: GENERAL PROVISIONS**—
 - (i) for paragraphs 4.1 to 4.34 substitute—

4.1. The Quality Assurance and Improvement Framework (QAIF) is set out in Annex D to this SFE.

4.2. Participation in the QAIF 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.

4.3. This Section explains the types of payments available to those contractors who participate in the QAIF and sets out the mechanism for measuring Achievement Payments in respect of the Quality Assurance (“QA”), Quality Improvement (“QI”) Access and GP Collaborative domains.

4.4. The annual cycle for QA, QI and GP Collaborative will run from 1 October to 30 September of each year and the annual cycle for Access will run from 1 April to 31 March – see paragraphs 4.6 to 4.36.

The four principal domains of the QAIF

4.5. The QAIF is divided into four principal domains, which are—

- (a) the Quality Assurance (“QA”) Domain comprising of two sub-domains—
 - (i) Active Clinical Indicators, and
 - (ii) Practice Quality Assurance;
- (b) the Quality Improvement (“QI”) Domain^(a);
- (c) the Access Domain^(b); and
- (d) the GP Collaborative Domain.

Types of payments in relation to the QAIF

4.6. There are two types of payments that are made in relation to the QA, QI and GP Collaborative domains of QAIF—

- (a) Aspiration Payments (see section 5), and
- (b) Achievement Payments (see section 6).

4.7. Aspiration payments are not made in relation to the Access Domain. The only payments are Achievement Payments.

Aspiration Payments – QAIF (QA, QI and GP Collaborative) year 1 October 2021 to 30 September 2022

4.8. The LHB must pay Aspiration Payments for the QAIF (QA, QI and GP Collaborative) year beginning with 1 October 2021 and ending with 30 September 2022 to GMS contractors at the rate the GMS contractor received for the QAIF (QA, QI and GP Collaborative) year 1 October 2020 to 30 September 2021, divided into 12 instalments and paid on a monthly basis.

Aspiration Payments – QA, QI and GP Collaborative elements of QAIF years from 1 October 2022

4.9. Aspiration payments are an estimated payment made in advance of Achievement Payments being calculated under the QA, QI and GP Collaborative domains of the QAIF.

4.10. Aspiration payments may be calculated using one of two different methods—

(a) See paragraphs 4.31-34.
(b) See paragraphs 4.35-36.

- (a) a calculation based on 70% of the contractor’s previous year’s Unadjusted Achievement Payment (“the 70% method”) based on the Unadjusted Achievement Payment at 30 September of the previous QAIF (QA and QI) year; or
- (b) a calculation based on the total number of points that a contractor has agreed with the LHB that it is aspiring to achieve under the QAIF during the QAIF (QA, QI and GP Collaborative) year in respect of which the Aspiration payment is made (“the Aspiration Points Total method”). The total points agreed with the LHB is the contractor’s Aspiration Points Total. The number of points available for particular indicators are set out in the QAIF indicators in Annex D.

4.11. Aspiration Points Totals must be agreed between the contractor and the LHB in advance of—

- (a) 1 October of the forthcoming QAIF (QA, QI and GP Collaborative) year, or
- (b) if the contractor’s GMS contract takes effect after 1 October in any QAIF (QA, QI and GP Collaborative) year, no later than the date on which the contractor’s GMS contract takes effect.

Achievement Payments – QA, QI and GP Collaborative

4.12. Achievement Payments are payments based on the points total that the contractor actually achieves under the QAIF (QA, QI and GP Collaborative) as calculated—

- (a) on the 30 September(a) each year, or
- (b) the date on which its contract terminates(b),

and this points total will be the contractor’s achievement points total.

4.13. Achievement Payments will 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 for the period 1 October to 30 September of the same QAIF year.

Calculation of points in respect of the domains

4.14. Each domain contains areas for which there are a number of indicators which are set out in 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 paragraphs 4.15 to 4.24.

Calculation common to all domains

4.15. Some of the indicators simply require particular tasks to be accomplished 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 completely. What is required to accomplish these tasks and the evidence the LHB may request is set out in Parts 2 and 4 of Annex D(c).

(a) Subject to paragraph 6.2.

(b) See paragraph 6.4.

(c) See also the QAIF guidance at:
<http://www.wales.nhs.uk/sites3/Documents/480/Guidance%20for%20GMS%20Contract%20Wales%20-%20Quality%20and%20Improvement%20Framework%202019-20.pdf>

Calculations in respect of the Active Clinical Sub-domain

4.16. Some indicators have designated achievement thresholds^(a). The contractor's performance against the standards set out in these indicators is assessed by a percentage (referred to as "Fraction" indicators). 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.

4.17. Firstly calculate the percentage the contractor actually scores (E) by dividing—

- (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 (C). The calculation can be expressed as—

$$\frac{A}{(B-C)} = D$$

4.18. For the purposes of paragraph 4.17 "excepted patients" means patients who fall within the criteria for exception reporting as set out in Annex D, Part 1, paragraphs D.25 – D.32.

4.19. The fraction derived from the calculation in paragraph 4.17 (D) is then multiplied by 100 for the percentage score (E). The calculation can be expressed as—

$$D \times 100 = E$$

4.20. 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.

4.21. 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.

4.22. Once the percentage the contractor actually scores has been calculated (E), subtract from this the minimum percentage score set for that indicator (F), then divide the result by the difference between the maximum (G) and minimum (F) 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 (H).

4.23. The result is the number of points to which the contractor is entitled in relation to that indicator (I). The calculation can be expressed as—

$$\frac{(E - F)}{(G - F)} \times H = I$$

4.24. If a contractor has achieved a percentage score in relation to a particular indicator that is the maximum set for that indicator, or is above that maximum, it achieves the full number of points in relation to that indicator.

(a) See Annex D, Section 2 – Clinical Sub-Domain Active Registers and Indicators.

General Provisions relating to the QA Practice Quality Assurance sub-domain

4.25. There are 80 points available in the QA Practice Quality Assurance sub-domain, with the focus on Demand and Capacity. This is to be evidenced in the Cluster IMTP, which attracts 40 points, and by evidencing operation of an effective system of clinical governance, which attracts 40 points. The detail can be found at Part 3 of Annex D.

General Provisions relating to the GP Collaborative Domain

4.26. The GP Collaborative indicators can be found at Part 6 of Annex D. Within the GP Collaborative domain, 100 points are available with the focus on outputs of improved patient care and better systems to support the workforce to respond to need and to deliver care most effectively. Achievement payments for the GP Collaborative domain will be calculated in accordance with section 6, paragraphs 6.11-18.

General Provisions relating to the Quality Improvement Domain

4.27. The QI domain is based on a number of quality improvement projects. The detail can be found at Part 4 of Annex D. The projects available during the QAIF (QA, QI and GP Collaborative) 2021/22 year are—

- (a) Data and Patient Safety QI mandatory projects,
 - (b) Legacy 2020-21 QI project, and
 - (c) Practice Choice QI project or a cluster freestyle mini project and the Green Inhaler mini project.”;
- (ii) for paragraphs 4.35 and 4.36 substitute—

“General Provisions relating to the Access Domain

4.28. There are two groups of access standards within the Access Domain. Group 1 contains five standards and Group 2 contains two standards. Contractors will be paid annually for the standards completed during a QAIF (Access) year subject to evidencing that they have complied with the relevant access standards for at least one calendar month prior to the end of the financial year for which payment is being claimed. Contractors are expected to achieve standards 1, and 3 to 7, by 31 March 2022 and are required to provide a report to the LHB on their achievement progress at the end of each quarter. The standards can be found at Part 5 of Annex D.

4.29. Practices will not be assessed on their achievement of Standard 2 with achievement assumed and counting towards Group 1 payments (with a minimum of 3 in order for payment to be made). However, similar to the approach taken with call abandonment, ongoing reporting against this measure will be required to inform LHB understanding of system pressures.

