

2013 No. 8

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

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

Amended, as in force at 01.10.24

Made

10 June 2013

Coming into force

11 June 2013

Consolidated version as at
01.10.2024

Prepared on behalf of GPDF

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Introduction

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

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

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

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

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

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

1.7 This SFE applies in relation to Wales.

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

Application and commencement

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

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

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

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

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



Date: 10 June 2013

NATIONAL HEALTH SERVICE, WALES

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

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PART 1 – GLOBAL SUM AND PRACTICE SUPPORT MONTHLY PAYMENTS

Section 2: GLOBAL SUM PAYMENTS

Global Sum Payments: General

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

monthly.

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

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

- (a) at the start of the financial year; or
- (b) if the contract takes effect after the start of the financial year, on the date on which the GMS contract takes effect.

2.3. Once the contractor's CRP has been established, this number is to be adjusted by the Global Sum Allocation Formula, a summary of which is included in Annex B of this SFE. The resulting figure, which is the contractor's Weighted Population for the quarter, is to be multiplied by £117.48 for the period beginning with 1 April 2023.

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

2.4A. £2.71 of the figure of £117.48 in paragraph 2.3 is to account for the agreed 5% increase in annual remuneration to practice staff employed by the GMS contractor and which GMS contractors must reflect as at least a 5% pay increase for those staff beginning with 1 April 2023. 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 by at least 5% for the financial year 2023/2024.

Calculation of Adjusted Global Sum Monthly Payments

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

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

Table 1

<i>Additional Services</i>	<i>Percentage of Initial GSMP</i>
Cervical Screening Services	1.1
Child Health Surveillance	0.7

Minor Surgery	0.6
Maternity Medical Services	2.1
Contraceptive Services	2.4
Childhood vaccines and immunisations	1.0
Vaccines and immunisations	2.0

First Payable Global Sum Monthly Payments

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

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

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

Revision of Payable Global Sum Monthly Payments

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

- (a) at the start of each quarter;
- (b) if there are to be new Additional Services opt-outs (whether temporary or permanent);
- (c) if the contractor is to start or resume providing specific Additional Services that it has not been providing; or
- (d) if the amount specified in paragraph 2.3 is changed.

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

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

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

2.12. Payment of the new Payable GSMP must (until it is next revised) be made monthly, and it is to fall due on the last day of each month. However, if a change is made to the Additional

Services that a contractor is under an obligation to provide and that change takes effect on any day other than the first day of the month, the contractor's Payable GSMP for that month is to be adjusted accordingly. Its amount for that month is to be the total of—

- (a) the appropriate proportion of its previous Payable GSMP. This is to be calculated by multiplying its previous Payable GSMP by the fraction produced by dividing—
 - (i) the number of days in the month during which it was providing the level of services based upon which its previous Payable GSMP was calculated, by
 - (ii) the total number of days in the month; and
- (b) the appropriate proportion of its new Payable GSMP. This is to be calculated by multiplying its new Payable GSMP by the fraction produced by dividing—
 - (i) the number of days left in the month after the change to which the new Payable GSMP relates takes effect, by
 - (ii) the total number of days in the month.

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

Conditions attached to Payable Global Sum Monthly Payments

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

- (a) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's Payable GSMP;
- (b) the contractor must make any returns required of it (whether computerised or otherwise) to the Primary Care Registration System administered by NHS Digital, and do so promptly and fully;
- (c) the contractor must immediately notify the LHB if for any reason it is not providing (albeit temporarily) any of the services it is under an obligation to provide under its GMS contract; and
- (d) all information supplied to the LHB pursuant to or in accordance with this paragraph must be accurate.

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

2.16. The CPI is the contractor's most recently established CRP divided by the NARP.

2.17. Beginning with 1 April 2024, the value of a QIF point for QI must be recalculated each year after the NARP has been established and applies to the current QI year, subject to any uplift that may or may not be applied.

2.18. The revised QIF point value for QI is to be calculated by multiplying the previous QI point value by the fraction produced by dividing the newly established NARP that applies for the forthcoming QI year by the NARP that applied to the previous QI year. The calculation is expressed as—

Revised QIF point value for the following QIF QI year =

$$\begin{array}{r}
 \textit{Previous QIF point value} \quad \times \quad \frac{\textit{Newly established NARP for} \\
 \textit{the forthcoming QIF QI year}}{\textit{NARP for the previous QIF QI year}}
 \end{array}$$

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. From 1 April 2021, MPIG ceased to be applicable and CFMP ceased to be payable. 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 the 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, may 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 not 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.

PART 2 – QUALITY IMPROVEMENT FRAMEWORK

Section 4: GENERAL PROVISIONS

General

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

4.2. The QIF consists of two domains – Access and Quality Improvement (QI).

4.3. There are two types of payments that are made in relation to the QI domain which are Aspiration Payments and Achievement Payments.

4.4. There is one payment in relation to the Access domain which is Achievement Payments.

4.5. Information on Aspiration Payments and Achievement payments are set out in Section 5: Access and Section 6: Quality Improvement. The standards can be found at Part 2 of Annex D.

SECTION 5: ACCESS

General

5.1. The access standards take a reflective approach. This allows practices time to reflect, listen to patient experience and make improvements to access. Practices will be required to report the access standards quarterly and be prepared to supply evidence (which could include but is not limited to the practice's appointment system, patient experience survey outcomes and up to date infographics) via the PCIP Access Reporting Tool.

5.2. The standards are set out in <https://gov.wales/guidance-general-medical-services-gme-contract-access-commitment-2022-2023>.

Access Standards

5.3. Practices are required to achieve all 6 measures listed below in order to receive 40 points for this section of the commitment.

Service Delivery and Communication

5.3.1. All existing patient facing staff who have not previously undertaken the national care navigation training package provided by HEIW in the period beginning with 1 April 2022 and ending with 31 March 2024 are required to undertake that training, and new patient facing staff must complete the training within 3 months of commencing their employment beginning with their start date. Practices will supply names of new starters and the date training was undertaken along with names of existing staff who undertake the training.

5.3.2. All patients telephoning the practice are to have their calls received by a standard recorded message, and subsequently calls are answered with appointments made available for advanced booking each day with declaration confirming that every patient contact is supported throughout the day. Patients will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without the need for the patients to contact the service again. Where clinically appropriate, patients may be signposted to another appropriate service.

5.3.3. To maintain a planned and forward-looking approach to consultations, practices are required to undertake a regular assessment of their scheduling appointment system to ensure a mix of remote, face to face, urgent, on the day and pre-bookable appointments. A more planned and forward-looking approach should be taken to the scheduling of appointments throughout the day, or for future dates, meaning it is no longer acceptable for all appointments for that day to be released at 8.00am.

Patient Engagement

5.3.4. Practices must regularly maintain an automated and standardised public facing dashboard and make this available via a range of communication methods to meet the needs of their patients.

5.3.5. Practices are required to undertake the national patient experience survey, which should include 25 completed questionnaires per 1000 registered patients from a range of practice population and captured through a range of methods.

Digital

5.3.6. Practices are required to undertake care navigation on digital requests in a similar and equitable fashion to telephone requests.

Reflective Report

5.4. Practices are required to produce a reflective report (60 points) to include 5.4.1 to 5.4.4 points below and all the requirements listed in Annex A of the Guidance for the GMS Contract, Access Commitment 2022/23 which can be found at <https://gov.wales/guidance-general-medical-services-gms-contract-access-commitment-2022-2023>. Practices must—

5.4.1. Produce an Equality Impact Assessment to review population and access needs;

5.4.2. Utilise results of the national patient experience survey to develop a action plan which will demonstrate how practices plan to move forward with implementing and communicating change effectively;

5.4.3. Detail how they have reflected on patient experience and can demonstrate improvements made, with improvements made to be discussed at collaborative level; and

5.4.4. Use intelligence from their telephony system to show how they have interrogated the data, and evidence call demand comparisons.

5.5. Practices must complete the report and upload it to the PCIP Access Reporting Tool on or before 31 March of the Access year.

5.6. The total points available for the Access domain is 100.

5.7. The indicators for Access 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.

5.8. The annual cycle for Access runs for the period beginning with 1 April and ending with 31 March of each year.

Achievement Payments for Access from 1 April 2024 to 31 March 2025

5.9. Achievement payments are to be based on the achievement points to which a contractor is entitled to for Access during each financial year as calculated in accordance with paragraphs 5.10 to 5.17 of this Section.

Calculation of Achievement Payments from 1 April 2024 to 31 March 2025

5.10. The Access points value for Achievement Payments will be £198. The calculation for achievement payments for Access will be made by using the contractor's registered patient list size as at 1 January in that Access year against the mean average of contractor registered patients also taken at 1 January of that same Access year.

5.11. Subject to paragraph 5.12, the date in respect of which the assessment of achievement points is to be made is the last day of the financial year for Access.

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

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

Returns in respect of Achievement Payments

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

5.14. Based on that return, the LHB must calculate the contractor's Achievement Payment in accordance with paragraph 5.10.

Accounting arrangements and due date for Achievement Payments

5.15. 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 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 5.12), 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 financial year after the financial year into which the relevant date falls (see paragraph 5.13).

Conditions attached to Achievement Payments

5.16. 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 5.13;
- (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.

5.17. 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.

SECTION 6: QUALITY IMPROVEMENT

General Provisions relating to the Quality Improvement Domain

- 6.1. The QI domain is based on QI projects the practice will complete.
- 6.2. The QI projects that the contractors must complete will be set out here in due course.
- 6.3. The total points available for the QI domain is 170 for the QIF (QI) year 1 April 2024 to 31 March 2025.

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

- 6.4. Aspiration Payments are a payment made in advance of Achievement Payments being calculated under the QI domain of the QIF.
- 6.5. 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.
- 6.6. The QI points value for Achievement Payments will be £198.
- 6.7. 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.
- 6.8. 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.
- 6.9. 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.
- 6.10. If the contractor cannot evidence the completion of the QI projects, then the Local Health Board is entitled to recover any Aspiration Payments made.

PART 3 - IMMUNISATIONS

SECTION 7: CHILDHOOD IMMUNISATIONS

General: Childhood vaccines and immunisations

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

Childhood Immunisation Scheme plans

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

Target payments in respect of two-year-olds

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

- (a) the contractor has, as part of its GMS contract, a Childhood Immunisations Scheme plan which has been agreed with the LHB; and
- (b) subject to paragraph 7.4 as regards the cohort of children, established on that day, who are registered with the contractor and who are aged two (i.e. who have passed their second birthday but not yet their third), by the end of that quarter at least 70%, for the lower payment, or at least 90%, for the higher payment, have completed the recommended immunisation courses (i.e. those that have been recommended nationally and by the World Health Organisation) for protection against—
 - (i) diphtheria, tetanus, poliomyelitis, pertussis, Haemophilus influenza type B (HiB) and hepatitis B;
 - (ii) measles/mumps/rubella; and
 - (iii) Meningitis C.

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

Calculation of Quarterly Two-Year-Olds Immunisation Payment

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

- (a) $(0.7 \times A \times 4) = B^1$ (the number of completed immunisation courses needed to meet the 70% target); and
- (b) $(0.9 \times A \times 4) = B^2$ (the number of completed immunisation courses needed to meet the 90% target).

