WG25-06

THE NATIONAL HEALTH SERVICE (WALES) ACT 2006

Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2025

Made	*06 February 2025*
Coming into force	*07 February 2025*

The Welsh Ministers, in exercise of the powers conferred on them by sections 45, 203(9) and (10) and 204(1) of the National Health Service (Wales) Act 2006(**a**) 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 2025.

(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 are made on 06 February 2025 and come into force on 07 February 2025.

(4) These Directions have effect from 1 April 2024.

Amendment to the Statement of Financial Entitlements

2. 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 Directions listed in Annex J of the Schedule to these Directions, are further amended as follows.

Amendment of Table of Contents

3. In the table of contents for—

"**6. GENERAL PROVISIONS RELATING TO THE QUALITY IMPROVEMENT DOMAIN PAYMENT ARRANGEMENTS FOR MONTHLY ASPIRATION PAYMENTS QI YEAR FROM 1 APRIL**

General Provisions relating to the Quality Improvement Domain Payment arrangements for Monthly Aspiration Payments QI year from 1 April",

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

substitute—

"**6. QUALITY IMPROVEMENT**

General Provisions relating to the Quality Improvement Domain

Payment arrangements for Monthly Aspiration Payments QI year from 1 April 2024 to 31 March 2025

Achievement Payments – QI year from 1 April 2024 to 31 March 2025

Assessment of Achievement Payments where a GMS contract terminates between 1 April 2024 and 31 March 2025

Evidence and Verification

Accounting arrangements and due date for Achievement Payments

Conditions attached to Achievement Payments".

4. In the table of contents under the heading "**ANNEXES**", for "**D. Quality Improvement Framework**" substitute—

"D. QI Project – Prescribing Safety

E. QI Project – Unhealthy Behaviours".

Amendment of Part 1, Section 2 - GLOBAL SUM PAYMENTS

5. In paragraph 2.1, for "essential and additional" substitute "unified".

6. For paragraph 2.3 substitute—

"**2.3.** Once the contractor's CRP has been established, this number is to be adjusted by the Global Sum Allocation Formula, a summary of which is included in Annex B of this SFE. The resulting figure, which is the contractor's Weighted Population for the quarter, is to be multiplied by £132.00 (GP pay, staff pay, expenses and the non-recurring £23m) for the period beginning with 1 April 2024 and ending 31 March 2025. From 1 April 2025 the contractor's Weighted Population for the quarter is to be multiplied by £125.20 (with the £23m excluded and 0.5m included for the Learning Disabilities DSS)."

7. For paragraph 2.4A substitute—

"**2.4A.** £3.85 of the figure of £132.00 in paragraph 2.3 is to account for the agreed 6% increase in annual remuneration to practice staff employed by the GMS contractor and which GMS contractors must reflect as at least a 6% pay increase for those staff beginning on 1 April 2024. This 6% increase must be applied to relevant staff's pay after the statutory increase for the national minimum and living wages has been applied. The LHB may recover this amount from a GMS contractor in accordance with section 19 if it becomes apparent that the GMS contractor has not increased the remuneration of their practice staff in this way by at least 6% above their existing pay level or the statutory national minimum and living wages for the financial year 2024/2025."

8. Omit the heading "Calculation of Adjusted Global Sum Monthly Payments".

9. Omit paragraph 2.5.

10. Omit Table 1.

11. In paragraph 2.8 omit sub-paragraphs (b) and (c).

12. Omit paragraph 2.10.

13. In paragraph 2.12 omit everything after the words "Payment of the new Payable GSMP must (until it is next revised) be made monthly, and it is to fall due on the last day of each month."

Amendment of Part 1, Section 6 – Quality Improvement

14. For all of the text in Section 6 beneath the heading, substitute—

"General Provisions relating to the Quality Improvement Domain

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

6.2. To be able to claim any points for achievement of projects in the QI projects domain, the practice must complete the 2 mandatory data projects.

6.3. The 2 mandatory projects for the QI year 1 April 2024 to 31 March 2025—

(a) Prescribing Safety – 70 points, and

(b) Unhealthy Behaviours - 100 points.

6.4. The details of the QI projects and what tasks contractors must undertake to achieve the 170 points can be found at—

QI Project – Prescribing Safety – Annex D

(https://www.gov.wales/quality-improvement-project-practice-guidance-prescribing-safety)

QI Project – Unhealthy Behaviours – Annex E

(https://www.gov.wales/quality-improvement-project-practice-guidance-supporting-healthy-behaviours)

Payment arrangements for Monthly Aspiration Payments QI year from 1 April 2024 to 31 March 2025

6.5. Aspiration Payments are a payment made in advance of Achievement Payments being calculated under the QI domain of the QIF.