4.30. Achievement Payments will be calculated in accordance with paragraphs 6.9 and 6.10.”;

- (b) in **Section 5: ASPIRATION PAYMENTS: CALCULATION, PAYMENT ARRANGEMENTS AND CONDITIONS OF PAYMENTS** for paragraphs 5.1 to 5.19 substitute—

“Aspiration Payments – QA and QI for QAIF (QA, QI and GP Collaborative) year 1 October 2021 to 30 September 2022

5.1. The LHB must pay Aspiration Payments for the QAIF (QA, QI and GP Collaborative) year beginning with 1 October 2021 and ending with 30 September 2022 to GMS contractors at the rate the GMS contractor received for the QAIF (QA and QI) year 1 October 2020 to 30 September 2021, divided into 12 instalments and paid on a monthly basis.

Calculation of Monthly Aspiration Payments QA, QI and GP Collaborative each QAIF year commencing 1 October 2022: General

5.2. On 1 October each year (or if a GMS contract starts after the 1 October, the date on which the GMS contract takes effect) subject to paragraph 5.3(b), the LHB must calculate, for each contractor that has agreed to participate in the QAIF (QA, QI and GP Collaborative), the amount of the contractor’s Monthly Aspiration Payments for that, or for the rest of that, QAIF (QA, QI and GP Collaborative) year.

5.3. As indicated in paragraph 4.10 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 a contractor using the Aspiration Points Total method, that is the method which must be used, and
- (b) if the contractor’s GMS contract is to take effect on or after 2 August but before 1st October in the same calendar year, no Aspiration Points Total is to be agreed for the QAIF (QA, QI and GP Collaborative) year into which that 2 August falls, so the contractor will not be able to claim Monthly Aspiration Payments in that QAIF (QA, QI and GP Collaborative) year. The contractor will nevertheless be entitled to Achievement Payments under the QAIF if that contractor participates in the QAIF.

Calculation of Monthly Aspiration Payments each QAIF (QA, QI and GP Collaborative) year commencing 1 October 2022: the 70% method

5.4. A contractor’s Monthly Aspiration Payments may be calculated using the 70% method, if—

- (a) the contractor’s GMS contract took effect before the 1 October of a QAIF (QA, QI and GP Collaborative) year in respect of which the claim for Monthly Aspiration Payments is made, and
- (b) in respect of the previous QAIF (QA, QI and GP Collaborative) year the contractor was entitled to an Achievement Payment under this SFE.

5.5. To calculate a contractor’s Monthly Aspiration Payments by the 70% method, the contractor’s Unadjusted Achievement Payment for the previous QAIF (QA, QI and GP Collaborative) year needs to be established (that is, the total established in accordance with Section 6 of this SFE). Generally, this will not be possible in the first quarter of the QAIF (QA, QI and GP Collaborative) 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 6.7 and 6.8 (returns in respect of Achievement Payments) of this SFE.

5.6. 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.

5.7. Once an annual amount for the contractor’s Provisional Unadjusted Achievement Payment has been determined, this is to be multiplied by the QAIF Uprating Index for the QAIF (QA, QI and GP Collaborative) year. The QAIF Uprating Index is to be determined by dividing—

- (a) the amount set out in paragraph 6.14 as the value of each Achievement Point for the QAIF (QA, QI and GP Collaborative) year in respect of which the claim for Monthly Aspiration Payments is being made, by
- (b) the amount which was previously set out in paragraph 6.14 as the value of each achievement point for the previous QAIF (QA, QI and GP Collaborative) year,

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

5.8. The total produced by paragraph 5.7 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 QAIF for the QAIF (QA, QI and GP Collaborative) year in respect of which the calculation is being made divided by the maximum number of points available under the QAIF (QA, QI and GP Collaborative) in the previous QAIF (QA, QI and GP Collaborative) year.

5.9. Once the correct amount of the contractor's Achievement Payment in respect of the previous QAIF (QA, QI and GP Collaborative) 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 QAIF (QA, QI and GP Collaborative) year using the Unadjusted Achievement Payment and Total Aspiration Payment for the QAIF (QA, QI and GP Collaborative) 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 QAIF (QA, QI and GP Collaborative) year.

5.10. If the contractor's Total Aspiration Payment for the QAIF (QA, QI and GP Collaborative) year using the Unadjusted Achievement Payment is lower than the Total Aspiration Payment for the QAIF (QA, QI and GP Collaborative) 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 QAIF (QA, QI and GP Collaborative) 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 QAIF (QA, QI and GP Collaborative) year.

5.11. If the contractor's Total Aspiration Payment for the QAIF (QA, QI and GP Collaborative) year using the Unadjusted Achievement Payment is higher than the Total Aspiration Payment for the QAIF (QA, QI and GP Collaborative) 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 QAIF (QA, QI and GP Collaborative) 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 QAIF (QA, QI and GP Collaborative) year.

Calculation of Monthly Aspiration Payments QA, QI and GP Collaborative each QAIF year commencing 1 October 2022: the Aspiration Points Total method

5.12. Any contractor who is participating in the QAIF (QA, QI and GP Collaborative) may instead have their Monthly Aspiration Payments calculated by the Aspiration Points Total method, provided that the contractor's GMS contract takes effect before 2 August prior to the QAIF (QA, QI and GP Collaborative) year in respect of which the claim for Monthly Aspiration Payments is made.

5.13. If the contractor is to have its Monthly Aspiration Payments calculated by this method, at the start of each QAIF (QA, QI and GP Collaborative) year – or if a GMS contract starts after the start of the QAIF (QA, QI and GP Collaborative) 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 4.10(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 QAIF (QA, QI and GP Collaborative) during the QAIF (QA, QI and GP Collaborative) year in respect of which the Aspiration Payment is made.

5.14. 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 £184.00 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 6.19 (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 QA, QI and GP Collaborative each QAIF year commencing 1 October 2022

5.15. If, as regards any QAIF (QA, QI and GP Collaborative) 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 QAIF (QA, QI and GP Collaborative) year.

5.16. The LHB must pay the contractor under the contractor's GMS contract its Monthly Aspiration Payment. 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 QAIF (QA, QI and GP Collaborative) year, by
- (b) the total number of days in that month.

5.17. The amount of a contractor's Monthly Aspiration Payments is thereafter to remain unchanged throughout the QAIF 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

5.18. 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 computerised 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 QAIF, 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 to the contractor's best knowledge or belief.

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

- (c) in **Section 6: ACHIEVEMENT PAYMENTS: CALCULATION, PAYMENT ARRANGEMENTS AND CONDITIONS OF PAYMENTS**, for paragraphs 6.1 to 6.22, substitute—

“**6.1.** Achievement payments are to be based on the achievement points to which a contractor is entitled to for—

- (a) QA, QI and GP Collaborative during the QAIF (QA, QI and GP Collaborative) year (1 October to 30 September), and
- (b) Access during each financial year,

as calculated in accordance with this Section and Section 4.

Achievement Payments for QAIF (QA, QI and GP Collaborative) year 2021/2022

6.2. The LHB must pay GMS contractors a payment for the QAIF (QA, QI and GP Collaborative) year beginning with 1 October 2021 and ending with 30 September 2022, the sum of which must be assessed on 30 September 2022 and calculated on the basis that the contractor has achieved all 515 points available for the QAIF (QA, QI and GP Collaborative) year 2021/22 at the value of £184 per point, with such sum paid to GMS contractors on 31 December 2022.

Assessment of Achievement Payments

6.3. Subject to paragraph 6.5, the date in respect of which the assessment of achievement points is to be made is—

- (a) 30 September for QA, QI and GP Collaborative, or
- (b) the last of the financial year for Access.

6.4. For QI, the LHB will assess whether a contractor has met the requirements under the paragraph “Measurement of the implementation of the project” in the relevant project as outlined in the QAIF guidance (<http://www.wales.nhs.uk/sites3/Documents/480/Guidance%20for%20GMS%20Contract%20Wales%20-%20Quality%20and%20Improvement%20Framework%202019-20.pdf>).