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

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

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

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

- (a) the Contractor;
- (b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “GMS contractor” includes a contractor providing services under section 42 of the 2006 Act, section 84 of the National Health Service Act 2006, a contractor providing services under a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “PMS Contractor” includes a contractor providing services under section 50 of the 2006 Act, a contractor providing services under section 92 of the National Health Service Act 2006, a contractor providing services under section 17C of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (d) an Alternative Provider Medical Services contractor (“APMS contractor”) as part of primary medical services to a patient who was at that time registered with that contractor (where the term “APMS contractor” includes a contractor providing services under arrangements made under section 41 of the 2006 Act, section 83(2) of the National Health Service Act 2006, a contractor providing services under arrangements made under a contractor providing services under section 2C(2) of the National Health Services (Scotland) Act 1978 or a contractor providing services under arrangements made under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or
- (e) a Local Health Board Medical Services practice as part of primary medical services to a patient who was at that time registered with such a practice which provided services under arrangements made under section 41(2) of the 2006 Act, section 83(2)(a) of the National Health Service Act 2006 (before the coming into force of section 34 (abolition of Primary Care Trusts) of the Health and Social Care Act 2012) or Article 56(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 (such arrangements in Northern Ireland being referred to as Health and Social Services Board Medical Services)).

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

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

$$\begin{aligned} & C1 \times 2 \text{ minus } E1 \times 2 \\ & + C2 \text{ minus } E2 \\ & + C3 \text{ minus } E3 \\ & = D \end{aligned}$$

For these purposes –

- (E^X) is the number of completed immunisation courses in each disease group where the completing immunisation was carried out other than by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 7.7(a) to (e) (e.g. for the diseases referred to in paragraph 7.3(b)(i), E1);
- (a) (C^X) is the number of children in the cohort of children in respect of whom the calculation is to be made who have completed the immunisation course in respect of a particular disease group (e.g. for the diseases referred to in paragraph 7.3(b)(i), (C1);
 - (b) in the case of the disease group referred to in paragraph 7.3(b)(i), the value of $(C1 \times 2) - (E1 \times 2)$

2) can never be greater than $(A \times 2) \times 0.7$ or 0.9 (depending on which target achieved); where it is, it is treated as the result of: $A \times 0.7$ or, as the case may be, 0.9 .

7.10 The maximum amounts payable to a contractor will depend on the number of children aged two whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 61. The maximum amounts payable to the contractor (F) are therefore to be calculated as follows –

- (a) where the 70% target is achieved: $(F^1) = \frac{A \times \pounds 612.54}{61}$; or
- (b) where the 90% target is achieved: $(F^2) = \frac{A \times \pounds 1,837.63}{61}$

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

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

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

Conditions attached to Quarterly Two-Year-Olds Immunisation Payments

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

- (a) the contractor must meet its obligations under its Childhood Immunisations Scheme plan;
- (b) the contractor must make available to the LHB sufficient information to enable it to calculate the contractor's Quarterly TYOIP. In particular, the contractor must supply the following figures–
- (i) the number of two-year-olds whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which a payment is claimed;
 - (ii) how many of those two-year-olds have completed each of the recommended immunisation courses (i.e. that have been recommended nationally and by the World Health Organisation) for protection against the disease groups referred to in paragraph 7.3(b) by the end of the quarter in respect of which a payment is claimed; and
 - (iii) of those completed immunisation courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 7.7(a) to (e); and
- (c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

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

Target payments in respect of five-year-olds

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

- (a) the contractor has, as part of its GMS contract, a Childhood Immunisations Scheme plan which

has been agreed with the LHB; and

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

Calculation of Quarterly Five-Year-Olds Immunisation Payments

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

- (a) $(0.7 \times A) = B^1$ (the number of completed booster courses needed to meet the 70% target); and
- (b) $(0.9 \times A) = B^2$ (the number of completed booster courses needed to meet the 90% target).

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

- (a) if $C \geq B^1$, then the 70% target is achieved; and
- (b) if $C \geq B^2$, then the 90% target is achieved.

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

- (a) the Contractor;
- (b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “GMS contractor” includes a contractor providing services under section 42 of the 2006 Act, a contractor providing services under section 84 of the National Health Service Act 2006, a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “PMS Contractor” includes a contractor providing services under section 50 of the 2006 Act, a contractor providing services under section 92 of the National Health Service Act 2006, a contractor providing services under section 17C of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (d) an Alternative Provider Medical Services contractor (“APMS contractor”) as part of primary medical services to a patient who was at that time registered with that contractor (where the term “APMS contractor” includes a contractor providing services under arrangements made under section 41(2)(b) of the 2006 Act, a contractor providing services under arrangements made under section 83(2) of the National Health Service Act 2006, a contractor providing services under section 2C(2) of the National Health Services (Scotland) Act 1978 or a contractor providing

services under arrangements made under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or

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

7.19 If $D > B^1$ or B^2 (depending on the target achieved), then D is adjusted to equal the value of (B^1) or (B^2) as appropriate. The maximum amounts payable to a contractor will depend on the number of children aged five whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 65. The maximum amounts payable to the contractor (E) are therefore to be calculated as follows –

(a) where the 70% target is achieved: $E^1 = \frac{A \times £227.70}{65}$ or

(b) where the 90% target is achieved: $E^2 = \frac{A \times £683.06}{65}$

7.20A Paragraph 7.20 applies from 1 July 2019.

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

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

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

Conditions attached to Quarterly Five-Year-Olds Immunisation Payments

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

- (a) the contractor must meet its obligations under its Childhood Immunisations Scheme plan;
- (b) the contractor must make available to the LHB sufficient information to enable the LHB to calculate the contractor's Quarterly FYOIP. In particular, the contractor must supply the following figures—
 - (i) the number of five-year-olds whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter in respect of which a payment is claimed;
 - (ii) how many of those five-year-olds have received the complete course of recommended reinforcing doses (i.e. that have been recommended nationally and by the World Health Organisation) for protection against the diphtheria, tetanus, pertussis and poliomyelitis by the end of the quarter in respect of which a payment is claimed; and
 - (iii) of those completed courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 7.18(a) to (e); and
- (c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

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

PART 4 - PAYMENTS FOR SPECIFIC PURPOSES

Section 8: ROTAVIRUS VACCINE

General

8.1 Section 8 makes provision in respect of payments to be made in respect of the administration of the rotavirus vaccine by a contractor. A contractor may be contracted to provide the childhood vaccines and immunisations which are classified as Additional Services. The rotavirus vaccine is part of the routine childhood immunisation schedule (see Annex I) and therefore falls within the childhood vaccines and immunisations which are classified as Additional Services.

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

Payment for administration of rotavirus vaccine

8.3 The LHB must pay a contractor who qualifies for the payment, a payment of £10.03 in respect of each child registered with the contractor who receives a completed course of immunisation (as set out below) as part of their routine childhood immunisation schedule.

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

<i>When to immunise</i>	<i>How vaccine is given</i>
2 months	One oral dose
3 months	One oral dose

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

- (a) the final completing dose at least one month following the administration of the first dose; and
 - (b) the second dose of the vaccine to the child before the child reaches the age of 24 weeks,
- the LHB must pay a contractor in accordance with paragraph 8.3.

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

- (a) the final completing dose of the vaccine at least one month following the administration of the first dose (which must have been given before the child reaches the age of 15 weeks); and
 - (b) the second dose of the vaccine to the child before that child reaches the age of 24 weeks,
- the LHB must pay contractor in accordance with paragraph 8.3.

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

(a) See "Immunisation against infectious diseases – The Green Book".

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

Eligibility for payment

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

- (a) the contractor is contracted to provide the childhood vaccines and immunisations as part of Additional Services;
- (b) the child in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the final completing course of the vaccine was administered;
- (c) the contractor administers the final completing course of the vaccine to the child in respect of whom the payment is claimed;
- (d) the contractor does not receive any payment from any other source in respect of the vaccine (if the contractor does receive any such payment in respect of any child from any other source, the LHB must give serious consideration to recovering any payment made under this Section in respect of that patient pursuant to paragraphs 19.1 and 19.2 (overpayments and withheld amounts); and
- (e) the contractor submits the claim within 6 months of administering the final completing course of the vaccine.

Claims for payment

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

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

Conditions attached to payment

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

- (a) the contractor must supply the LHB with the following information in respect of each child for which a payment is claimed—
 - (i) the name of the child;
 - (ii) the date of birth of the child;
 - (iii) the NHS number, where known, of the child;
 - (iv) except where paragraph (v) applies, confirmation that the child has received two doses of the rotavirus vaccine in accordance with the table at paragraph 8.4;
 - (v) if the claim is made in the circumstances set out in paragraph 8.5, confirmation that all required vaccines have been administered; and
 - (vi) the date of the final completing course of the vaccine, which must have been administered by the contractor,

but where a parent or carer objects to details of the child's name or date of birth being supplied to the LHB, the contractor need not supply such information to the LHB but must supply the child's NHS number;
- (b) the contractor must provide appropriate information and advice to the parent or carer of the child;
- (c) the contractor must record in the child's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, any refusal of an offer of the rotavirus vaccine;

- (d) where the rotavirus vaccine is administered, the contractor must record in the child's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004 Regulations;
- (e) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable him to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;
- (f) the contract must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;
- (g) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully; and
- (h) all information provided pursuant to or in accordance with this paragraph must be accurate.

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

Section 9: PNEUMOCOCCAL VACCINE AND HIB/MENC VACCINE FOR CHILDREN BORN BEFORE 1 JANUARY 2020

General

9.1 Section 9 applies to children born before 1 January 2020. It makes provision in respect of payments to be made in respect of the administration by a contractor, which is contracted to provide childhood vaccines and immunisations as part of Additional Services (such vaccines are classified as an Additional Service), of the pneumococcal conjugate vaccine (PCV) and the combined Hib and Men C vaccine (Hib/MenC) as part of the routine childhood immunisation schedule and in certain non-routine cases.

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

Payment for administration of PCV vaccine and Hib/MenC vaccine as part of the routine childhood immunisation schedule for children born before 1 January 2020

9.3 The LHB must pay to a contractor who qualifies for the payment, a payment of £20.06 in respect of each child born before 1 January 2020 and registered with the contractor—

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

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

9.5 The table below sets out the schedule for the administration of the PCV and the Hib/MenC vaccines as part of the routine childhood immunisation schedule for children born before 1 January 2020.

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

Payment for administration of PCV vaccine other than as part of the routine childhood immunisation schedule for children born before 1 January 2020

9.6 The LHB must pay to a contractor who qualifies for the payment, a payment of £20.06 in respect of each child born before 1 January 2020 and registered with the contractor who has received the PCV vaccine in any of the circumstances set out in paragraphs 9.8 to 9.14 and in respect of whom the contractor administered the final completing course of the vaccine.

Children born before 1 January 2020 at increased risk of pneumococcal infection

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

<i>Clinical risk group</i>	<i>Examples (decision based on clinical judgement)</i>
Asplenia or dysfunction of the spleen	This includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction
Chronic respiratory disease (chronic respiratory disease refers to chronic lower respiratory tract disease)	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neuromuscular disease (e.g. cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless so severe as to require continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below).
Chronic heart disease	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
Chronic kidney disease	Nephrotic syndrome, chronic kidney disease at stages 4 and 5 and those on kidney dialysis or with kidney transplantation.
Chronic liver disease	This includes cirrhosis, biliary atresia and chronic hepatitis.
Diabetes	Diabetes mellitus requiring insulin or oral hypoglycaemic drugs. This does not include diabetes that is diet controlled.
Immunosuppression	Due to disease or treatment, including patients undergoing chemotherapy leading to immunosuppression bone marrow transplant, asplenia or splenic dysfunction, HIV infection at all stages, multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4, NEMO, complement deficiency), individuals on or likely to be on systemic steroids for more than a month at a dose equivalent to prednisolone at

	20mg or more per day (any age), or for children under 20kg, a dose of 1mg or more per kg per day .
Individuals with cochlear implants	This includes individuals with cochlear implants. Furthermore, it is important that immunisation does not delay the cochlear implantation.
Individuals with Cerebrospinal fluid leaks	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery. Conditions related to CSF leaks include all CSF shunts.