6.6. The contractor is only entitled to receive Aspiration Payments if they received an Achievement Payment for a QI project as part of the 2022 to 2024 QAIF cycle.

6.7. The QI points value for Achievement Payments will be £198.

6.8. Aspiration Payments are to be made by calculating 70% of the 170 achievement points available at 1 April 2024 under the QI domain divided by 12 multiplied by CPI at 1 April 2024.

6.9. If a contractor's GMS contract takes effect after 1 April 2024 in the QIF (QI) year the monthly Aspiration Payment is to be agreed between the contractor and the LHB.

6.10. 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.

6.11. If the contractor cannot evidence the completion of the QI projects, then the Local Health Board is entitled to recover any Aspiration Payments made.

Achievement Payments – QI year from 1 April 2024 to 31 March 2025

6.12. The achievement payment is the 170 points total multiplied by £198 and then 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 QIF QI year for which the Achievement Payment relates; or

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

6.13. A contractor will be entitled to an achievement payment at 30 June 2025 if at 31 March 2025, the contractor has submitted evidence for the 2 QI projects to the Local Health Board for verification.

6.14. The achievement payment will also take into account the deduction of the Aspiration Payments that the contractor has received for the period 1 April 2024 to 31 March 2025.

Assessment of Achievement Payments where a GMS contract terminates between 1 April 2024

6.15. If a contractor can evidence that they have completed the 2 QI projects, then the contractor is entitled to an achievement payment at 170 points multiplied by £198 and then multiplied by CPI (at the start of the financial year quarter during which its GMS contract was terminated) with a deduction for any aspiration payments made. If the contractor cannot evidence the completion of the 2 QI projects, then no achievement payment is to be made and the Local Health Board is entitled to recover any aspiration payments made.

Evidence and Verification

6.16. At 31 March 2025, contractors must submit evidence to the Local Health Board against the 2 QI projects for verification.

6.17. Contractors who do not submit evidence to the Local Health Board for the 2 QI projects or submit evidence that cannot be verified, will be subject to recovery of all aspiration payments.

Accounting arrangements and due date for Achievement Payments

6.18. The contractor's achievement payment 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 at the end of the quarter after the quarter during which the GMS contract was terminated, and

(b) in the case of achievement payments, at the end of the first quarter of the QIF (QI) year 1 April 2024 to 31 March 2025 into which the relevant date falls.

Conditions attached to Achievement Payments

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

(a) the contractor must submit evidence to the LHB at 31 March 2025;

(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 co-operate fully with any reasonable inspection or review that the LHB or another relevant statutory authority wishes to undertake in respect of the achievement points to which it says it is entitled; and

(f) all information supplied pursuant to or in accordance with this paragraph must be accurate to the contractor's best knowledge or belief.

6.20. 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."

Amendment of, Part 3, Section 7

15. For paragraph 7.1, substitute "In order to meet the required standard under these directions Contractors must provide the vaccines and immunisations of the type and in the circumstances which are set out in Annex I."

16. In paragraph 7.2 for "Childhood Immunisation plans" substitute "certain Childhood Immunisations".

Amendment of, Part 4, Section 8

17. In paragraph 8.1—

(a) omit "A contractor may be contracted to provide the childhood vaccines and immunisations which are classified as Additional Services.", and

(b) omit "and therefore falls within the childhood vaccines and immunisations which are classified as Additional Services".

18. Omit paragraph 8.8(a) and re-number the remaining sub-paragraphs accordingly.

19. In paragraph 8.11(c), for "paragraph 72 of Schedule 6 to the 2004" substitute "paragraph 78 of Schedule 3 to the 2023".

20. In paragraph 8.11(d), for "paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004" substitute "paragraph 78 of Schedule 3 to the 2023 Regulations, those matters set out in paragraph 3(2)(d) of Schedule 2 to the 2023".

Amendment of, Part 4, Section 9

21. In paragraph 9.1 omit ", which is contracted to provide childhood vaccines and immunisations as part of Additional Services (such vaccines are classified as an Additional Service),".

22. Omit paragraph 9.13(a) and re-number the remaining sub-paragraphs accordingly.

23. In paragraph 9.18(c) for "paragraph 72 of Schedule 6 to the 2004" substitute "paragraph 78 of Schedule 3 to the 2023".

24. In paragraph 9.18(d), for "paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004" substitute "paragraph 78 of Schedule 3 to the 2023 Regulations, those matters set out in paragraph 3(2)(d) of Schedule 2 to the 2023".