Assessment of Achievement Payments where a GMS contract terminates during the year for QAIF (QA, QI and GP Collaborative)

6.5. In a case where a GMS contract terminates prior to 30 September during a QAIF (QA, QI and GP Collaborative) 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 QAIF (QA, QI and GP Collaborative) year on which that contractor is required under the contractor's GMS contract to provide essential services.

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

6.6. In a case where a GMS contract terminates before the end of the financial year during a QAIF Access 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

6.7. 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 30 September during a QAIF (QA, QI and GP Collaborative) year, or before the end of the financial year for QAIF Access, 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 QAIF (QA, QI and GP Collaborative) year or financial year.

6.8. 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 for QAIF Access from 1 April 2021

6.9. The QAIF Access points value for Achievement Payments will be made at the QAIF (QA, QI and GP Collaborative) point value calculated for the QAIF (QA, QI and GP Collaborative) year in which the QAIF Access year ends using the contractor's registered patient list size as at 1 January in that QAIF Access year against the mean average of contractor registered patients also taken at 1 January of that same QAIF Access year.

6.10. Practices will not be assessed on their achievement of Standard 2 with achievement assumed and counting towards Group 1 payments (minimum of 3 in order for payment to be made).

Calculation of Achievement Payments for QAIF (QA, QI and GP Collaborative)

6.11. For the Achievement Payment that relates to the Clinical Active Indicators sub-domain (other than the palliative care indicator), where there is a disease register in respect of an indicator, (within the core contract) 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 £184.00 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 sub domain are to be added together to give the cash total in respect of the sub domain.

6.12. 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.

6.13. The part of the Achievement Payment that relates to the palliative care indicator in the clinical active domain must be calculated by multiplying the total number of achievement points gained by the contractor by £184.00.

6.14. For all of the other achievement points gained by the contractor under the QA Clinical Active sub-domain, the QA Practice Quality Assurance sub-domain, the GP collaborative domain, and the QI domain, the total number of achievement points is to be multiplied by £184.00.

6.15. The cash totals produced under paragraphs 6.11, 6.13 and 6.14 are then added together and multiplied by the contractor's CPI, calculated in accordance with the provisions of paragraphs 2.17 and 2.18—

- (a) at the start of the final quarter of the QAIF (QA, QI and GP Collaborative) year for QA, QI and GP Collaborative to which the Achievement Payment relates;

- (b) if its GMS contract takes effect after the start of the final quarter of the QAIF (QA, QI and GP Collaborative) year for QA, QI and GP Collaborative, 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 financial year quarter during which its GMS contract was terminated.

6.16. The cash total produced as a consequence of paragraph 6.15 is the Unadjusted Achievement Payment for the purposes of calculating aspiration payments for the following QAIF (QA, QI and GP Collaborative) year.

6.17. If the contractor’s GMS contract had effect—

- (a) throughout the QAIF (QA, QI and GP Collaborative) year, the resulting amount is the interim total for the contractor’s Achievement Payment for the QAIF (QA, QI and GP Collaborative) year; or
- (b) for only part of the QAIF (QA, QI and GP Collaborative) year, the resulting amount is to be adjusted by the fraction produced by dividing the number of days during the QAIF (QA, QI and GP Collaborative) year for which the contractor’s GMS contract had effect by 365 (or 366 where a QAIF (QA, QI and GP Collaborative) year includes 29th February), and the result of that calculation is the interim total for the contractor’s Achievement Payment for the QAIF (QA, QI and GP Collaborative) year.

6.18. 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 QAIF (QA, QI and GP Collaborative) 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 QAIF (QA, QI and GP Collaborative) year.

Recovery where Aspiration Payments have been too high

6.19. If the resulting amount from the calculation under paragraph 6.18 is a negative amount, that negative amount, expressed as a positive amount (“the paragraph 6.18 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 6.18 amount is to be recovered by deducting one twelfth of that amount from each of the contractor’s Monthly Aspiration Payments for the QAIF (QA, QI and GP Collaborative) year after the QAIF (QA, QI and GP Collaborative) year to which the paragraph 6.18 amount relates. In these circumstances—
 - (i) the gross amount of the contractor’s Monthly Aspiration Payments for accounting and superannuation purposes in the QAIF (QA, QI and GP Collaborative) year after the QAIF (QA, QI and GP Collaborative) year to which the paragraph 6.18 amount relates is to be the amount to which the contractor is otherwise entitled under paragraphs 5.4 to 5.11 or paragraph 5.12 to 5.14, and
 - (ii) the paragraph 6.18 amount is to be treated for accounting and superannuation purposes as an overpayment in respect of the contractor’s Monthly Aspiration Payments for the QAIF (QA, QI and GP Collaborative) year to which the paragraph 6.17 amount relates; or
- (b) if it is not possible to recover all or part of the paragraph 6.18 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 QAIF (QA, QI and GP Collaborative) year to which the paragraph 6.17 amount relates, and is to be recovered accordingly (i.e. in accordance with paragraph 19.1).

Accounting arrangements and due date for Achievement Payments

6.20. The contractor's Achievement Payment, as calculated in accordance with paragraph 6.18 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 6.5 and 6.6), at the end of the quarter after the quarter during which the GMS contract was terminated,
- (b) in the case of achievement payments for Access, at the end of the first quarter of the financial year after the financial year into which the relevant date falls (see paragraph 6.3), and
- (c) in the case of achievement payments for QAIF (QA, QI and GP Collaborative), at the end of the first quarter of the QAIF (QA, QI and GP Collaborative) year after the QAIF (QA, QI and GP Collaborative) year into which the relevant date falls (see paragraph 6.3).

Conditions attached to Achievement Payments

6.21. 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 6.7;
- (b) the contractor 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 computerised or otherwise) to the LHB in such manner as the LHB may reasonably require, and do so promptly and fully;
- (e) the contractor must engage with the national clinical audits that are undertaken in Wales;
- (f) 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
- (g) all information supplied pursuant to or in accordance with this paragraph must be accurate to the contractor's best knowledge or belief.

6.22. 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."

(5) In PART 4 – PAYMENTS FOR SPECIFIC PURPOSES—

- (a) in *Section 11 (PAYMENTS FOR LOCUMS OR SALARIED GPs ON A FIXED TERM CONTRACT OR GP PERFORMER COVERING MATERNITY, PATERNITY ADOPTION LEAVE AND SHARED PARENTAL LEAVE)*—
 - (i) in paragraph 11.2—
 - (aa) for "or" in the third place it occurs, substitute ",", and
 - (bb) after "(or more than one such person)" insert "or engage an independent prescriber locum";

- (ii) in paragraph 11.2A, after “practitioner” insert “(but not an “independent prescriber locum”);”;
- (iii) in paragraph 11.3(1), after “locum” insert “, an independent prescriber locum”,
- (iv) in paragraph 11.3A(1)—
 - (aa) in the introductory text after “locum” insert “or independent prescriber locum”, and
 - (bb) in the closing text after “locum” insert “or independent prescriber locum”;
- (v) in paragraph 11.4—
 - (aa) in the introductory text after “locum” insert “or independent prescriber locum,”,
 - (bb) in sub-paragraph (a) after “locum” insert “or independent prescriber locum”, and
 - (cc) in sub-paragraph (b) after “locum” insert “or independent prescriber locum”; and
- (vi) after paragraph 11.4 insert—

“Reimbursement of costs of a salaried GP on Shared Parental Leave entitled to Enhanced Shared Parental leave pay

11.4A.—(1) If a salaried GP takes shared parental leave, the LHB may reimburse a contractor for the costs of enhanced shared parental leave pay where the following conditions are satisfied—

- (a) the salaried GP is employed by the contractor as a GP performer;
- (b) under the terms of the salaried GP’s contract of employment they are entitled to enhanced shared parental leave pay during a period of shared parental leave; and
- (c) during the period of shared parental leave the contractor actually and necessarily makes payment to the salaried GP in the form of enhanced shared parental leave pay in accordance with the terms of the salaried GP’s contract of employment.