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

- (a) consequently cannot receive, and has not received the four vaccines referred to in paragraph 9.3(a) in accordance with the routine schedule set out in the table in paragraph 9.5; but
- (b) who nevertheless still presents in time to enable the child to receive, and did receive two doses of PCV before the age of 12 months, the Hib/MenC at around the age of 12 months and a third dose of PCV at around the age of 13 months,

the LHB must pay to the contractor administering the final completing course of the vaccine a payment of £20.06 in respect of that child. The third dose of PCV is considered the final completing course of the vaccine for this purpose.

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

- (a) consequently cannot receive, and has not received, two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months; but
- (b) nevertheless receives either a single dose of PCV or, if the child has asplenia, splenic dysfunction or is immunocompromised, two doses of PCV, the second of which is administered two months after the first dose,

the LHB must pay to the contractor administering the final completing course of the vaccine a payment of £20.06 in respect of that child. The single dose of PCV or, in the case of a child where a second dose of PCV is required, the second dose of PCV is considered the final completing course of the vaccine for this purpose.

Children born before 1 January 2020 over the age of 13 months but under the age of 5 years who have previously had invasive pneumococcal disease

9.10 Where a child who is over the age of 13 months but under the age of 5 years and who has previously had invasive pneumococcal disease receives a single dose of PCV in accordance with the recommendation contained in Immunisation against infectious diseases – The Green Book, the LHB must pay to the contractor administering the final completing course of the vaccine a payment of £20.06 in respect of that child unless a payment is otherwise payable for that same final completing course of the vaccine under paragraph 9.9 or 9.12. The single dose of PCV is considered the final completing course of the vaccine for this purpose.

Children born before 1 January 2020 with an unknown or incomplete immunisation status

9.11 Where a child who has an unknown or incomplete immunisation status receives vaccines sufficient to ensure that he has received two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months, the LHB must pay to the contractor administering the final completing course of the vaccine a payment of £20.06 in respect of that child. The third dose of PCV is considered the final completing course of the vaccine for this purpose.

9.12 Where a child who has an unknown or incomplete immunisation status and is too old to be able to receive two doses of PCV before the age of 12 months, the Hib/MenC at around the age of 12 months and a third dose of PCV at around the age of 13 months, receives a single dose of PCV prior to the age of 24 months, the LHB must pay to the contractor who administers the final completing course of the vaccine a payment of £20.06 in respect of that child. The single dose of PCV is considered the final completing course of the vaccine for this purpose.

Eligibility for payment

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

- (a) the contractor is contracted to provide the childhood vaccines and immunisations as part of Additional Services;
- (b) the child in respect of whom the payment is claimed was-
 - (i) born before 1 January 2020, and
 - (ii) on the contractor's list of registered patients at the time the final completing course of the vaccine was administered;
- (c) the contractor administers the final completing course of the vaccine to the child in respect of whom the payment is claimed;
- (d) subject to sub-paragraph (e), the child in respect of whom the payment is claimed is aged around 13 months when the final completing course of the vaccine is administered;
- (e) in the case of payments in respect of the vaccines administered in accordance with paragraphs 9.9 or 9.10, the child must be under the age of 5 years when the final completing course of the vaccine is administered and in the case of the vaccines administered in accordance with paragraph 9.14, the child must be under the age 2 years when the final completing course of the vaccine is administered;
- (f) the contractor does not receive any payment from any other source in respect of any of the series of three PCV vaccines and the Hib/MenC vaccine set out in the table at paragraph 9.5 or in respect of any vaccine administered under any of the circumstances set out in paragraphs 9.8 to 9.12 of this Section (if the contractor does receive any such payment in respect of any child from any other source, the LHB must give serious consideration to recovering any payment made under this Section in respect of that child pursuant to paragraph 9.1(a) (overpayments and withheld amounts); and
- (g) the contractor submits the claim within 6 months of administering the final completing course of the vaccine.

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

9.15 The contractor is not entitled to payment of more than £20.06 in respect of any child under this Section, other than where –

- (a) the contractor claims for payment for a final completing course of the vaccine administered under the circumstances set out in paragraph 9.10; and
- (b) by virtue of that paragraph, the contractor is entitled to a payment under that paragraph, irrespective of any previous payment made in respect of that child under the provisions of this Section.

Claims for payment

9.16 The contractor is to submit claims in respect of the final completing course of the vaccine after they have been administered at a frequency to be agreed between the LHB and the contractor (which must be a frequency which provides for the claim to be submitted within 6 months of administering the final completing vaccine), or if agreement cannot be reached, within 14 days of the end of the month during which the final completing course of the vaccine was administered.

Any amount payable falls due on the next date, following the expiry of 14 days after the claim is submitted, when the contractor's Payable GSMP falls due.

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

Conditions attached to payment

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

- (a) the contractor must supply the LHB with the following information in respect of each child for which a payment is claimed—
 - (i) the name of the child;
 - (ii) the date of birth of the child;
 - (iii) the NHS number, where known, of the child;
 - (iv) except where paragraph (v) applies, confirmation that the child has received three doses of PCV and one dose of Hib/MenC vaccination in accordance with the table at paragraph 9.5;
 - (v) if the claim is made in the circumstances set out in paragraph 9.9, 9.10 or 9.12, confirmation that all required vaccines have been administered; and
 - (vi) the date of the final completing course of the vaccine, which must have been administered by the contractor,

but where a parent or carer objects to details of the child's name or date of birth being supplied to the LHB, the contractor need not supply such information to the LHB but must supply the child's NHS number;
- (b) the contractor must provide appropriate information and advice to the parent or carer of the child, and where appropriate, also to the child, about pneumococcal vaccine and the Hib/MenC vaccine;
- (c) the contractor must record in the child's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, any refusal of an offer of a pneumococcal vaccine or a Hib/MenC booster vaccine;
- (d) where a pneumococcal vaccine or a Hib/MenC vaccine is administered, the contractor must record in the child's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004 Regulations;
- (e) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable that health care professional to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;
- (f) the contract must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;
- (g) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully; and
- (h) all information provided pursuant to or in accordance with this paragraph must be accurate.

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

Section 9A - HEPATITIS B VACCINATION FOR BABIES

9A.1. This section makes provision in respect of payments to be made in respect of the administration of the Hepatitis B vaccination to babies, as part of the Hepatitis B Vaccination Programme, 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).

9A.2. The LHB must pay to the contractor who qualifies for the payment, a payment of £10.03 in respect of each dose administered to a baby who is on the contractor's list of registered patients and who is born to a mother who is infected with Hepatitis B

9A.3. The contractor must not administer the Hepatitis B vaccination to a baby in a case where the Hepatitis B status of the mother is unknown.

9A.4. The first dose of the Hepatitis B vaccine is to be administered by the contractor to a baby as soon as possible after the birth of the baby, but only if it has not already been administered by a hospital immediately after the birth of the baby.

9A.5. The second dose of the Hepatitis B vaccine is to be administered by the contractor to a baby—

- (a) who has attained the age of one month; or
- (b) after the period of at least four weeks from the date on which the first dose was administered.

9A.6. The third dose of the Hepatitis B vaccine may only be administered by the contractor to a baby who has attained the age of 12 months.

Claims for Payment

9A.7. A contractor may not claim a payment for the administration of the third dose of the Hepatitis B vaccine to a baby unless the contractor has recorded the results in the baby's patient record of a blood test to ascertain the existence of Hepatitis B infection.

9A.8. A contractor is eligible for a payment in respect of the administration of the Hepatitis B vaccine to a baby in any case where the vaccine status of the baby is unknown or incomplete and the contractor completes the administration of the required doses of the Hepatitis B vaccine to that baby.

9A.9. Claims for payment must be submitted within 6 months of the administration of the vaccination. Any amount payable falls due on the next date when the contractor's Payable GSMP falls due.

9A.10. The LHB must ensure that the receipt and payment in respect of claims are properly recorded and that each such claim has a clear audit trail.

Eligibility for payment

9A.11. A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met—

- (a) the contractor is contracted to provide vaccines and immunisations as part of Additional Services;
- (b) the baby in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the vaccine was administered;
- (c) the contractor does not receive any payment from any other source in respect of the vaccine (if the contractor does receive any such payment in respect of any baby from any other source, the Board must give serious consideration to recovering any payment made under this Section in respect of that patient pursuant to paragraphs 19.1 and 19.2 (overpayments and withheld amounts)); and

- (d) the contractor submits the claim for payment—
 - (i) for the first dose of the vaccine, within 6 months of administering that dose,
 - (ii) for the second dose of the vaccine, within 6 months of administering that dose, or
 - (iii) for the third dose of the vaccine, within 6 months of administering that dose.

Conditions attached to payment

9A.12. A payment under the provisions of this Section is only payable if the contractor satisfies the following conditions—

- (a) the contractor must supply the LHB in respect of each baby for which a payment is claimed—
 - (i) the name of the baby;
 - (ii) the date of birth of the baby;
 - (iii) the NHS number, where known, of the baby;
 - (iv) confirmation that the baby has received the required doses of the Hepatitis B vaccine in accordance with paragraph 9A.4 to 9A.6; and
 - (v) the date on which each dose of the vaccine was administered by the contractor,

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

- (b) the contractor must provide appropriate information and advice to the parent or carer of the baby;
- (c) the contractor must record in the baby's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, any refusal of an offer of the Hepatitis B vaccine;
- (d) where the Hepatitis B vaccine is administered, the contractor must record in the baby's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004 Regulations;
- (e) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable that health care professional to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;
- (f) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;
- (g) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully; and
- (h) all information provided pursuant to or in accordance with this paragraph must be accurate.

9A.13. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of any, or any part of, the payment due under this Section.

Section 9ZA: PNEUMOCOCCAL VACCINE AND HIB/MEN C VACCINE FOR CHILDREN BORN AFTER 31 DECEMBER 2019

General

9ZA.1. Section 9ZA applies to children born after 31 December 2019. It makes provision in respect of payments to be made for the administration by a contractor, which is contracted to provide childhood vaccines and immunisations as part of Additional Services (such vaccines are classified as an Additional Service), of the pneumococcal conjugate vaccine (PCV) and the combined Hib and MenC vaccine (Hib/MenC) as part of the routine childhood immunisation schedule and in certain non-routine cases.

9ZA.2. Where reference is made in this Section to a vaccine being administered at a certain age, this is an indication of the recommended schedule for the administration of the vaccine contained in “Immunisation against Infectious Diseases - The Green Book” which is published by Public Health England. The specific timing of the administration of the vaccine, which should be within the parameters of the recommended schedule, is a matter for the clinical judgement of the relevant health care professional.

Payment for the administration of PCV and Hib/MenC vaccine as part of the routine childhood immunisation schedule for children born after 31 December 2019

9ZA.3. The LHB must pay to a contractor who qualifies for the payment, a payment of £20.06 in respect of each child born after 31 December 2019 registered with the contractor—

- (a) who has received, as part of their routine childhood immunisation schedule, all three doses of the vaccines set out in the table at paragraph 9ZA.5, namely the series of two PCV doses, the first of which is to be administered at 12 weeks, with the second at 12-13 months, and the Hib/MenC vaccination which is to be also administered at 12-13 months; and
- (b) in respect of whom the contractor administered the final dose completing the vaccine course.

9ZA.4. For the purpose of paragraph 9ZA.3(b), the “final dose completing the vaccine course” means the second in the series of the two PCV doses which is scheduled in the table at paragraph 9ZA.5 to be administered at 12-13 months.