Amendment of, Part 4, Section 9A

25. In paragraph 9A.1 omit ", by a contractor, which is contracted to provide childhood vaccines and immunisations as part of Additional Services. Vaccines and immunisations are classified as an Additional Service)".

26. Omit paragraph 9A.11(a) and re-number the remaining sub-paragraphs accordingly.

27. In paragraph 9A.12(c) for "paragraph 72 of Schedule 6 to the 2004" substitute "paragraph 78 of Schedule 3 to the 2023".

28. In paragraph 9A.12(d), for "paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004" substitute paragraph 78 of Schedule 3 to the 2023 Regulations, those matters set out in paragraph 3(2)(d) of Schedule 2 to the 2023".

Amendment of, Part 4, Section 9ZA

29. In paragraph 9ZA.1 omit ", which is contracted to provide childhood vaccines and immunisations as part of Additional Services (such vaccines are classified as an Additional Service),".

30. Omit paragraph 9ZA.11(a) and re-number the remaining sub-paragraphs accordingly.

31. In paragraph 9ZA.14(c) for "paragraph 72 (patient records) of Schedule 6 to the 2004" substitute "paragraph 78 of Schedule 3 to the 2023".

32. In paragraph 9ZA.14(d), for "paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004" substitute paragraph 78 of Schedule 3 to the 2023 Regulations, those matters set out in paragraph 3(2)(d) of Schedule 2 to the 2023".

Amendment of, Part 4, Section 17

33. In paragraph 17.1 for, "paragraph 51 (provision of drugs, medicines and appliances for immediate treatment or personal administration) of Part 3 of Schedule 6 to the 2004" substitute "paragraph 59 (provision of drugs, medicines and appliances for immediate treatment or personal administration) of Part 5 of Schedule 3 to the 2023".

34. In paragraph 17.2(b), for "51(1)(b) in Part 3 of Schedule 6 to the 2004 Regulations" substitute "59(1)(b) of Part 5 of Schedule 3 to the 2023".

35. In paragraph 17.3 (c), for "51(1)(b) in Part 3 of Schedule 6 to the 2004", substitute "59(1)(b) of Part 5 of Schedule 3 to the 2023".

36. In paragraph 17.5, for "51(1)(b) in Part 3 of Schedule 6 to the 2004", substitute "59(1)(b) of Part 5 of Schedule 3 to the 2023".

Amendment of, Part 4, Section 18

37. In paragraph 18, for "paragraph 51 (provision of drugs, medicines and appliances for immediate treatment or personal administration) of Part 3 of Schedule 6 to the 2004" substitute "paragraph 59 (provision of drugs, medicines and appliances for immediate treatment or personal administration) of Part 5 of Schedule 3 to the 2023".

Amendment of, Part 4, Section 19

38. In paragraph 19.3 (b), for "22 of the 2004" substitute "20 of the 2023".

39. In paragraph 19.13, for "Part 7 of Schedule 6 to the 2004" substitute "Part 10 of Schedule 3 to the 2023".

Amendment of Annex A, Part 2 Definitions,

40. In the first sentence for "2004", in both places it occurs, substitute "2023".

41. For ""2004 Regulations" means the National Health Services (General Medical Services Contracts) (Wales) Regulations 2004(b)" including the footnote, substitute ""2023 Regulations" means the National Health Services (General Medical Services Contracts) (Wales) Regulations 2023(**a**)" including the footnote.

42. Omit the definitions "Additional Services" and "Additional or Out of Hours Services";

43. In the definition of "Childhood Immunisations", for "additional service referred to in the 2004 Regulations" substitute "service described in regulation 17 of the 2023 Regulations as supplemented by Schedule 2 to those regulations;".

44. In the definition of "Locum Practitioner" in paragraph (b) omit "(ii) additional services;";

45. For the definition of "National Average of Registered Patients" substitute "National Average of Registered Patients" means the aggregate CRP of contractors in Wales, as calculated using the number of patients recorded on the Primary Care Registration System administered by NHS Digital as being registered with contractors on the 1 April divided by the number of contractors on 1 April for the QIF year to which the relevant payment relates;".

46. Omit the definition for "Red Book".

Amendment of Annex B, Global Sum

47. In Annex B – Global Sum – Part 1, at the appropriate place, insert "B.10A. This will also apply where "new registrations" take place, as part of list dispersal or as part of an allocation of patients, as directed by the Health Board. However, this will not apply where a GMS contract is taken over/acquired, a new contract awarded, or where there is a contract merger, in which case practices may wish to discuss discretionary financial support which will need to be agreed between the contractor and the LHB."