(2) The amount payable by the LHB to a contractor under this Section in respect of a contractor’s costs of enhanced shared parental leave pay for a salaried GP is calculated as the difference between the value of enhanced shared parental leave pay the salaried GP is entitled to under their contract of employment and the value of their statutory entitlement. If the salaried GP undertakes NHS and private work under the terms of their contract of employment, for the purposes of the calculation of the value of enhanced shared parental leave pay to which the salaried GP is entitled to is based on the pro-rated proportion of the salary that the salaried GP receives for their provision of NHS work.

(3) The maximum amount payable under this Section by the LHB to a contractor in respect of the cost of enhanced shared parental leave pay is the equivalent of—

- (a) 6 weeks’ full contractual pay minus 6 weeks’ statutory entitlement, and
- (b) 18 weeks’ half contractual pay.”;

(vii) in paragraph 11.5(2), in the introductory text, after “reimbursement” insert “(other than reimbursement for enhanced shared parental leave pay)”;

(b) in **Section 15: SENIORITY PAYMENTS** for paragraph 15.1E substitute—

“15.1E. GPs currently within the Seniority Payment Scheme who leave their current practice and join a different practice in Wales within 12 weeks of the date beginning with the day on which they left their previous practice, and who do not migrate to the Partnership Premium Scheme upon joining their new practice, may remain within the Seniority Payment Scheme. Where the GP joins a different practice after 12 weeks of leaving their previous practice beginning with the day on which they left that practice, the GP may not remain within the Seniority Payment Scheme and, other than in exceptional

circumstances, the LHB must migrate them to the Partnership Premium Scheme beginning with the date on which the GP joins the new practice.”;

(c) after **Section 15A: THE PARTNERSHIP PREMIUM SCHEME** insert—

“Section 15B: THE PARTNERSHIP PREMIUM SCHEME FOR NON-GP PARTNERS

General

15B.1. The Partnership Premium Scheme for Non-GP Partners (PPSNGP) is available to eligible non-GP partners of a partnership that holds a GMS or APMS Contract but who are not GP Partners for the purposes of section 15A (each such partner being a “Non-GP Partner” in this Section 15B).

15B.2. The PPSNGP will provide an annual payment, in relation to each Non-GP Partner in Wales who opts to participate in the scheme. For eligible registered healthcare professionals who are Non-GP Partners, payment will be based on the average number of clinical sessions performed by the Non-GP Partner per quarter over the financial year and a requirement to deliver a minimum of 4 clinical sessions per week. For eligible non-healthcare professionals who are Non-GP Partners, eligibility for payment will be based on the average equivalent contracted hours worked per quarter and a requirement to work a minimum of 16 hours 40 minutes per week (the equivalent to 4 clinical sessions at 4 hours 10 minutes each) in their general practice setting. The level of the annual payment will be £1,000 multiplied by the Non-GP Partner’s average number of clinical sessions or equivalent contracted hours worked per quarter, with a maximum average of 8 sessions or 33 hours 20 minutes per quarter counting for PPSNGP purposes and a possible maximum PPSNGP payment of £8,000 per annum.

15B.3. The PPSNGP includes a senior premium under which a Non-GP Partner receives an additional £200 multiplied by either—

- (a) their annual average number of clinical sessions per quarter if they are an eligible registered healthcare professional Non-GP Partner (up to the maximum of 8 sessions per quarter or £1,600 per annum), or
- (b) their average annual equivalent contracted hours worked per quarter divided by 4.16 if they are an eligible non-healthcare professional Non-GP Partner (up to the maximum of 33 hours and 20 minutes per quarter or £1,600 per annum),

where that Non-GP Partner is in receipt of PPSNGP and has 16 years or more Reckonable Service. Reckonable Service for the purposes of PPSNGP is continuous employment with any NHS organisation without a break of 12 or more consecutive weeks. Continuous employment in this context includes periods of service with any Primary Care Contractor (GP Practice, Dental Practice, Optometry Practice or Community Pharmacy) or NHS employer which includes Health Authorities, NHS Boards, NHS Trusts, Primary Care Trusts and the Northern Ireland Health Services, provided that there are no breaks in service of 12 or more consecutive weeks. In order to have previous service regarded as reckonable service Non-GP Partners must provide formal documentary evidence of any relevant, reckonable service.

15B.4. Beginning with 1 April 2021, phase 1 of the PPSNGP will be open to applications from Non-GP Partners who entered into an equity sharing partnership agreement no later than 31 March 2021.

15B.5. Beginning with 1 April 2022, phase 2 of the PPSNGP will be open to applications from Non-GP Partners who entered into an equity sharing partnership agreement on or after 1 April 2021.

Eligible Non-GP Partners

15B.6. A person is an eligible non-GP partner and may apply for inclusion in the PPSNGP if that person is—

- (a) a partner^(a),
- (b) either—
 - (i) an eligible registered healthcare professional, or
 - (ii) an eligible non-healthcare professional, and
- (c) not employed on a salaried basis by the practice of which they are a partner.

15B.7. In this Section—

“eligible registered healthcare professional” means a Nurse (including Advanced Nurse Practitioner), Pharmacist, Pharmacist Technician, Physiotherapist, Paramedic, Midwife, Dietician, Podiatrist, Occupational Therapist, Mental Health Practitioner, and Physician Associate;

“eligible non-healthcare professional” means any person who is a partner working in general practice and is not a GP Partner or an eligible registered healthcare professional.

Clinical Sessions

15B.8. For PPSNGP purposes, for eligible registered healthcare professional Non-GP Partners, a clinical session is defined as 4 hours 10 minutes and can consist of patient contact (which might be via phone at the premises) plus time for correspondence, test follow up and other administrative tasks involved in patient care; a session may also include time spent on Undergraduate or Post graduate medical teaching, attending cluster meetings on behalf of the practice, mandatory training as well as attendance at coroners courts (provided such activities are undertaken in their role as a GP provider or GP performer under the GMS contract).

15B.9. Clinical sessions do not include time spent on locum work or any work undertaken outside of the normal business of the practice.

15B.10. When calculating an eligible registered healthcare professional Non-GP Partner’s average number of clinical sessions per quarter for PPSNGP purposes, all sessions undertaken in that quarter will be counted.

Equivalent Contracted Hours

15B.11. For PPSNGP purposes, for eligible non-healthcare professional Non-GP Partners, there is a requirement to work a minimum of 16 hours 40 minutes per week (the equivalent to 4 clinical sessions at 4 hours 10 minutes each) in their general practice setting. When calculating an eligible non-healthcare professional Non-GP Partner’s average equivalent contracted hours worked per quarter for PPSNGP purposes, all hours worked in that quarter will be counted.

Annual Leave

15B.12. Annual leave up to a maximum of 6 weeks (excluding bank holidays) per annum (reduced pro rata for Non-GP Partners working part-time) will be ignored for the purposes of calculating a Non-GP Partner’s average clinical sessions or average equivalent contracted hours worked per quarter for PPSNGP purposes.

(a) Within the meaning of the Partnership Act 1890 (c.39).

Sickness Absence

15B.13. A Non-GP Partner's absence due to sickness will be ignored for the purposes of calculating the Non-GP Partner's average clinical sessions or average equivalent contracted hours worked per quarter for PPSNGP purposes.

Maternity, Paternity, Adoption, Shared Parental and Compassionate Leave

15B.14. A Non-GP Partner's absence on maternity, paternity, adoption or shared parental leave will be ignored for the purposes of calculating the Non-GP Partner's average clinical sessions or average equivalent contracted hours worked per quarter for PPSNGP purposes.

15B.15. A Non-GP Partner's absence on compassionate leave will be ignored for the purposes of calculating the Non-GP Partner's average clinical sessions or average equivalent contracted hours worked per quarter for PPSNGP purposes.