9ZA.5. The table below sets out the schedule for administration of the PCV and the Hib/MenC vaccines as part of the routine childhood immunisation schedule for children born after 31 December 2019.

<i>When to immunise</i>	<i>What is given</i>	<i>How is vaccine given</i>
12 weeks old	Pneumococcal (PCV) (first dose)	1 injection
12-13 months	Haemophilus influenza type B, Meningococcal C (Hib/MenC)	1 injection
12-13 months	Pneumococcal (PCV) (second dose)	1 injection

Payment for administration of PCV and Hib/MenC vaccine other than as part of the routine childhood immunisation schedule for children after 31 December 2019

9ZA.6. The LHB must pay to a contractor, who qualifies for the payment, a payment of £20.06 in respect of each child registered with the contractor who has received the PCV and Hib/MenC vaccine in any of the circumstances set out in paragraphs 9ZA.7 to 9ZA.12 and in respect of whom the contractor administered the final dose completing the vaccine course. For the purposes

of this paragraph, the final dose completing the vaccine course means the fourth in the series of PCV doses which is scheduled in the table at paragraph 9ZA.7.

Children born after 31 December 2019 who are severely immunocompromised or have complement deficiency, asplenia or splenic dysfunction

9ZA.7. Children born after 31 December 2019 who are severely immunocompromised or have complement deficiency, asplenia or splenic dysfunction must receive the PCVs and Hib/MenC vaccine in accordance with both the following table and “Immunisation against Infectious Diseases” in The Green Book.

<i>When to immunise</i>	<i>What is given</i>	<i>How vaccine is given</i>
Infants under 1 year old	Pneumococcal (PCV) (first set of doses)	2 injections, 8 weeks apart
12-13 months old	Haemophilus influenza type B, Meningococcal C (Hib/MenC)	1 injection
12-13 months	Pneumococcal (PCV) (second set of doses)	2 injections, 8 weeks apart

9ZA.8. Where a child born after 31 December 2019 under 2 years of age is severely immunocompromised or has complement deficiency, asplenia or splenic dysfunction, and—

- (a) consequently cannot, or did not, receive, or presents, or presented, too late to receive, two doses of PCV before the age of 12-13 months, the Hib/MenC vaccine at 12-13 months and two doses of PCV during their second year of life; but
- (b) receives two doses of PCV in the second year of life, the second of which is administered at least 8 weeks after the first dose,

the LHB must pay to the contractor administering the final dose completing the vaccine a payment of £20.06 in respect of that child. The second dose of PCV, administered in the second year of life, is considered the final completing course of the vaccine for this purpose.

Payment for children born after 31 December 2019 with an unknown or incomplete immunisation status

9ZA.9. Where a child born after 31 December 2019 has an unknown or incomplete immunisation status and receives vaccines sufficient to ensure that it has received the vaccine course in accordance with the schedule set out in the table at paragraph 9ZA.5, the LHB must pay to the contractor administering the final dose completing the vaccine course a payment of £20.06 in respect of that child. The PCV dose administered at 12-13 months is considered the final dose completing the vaccine course for this purpose.

9ZA.10. Where a child born after 31 December 2019 has an unknown or incomplete immunisation status and is too old to be able to receive the first of the two doses of PCV at the age of 12 weeks, the Hib/MenC vaccine at 12-13 months and the second dose of PCV at 12-13 months, but receives a Hib/MenC vaccine and a PCV dose on or after turning 1 year old and prior to 2 years of age, the LHB must pay to the contractor who administers the final dose completing the vaccine course a payment of £20.06 in respect of that child. The single dose of PCV is considered the final dose completing the vaccine course for this purpose.

Eligibility for payment

9ZA.11. A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met—

- (a) the contractor is contracted to provide the childhood vaccines and immunisations as part of Additional Services,
- (b) the child in respect of whom the payment is claimed was—
 - (i) born after 31 December 2019, and
 - (ii) on the contractor's list of registered patients at the time the final completing course of the vaccine was administered,
- (c) the contractor administers the final dose completing the vaccine course to the child in respect of whom the payment is claimed,
- (d) subject to sub-paragraph (e), the child in respect of whom the payment is claimed is or was aged 1 year when the final dose completing the vaccine course is administered,
- (e) in the case of payments in respect of the vaccines administered in accordance with paragraphs 9ZA.8 and 9ZA.10, the child must be under 2 years of age when the final dose completing the vaccine course is administered,
- (f) the contractor does not receive any payment from any other source in respect of any of the series of PCV vaccines and the Hib/MenC vaccine set out in the table at paragraph 9ZA.5 or in respect of any vaccine administered under any of the circumstances set out in paragraphs 9ZA.7 to 9ZA.11 (if the contractor does receive payments from other sources in respect of any child, the LHB must consider whether to recover any payment made under this Section in respect of that child pursuant to paragraphs 19.1 and 19.2 (overpayments and withheld amounts), and
- (g) the contractor submits the claim within 6 months of administering the final dose completing the vaccine course.

9ZA.12. The contractor is not entitled to payment of more than £20.06 in respect of any child under this Section.

Claims for payment

9ZA.13. The contractor must submit claims in respect of the final dose completing the vaccine course after they have been administered at a frequency to be agreed between the LHB and the contractor (which must be a frequency which provides for the claim to be submitted within 6 months of administering the final completing vaccine), or if agreement cannot be reached, within 14 days of the end of the month during which the final dose completing the vaccine course was administered. Any amount payable falls due on the next date, following the expiry of 14 days after the claim is submitted, when the contractor's Payable GSMP falls due.

Conditions attached to payment

9ZA.14. A payment under the provisions of this Section is only payable if the contractor satisfies the following conditions—

- (a) the contractor must supply the LHB with the following information in respect of each child for which a payment is claimed—
 - (i) the name of the child,
 - (ii) the date of birth of the child,
 - (iii) the NHS number, where known, of the child,
 - (iv) except where paragraph (v) applies, confirmation that the child has received two doses of PCV and one dose of Hib/MenC in accordance with the table at paragraph 9ZA.5,
 - (v) if the claim is made in the circumstances set out in paragraph 9ZA.7, 9ZA.8 or 9ZA.11, confirmation that all required vaccines have been administered, and

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

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

- (b) the contractor must provide appropriate information and advice to the parent or carer of the child, and where appropriate, also to the child, about pneumococcal vaccine and the Hib/MenC vaccine,
- (c) the contractor must record in the child's records, kept in accordance with paragraph 72 (patient records) of Schedule 6 to the 2004 Regulations, any refusal of an offer of a pneumococcal vaccine or a Hib/MenC vaccine,
- (d) where a pneumococcal vaccine or a Hib/MenC vaccine is administered, the contractor must record in the child's records, kept in accordance with paragraph 72 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004 Regulations,
- (e) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as is necessary to enable that health care professional to properly perform such services, and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis,
- (f) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order for the LHB to form an opinion on whether the contractor is eligible for payment under the provisions of this Section,
- (g) the contractor must make any returns required of it (whether computerised or otherwise) to the registration system approved by the LHB, and do so promptly and fully, and
- (h) all information provided pursuant to, or in accordance with, this paragraph must be accurate.

9ZA.15 If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of any, or any part of, payments due under this Section.”.

Section 10: SHINGLES IMMUNISATION PROGRAMME IMMUNOCOMPROMISED

General

10.1 Section 10 makes provision in respect of payments to be made in respect of the administration by a contractor to provide the Shingrix® vaccines as part of the Shingles Immunisation Programme to immunocompromised individuals as defined by the Greenbook chapter 28a, aged 50 years and over (with no upper age limit), including those anticipating immunosuppressive therapy. Further details on the Shingles Immunisation Programmes can be found in WHC (2023) 024.

Administration of the Shingrix® vaccine

10.2 Contractors must offer two doses of Shingrix® vaccine to immunocompromised eligible patients who are 50 years and over, including those anticipating immunosuppressive therapy, from 1 September 2023.

10.3 The second dose should be administered eight weeks to 6 months after the first dose.

10.4 Rollout to immunocompromised individuals who are aged over 50 years should take place in the first year beginning with 1 September 2023 and concluding by 1 September 2024.

10.5 Beginning with the 1 September 2024 immunocompromised individuals who turn 50 years

old should be offered vaccination within 12 weeks of reaching their invitation age.

10.6 Contractors should also opportunistically vaccinate those individuals aged 50 or over from 1 September 2023 who missed their initial appointment.

10.7 Newly diagnosed unvaccinated immunocompromised individuals already over 50 years old should be vaccinated within 12 weeks of immunocompromised diagnosis.

Payment for administration of the Shingrix® vaccine

10.8 A contractor may claim a payment of £10.03 in respect of each dose given to immunocompromised registered patients who are aged 50 or over beginning with 1 September 2023.

Eligibility for payment

10.9 A contractor is only eligible to make a claim for a payment under this Section in circumstances where the following conditions are met—

- (i) the patient in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the vaccine was administered;
- (ii) the contractor administers the vaccine to the patient in respect of whom the payment is claimed;
- (iii) the patient in respect of whom the payment is claimed falls within the groups referred to in paragraph 10.2 to 10.7 when the vaccine is administered;
- (iv) the contractor does not receive any payment from any other source in respect of the vaccine (if the contractor does receive any such payment in respect of any patient from any other source, the LHB must give serious consideration to recovering any payment made under this Section in respect of that patient pursuant to paragraphs 19.1 and 19.2 (overpayments and withheld amounts); and
- (v) the contractor submits the claim within 6 months of administering the vaccine.

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

Claims for payment

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

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

Conditions attached to payment

10.13 A claim for payment under the provisions of this Section is only payable by the LHB if the contractor satisfies the following conditions—

- (a) the contractor must supply the LHB with the following information in respect of each patient for which a payment is claimed—
 - (i) the name of the patient;
 - (ii) the date of birth of the patient;
 - (iii) the NHS number, where known, of the patient;

- (iv) confirmation that the patient has received the vaccine in accordance with paragraph 10.2;
 - (v) the date on which the vaccine was administered by the contractor,
- but where the patient objects to details of that patient's name or date of birth being supplied to the LHB, the contractor need not supply such information to the LHB but must supply the patient's NHS number;
- (b) the contractor must—
 - (i) develop a proactive and preventative approach to offering immunisation by adopting robust call and reminder systems to contact patients, with the aims of—
 - (aa) maximising uptake in the interests of patients, and
 - (bb) meeting any public health targets in respect of such immunisations;
 - (ii) make up to three attempts to contact eligible individuals within 12 weeks of reaching their invitation age. At least one of these contacts must be a written invitation.
 - (c) A requirement that the engaged GMS contractor takes all reasonable steps to ensure that the lifelong medical records held by an at-risk patient's general practitioner are kept up to date with regard to their immunisation status and, in particular, to include—
 - (i) Any refusal of an offer of vaccination, or
 - (ii) Where an offer of vaccination was accepted—
 - (aa) details of the consent to the vaccination or immunisation (where a person has consented on an at-risk patient's behalf, that person's relationship to the at-risk patient must also be recorded,
 - (bb) the batch number, expiry date and title of the vaccine,
 - (cc) dose administered,
 - (dd) the date of the administration of the vaccine,
 - (ee) where 2 vaccines are administered, the route of administration and the injection site of each vaccine,
 - (ff) any contraindication to the vaccination or immunisation,
 - (gg) any adverse reaction to the vaccination or immunisation;
 - (d) A requirement that the engaged GMS contractor ensures that it adheres to the current guidance in chapter 3 (Storage, distribution and disposal of vaccines) of the latest edition of the Green Book;
 - (e) A requirement that the engaged GMS contractor supplies Public Health Wales with information on patients, via automated data extraction, for the purposes of monitoring local and national uptake;
 - (f) the contractor must provide appropriate information and advice to the patient about the vaccine and immunisation;
 - (g) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable that health care professional to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;
 - (h) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;
 - (i) all information provided pursuant to or in accordance with this paragraph must be accurate.