Insertion of New Annexes

48. In the Annexes, in the appropriate place, insert Annex D in the Schedule to these directions.

49. In the Annexes, in the appropriate place, insert Annex E in the Schedule to these directions.

Amendment of Annex J

50. For "ANNEX J – AMENDMENTS" substitute Annex J in the Schedule to these Directions.

Signed by Paul Casey, Deputy Director of Primary Care under the authority of the Minister for Health and Social Services, one of the Welsh Ministers

Date: 06 February 2024

(**a**) S.I 2023//953 (W. 155) as amended.

SCHEDULE Directions 2, 48, 49 and 50

"ANNEX D – QI PROJECT – PRESCRIBING SAFETY

Practice guidance for Prescribing Safety QI project 2024-25

Background

The prescribing of a medication is the most common intervention in healthcare.

Close to 84.5 million items were prescribed by all primary care practitioners in Wales and dispensed in the community in 2022-23. Of these, 84.2 million items were prescribed through general practices, an increase of 1.3 million (1.6%) items since 2021-22 and the highest number on record.[a]

Whilst prescribing a medicine has the potential to improve health, it may also be associated with harm which may arise from unintended consequences of therapeutic use (i.e. adverse drug reaction), or medication error (i.e. through inappropriate prescribing, dispensing, administering, monitoring or use).

Demographic changes, including an ageing population and the increasing prevalence of co-morbidities, have driven increases in the concurrent use of multiple medicines (so called "poly-pharmacy") with patients on multiple medicines more likely to suffer side effects from medicines.

Most preventable adverse drug events in primary care are attributable to errors in prescription and medication monitoring, and changes in practice enabled by information technology have substantial potential to reduce the frequency of these errors.[b]

The pharmacist-led information technology intervention for medication errors (PINCER) study demonstrated how a multifaceted intervention comprising feedback, educational outreach, dedicated pharmacist support and use of information technology can improve quality through improvements in prescription safety and medication monitoring in general practices, at a low cost per error avoided.[c]

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a Primary care prescriptions: April 2022 to March 2023 | GOV.WALES.

b Schedlbauer A, Prasad V, Mulvaney C, et al. What evidence supports the use of computerized alerts and prompts to improve clinicians' prescribing behavior? J Am Med Inform Assoc 2009; 16: 531–38.

c Avery A et al. A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis. Lancet 2012; 379: 1310–1319.

Previous GMS quality improvement projects, between 2019 and 2022, focused on incentivising GMS contractors to take action to reduce the prevalence of risk factors associated with avoidable medicines related harm. The intention is to build on and develop this earlier work, in the context of the new Unified Contract and associated Assurance Framework. This framework sets out a number of quality indicators, including the completion of the Prescribing Safety Module on the Primary Care Information Portal, where being an outlier in terms of prescribing prompts further discussion with the local health board.

Aim

The aim of this QI project is to improve the prescribing safety indicators (reduction in numbers at risk) at practice level.

Objectives

All contractors will complete these 3 objectives (A, B and C) by the end of the QI period 31st March 2025:

A. At the start of the QI cycle, the practice clinical team will review practice-level Prescribing Safely data indicators (Listed at Annex A) and agree **at least two themes** for targeted improvement. These may be selected because:
   - Indicators where the practice has the highest levels of prescribing;
   - Indicators where the practice is furthest from the health board average prescribing levels; and/or
   - Indicators where there is a high-risk of harm through errors in prescribing.

   This selection should not include indicators covered in local prescribing incentive schemes.

B. Practices will undertake QI project activity designed to reduce rates of prescribing against each of the indicators under the identified themes. This could include (but not be limited to):
   - Using GP systems to identify possible prescribing issues;
   - Inviting patients to surgery for review;
   - Ensuring patients have appropriate tests for known side effects;
   - Making arrangements for ongoing review; and
   - Educational meetings with prescribers.

C. The practice clinical team will meet at the end of the QI cycle to review progress against the identified themes and to agree project outputs, including how learning will be embedded within the practice team following the conclusion of the project.