Data

15B.16. The data on the number of clinical sessions or equivalent contracted hours worked will be collated by NHS Wales Shared Services Partnership (NHSWSSP) on a quarterly basis as set out in the guidance at <https://gov.wales/sites/default/files/publications/2022-02/non-gp-partnership-premium-scheme-guidance-for-the-gms-contract.pdf>.

Payments

15B.17. Payments for the PPSNGP are to be made quarterly and, where applicable, subject to superannuation. The payment is not linked to reckonable service apart from those Non-GP Partners eligible for the senior premium.

15B.18. The payment must be made on a pro rata basis according to—

- (a) an eligible registered healthcare professional Non-GP Partner's average number of clinical sessions for the quarter (provided they have completed a minimum of 4 sessions per week and up to the maximum average of 8 sessions per week during the quarter); or
- (b) an eligible non-healthcare professional Non-GP Partner's average number of equivalent contracted hours worked per quarter (subject to them having worked an average of at least 16 hours and 40 minutes per week during the quarter and up to the maximum average of 33 hours and 20 minutes per week during the quarter), and

subject to paragraph 15B.20(i) below, the maximum payment a Non-GP Partner may receive per quarter is therefore £2,000 (or £2,400 where the senior premium applies).

15B.19. Payments are to be made during the following months in a financial year—

- (a) Quarter 1 – June,
- (b) Quarter 2 – September,
- (c) Quarter 3 – December, and
- (d) Quarter 4 – March.

15B.20. Where the Non-GP Partner has been absent as described in 15B.12 to 15B.15 for an entire quarter, the average number of their clinical sessions or equivalent contracted hours worked is to be assumed to be the same as for the preceding quarter (or where they were also absent for the preceding quarter, the average must be taken from the last quarter during which they were not absent as described in 15B.12 to 15B.15).

15B.21. The Partnership Premium Scheme for Non-GP Partners is subject to post payment verification.

Conditions attached to payment of Quarterly Partnership Premium Scheme for Non-GP Partners Payments

15B.22. A PPSNGP Payment, or any part thereof, is only payable to a contractor if the following conditions are satisfied—

- (a) if a Non-GP Partner receives a PPSNGP Payment from more than one contractor, those payments taken together must not amount to more than £8,000 (or (£9,600 where the senior premium applies) per annum or £2,000 (or £2,400 where the senior premium applies) per quarter;
- (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 PPSNGP Payment in respect of a Non-GP Partner must give that payment to that non-GP Partner—
 - (i) within one calendar month, beginning with the date on which the contractor receives the payment, and
 - (ii) as an element of the personal income of that Non-GP Partner.

15B.23. If any of the conditions set out in paragraph 15B.22(a) to (c) are breached, the LHB may withhold payment of all or any part of any payment to which the conditions relate that is otherwise payable.

15B.24. If a contractor breaches the condition in paragraph 15B.20(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.”.

(6) For ANNEX D - QUALITY ASSURANCE AND IMPROVEMENT FRAMEWORK, substitute Annex D in Schedule 2 to these Directions.

(7) For ANNEX F - ADJUSTED PRACTICE DISEASE FACTOR CALCULATIONS, substitute Annex F in Schedule 3 to these Directions.

(8) For ANNEX J – AMENDMENTS, substitute Annex J in Schedule 4 to these Directions.



Signed by Alex Slade, Director, Primary Care and Mental Health Directorate under the authority of the Minister for Health and Social Services, one of the Welsh Ministers

Date: 29 March 2022

SCHEDULE 1 Direction 2(2)

“TABLE OF CONTENTS

1. INTRODUCTION

PART 1

GLOBAL SUM AND PRACTICE SUPPORT PAYMENTS

2. GLOBAL SUM PAYMENTS

Global Sum Payments: General

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

Calculation of Adjusted Global Sum Monthly Payments

First Payable Global Sum Monthly Payments

Revision of Payable Global Sum Monthly Payments

Conditions attached to Payable Global Sum Monthly Payments

Contractor Population Index

QAIF Point Value 2019/20

3. PRACTICE SUPPORT PAYMENTS

Practice Support Monthly Payments

Practice mergers or splits and Practice Support Monthly Payments

Conditions attached to payment of Practice Support Monthly Payments

PART 2

QUALITY ASSURANCE AND IMPROVEMENT FRAMEWORK

4. GENERAL PROVISIONS

Background

The four principal domains of the QAIF

Types of payments in relation to the QAIF

Aspiration Payments – QAIF (QA, QI and GP Collaborative) year 1

October 2021 to 30 September 2022

Aspiration Payments – QA, QI and GP Collaborative elements of QAIF years from 1 October 2022

Achievement Payments – QA, QI and GP Collaborative

Calculation of points in respect of the domains

Calculation common to all domains

Calculations in respect of the Active Clinical Sub-domain

General Provisions relating to the QA Practice Quality Assurance sub-domain

General Provisions relating to the GP Collaborative Domain

General Provisions relating to the Quality Improvement Domain

General Provisions relating to the Access Domain

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

Aspiration Payments – QA and QI for QAIF (QA, QI and GP Collaborative) year 1 October 2021 to 30 September 2022
Calculation of Monthly Aspiration Payments QA, QI and GP Collaborative each QAIF year commencing 1 October 2022: General
Calculation of Monthly Aspiration Payments each QAIF (QA, QI and GP Collaborative) year commencing 1 October 2022: the 70% method
Calculation of Monthly Aspiration Payments QA, QI and GP Collaborative each QAIF year commencing 1 October 2022: the Aspiration Points Total method
Payment arrangements for Monthly Aspiration Payments QA, QI and GP Collaborative each QAIF year commencing 1 October 2022
Conditions attached to Monthly Aspiration Payments

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

Basis of Achievement Payments
Achievement Payments for QAIF (QA, QI and GP Collaborative) year 2021/2022
Assessment of Achievement Payments
Assessment of Achievement Payments where a GMS contract terminates during the year for QAIF (QA, QI and GP Collaborative)
Assessment of Achievement Payments where a GMS contract terminates during the year for Access
Returns in respect of Achievement Payments
Calculation of Achievement Payments for QAIF Access from 1 April 2021
Calculation of Achievement Payments for QAIF (QA, QI and GP Collaborative)
Recovery where Aspiration Payments have been too high
Accounting arrangements and due date for Achievement Payments
Conditions attached to Achievement Payments

PART 3 ***IMMUNISATIONS***

7. CHILDHOOD IMMUNISATIONS

General: Childhood vaccines and immunisations
Childhood Immunisation Scheme plans
Target payments in respect of two-year olds
Calculation of Quarterly Two-Year Olds Immunisation Payment
Conditions attached to Quarterly Two-Year Olds Immunisation Payments
Target payments in respect of five-year-olds
Calculation of Quarterly Five-Year-Olds Immunisation Payment
Conditions attached to Quarterly Five-Year-Olds Immunisation Payment

PART 4 ***PAYMENTS FOR SPECIFIC PURPOSES***

8. ROTAVIRUS VACCINE

General

Payment for administration of rotavirus vaccine

Eligibility for payment

Claims for payment

Conditions attached to payment

9. PNEUMOCOCCAL VACCINE AND HIB/MENC BOOSTER VACCINE

General

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

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

Children at increased risk of pneumococcal infection

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

Children with an unknown or incomplete immunisation status

Eligibility for payment

Claims for payment

Conditions attached to payment

9A. HEPATITIS B VACCINATION FOR BABIES

Claims for Payment

Eligibility for payment

Conditions attached to payment

10. SHINGLES IMMUNISATION PROGRAMME

General

Payment for administration of the Shingles vaccine

Eligibility for payment

Claims for payment

Conditions attached to payment

11. PAYMENTS FOR LOCUMS OR SALARIED GPs ON A FIXED TERM CONTRACT OR GP PERFORMER COVERING MATERNITY, PATERNITY ADOPTION LEAVE AND SHARED PARENTAL LEAVE

General

Locums

Entitlement to payments for covering ordinary maternity leave, ordinary adoption leave, shared parental leave and paternity and special leave