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

Section 10A: SHINGLES IMMUNISATION PROGRAMME IMMUNOCOMPETENT

General

10A-1. Section 10A makes provision in respect of payments to be made in respect of the administration by a contractor to provide the Shingrix® vaccine as part of the Shingles Immunisation Programme to immunocompetent individuals. Further details on the Shingles Immunisation Programmes can be found in WHC (2023) 024.

Administration of the Shingrix® vaccine

Phase 1

10A.2. From 1 September 2023 to 31 August 2028, those individuals who reach age 65 or 70 years during this period should be called in on/after their 65th or 70th birthday for their first dose of Shingrix®.

10A.3. The second dose of Shingrix® should be administered 6 to 12 months after the first dose.

10A.4. Those cohorts previously eligible for Zostavax® prior to 1 September 2023 remain eligible until their 80th birthday. Those individuals who are under 80 years of age, should continue to be offered Zostavax® (unless contraindicated) until central stocks deplete when they should be offered Shingrix®.

10A.5. Where an individual has turned 80 years of age following their first dose of Shingrix®, a second dose should be provided before the individual's 81st birthday to complete the course.

10A.6. If the individual received Zostavax® there is no need for a second dose as Zostavax is a one dose schedule.

Phase 2

10A.7. From 1 September 2028 to 31 August 2033, those individuals who reach age 60 or 65 years during this period should be called in on/after their 60th or 65th birthday for their first dose of Shingrix®.

10A.8. The second dose should be administered 6 to 12 months after the first dose.

Ongoing routine offer

10A.9. From 1 September 2033 onwards, those individuals turning 60 years of age should be called in on/after their 60th birthday. Those who have been previously eligible will remain eligible until their 80th birthday.

10A.10. The second dose should be administered 6 to 12 months after the first dose.

Opportunistic vaccination

10A.11. In instances where an individual has already attained or passed the age of 65 but not yet 80 for phase one, or 60 but not yet 80 in phase two, then contractors can accommodate opportunistic vaccination if operationally possible.

10A.12. The second dose should be administered 6 to 12 months after the first dose.

Eligibility for payment

10A.13. A contractor is only eligible to make a claim for a payment under this Section in circumstances where the following conditions are met—

- (i) the patient in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the vaccine was administered;
- (ii) the contractor administers the vaccine to the patient in respect of whom the payment is claimed;
- (iii) the patient in respect of whom the payment is claimed falls within the age group referred to in paragraph 10A.2 to 10A.5 and 10A.7 to 10A.12 when the vaccine is administered;

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

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

10A.14. The LHB may set aside the requirement that the contractor submit the claim within 6 months of administering the vaccine if it considers it is reasonable to do so.

Claims for payment

10A.15. The contractor must submit claims after administering each dose of the Shingrix® vaccine at a frequency to be agreed between the LHB and the contractor (which must be a frequency which provides for the claim to be submitted within 6 months of administering the vaccination), or if agreement cannot be reached, within 14 days of the end of the month during which the vaccine was administered. Any amount payable falls due on the next date, following the expiry of 14 days after the claim is submitted, when the contractor's Payable GSMP falls due.

10A.16. The LHB must ensure that the receipt and payment in respect of any claims are properly recorded and that each claim has a clear audit trail.

Conditions attached to payment

10A.17. A claim for payment under the provisions of this Section is only payable by the LHB if the contractor satisfies the following conditions—

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

(i) the name of the patient;

(ii) the date of birth of the patient;

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

(iv) confirmation that the patient has received the vaccine in accordance with paragraph 10A.2 to 10A.8;

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

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

(b) the contractor must—

(i) develop a proactive and preventative approach to offering immunisation by adopting robust call and reminder systems to contact patients, with the aims of—

(aa) maximising uptake in the interests of patients, and

(bb) meeting any public health targets in respect of such immunisations;

(cc) make up to three attempts to contact eligible individuals within 12 weeks of reaching their invitation age. At least one of these contacts must be a written invitation.

(c) A requirement that the engaged GMS contractor takes all reasonable steps to ensure that the lifelong medical records held by an at-risk patient's general practitioner are kept up to date with regard to their immunisation status and, in particular, to include—

(i) Any refusal of an offer of vaccination, or

(ii) Where an offer of vaccination was accepted—

(aa) details of the consent to the vaccination or immunisation (where a person has consented on an at-risk patient's behalf, that person's relationship to the at-risk patient must also be recorded,

(bb) the batch number, expiry date and title of the vaccine,

(cc) dose administered,

(dd) the date of the administration of the vaccine,

- (ee) where 2 vaccines are administered, the route of administration and the injection site of each vaccine,
 - (ff) any contraindication to the vaccination or immunisation,
 - (gg) any adverse reaction to the vaccination or immunisation;
- (d) A requirement that the engaged GMS contractor ensures that it adheres to the current guidance in chapter 3 (Storage, distribution and disposal of vaccines) of the latest edition of the Green Book;
 - (e) A requirement that the engaged GMS contractor supplies Public Health Wales with information on patients, via automated data extraction, for the purposes of monitoring local and national uptake;
 - (f) the contractor must provide appropriate information and advice to the patient about the vaccine and immunisation;
 - (g) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable that health care professional to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;
 - (h) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;
 - (i) all information provided pursuant to or in accordance with this paragraph must be accurate.

10A.18. If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of all or any part of any payment due under this Section.

Section 11: PAYMENTS TO GMS CONTRACTORS FOR LOCUMS OR SALARIED GPs ON A FIXED TERM CONTRACT OR GP PERFORMER COVERING MATERNITY, PATERNITY, ADOPTION LEAVE AND SHARED PARENTAL LEAVE

General

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

11.2 If an employee or partner who takes any such leave is a performer under a GMS contract, the contractor may need to employ a locum or a salaried GP under a fixed term contract, use the services of a GP performer who is party to the contract or who is already employed or engaged by the contractor (or more than one such person) or engage an independent prescriber locum to maintain the level of services that it normally provides. Even if the LHB is not directed in this SFE to pay for such cover, it may do so as a matter of discretion. However, if—

- (a) the performer is a GP performer; and
- (b) the leave is ordinary or additional maternity leave, paternity leave, ordinary or additional adoption leave or shared parental leave,

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

Locums

11.2A For the purposes of Section 11 “locum” means a Locum practitioner (but not an “independent prescriber locum”) sourced from the All Wales Locum Register, unless when involving internal cover arrangements or in exceptional circumstances, with the agreement of the Local Health Board, where there are no available locums on the register.

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

11.3.—(1) Where a contractor actually and necessarily engages a locum or independent prescriber locum or uses the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor (or more than one such person) to cover the absence of a GP performer on:

- (a) ordinary maternity leave for a period of no more than 26 weeks;
- (b) ordinary adoption leave for a period of no more than 26 weeks;
- (bb) shared parental leave,
- (c) paternity leave for a period of no more than 2 weeks where the GP performer going on leave is not the main care provider; or
- (d) special leave for a period of no more than 2 weeks where the GP performer going on leave is not the main care provider,

the LHB must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which will be the lower of the actual invoiced costs or the maximum amount as set out in paragraph 11.5) if it is satisfied that the conditions in subparagraph (2) are met.

(2) The conditions are:

- (a) the leave of absence is for more than one week;
- (b) the performer on leave is entitled to that leave either under—
 - (i) statute;
 - (ii) a partnership agreement or other agreement between the partners of a partnership; or
 - (iii) a contract of employment, provided that the performer on leave is entitled under their contract of employment to be paid their full salary by the contractor during their leave of absence; and
- (c) the contractor is not claiming another payment for locum cover in respect of the performer on leave pursuant to this Part.**11.4** The LHB must consider whether or not it is necessary for the contractor to engage, or continue to engage, a locum or to use, or continue to use, the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor (or more than one such person) to cover for the absence of a GP performer under this Section having regard to the following principles-
 - a) it should not normally be considered necessary for the contractor to employ a locum, or to use the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor, if the performer on leave had a right to return by that right has been extinguished;
 - b) it should not normally be considered necessary for the contractor to employ a locum, or to use the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor, if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on his return.

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

11.3A.—(1) Where a contractor actually and necessarily engages a locum or independent prescriber locum or uses the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor (or more than one such person) to cover the absence of a GP performer on:

- (a) additional maternity leave (for a period of no more than 26 weeks, beginning on the date when the ordinary maternity leave period set out in paragraph 11.3(1)(a) ends);
- (b) additional adoption leave (for a period of no more than 26 weeks beginning on the date when the ordinary adoption leave period set out in paragraph 11.3(1)(b) ends); and
- (c) shared parental leave,

the LHB may provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum or independent prescriber locum.

11.4 The LHB must consider whether or not it is necessary for the contractor to engage, or continue to engage, a locum or independent prescriber locum or a salaried GP on a fixed term contract or to use, or continue to use, the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor to cover for the absence of a GP performer under this Section having regard to the following principles-

- a) it should not normally be considered necessary for the contractor to employ a locum or independent prescriber locum or a salaried GP on a fixed term contract, or to use the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor, if the performer on leave had a right to return but that right has been extinguished;
- b) it should not normally be considered necessary for the contractor to employ a locum or independent prescriber locum or a salaried GP on a fixed term contract, or to use the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor, if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on his return.

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.

Amounts payable

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

- (a) in respect of the first two weeks for which the LHB provides reimbursement, £1,131.74 per week; and
- (b) in respect of any week thereafter for which the LHB provides reimbursement in respect of cover, £1,734.18 per week.

(2) Any amounts payable by way of reimbursement (other than reimbursement for enhanced shared parental leave pay) under this Section—

- (a) are not to be paid on a pro-rata basis having regard to the absent performer's working pattern; and
- (b) are to be whichever is the lower of the invoiced costs or the maximum amount payable in respect of any week under sub-paragraph (1).

Payment arrangements

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

Conditions attached to the amounts payable

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

- (a) if the leave of absence is maternity leave, the contractor must supply the LHB with a certificate of expected confinement as used for the purposes of obtaining statutory maternity pay, or a private certificate providing comparable information;
- (b) if the leave of absence is for paternity leave, the contractor must supply the LHB with a letter written by the GP performer confirming prospective fatherhood and giving the date of expected confinement;
- (c) if the leave of absence is for adoption leave, the contractor must supply the LHB with a letter written by the GP performer confirming the date of the adoption and the name of the main care provider, countersigned by the appropriate adoption agency;
 - (ca) if the leave of absence is for shared parental leave, the contractor must supply the LHB with a certificate as used for the purposes of confirming the GP performer's eligibility for shared parental leave or a letter written by the GP performer providing comparable information and countersigned by the practice;
- (d) the contractor must, on request, provide the LHB with written records demonstrating the actual cost to it of the cover, or the additional cost to it of the cover provided by another GP performer who is already employed or engaged by it; and
- (e) once the arrangements are in place, the contractor must inform the LHB—
 - (i) if there is to be any change to the arrangements; or
 - (ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the performer on leave,
at which point the LHB is to determine whether it still considers the cover necessary.