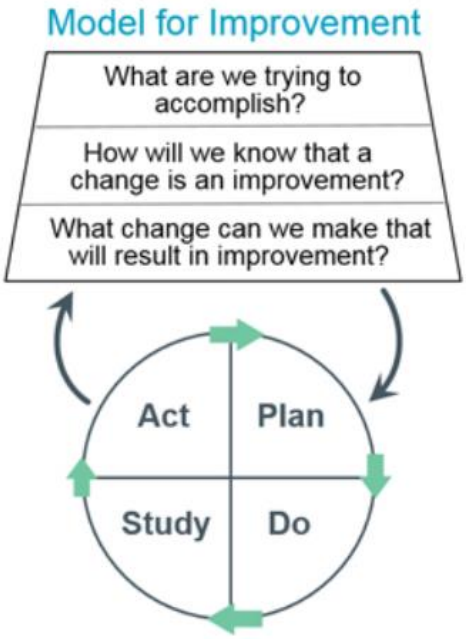
Requirements of the QI Project

<u>Practice level</u>

- Each general practice will have access to an online prescribing safety dashboard and will meet at the start of the QI cycle to discuss the information provided by the dashboard.
- Practices will identify a GP or pharmacist prescribing safety lead, who will be expected to lead the practice team in the use of a range of techniques to help correct medication errors and prevent future ones.
- Practices to adopt a QI methodology, including:
  - Review of baseline data
  - Review of their processes
  - Introduction of tested small cycles of change.

  Further information on QI methodology can be found at the links below:

  How to Improve | IHI - Institute for Healthcare Improvement
  https://youtu.be/nPysNaF1oMw
- Practices will discuss their learning with their GMS collaborative. Minutes of this meeting should be submitted to health boards as confirmation that this discussion has taken place.
- Practices will complete a nationally agreed QI Poster for sharing at the final collaborative meeting before 31/3/2025, confirming conclusion of the project and highlighting outcomes achieved.



GMS Collaborative level

- Practices to share aggregate practice-level data on prescribing indicators.
- Practices to discuss accuracy of data and process for refinement.
- Discuss, share best practice, and consider adaptation of QI processes if applicable across collaborative.

DHCW level

- DHCW will continue to support the Prescribing Safety PCIP module, providing the ability for practices to view their own aggregate data in comparison to their and other Clusters, their and other LHBs, and the all-Wales level.
- In the event that this aggregate data extraction is not in place for the duration of the QI project cycle, DHCW will aim to provide either a solution via dataset & business rules for each GP system supplier to implement; or make available pre-authored searches to enable practices to undertake their own local searches.

LHB level

- LHBs to ensure practice completion is verified against agreed indicators via completion of a nationally agreed QI Poster, shared and discussed with the collaborative and shared with the LHB by 31st March 2025.
- LHBs will collate the posters to allow thematic review at national level.

Verification and achievement

Practices:

- Practices will need to demonstrate achievement of the Objectives A, B and C by 31st March 2025. Evidence of achievement will be set out in a nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB. Minutes of the collaborative meeting should also be shared as evidence of the discussion.
- The contractor should ensure that the poster states where the QI activity has resulted improved prescribing outcomes.
- A poster template and further guidance for completion will be circulated to practices by end of October 2024.

LHB:

- LHBs will be required to verify that practices have undertaken all actions required to meet Objectives A, B and C, to confirm achievement and award payment.
- This will be done by reviewing each individual practice's nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB by 31st March 2025.

Annex A: Prescribing Safety QI Project Selected Indicators

Theme 1: Reducing harm from medication induced acute kidney injury (AKI)

- Number of patients on the CKD register (CKD stage 3–5) who have received a repeat prescription for an NSAID within the last 3 months.
- Number of patients who are not on the CKD register but have an eGFR of
  < 59 ml/min and have received a repeat prescription for an NSAID within the
  last 3 months.
- Number of patients with concurrent prescriptions of an NSAID, renin-angiotensin system (RAS) drug and a diuretic.
- Number of patients aged 75 years and over with a current prescription for an
  ACE Inhibitor or loop diuretic without a check of renal function and electrolytes
  in the previous 15 months.

Theme 2: Reducing harm from medication induced bleeds

- Number of patients with a peptic ulcer who have been prescribed NSAIDs
  without a PPI.
- Number of patients with concurrent prescriptions of warfarin and an oral NSAID.
- Number of patients with concurrent prescriptions for a DOAC and an oral
  NSAID.
- Number of patients aged 65 years or over who are prescribed an NSAID plus
  aspirin and/or clopidogrel but without gastroprotection (PPI or H2-receptor
  antagonist).
- Number of patients with concurrent prescriptions of an oral anticoagulant
  (warfarin or DOAC) and an SSRI.

Theme 3: Reducing harm from antipsychotic and anticholinergic medicines

- Number of patients aged 65 years or over prescribed an antipsychotic.
- Number of patients aged 75 years and over with an Anticholinergic Effect on
  Cognition (AEC) score of three or more for items on active repeat.

Theme 4: Minimising risks associated with hormonal contraception and hormone replacement therapy

- Number of female patients with a current prescription of oestrogen-only hormone replacement therapy (HRT) without any hysterectomy READ/SNOMED codes.
- Number of female patients with a past medical history of venous or arterial
  thrombosis who have been prescribed combined hormonal contraceptives.