Discretionary payments for covering additional maternity leave, additional adoption leave or shared parental leave

Reimbursement of costs of a salaried GP on Shared Parental Leave entitled to Enhanced Shared Parental leave pay

Amounts payable

Payment arrangements
Conditions attached to the amounts payable

12. PAYMENTS FOR LOCUMS OR SALARIED GPs ON A FIXED TERM CONTRACT OR GP PERFORMERS COVERING SICKNESS LEAVE

General
Locums
Entitlement to payments for covering sickness leave
Discretionary payments for cover of an employed GP on a phased return to work or adjusted hours
Discretionary payments for covering long-term sickness leave
Ceilings on the amounts payable
Payment arrangements
Conditions attached to the amounts payable

13. PAYMENTS FOR LOCUMS TO COVER FOR SUSPENDED DOCTORS

General
Locum Practitioners
Eligible cases
Ceilings on the amounts payable
Payment arrangements
Conditions attached to the amounts payable

14. PAYMENTS IN RESPECT OF PROLONGED STUDY LEAVE

General
Locums
Types of study in respect of which Prolonged Study Leave may be taken
Educational Allowance Payment
Locum cover in respect of doctors on Prolonged Study Leave
Payment arrangements
Conditions attached to the amounts payable

15. SENIORITY PAYMENTS

General
Eligible posts
Service that is Reckonable Service
Calculation of years of Reckonable Service
Determination of the relevant dates
Calculation of the full annual rate of Seniority Payments
Superannuable Income Fractions
Amounts payable
Conditions attached to the payment of Quarterly Seniority Payments

15A. THE PARTNERSHIP PREMIUM SCHEME

General

Clinical Session
Annual Leave
Sickness Absence
Maternity, Paternity, Adoption and Shared Parental Leave
Data
Payments
Condition attached to payment of Quarterly Partnership Premium
Payments

15B. THE PARTNERSHIP PREMIUM SCHEME FOR NON-GP PARTNERS

General
Eligible Non-GP Partners
Clinical Sessions
Equivalent Contracted Hours
Annual Leave
Sickness Absence
Maternity, Paternity, Adoption, Shared Parental and Compassionate
Leave
Data
Payments
Conditions attached to payment of Quarterly Partnership Premium
Scheme for Non-GP Partners Payments

16. DOCTORS' RETAINER SCHEME

General
Payments in respect of sessions undertaken by members of the Scheme
Provisions in respect of leave arrangements
Payment conditions

16A. GP RETENTION SCHEME

General
Payments in respect of sessions under the scheme
Provisions in respect of leave arrangement
Payment conditions
Professional expenses supplement annual payment

17. DISPENSING

General
Costs in respect of which reimbursement is payable
Personally administered drugs and appliances and those used for
diagnosis
Products not covered by this Section
Deductions in respect of charges
Contractors unable to obtain discounts
Contractors that are to receive special payments
Preconditions before payments under this Section are payable

**Payment arrangements
Accounting obligations**

18. DISPENSARY SERVICES QUALITY SCHEME

**Dispensary Services Quality Payments: General
Eligibility for Dispensary Services Quality Payments
Calculation of Dispensary Services Quality Payments
Conditions attached to Dispensary Services Quality Payments
Accounting arrangements and date payment is due
Part payment of Dispensary Services Quality Payments in special
circumstances
Provisions relating to contractors whose practices merge
Provisions relating to contractors whose practices split
Discretionary matters**

PART 5 SUPPLEMENTARY PROVISIONS

19. ADMINISTRATIVE PROVISIONS

**Overpayments and withheld amounts
Underpayments and late payments
Payments on account
Payments to or in respect of suspended doctors whose suspension ceases
Effect on periodic payments of termination of a GMS contract
Time limitation for claiming payments
Dispute resolution procedures
Protocol in respect of locum cover payments
Adjustment of Contractor Registered Populations**

20. SUPERANNUATION CONTRIBUTIONS

**The LHB's responsibilities in respect of contractors' employer's and
employee's superannuation contributions
Monthly deductions in respect of superannuation contributions
End-year adjustments
Locums practitioners
Recovery of unpaid contributions**

PART 6 TRANSITIONAL, REVOCATION AND SAVING PROVISIONS

21. TRANSITIONAL PROVISIONS

**Transitional provisions
Revocations
Savings**

ANNEXES

- A. Glossary**
- B. Global Sum**
- C. Temporary Patients Adjustment**
- D. Quality Assurance and Improvement Framework**
- F. Adjusted Practice Disease Factor Calculations**
- G. Dispensing Payments**
- H. Dispensary Services Quality Scheme**
- I. Routine childhood vaccines and immunisations**
- J. Amendments to the Directions to Local Health Boards as to the Statement of Financial Entitlements Directions 2013 which came into force on 11 June 2013”**

SCHEDULE 2 Direction 2(6)

“ANNEX D – QUALITY ASSURANCE AND IMPROVEMENT FRAMEWORK

Part 1: Introduction

General

D.1. The QAIF rewards contractors for the provision of quality care and helps to embed quality improvement into general practice. Contractor participation in QAIF is voluntary.

D.2. The QAIF consists of four domains; Quality Assurance (QA), Quality Improvement (QI), Access and GP Collaborative Domain.

Quality Assurance (QA)

D.3. The 2019-20 GMS contract agreement includes GPC Wales support for national audits in Wales, with appropriate governance arrangements. The QA domain has been designed taking account of complimentary engagement in national audits. The QA domain has two sub-domains, **clinical active** indicators and **practice quality assurance** indicators.

D.4. The total points for the sub-domain **clinical active** indicators are 125 points.

D.5. There are 80 points available in the QA **practice quality assurance** sub-domain with the focus on Demand and Capacity – to be evidenced in the Cluster IMTP – 40 points and evidence of operating an effective system of clinical governance – 40 points.

D.6. The total points under QA is 205.

Quality Improvement (QI)

D.7. The QI domain is based on QI projects the practice will complete.

D.8. To be able to claim any points for achievement of projects in the QI projects domain, the practice must complete the mandatory data and patient safety projects in QAIF (QA, QI and GP Collaborative) year 2021/22.

D.9. The practice must choose a Legacy 2020-21 QI project for QAIF (QA, QI and GP Collaborative) year 2021/22 and a practice choice QI project. If a practice undertook the Multidisciplinary Antimicrobial Stewardship Urinary Tract Infection project in QAIF (QA and QI) year 2020/21 that practice is unable to choose that project as a Legacy 2020-21 QI project for the QAIF (QA, QI and GP Collaborative) year 2021/22.

D.10. The total points available for the QI domain is 205.

Access

D.11. The Access domain is based on the Access to In-Hours GMS Services Standards announced by the Minister for Health and Social Services on 20 March 2019. The standards set clear requirements on GP providers in terms of expectations relating to access including an increased digital offering.

D.12. Practices will not be assessed on their achievement of Standard 2 with achievement assumed and counting towards Group 1 payments (with a minimum of 3 in order for payment to be made).

D.13. The standards have been separated into two groups. Each Access Standard is a QAIF indicator; they have been grouped as follows—

Group 1

- Less than 3 standards = no payment (0 points)
- 3 standards = 60% payment (30 points)
- 4 standards = 80% payment (40 points)
- All standards in Group 1 = 100% payment (50 points)

Group 2

GP providers will be required to undertake standards 6 and 7 in order to receive payment (50 points total).

Quality Payment

A quality payment of 25 points will be awarded to a GP provider for achievement of all Group 1 and Group 2 Standards.

D.14. The total points available for the Access domain is 125.

GP Collaborative

D.15. Contractors are expected to attend GP Collaborative meetings, contribute clear information to Integrated Medium Term Plans (IMTP) and deliver activities and outcomes.

General information on the Quality Assurance Clinical Domain

General information on indicators

D.16. Indicators have been prefixed by an abbreviation of the category to which they belong, as per their description under the old QOF scheme. For the purposes of calculating achievement payments, contractor achievement against QAIF indicators is measured on a cycle—

- (a) beginning with 1 October, and
- (b) ending with 30 September or, in cases where the contract terminates mid-year, the last day on which the contract subsists.