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

***Section 12: PAYMENTS FOR GP LOCUMS OR SALARIED GPs ON A
FIXED TERM CONTRACT OR GP PERFORMERS OR INDEPENDENT
PRESCRIBER LOCUMS COVERING SICKNESS LEAVE***

General

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

12.2. If an employee or partner who takes any sickness leave is a performer under a GMS contract, or an employed independent prescriber takes any sickness leave, the contractor may need to employ a GP locum or a salaried GP on a fixed term contract, or use the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor, (or more than one such person) or engage an independent prescriber locum, to maintain the level of services that it normally provides. Even if the LHB is not directed in this SFE to pay for such cover, it may do so as a matter of discretion and it may also provide support in order for the contractor to provide cover for performers or independent prescribers who are returning from sickness leave or for those who are at risk of needing to go on sickness leave. It should in particular consider exercising its discretion—

- (a) where there is an unusually high rate of sickness in the area where the performer performs services; or
- (b) to support contractors in rural areas where the distances involved in making home visits make it impracticable for a GP performer returning from sickness leave to assume responsibility for the same number of patients for which that performer previously had responsibility.

GP Locums

12.2A. For the purposes of this Section, “GP locum” means a GP Locum practitioner sourced from the All Wales Locum Register, unless when involving internal cover arrangements or in exceptional circumstances, with the agreement of the Local Health Board, where there are no available GP locums on the register.

Entitlement to payments for covering sickness leave

12.3.—(1) Where a contractor actually and necessarily engages a GP locum or a salaried GP on a fixed term contract, or uses the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor (or more than one such person), or engages an independent prescriber locum to cover the absence of a GP performer or independent prescriber on sickness leave, a phased return to work or adjusted hours, the LHB must provide financial assistance to the contractor under its GMS contract in respect of the cost of providing that cover (which will be the lower of the actual invoiced costs or the maximum amount as set out in paragraph 12.5), if it is satisfied that the conditions in paragraph (2) are met.

(2) The conditions are—

- (a) if the performer or independent prescriber on sickness leave is employed by the contractor, the contractor must—
 - (i) be required to pay statutory sick pay to that performer or independent prescriber; or
 - (ii) be required to pay the performer on leave their full salary during absences on sickness leave under their contract of employment,
- (b) if the GP performer’s or independent prescriber’s absence is as a result of an accident, the contractor must be unable to claim any compensation from whoever caused the accident towards meeting the cost of engaging a GP locum or salaried GP on a fixed term contract or an independent prescriber locum to cover for the GP performer

during the performer's or independent prescriber's absence. But if such compensation is payable, the LHB may loan the contractor the cost of the GP locum, salaried GP on a fixed term contract or independent prescriber locum, on the condition that the loan is repaid when the compensation is paid unless—

- (i) no part of the compensation paid is referable to the cost of the cover, in which case the loan is to be considered a reimbursement by the LHB of the costs of the cover which is subject to the following provisions of this Section; or
 - (ii) only part of the compensation paid is referable to the cost of the cover, in which case the liability to repay shall be proportionate to the extent to which the claim for full reimbursement of the costs of the cover was successful; and
- (c) the contractor is not already claiming another payment for cover of a GP locum, salaried GP on a fixed term contract or an independent prescriber locum in respect of the performer on leave pursuant to Part 4.

Discretionary payments for cover of an employed GP or an employed independent prescriber on a phased return to work or adjusted hours

12.3ZA. Where the requirements of paragraph 12.3(2)(a) are not met, the LHB may make payments in the following circumstances—

- (a) the employed GP performer's or independent prescriber's phased return arrangement directly follows sickness absence leave which attracted a GP locum or independent prescriber locum payment under this Section;
- (b) where the phased return or adjusted hours arrangement has been advised under a Statement of Fitness for Work (and for the period only that Statement of Fitness for Work covers or advises); and
- (c) where the contractor is paying the employed GP performer or independent prescriber their full salary in respect of their phased return or adjusted hours arrangement, for example, taking account of both working and sickness absence days/sessions.

Discretionary payments for covering long-term sickness leave

12.3A.—(1) Where a contractor actually and necessarily engages a GP locum, or uses the services of a GP performer who is a party to the contract or who is already employed or engaged by the contractor (or more than one such person), or engages an independent prescriber locum, to cover the absence of a GP performer or independent prescriber on sickness leave for a period of more than the maximum period in respect of which payments are payable by virtue of paragraph 12.6 ("long term sickness leave"), the LHB may provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that GP locum or independent prescriber locum.

12.4. It is for the LHB to determine whether or not it was in fact necessary for the contractor to engage the GP locum, a salaried GP on a fixed term contract, an independent prescriber locum or to continue to engage the GP or independent prescriber locum, but the LHB must have regard to the following principles—

- (a) it should not normally be considered necessary to employ a GP or independent prescriber locum if the performer or independent prescriber on leave had a right to return but that right has been extinguished; and
- (b) it should not normally be considered necessary to employ a GP or independent prescriber locum if the contractor has engaged a new employee or partner to perform the duties of the performer or independent prescriber on leave and it is not carrying a vacancy in respect of another position which the performer or independent prescriber on leave will fill on return.

Ceilings on the amounts payable

12.5. The maximum amount payable under this Section by the LHB in respect of GP or

independent prescriber locum cover for a GP performer or independent prescriber is £1,734.18 per week.

12.5A. Any amount payable by way of reimbursement under this Section—

- (a) is not to be paid on a pro-rata basis, having regard to the absent performer's or independent prescriber's working pattern; and
- (b) is to be whichever is the lower of the invoiced costs or the maximum amount payable in respect of any week specified in paragraph 12.5.

12.6. No reimbursement under this Section will be paid in respect of the first two weeks' period of the leave of absence. After that, the maximum periods in respect of which payments under this Section are payable in relation to a particular GP performer or independent prescriber in respect of any such period are—

- (a) 26 weeks for the full amount of the sum that the LHB has determined is payable; and
- (b) a further 26 weeks for half the full amount of the sum the LHB initially determined was payable.

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

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

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

Payment arrangements

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

Conditions attached to the amounts payable

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

- (a) the contractor must obtain the prior agreement of the LHB to the engagement of the GP locum, salaried GP on a fixed term contract or independent prescriber locum (but its request to do so must be determined as quickly as possible by the LHB), including agreement as to the amount that is to be paid for the cover;
- (b) the contractor must, without delay, supply the LHB with a Statement of Fitness for Work in respect of each period of absence for which a request for assistance with payment for cover is being made;
- (c) the contractor must, on request, provide the LHB with written records demonstrating the actual cost to it of the cover;
- (d) once the arrangements for cover are in place, the contractor must inform the LHB—
 - (i) if there is to be any change to the arrangements for cover; or
 - (ii) if, for any other reason, there is to be a change to the contractor's arrangements

for performing the duties of the GP performer or independent prescriber on leave, at which point the LHB must determine whether it still considers the cover necessary;

- (e) if the arrangements for cover are in respect of a performer on leave or an independent prescriber who is, or was, entitled to statutory sick pay, the contractor must inform the LHB immediately if it stops paying statutory sick pay to that employee;
- (f) the GP performer or independent prescriber on leave must not engage in conduct that is prejudicial to that performer's or independent prescriber's recovery; and
- (g) the GP performer or independent prescriber on leave must not be performing clinical or prescribing services for any other person, unless under medical direction and with the approval of the LHB.

Section 13: PAYMENTS FOR LOCUMS TO COVER SUSPENDED DOCTORS

General

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

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

Locum Practitioners

13.2A For the purposes of Section 13 "locum" means a Locum practitioner sourced from the All Wales Locum Register unless when involving internal cover arrangements or in exceptional circumstances, with the agreement of the Local Health Board, where there are no available locums on the register.

Eligible cases

13.3 In any case where a contractor—

- (a) either –
 - (i) is a sole practitioner who is suspended from the LHB's medical performers list and is not in receipt of any financial assistance from the LHB under section 53 of the 2006 Act as a contribution towards the cost of the arrangements to provide primary medical services under the contractor's GMS contract during the contractor's suspension;
 - (ii) is paying a suspended GP performer –
 - (aa) who is a partner of the contractor, at least 90% of that performer's normal monthly drawings (or a pro rata amount in the case of part months) from the partnership account; or
 - (bb) who is an employee of the contractor, at least 90% of that performer's normal salary (or a pro rata amount in the case of part months); or
 - (iii) paid a suspended GP performer the amount mentioned in paragraph (ii)(aa) or (bb) for at least six months of that performer's suspension, and the suspended GP performer is still a partner or employee of the contractor;
- (b) actually and necessarily engages a locum (or more than one such person) to cover for the absence of the suspended GP performer;
- (c) the locum is not a partner in a partnership or shareholder in a company limited by shares where that partnership or company is the contractor, or already an employee of the contractor, unless the absent performer is a job-sharer; and
- (d) the contractor is not also claiming any other payment for locum cover in respect of the absent

performer under Part 4,
then subject to the provisions in this Section, the LHB must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 13.5).

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

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

Ceilings on the amounts payable

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

Payment arrangements

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

Conditions attached to the amounts payable

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

- (a) the contractor must, on request, provide the LHB with written records demonstrating—
 - (i) the actual cost to it of the locum cover; and
 - (ii) that it is continuing to pay the suspended GP performer at least 90% of that performer's normal income before the suspension (i.e. the normal monthly drawings from the partnership account, that performer's normal salary or a pro rata amount in the case of part months); and
- (b) once the locum arrangements are in place, the contractor must inform the LHB—
 - (i) if there is to be any change to the locum arrangements, or
 - (ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the absent performer,at which point the LHB is to determine whether it still considers the locum cover necessary.

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

Section 14: PAYMENTS IN RESPECT OF PROLONGED STUDYLEAVE

General

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

- (a) an educational allowance, to be forwarded to the GP performer taking Prolonged Study Leave; and
- (b) the cost of, or a contribution towards the cost of, locum cover.

Locums

14.1A For the purposes of Section 14 “locum” means a Locum practitioner sourced from the All Wales Locum Register, unless when involving internal cover arrangements or in exceptional circumstances, with the agreement of the Local Health Board, where there are no available locums on the register.

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

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

- (a) the study leave is for at least 10 weeks but not more than 12 months;
- (b) the educational aspects of the study leave have been approved by the Dean of General Practice, University Wales College of Medicine, having regard to any guidance on Prolonged Study Leave that the Dean of General Practice, University Wales College of Medicine has been agreed nationally; and
- (c) the LHB has determined that the payments to the contractor under this Section in respect of the Prolonged Study Leave are affordable, having regard to the budgetary targets it has set itself.

Educational allowance payment

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

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

Locum cover in respect of doctors on Prolonged Study Leave

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

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

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

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

Payment arrangements

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

Conditions attached to the amounts payable

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

- (a) the contractor must obtain the prior agreement of the LHB to the engagement of the locum (but its request to do so must be determined as quickly as possible by the LHB), including agreement as to the amount that is to be paid for the locum cover;
- (b) the locum must not be a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer;
- (c) the contractor must, on request, provide the LHB with written records demonstrating the actual cost to it of the locum cover; and
- (d) once the locum arrangements are in place, the contractor must inform the LHB—
 - (i) if there is to be any change to the locum arrangements; or
 - (ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the performer on leave,at which point the LHB is to determine whether it still considers the locum cover necessary.

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

Section 15: SENIORITY PAYMENTS

General

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

15.1A The Seniority Payment Scheme will be closed to new participants from 1 October 2019.

15.1B GP providers who are not in the Seniority Payment Scheme and who are partners in a partnership that holds a GMS contract may be eligible to join the Partnership Premium Scheme – see section 15A.

15.1C GPs providers who are currently in the Seniority Payment Scheme and who migrate to the Partnership Premium Scheme will cease to be entitled to payments under the Seniority Payment Scheme and they will not be eligible to revert back to the Seniority Payment Scheme.

15.1D GP providers currently in the Seniority Payment Scheme may choose not to migrate to the Partnership Premium Scheme but continue to receive seniority payments.

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 leave 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.