Theme 5: Reducing foetal exposure to potentially harmful medicines

- Number of female patients aged 14–55 years with a prescription for sodium
  valproate.
- Number of female patients aged 14–55 years with a prescription for oral
  retinoids.”

“ANNEX E – QI PROJECT – UNHEALTHY BEHAVIOURS

Practice guidance for Supporting Healthy Behaviours QI project 2024-25

Background

GMS has always played a key role in the prevention agenda. Through the course of contract reform, agreement was reached in the 22/23 round to develop a focus on prevention and making every contact count.

The pandemic has exacerbated the challenge of providing health and care services that can support people to manage their condition well enough to avoid significant disease progression and the development of serious complications. This is likely to result in large scale population-level morbidity, mortality, and healthcare utilisation. There is an opportunity to improve outcomes and reduce healthcare demand by focusing on, and enabling, effective prevention of illness at key encounters with primary care. Such contacts include new patient registrations and chronic condition management reviews.

This QI project is focused on specific identified behaviours in newly registered patients and patients with certain long-term or chronic conditions.

These identified behaviours are:

- obesity/high BMI
- high risk alcohol intake, and
- tobacco use.

The long-term conditions are:

- Diabetes (all types)
- Cardiovascular Disease
    - Stroke
    - Heart Failure
    - Ischaemic Heart Disease
    - Atrial Fibrillation
- Hypertension
- Asthma
- Chronic Obstructive Pulmonary Disease

Whilst we want to support patients to make healthier behaviour choices, this QI project encourages primary care clinicians, collaboratives/clusters, and Health Boards to try new ways of delivering services and assess their impact.

This project builds on, and extends, improvement activity under the Unhealthy Behaviours QI project throughout 2023-24.

As in all Quality Improvement projects, it is *not* necessary to demonstrate an absolute improvement after an intervention. However, it is necessary to collect data 'before' and 'after' any intervention and share any learning widely. This will also support contractors and collaboratives to use and evaluate the new Accelerated Cluster Developments.

Aims

The **primary** aim of this QI project is to improve mortality and morbidity caused by the consequences of obesity, alcohol and tobacco use.

The **secondary** aim is to construct a list of interventions, devised and evaluated by contractors and/or collaboratives/clusters, as part of service improvements, and share the learning widely (regardless of whether any changes had positive or negative outcomes).

Objectives

All contractors will complete these 3 Objectives (A, B and C) by the end of the QI period 31st March 2025:

A. **Agreed Read codes** chosen from those listed in the Annex at the end of this document will be used by all practices when:

a) **recording** patients who:

1. are drinking alcohol at an increased or higher risk level;
2. are users of tobacco products;
3. have a high BMI; and

b) **documenting** any supportive interventions offered, such as advice, referral or signposting and clinically important related demographic data (e.g., ethnicity),

B. All these agreed Read codes together will form **a minimum data set** that will be used in two situations:
   - in any '**new patient questionnaire**' used for all patients aged 16 or older, who register with the practice
   - in **chronic disease reviews for patients with long term conditions**

C. Practices will then **undertake a QI project** aimed at developing and refining their processes for intervention and signposting of those patients displaying identified behaviours to appropriate resources. The QI project will only apply to two cohorts of patients:
   1. Newly registered patients
   2. Patients attending clinics or chronic condition reviews with the following long-term conditions
      - Diabetes (all types)
      - Cardiovascular Disease
        - Stroke
        - Heart Failure
        - Ischaemic Heart Disease
        - Atrial Fibrillation
      - Hypertension
      - Asthma
      - Chronic Obstructive Pulmonary Disease

   Practices will collect data before and after any interventions (e.g., Using IHI Quality Improvement Methodology and by using searches designed for this purpose), and share any learning (whether positive or negative) within their practice teams, collaborative/clusters and more widely.