D.17. In the case of a contract that has come to an end on or before 30 September in any relevant financial year, the reference to periods of time are still calculated on the basis that the period ends on 30 September in the financial year to which the achievement payment relates. The SFE sets out the rules that apply to measuring achievement for contracts that end before the end of the QA and QI achievement year.

D.18. Disease Registers are lists of patients registered with the contractor who have been diagnosed with the disease or risk factor. Contractors are required to establish and maintain disease registers for the disease areas of QAIF during 2021/22 and this will be written into the GMS Contracts Regulations.

D.19. It is the responsibility of the contractor to demonstrate that it has systems in place to maintain a high quality register. Verification by a LHB may involve it asking how the register is constructed and maintained. The LHB may also compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations.

D.20. For some QA clinical indicators, there is no disease register, but instead there is a target population group. For example, for FLU001W the target population group is the registered population aged 65 or more.

D.21. Indicators in the QI, Access and GP Collaborative domains have neither a disease register nor a target population. These are indicators which require a particular activity to be carried out and points are awarded in full if that activity is carried out. Should the activity not be carried out, no points are awarded.

Verification

D.22. For indicators where achievement is not extracted automatically from GP clinical systems, the guidance outlines the evidence or type of evidence which the LHB requires the contractor to produce for verification purposes. The evidence will not need to be submitted unless requested by the LHB. Practices will be responsible for ensuring that any and all required evidence to support the claimed achievement is available on request for examination by the LHB.

D.23. The Statement of Financial Entitlement Directions set out the reporting requirement for contractors and the rules for the calculation of QAIF payments.

Business Rules

D.24. The Dataset and Business Rules that support disease registers and the reporting requirements of the QA clinical indicators of QAIF are based on Read codes (version 2 and Clinical Terms Version 3) and associated dates. Read codes are an NHS standard. Contractors using proprietary coding systems and/or local/practice specific codes will need to be aware that these codes will not be recognised within QAIF reporting. Contractors utilising such systems may need to develop strategies to ensure that they are using appropriate Read codes in advance of producing their achievement report. NHS Wales expect to move to SNOMED clinical terms as the NHS standard for coding, in line with the NHS in the rest of the UK.

Exception reporting

D.25. Exception reporting applies to those indicators in the clinical domain of QAIF where the achievement is determined by the percentage of patients receiving the specified level of care.

D.26. “Exceptions” relate to registered patients who are on the relevant disease register or in the target population 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. Patients are removed from the denominator and numerator for an indicator if they have been both excepted **and** they have not received the care specified in the indicator wording. If the patient has been excepted, but the care has subsequently been carried out within the relevant time period, the patient will be included in both the denominator and the numerator, i.e. achievement will always override an exception.

Exception Reporting Criteria

D.27. Patients may be excepted if they meet the following criteria for exception reporting—

- Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the annual cycle to which the achievement payments relate.
- Disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail.

- Patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards.
- Where a patient does not agree to treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.
- Where the patient has a supervening condition which makes treatment of their condition inappropriate.

D.28. 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 can be identifiable in the patient record.

Principles

D.29. The overriding principles for contractors to follow in the decision to except a patient are—

- A duty of care remains for all patients, irrespective of exception reporting arrangements.
- It is good practice for clinicians to review from time to time those patients who are excepted from treatment, e.g. to have continuing knowledge of health status and personal health goals.
- The decision to exception report should be based on clinical judgement, relevant to the patient, with clear and auditable reasons coded or entered in free text on the patient record.
- There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

D.30. In each case where a patient is exception reported, in addition to recording what should be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the clinical reason for the exception is fully recorded in a way that can facilitate an audit in the patient record. This is both in order to manage the care of that particular patient and for the purpose of verification.

D.31. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. For the purposes of managing the care of the patient and for subsequent audit and verification, it is important that the reason the patient meets one or more of the exception reporting criteria and any underlying clinical reason for this is recorded in the patient's clinical record.

D.32. Invitations to attend a review should be made to the individual patient and can be in writing, by telephone or by SMS text messaging. This can also include a note at the foot of the patient's prescription requesting that they attend for review. The three invitations need to have taken place within the QAIF period in question. There should be three separate invitations at three unique periods of time. The telephone call invitation may lead to the application of exception criteria 'informed dissent' if the patient refuses to take up the invitation to attend. The following are examples that are not acceptable as an invitation—

- A generic invitation on the right hand side of the script to attend a clinic or an appointment e.g. influenza immunisation.
- A notice in the waiting room inviting particular groups of patient to attend clinics or make appointments (e.g. influenza immunisation).

Guidance

D.33. Further information on QAIF can be accessed via the following link—

<https://gov.wales/sites/default/files/publications/2022-02/quality-assurance-and-improvement-framework-2021-2022.pdf>

Part 2: Active Clinical Sub-Domain Indicators

Clinical Sub-Domain Active Indicators

INFLUENZA (FLU)		
Indicator	Points	Threshold
FLU001W. The percentage of the registered population aged 65 years or more who have had influenza immunisation in the preceding 1 August to 31 March.	5	55-75%
FLU002W. The percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March.	15	45-65%
DEMENTIA (DEM)		
Indicator	Points	Threshold
DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in person or if clinically appropriate via telephone or remote video consultation in the preceding 15 months.	28	55-75%
DIABETES MELLITUS (DM)		
Indicator	Points	Threshold
DM002. The percentage of patient with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.	8	51–91%
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less.	10	40-72%
DM007. 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.	17	40-62%
DM012. 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 pulse), 2) increased risk (neuropathy or absent pulse) 3) high risk (neuropathy or absent pulses plus deformity of skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months.	4	55–90%
DM0014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 October to 30 September who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	11	40–90%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)		
Indicator	Points	Threshold
COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional,	9	50–90%

including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months.		
MENTAL HEALTH (MH)		Threshold
Indicator	Points	
MH011W. The percentage of patients with Schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure, BMI, smoking status and alcohol consumption in the preceding 15 months and in addition to those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 months.	12	45-74%
PALLIATIVE CARE (PC)		Threshold
Indicator	Points	
PC002W. The contractor has regular (at least 2 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed.	6	

Part 3: Practice Quality Assurance

	Points
<p>Demand and Capacity – to be evidenced in the Collaborative IMTP.</p> <p>The below should be taken into consideration;</p> <ul style="list-style-type: none"> • A population needs assessment; • An analysis of current services available to the collaborative population and identifying any gaps in provision; • A consideration and analysis of current numbers and skills of workforce and its development needs; • An analysis of current performance against the phase 2A primary care measures • Measurement of local health needs as determined by the collaborative. 	40
<p>Evidence of operating an effective system of clinical governance (quality assurance) in the practice, through engagement in peer review and through discussion of clinical incidents that had occurred within the practice and local services.</p> <p>Contractors will need to evidence completion of CGSAT and IG toolkit.</p>	40

Part 4: Quality Improvement (QI)

Overview of QI projects sub domain;

To be able to claim any points for achievement of projects in the QI projects sub domain, the practice must complete the mandatory data and patient safety projects.