15.1 F For the avoidance of doubt, Section 15 of this SFE will not apply in relation to a GP provider who, on 30 September 2019, is—

- (a) not in the Seniority Payment Scheme; or
- (b) in the Seniority Payment Scheme but joins the Partnership Premium Scheme.

Eligible posts

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

- (a) in case of posts held prior to 1st April 2004, if the post-holder provided unrestricted general medical services and was eligible for a basic practice allowance under the Statement of Fees and Allowance made under section 34 of the National Health Service (General Medical Services) Regulations 1992 (a) as in force on 31st March 2004; and
- (b) in the case of posts held on or after 1st April 2004, if the post-holder performs primary medical services and—
 - (i) that post-holder is a GMS contractor (i.e. a sole practitioner);
 - (ii) is a partner in a partnership that is a GMS contractor, or
 - (iii) is a shareholder in a company limited by shares that is a GMS contractor.

Service that is Reckonable Service

153 Work shall be counted as Reckonable Service if—

- (a) it is clinical service as a doctor within the NHS or service as a doctor in the public service health care system of another EEA Member State (including service in that system pre- Accession);
- (b) it is clinical service as a doctor or service as a medical officer within the prison service or the civil administration (which includes the Home Civil Service) of the United Kingdom, or within the prison service or the civil administration of another EEA Member State (including service in that prison service or civil administration pre-Accession);
- (c) it is service as a medical officer—
 - (i) in the armed forces of an EEA Member State (including the United Kingdom) or providing clinical services to those forces in a civilian capacity (including service pre-Accession); or
 - (ii) in the armed forces under the Crown other than the United Kingdom armed forces or providing clinical services to those forces in a civilian capacity,
 - if accepted by the LHB or endorsed by the Welsh Ministers as Reckonable Service;
- (d) it is service with the Foreign and Commonwealth office as a medical officer in a diplomatic mission abroad, if accepted by the LHB or endorsed by the Welsh Ministers as Reckonable Service; or
- (e) it comprises up to a maximum of four years clinical service in a country or territory outside the United Kingdom—
 - (i) which followed the date of first registration of the GP provider in that country or territory; and
 - (ii) in circumstances where –
 - (aa) on 31st March 2003, that period of clinical service had been counted by the LHB as a period of registration for the purposes of a calculation of the annual rate of the GP Provider’s Seniority Payment under the Statement of Fees and Allowance made under regulation 34 of the National Health Service (General Medical Services) Regulations 1992; and
 - (bb) that period of clinical service is not counted as reckonable service by virtue of any preceding sub-paragraphs in this paragraph.

Calculation of years of Reckonable Service

154 Claims in respect of years of service are to be made to the LHB, and should be accompanied by appropriate details, including dates, of relevant clinical service. Where possible, claims should

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

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

- (a) only clinical service is to count towards Reckonable Service;
- (b) only clinical service since the date on which the GP provider first became registered (be it temporarily, provisionally, fully or with limited registration) with the General Medical Council, or an equivalent authority in another EEA Member State, is to count towards Reckonable Service, with the exception of Reckonable Service prior to registration that is taken into account by virtue of paragraph 15.3(c);
- (c) periods of part-time and full-time working count the same; and
- (d) generally, breaks in service are not to count towards Reckonable Service, but periods when doctors were taking leave of absence (i.e. they were absent from a post but had a right of return) due to compulsory national service, maternity leave, paternity leave, adoption leave, parental leave, holiday leave, sick leave or study leave, or because of a secondment elective or similar temporary attachment to a post requiring the provision of clinical services, are to count towards Reckonable Service.

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

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

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

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

- (a) members of the Foreign and Commonwealth Office and their families;
- (b) members of the Department for International Development and their families;
- (c) members of the British Council and their families;
- (d) British residents, official visitors and aid workers;
- (e) Commonwealth and EEA Member State official visitors; or
- (f) staff and their families of other Commonwealth, EEA, Member State or, in the opinion of the Foreign and Commonwealth Office, friendly State diplomatic missions,

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

Determination of the relevant dates

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

- (a) the date a GP provider's Reckonable Service began, which is the date on which that GP's first period of Reckonable Service started (referred to in this Section as "the Seniority Date"); and
- (b) the GP provider's qualifying date (see paragraph 15.2).

Calculation of the full annual rate of Seniority Payments

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

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

- (a) a GP provider's Seniority Date is on the first date of that quarter, or falls outside that quarter, that GP's Years of Reckonable Service are the number of complete years since the first Seniority Date, and the full annual rate of the Seniority Payment payable in respect of that GP is the full annual rate opposite the GP's Years of Reckonable Service in the Table below; and
- (b) if the GP provider's Seniority Date falls in that quarter on any date other than the first date of that quarter, the full annual rate of the Seniority Payment in respect of that GP changes on the Seniority Date – and so in respect of that quarter, the full annual rate of the Seniority Payment payable in respect of that GP is to be calculated as follows—
 - (i) calculate the daily rate of the full annual rate of payment for the first total of Years of Reckonable Service relevant to him (i.e. divide the annual rate by 365 (or 366 where the relevant year includes 29th February), and multiply that daily rate by the number of days in that quarter before the Seniority Date; and
 - (ii) calculate the daily date of the full annual rate of payment for the second total of Years of Reckonable Service relevant to that GP (i.e. divide the annual rate by 365 (or 366 where the relevant year includes 29th February), and multiply that daily rate by the number of days in that quarter after and including the Seniority Date,
 then add the totals produced by the calculations in heads (i) and (ii) together, and multiply by four.

TABLE

<i>Years of Reckonable Service</i>	<i>Full annual rate of payment per practitioner</i>
0	0
1	0
2	0
3	0
4	0
5	0
6	600
7	672
8	753
9	843
10	944
11	1,057
12	1,184
13	1,326
14	1,486

15	1,664
16	3,185
17	3,504
18	3,854
19	4,239
20	4,663
21	5,129
22	6,785
23	6,989
24	7,198
25	7,414
26	7,637
27	7,866
28	8,225
29	8,455
30	8,692
31	8,935
32	9,186
33	9,433
34	9,707
35	9,979
36	10,258
37	10,546
38	10,841
39	11,144
40	11,457
41	11,777
42	12,107
43	12,446
44	12,795
45	13,153

<i>Years of Reckonable Service</i>	<i>Full annual rate of payment per practitioner</i>
46	13,521
47	13,900

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

- (a) would have been entitled to an amount calculated in accordance with paragraph 15.13 of the 2005 SFE; or
- (b) received a Seniority Payment, an amount of which is calculated in accordance with paragraph 15.13 of the 2005 SFE,

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

Superannuable Income Fractions

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

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

- (a) that GP provider's NHS profits from all sources for the financial year to which the Seniority Payment relates, excluding—
 - (i) superannuable income which does not appear on that GP provider's certificate submitted to the LHB in accordance with paragraph 20.11 (superannuation contribution: end-year adjustments) (i.e. NHS income already superannuated elsewhere); and
 - (ii) any amount in respect of Seniority Payments; by
- (b) the Average Adjusted Superannuable Income.

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

- (a) all the NHS profits of the type mentioned in paragraph 15.15(a) of all the GP providers in Wales who have submitted certificates to the LHB in accordance with paragraph 20.11, by the required date, are to be aggregated; then
- (b) this aggregate is then to be divided by the number of GP providers in respect of which the aggregate was calculated; then
- (c) the total produced by sub-paragraph (b) is to be adjusted to take account of the shift towards less than full-time working. The index by which the amount is to be adjusted is to be the same as the index for the financial year to which the calculation of Average Adjusted Superannuable Income relates by which the uprating factor for pensions is to be adjusted to take account of the shift towards less than full-time working^(a),

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

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

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

Amounts payable

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

15.19 If, however, the GP provider's—

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

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

Condition attached to payment of Quarterly Seniority Payments

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

- (a) if a GP provider receives a Quarterly Seniority Payment from more than one contractor, those payments taken together must not amount to more than one quarter of the full annual rate of Seniority Payment in respect of that GP provider;
- (b) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the payment;
- (c) all information provided pursuant to or in accordance with sub-paragraph (b) must be accurate; and
- (d) a contractor who receives a Seniority Payment in respect of a GP provider must give that payment to that doctor—
 - (i) within one calendar month of it receiving that payment, and
 - (ii) as an element of the personal income of that GP provider subject (in the case of a GP provider who is a shareholder in a contractor that is a company limited by shares) to any lawful deduction of income tax and national insurance.

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

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

Section 15A: THE PARTNERSHIP PREMIUM SCHEME

General

15A.1. The Partnership Premium Scheme (PPS) is available to all GP providers who are partners in a partnership that holds a GMS Contract (each such partner being a "GP Partner" in this Section

15A), irrespective of length of service. The amount of partnership premium payable is linked to the GP Partner's average sessional commitment and not the number of contracts a partnership holds. Where a GP Partner holds more than one contract and undertakes clinical sessions under each contract, the GP Partner must notify the LHB of every such contract. Each clinical session will, for PPS purposes, count towards the contract under which it was undertaken and the Partnership Premium payment will be split between those contractors based on the average number of clinical sessions undertaken for each contract.

15A.2. The PPS will provide an annual payment, in relation to each GP Partner in Wales who opts to participate in the scheme, based on the average number of clinical sessions performed by the GP Partner per quarter over the financial year. The level of the annual payment will be £1,000 multiplied by the GP Partner's average number of clinical sessions per quarter, with a maximum average of 8 sessions per quarter counting for PPS purposes and a possible maximum PPS payment of £8,000 per annum.

15A.3. The PPS includes a senior premium under which a GP Partner who –

- (a) is in receipt of Partnership Premium, and
- (b) has 16 years or more Reckonable Service calculated in accordance with paragraphs 15.3 to 15.9 of this SFE,

will receive an additional £200 multiplied by their average number of clinical sessions per quarter (up to the maximum of 8 sessions per quarter or £1,600 per annum).

Clinical Session

15A.4. For PPS purposes, 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).

15A.5. Clinical sessions do not include time spent on locum work or any work undertaken outside of the normal business of the practice.

15A.6. When calculating a GP Partner's average number of clinical sessions per quarter for PPS purposes, all sessions undertaken in that quarter will be counted.

Annual Leave

15A.7. Annual leave up to a maximum of 6 weeks (excluding bank holidays) per annum (reduced pro rata for GP Partners working part-time) will be ignored for the purposes of calculating a GP Partner's average clinical sessions per quarter for PPS purposes..

Sickness Absence

15A.8. Section 12 of the SFE outlines the amounts and periods of time that the LHB will reimburse to a contractor who—

- (a) actually and necessarily engages a locum or a salaried GP on a fixed term contract; or
- (b) uses the services of a GP performer—
 - (i) who is a party to the contract, or
 - (ii) who is already employed or engaged by the contractor (or more than one such person)

to cover the absence of a GP performer on sickness leave, a phased return to work or adjusted hours.

15A.9. A GP Partner's absence (or the period of any phased return to work or adjusted hours) due to sickness will be discounted for PPS purposes for the period of time that the LHB reimburses the contractor (in relation to that GP Partner) in line with Section 12 of the SFE. The first two weeks of sickness absence (which under Section 12, the LHB does not reimburse) will also be discounted for the purposes of calculating the GP Partner's average clinical sessions per quarter for PPS purposes.

Maternity, Paternity, Adoption and Shared Parental Leave

15A.10. GP Partner's absence on maternity, paternity, adoption or shared parental leave will be ignored (for the purposes of calculating the GP Partner's average clinical sessions per quarter for PPS purposes) for the period of time that the LHB reimburses the contractor for that leave under Section 11 of the SFE.

15A.10A A GP Partner's absence on compassionate leave will be ignored for the purposes of calculating the GP Partner's average clinical sessions per quarter for PPS purposes.