Areas for Quality Improvement Project Activity

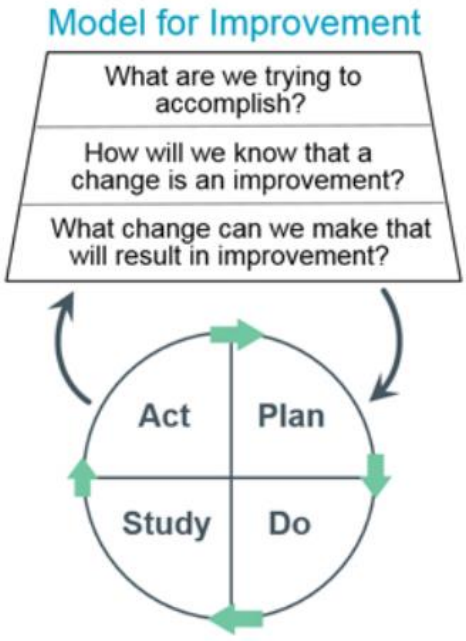
1. Improvement in identification, and recording, of newly registered patients with identified behaviours; appropriately recorded in the clinical record, and any necessary action taken to support behaviour change.
2. Improvement in identification, and recording, of patients with a chronic disease in the above list, who report identified behaviours, and appropriately recorded in the clinical record, and any necessary action taken to support behaviour change.
3. A review of skills and service gaps for intervention at local, regional, and national level.
4. Correction of any such gaps in skills or services in a practice team, or collaborative/cluster if practical.

Further information to support practices in undertaking the project and suggested QI activity is available in the Public Health Wales guide: Supporting Healthy Behaviours: A Guide for General Practice.

Practice Requirements

Practice Level

- Practices will have a named QI Project lead clinician.
- Practices will ensure that the agreed Read codes for BMI/Alcohol/Smoking behaviours will be incorporated into computer templates used for
    - New Patient Registration Health Checks; and
    - Chronic Disease Reviews.
      This may be by adopting a new endorsed National Template or by adjusting their own existing templates to include the national minimum dataset.
- Practices will consider how best to educate and/or signpost patients to appropriate resources for behaviour modification/weight loss, including digital methods and other modalities where appropriate. This should involve exploration of available local and national services and possible liaison with local services (including secondary care and third sector organisations).
- Practices to review Chronic Disease Management clinics in line with national guidance, consider processes for Hba1c testing in at risk individuals and opportunities for onward referral including the AWDPP.
- Practices to adopt a QI methodology, including:



    - Review of baseline data
    - Review of their processes
    - Introduction of tested small cycles of change.

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- Practices to review progress **at least quarterly.**
- Practices will discuss their learning with their GMS collaborative. Minutes of this meeting should be submitted to health boards as confirmation that this discussion has taken place.
- Practices will complete a nationally agreed QI Poster for sharing at the final collaborative meeting before 31/3/2025 confirming conclusion of the project and highlighting outcomes achieved.

GMS Collaborative Level

- Practices to share aggregate practice-level data on identified behaviours.
- Practices to discuss accuracy of data and process for refinement.
- Discuss, share best practice, and consider adaptation of QI processes if applicable across collaborative.
- The GMS Collaborative lead should bring themes for discussion to the wider cluster professionals e.g., to support *Making Every Contact Count* initiatives and signposting.
- The GMS Collaborative or Cluster may consider introducing collaborative/cluster initiatives to benefit the delivery of improved interventions in identified behaviours.
- The GMS Collaborative or Cluster should escalate deficiencies in systems/services or suggestions for system-wide improvement to Pan Cluster Planning Group for consideration of improved commissioning or inclusion in IMTP process.

DHCW Level

- DHCW will support the selection of agreed Read codes and creation of a minimum data set, with associated New Patient Registration Health Check, and Chronic Disease Review templates.
- DHCW will aim to provide either a solution via dataset & business rules for each GP system supplier to implement; or make available pre-authored searches to enable Practices to undertake their own local searches.
- Develop a PCIP tile for displaying required data and for practice upload of project materials for verification purposes.

Health Board Level

- Health Boards to ensure practice completion is verified against agreed indicators/contractual agreement via completion of a nationally agreed Poster shared at the collaborative meeting.
- Health Boards will collate the posters to allow thematic review at national level

Verification and achievement

Practices:

- Practices will need to demonstrate achievement of the Objectives A, B and C by 31st March 2025, by completion of the nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB. Minutes of the collaborative meeting should also be shared as evidence of the discussion.
- The contractor should ensure that the poster states that the minimum data set is applied in both new patient health check and chronic disease reviews.
- The contractor should ensure that the poster states where the QI activity has resulted improved outcomes.

- A poster template and further guidance for completion will be circulated to practices by end of October 2024.

LHB:

- LHBs will be required to verify that practices have undertaken all actions required to meet Objectives A, B and C, to confirm achievement and award payment.
- This will be done by reviewing each individual practice's nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB by 31st March 2025.

Minimum Dataset Codes – Recording Behaviour Codes

(incorporating codes from New Patient Questionnaire)

Recording of BMI (BMI calculated by GP system based on recorded height and weight measurements)

Read Code	Rubric	Value recorded
229..	O/E - height	Height in cm
22A..	O/E - weight	Weight in Kg
9NSZ.	Unsuitable for body height measurement	
9NSa.	Unsuitable for body weight measurement	

Clinical system will calculate BMI based on height and weight values and record value against Read code 22K..