Project	Points
Data & Patient Safety QI Mandatory Projects;	
Activity/Appointment Data	70
Patient Safety Clinical Data	35
Legacy 2020-21 QI project. In place for one further QI cycle to allow embedding of learning, governance advantages and collaborative conversations for the Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the collaborative population.	30
Practice Choice QI project; The practice has a choice of selecting a 70 point QI basket project not previously undertaken (Reducing stroke, ceilings of care, urinary tract infection). or a collaborative freestyle mini project in agreement with Health Board (35 points) and Green Inhaler mini project (35 points)	70
Total	205

Part 5: Access

Access Standards

Indicator	Points
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<p>Group 1</p> <p>I. Appropriate telephony and call handling systems are in place which support the needs of callers and avoids the need for people to call back multiple times. Systems also provide analysis data to the practice.</p> <p>Measure - A planned two year programme of implementation of appropriate systems resulting in:</p> <ul style="list-style-type: none"> • 100% of practices have a recording function for incoming and outgoing lines. • 100% of practices have the ability to stack calls and are utilising this fully. • 100% of practices interrogate their phone systems and analyse the data provided. <p>III. A practice has a recorded bilingual introductory message in place, which includes signposting to other local services and to emergency services for clearly identified life threatening conditions.</p> <p>Measure - 100% of practices to have recorded bilingual introductory message that usually lasts no longer than 2 minutes. (Standardised message to include Covid local messaging to explain cluster solutions).</p> <p>IV. A practice has in place appropriate and accessible alternative methods of contact, including digital solutions such as SMS text messaging and email, as well as face-to-face.</p> <p>Measure - No later than 31 March 2022:</p> <ul style="list-style-type: none"> • 100% of practices offer access to repeat prescriptions through a digital solution (e.g., MHOL). • 100% of practices offer care homes access to repeat prescription ordering service through a digital solution. <p>V. People are able to request a non-urgent consultation, including the option of a call back via email, subject to the necessary national governance arrangements being in place.</p> <p>Measure -</p> <ul style="list-style-type: none"> • 100% of practices are contactable via a digital package for patients to request non-urgent appointments or call backs. (For example; Email, E-Consult, Ask my GP) • Practices have in place the necessary governance arrangements for this process, which could include standardised and bilingual auto-responses. 	<p>Less than 3 Standards = 0 2 Standards = 30 3 Standards = 40 4 Standards = 50</p>
<p>Group 2</p> <p>VI. People are able to access information on the different ways of requesting a consultation with a GP and other healthcare professionals. Practices will display information relating to these standards.</p> <p>Measure -</p>	<p>Less than 2 Standards = 0 2 Standards (Standards V1 & VII) = 50</p>

<ul style="list-style-type: none"> • Practices display information on requesting a consultation in the surgery, in practice leaflets and on the practice website. • 100% of practices publicise how people can request a consultation (urgent and routine). • 100% of practices display information on standards of access. <p>VII. People receive a timely, co-ordinated and clinically appropriate response to their needs.</p> <p>Measure - Appropriate care navigation and triaging (with relevant training undertaken) and appointment systems in place:</p> <ul style="list-style-type: none"> • All children under 16 years of age with acute presentations are offered a same-day consultation. • URGENT – people who are clinically triaged as requiring an urgent assessment are offered a same day consultation (could be face to face, telephone, video call or a home visit). • Active signposting for appropriate queries to alternative cluster based services, health board wide and national services. 	
<p>Achievement Quality Payment A bonus of 25 points will be awarded to a contractor for achievement of all Group 1 and Group 2 standards</p>	25

Guidance on Access to In-Hours GMS Services Standards can be found at -

<https://gov.wales/sites/default/files/publications/2021-12/access-to-in-hours-gms-services-standards-amended-supplementary-guidance.pdf>

Part 6: GP Collaborative

Indicator	Points
<p>CND014W - The GP practice must attend the GP Collaborative which will meet on a minimum of 4 occasions during the year; the timing of meetings should be agreed around the planning of the HB and Pan Cluster Planning Group ideally, to avoid the period of winter pressure.</p> <p>The practice may be represented at these meetings by any clinical partner or other senior practice employed clinician. Where appropriate, senior administrators may also attend.</p>	40
<p>CND015W – The GP Practice will contribute relevant information to the Primary Care Cluster IMTP via the Cluster Planning Group. The contribution must include information on demand and capacity planning undertaken via the QI domain.</p> <p>Practices will need to demonstrate how they have engaged in planning & delivery of local services agreed within the cluster plan – This will need to include evidence of wide partnership/ multi-professional / multi-agency</p>	40

working and development of integrated services.	
CND016W – The GP practice will contribute to delivering specific cluster determined outcomes which include:- Engagement in planning of local initiatives through engagement with the Cluster Planning Group via the Collaborative Lead. (E.g., contribution to population needs assessment).	20

Guidance on the GP Collaborative domain can be found at—

[GMS contract: GP collaborative guidance 2021 to 2022 | GOV.WALES](#)”

SCHEDULE 3

Direction 2(7)

“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 active clinical sub domain other than the indicator for palliative care;
- (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 the register maintained based on the indicator specified in the relevant part of Part 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 30th September in the QAIF (QA, QI and GP Collaborative) 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 QAIF (QA, QI and GP Collaborative) year to which the Achievement Payment relates, but see paragraph 6.16 (calculation of Achievement Payments).

F.4. The Adjusted Practice Disease Factor is calculated by—

- (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 active clinical sub domain (other than the indicator for palliative care);
- (b) dividing 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 6.14 of this SFE as in force on the 1st October 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 COPD in the period beginning with 1 October 2021 and ending with 30 September 2022 would receive £220.80 per point scored on the AF indicators.

F.5. “Relevant year” in paragraph F.4.(b) means the QAIF year (QA, QI and GP Collaborative) to which the calculation of Achievement Payments relates.

F.6. 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).

F.7. This national prevalence figure and range of practice prevalence will be calculated on a Wales-only basis.

F.8. If the contractor's GMS contract terminates before 1 July 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.9. 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.10. Unless paragraph F.11 applies, if the contractor's GMS contract terminates on or after 1st July and before the end of the QAIF (QA, QI and GP Collaborative) 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 July; 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.11. If the contractor's GMS contract commences after 1st July and terminates before the end of the QAIF (QA, QI and GP Collaborative) 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.”.

SCHEDULE 4 Direction 2(8)

“ANNEX J AMENDMENTS

Amendments to the Directions to the Local Health Boards as to the Statement of Financial Entitlements Directions 2013, which came into force on 11 June 2013

- (a) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2013 (2013 No.60), which were made on 30 September 2013;
- (b) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2014 (2014 No.3), which were made on 16 June 2014;
- (c) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2014 (2014 No.17), which were made on 27 June 2014;
- (d) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2014 (2014 No.24), which were made on 30 September 2014;
- (e) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2015 (2015 No.7), which were made on 31 March 2015;
- (f) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment No 2) Directions 2015 (2015 No.14), which were made on 01 April 2015;
- (g) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment No 3) Directions 2015 (2015 No.15), which were made on 20 April 2015;
- (h) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment No 4) Directions 2015 (2015 No.19), which were made on 25 June 2015;
- (i) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.5) Directions 2015, which were made on 30 September 2015;
- (j) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2016, which were made on 30 March 2016;
- (k) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2016, which were made on 11 April 2016;
- (l) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2016, which were made on 13 July 2016;
- (m) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2016 (2016 No.19), which were made on 16 August 2016;
- (n) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.5) Directions 2016 which were made on 15 December 2016;

- (o) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 6) Directions 2017 which were made on 31 January 2017;
- (p) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2017 which were made on 27 April 2017;
- (q) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.2) Directions 2017 which were made on 9 August 2017;
- (r) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.3) Directions 2017 which were made on the 28 September 2017;
- (s) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2018 which were made on the 14 June 2018;
- (t) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2018 which were made on 19 November 2018;
- (u) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2019 which were made on 29 March 2019;
- (v) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2019 which were made on 28 June 2019;
- (w) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2019 which were made on 29 August 2019;
- (x) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2019 which were made on 30 September 2019;
- (y) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2019 which were made on 14 October 2019;
- (z) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2020 which were made on 24 March 2020;
- (aa) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2020 which were made on 22 June 2020;
- (bb) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2020 which were made on 15 July 2020;
- (cc) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2020 which were made on 16 September 2020;
- (dd) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2020 which were made on 2 November 2020;
- (ee) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2021 which were made on 19 April 2021;
- (ff) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2021 which were made on 31 August 2021; and
- (gg) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.3) Directions 2021 which were made on 1 December 2021.