Recording of alcohol consumption

Read Code	Rubric	Value recorded
136..	Alcohol Consumption	Alcohol units per week
136V.	Alcohol units per week	Alcohol units per week
136e.	Declines to state current alcohol consumption	

Recording of smoking status (look at old QOF smoking codes if required to capture tobacco product/quantity)

Smoking status:

Read Code	Rubric
1371.	Never smoked tobacco
137S.	Ex-smoker
137R.	Current smoker
137k.	Refusal to give smoking status

QOF Current Smoker codes:

Read Code	Rubric
137.	Tobacco consumption
1372.	Trivial smoker - < 1 cig/day
1373.	Light smoker - 1-9 cigs/day
1374.	Moderate smoker - 10-19 cigs/d
1375.	Heavy smoker - 20-39 cigs/day

1376.	Very heavy smoker - 40+cigs/d
137C.	Keeps trying to stop smoking
137D.	Admitted tobacco cons untrue ?
137G.	Trying to give up smoking
137H.	Pipe smoker
137J.	Cigar smoker
137M.	Rolls own cigarettes
137P.	Cigarette smoker
137Q.	Smoking started
137R.	Current smoker
137V.	Smoking reduced
137X.	Cigarette consumption
137Y.	Cigar consumption
137Z.	Tobacco consumption NOS
137a.	Pipe tobacco consumption
137b.	Ready to stop smoking
137c.	Thinking about stopping smoking
137d.	Not interested in stopping smoking
137e.	Smoking restarted
137f.	Reason for restarting smoking
137h.	Minutes from waking to first tobacco consumption
137m.	Failed attempt to stop smoking
137o.	Waterpipe tobacco consumption

Annex

Minimum Dataset Codes – Referral, Signposting and Advice

Hba1C 42-47 identified in Chronic Disease Clinics

679m4	Referral to NHS Diabetes Prevention Programme
679m3	Referral to NHS Diabetes Prevention Programme declined

Weight management advice

66CG.	Weight management programme offered
66CH.	Weight management plan started
66CJ.	Weight management plan completed
8Cd7.	Advice given about weight management
679P.	Health education - weight management
9N1yK	Seen in weight management clinic
8CA4z	Pt advised re diet NOS
8IAu.	Weight management advice declined

Weight management signposting

8CdC.	Weight management service signposted

Weight management referrals

8HHH.	Refer to weight management programme
8HHH0	Referral to local authority weight management programme
8HHH1	Referral to residential weight management programme
8IAM.	Referral to weigh management service declined

Alcohol advice

6792.	Health ed. - alcohol
8CE1.	Alcohol leaflet given
8CAM.	Patient advised about alcohol
8CAM0	Advised to abstain from alcohol consumption
67H0.	Lifestyle advice regarding alcohol

Alcohol Signposting

8CdK	Specialist alcohol treatment service signposted

Alcohol referrals

8H7p.	Referral to community alcohol team
8HHe	Referral to community drug and alcohol team
8HkG	Referral to specialist alcohol treatment service

8IEA	Referral to community alcohol team declined
8IAJ	Declined referral to specialist alcohol treatment service

Smoking advice

8CAL.	Smoking cessation advice
9N2k.	Seen by smoking cessation advisor
13p50	Practice based smoking cessation programme start date
9Ndf.	Consent given for follow-up by smoking cessation team
8IAj.	Smoking cessation advice declined
8IEK.	Smoking cessation programme declined
9Ndg.	Declined consent for follow-up by smoking cessation team

Smoking Signposting

8CdB.	Stop smoking service opportunity signposted

Smoking referrals

8HTK.	Referral to stop-smoking clinic
8HkQ.	Referral to NHS stop smoking service
8H7i.	Referral to smoking cessation advisor
8T08.	Referral to smoking cessation service
8IEo.	Referral to smoking cessation service declined"

"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;

(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;

(hh) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2022 which were made on 29 March 2022;

(ii) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2022 which were made on 8 June 2022;

(jj) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2022 which were made on 4 November 2022;

(kk) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2022 which were made on 29 November 2022;

(ll) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2023 which were made on 20 February 2023;

(mm) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2023 which were made on 29 March 2023;

(nn) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2023 which were made on 3 August 2023;

(oo) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2024 which were made on 8 February 2024;

(pp) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2024 which were made on 18 April 2024;

(qq) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2024 which were made on 10 October 2024;

(rr) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2024 which were made on 26 November 2024."