Data

15A.11. The data on the number of clinical sessions worked will be collated by Shared Services Partnership (SSP) on a quarterly basis as set out in the guidance at <http://www.wales.nhs.uk/sites3/Documents/480/Guidance%20for%20GMS%20Contract%20Wales%20-%20Partnership%20Premium%202019-20.pdf>

Payments

15A.12. Payments for the PPS will be made quarterly and will be subject to superannuation. The payment is not linked to reckonable service apart from those eligible for the senior premium.

15A.13. The payment will be made on a pro rata basis according to the GP Partner's average number of clinical sessions for the quarter (up to the maximum average of 8 sessions per quarter). Subject to section 15A.16(a) below, the maximum payment in relation to a GP Partner per quarter shall therefore be £2,000 (or £2,400 where the senior premium applies). Payments will be made as follows—

Quarter 1 – June

Quarter 2 – September

Quarter 3 – December

Quarter 4 – March

15A.14. Where the GP Partner has been absent as described in 15A.7 to 15A.10A for an entire quarter, the average number of their clinical sessions shall be assumed to be the same as for the preceding quarter (or where they were also absent for the preceding quarter, the average shall be taken from the last quarter during which they were not absent as described in 15A.7 to 15A.10A).

15A.15. The Partnership Premium Scheme will be subject to post payment verification.

Condition attached to payment of Quarterly Partnership Premium Payments

15A.16. A PPS Payment, or any part thereof, is only payable to a contractor if the following conditions are satisfied—

(a) if a GP Partner receives a PPS 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 PPS Payment in respect of a GP Partner must give that payment to that GP Partner—

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

(ii) as an element of the personal income of that GP Partner.

15A.17. If the conditions set out in paragraph 15A.16(a) to (c) are breached, the LHB may in appropriate circumstances withhold payment of all or any part of any payment to which the conditions relate that is otherwise payable.

15A.18. If a contractor breaches the condition in paragraph 15A.16(d), the LHB may require repayment of any payment to which the condition relates, or may withhold payment of any other payment payable to the contractor under this SFE, to the value of the payment to which the condition relates.

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

General

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

15B.2. (1) The PPSNGP will provide an annual payment, in relation to each eligible Non-GP Partner in Wales who opts to participate in the scheme. In order to be an eligible Non-GP Partner they must be a partner (and not be employed by the practice of which they are a partner) and—

(a) where the Non-GP Partner is a qualifying registered healthcare professional, deliver a minimum of 4 clinical sessions (totalling at least 16 hours 40 minutes per week) per week within their practice (and the payment in relation to that Non-GP Partner will be based on the average number of clinical sessions performed by the Non-GP Partner per week over the financial year within their practice);

(b) where the Non-GP Partner is a qualifying non-healthcare professional, 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 (and the payment in relation to that Non-GP Partner will be based on the average contracted hours worked per week over the financial year within their general practice setting).

(2) The level of the annual payment in relation to that Non-GP Partner will, subject to paragraph 15B.19, be £1,000 (or £1,200 where paragraph 15B.3 applies) multiplied by the Non-GP Partner’s average number of clinical sessions or equivalent contracted hours worked per week, with a maximum average of 8 sessions or 33 hours 20 minutes per week counting for PPSNGP purposes and a possible maximum PPSNGP payment of £8,000 per annum.

15B.3. This paragraph applies where the non-GP Partner has, prior to becoming a Non-GP Partner, 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 NHS primary care contractor (GP practice, dental practice, optometry practice or community pharmacy) or NHS employer (which includes Health Authorities, NHS Boards, NHS Trusts/Foundation Trusts, Clinical Commissioning Groups and the Northern Ireland Health Services) provided that there are no breaks in service. 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 a written 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 a written equity sharing partnership agreement on or after 1 April 2021.

15B.6. In this Section—

“qualifying 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;

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

Clinical Session

15B.7. For PPSNGP purposes, 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 partner and qualifying registered healthcare professional under the GMS contract).

15B.8. Clinical sessions do not include time spent on locum work or any work undertaken outside of the normal business of the practice.

Annual Leave

15B.9. 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 week for PPSNGP purposes..

Sickness Absence

15B.10. 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 week for PPSNGP purposes.

Maternity, Paternity, Adoption, Shared Parental and Compassionate Leave

15B.11. 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 week for PPSNGP purposes.

15B.12 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 week for PPSNGP purposes.

Data

15B.13. 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.14. Payments to the contractor 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.15. The payment must be made on a pro rata basis as described in paragraph 15B.2 and, subject to section 15B.19 below, the maximum payment in relation to a Non-GP Partner per quarter is therefore £2,000 (or £2,400 where the senior premium applies).

15B.16. 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.17. Where the Non-GP Partner has been absent as described in 15B.9 to 15B.12 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.9 to 15B.12).

15B.18. 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.19. 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.20. If any of the conditions set out in paragraph 15B.19 are breached, the LHB may withhold payment of all or any part of any payment to which the conditions relate that is otherwise payable or require repayment of any payment to which the condition relates, or may withhold payment of any other payment payable to the contractor under this SFE, to the value of the payment to which the condition relates.

Section 16: DOCTORS' RETAINER SCHEME

General

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

16.1A This Scheme is closed to new members from 30 August 2019.

16.1B Those doctors who are currently members of this scheme will transfer to new GP Retention scheme set out in section 16A from 1 April 2020.

Payments in respect of sessions undertaken by members of the Scheme

16.2 Subject to paragraph 16.3, where—

- (a) a contractor who is considered as a suitable employer of members of the Doctors' Retainer Scheme by the Dean of General Practice, University Wales College of Medicine employs or engages a member of the Doctors' Retainer Scheme; and
- (b) the service sessions for which the member of the Doctors' Retainer Scheme is employed or engaged by that contractor are arranged or approved by the Dean of General Practice, University Wales College of Medicine Health,

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

Provisions in respect of leave arrangement

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

- (a) annual holiday up to a maximum number of sessions annually equivalent to 6 weeks' worth of arranged sessions for the member of the Doctors' Retainer Scheme;
- (b) maternity, paternity or adoption, in accordance with the circumstances and for the periods referred to in Section 9 (payments for locums covering maternity, paternity and adoption leave);
- (c) parental leave, in accordance with statutory entitlements (except that the normal statutory qualifying period of one year's service with the contractor does not apply);
- (d) sickness, for a reasonable period as agreed by the contractor and the LHB;
- (e) an emergency involving a dependent, in accordance with employment law and any guidance issued by the Department for Business, Innovation and Skills; and
- (f) other pressing personal or family reasons where the contractor and the LHB agree that the absence of the member of the Doctors' Retainer Scheme is necessary and unavoidable.

Payment conditions

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

- (a) the contractor must inform the LHB of any change to the member of the Doctors' Retainer Scheme's working arrangements that may affect the contractor's entitlement to a payment under this section;
- (b) the contractor must inform the LHB of any absence on leave of the member of the Doctors' Retainer Scheme and the reason for such absence;
- (c) in the case of any absence on leave in respect of which there are any matters to be agreed between the contractor and the LHB in accordance with paragraph 16.3 above, the contractor must make available to the LHB any information which the LHB does not have but needs, and which the contractor either has or could be reasonably expected to obtain, in order to form an opinion in respect of any of the matters which are to be agreed between the contractor and the LHB;
- (d) the contractor must inform the LHB if the doctor in respect of whom the payment is made ceases to be a member of the Doctors' Retainer Scheme, or if it ceases to be considered a suitable employer of members of the Doctors' Retainer Scheme by the Dean of General Practice, University Wales College.

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

Section 16A: GP RETENTION SCHEME

General

16A.1. This Scheme is a package of financial and educational support designed to help keep doctors working in general practice.

16A.2. This Scheme applies to doctors who are entered in—

- (a) the register of medical practitioners kept by the General Medical Council under section 2 of the Medical Act 1983(a) (registration of medical practitioners) and who hold a license to practise; and
- (b) the medical performers list which the Local Health Board is required to prepare, maintain and publish under regulation 3 of the National Health Service (Performers Lists) (Wales) Regulations 2004(b),

and where paragraphs 3 and 4 apply to that doctor.

16A.3. This paragraph applies where a doctor to whom this Scheme applies has left, or is considering leaving, general practice—

- (a) because that doctor—
 - (i) is approaching retirement, or

(a) 1983 c.54. Section 2 was amended by S.I. 2002/3135, S.I. 2006/1914, S.I. 2007/3101, S.I. 2008/1774 and S.I. 2014/1101.

(b) S.I. 2004/1020 (W. 117)

- (ii) requires greater flexibility to undertake other work within general practice or otherwise; or
- (b) for such other reasons related to the personal circumstances of that doctor as the Local Health Board considers to be acceptable for the purposes of this Scheme.

16A.4. This paragraph applies where a doctor to whom this Scheme applies—

- (a) is not able to undertake a regular part-time role; and
- (b) there is a need for additional educational supervision.

16A.5. If a doctor has not worked for over two years, an application to the GP Induction and Refresher scheme would be appropriate.

Payments in respect of sessions under the Scheme

16A.6. Subject to paragraph 16A.7, where—

- (a) a contractor who the Local Health Board considers is a suitable employer of members of the Scheme employs or engages a member of the GP Retention Scheme; and
- (b) the service sessions for which the member of the GP Retention Scheme is employed or engaged by the contractor are identified by the applicant and arranged and approved by Health Education and Improvement Wales,

the Local Health Board must pay to that contractor under its GMS contract £76.92 in respect of each full session that the member of the GP Retention Scheme undertakes for the contractor in any week, up to a maximum of four sessions per week on average (additional sessions can only be worked with prior permission from Health Education and Improvement Wales).

Provisions in respect of leave arrangement

16A.7. The Local Health Board must pay to the contractor under its GMS contract any payment payable under paragraph 16A.6 in respect of any session which a member of the GP Retention Scheme is employed or engaged to undertake but which the member does not undertake because they are absent on leave related to—

- (a) annual holiday up to a maximum number of sessions annually equivalent to 6 weeks' worth of arranged sessions for the member of the GP Retention Scheme;
- (b) maternity, paternity adoption or shared parental leave, in accordance with the circumstances and for the periods referred to 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);
- (c) parental leave, in accordance with statutory entitlements (except that the normal statutory qualifying period of one year's service with the contractor does not apply);
- (d) sickness for a reasonable period as agreed by the contractor and the Local Health Board;
- (e) an emergency involving a dependent, in accordance with employment law and any guidance issued by the Department for Business, Energy and Industrial Strategy; and
- (f) other pressing personal or family reasons where the contractor and the Local Health Board agree that the absence of the member of the GP Retention Scheme is necessary and unavoidable.

Payment conditions

16A.8. Payments under this Section are to fall due at the end of the month in which the session to which the payment relates takes place. However, the payments, or any part of the payments, are only payable if the contractor satisfies the following conditions—

- (a) the contractor must inform the Local Health Board of any change to the member of the GP Retention Scheme's working arrangements that may affect the contractor's entitlement to a payment under this Scheme;
- (b) the contractor must inform the Local Health Board of any absence on leave of the member of the GP Retention Scheme and of the reason for such absence;
- (c) in the case of any absence on leave in respect of which there are any matters to be agreed between the contractor and the Local Health Board in accordance with paragraph 16A.7 above, the contractor must make available to the Local Health Board any information which the Local Health Board does not have but needs, and which the contractor either has or could reasonably be expected to obtain, in order to form an opinion in respect of any matters which are to be agreed between the contractor and the Local Health Board;
- (d) the contractor must inform the Local Health Board if the doctor in respect of whom the payment is made ceases to be a member of the GP Retention Scheme.

16A.9. If a contractor breaches any of the conditions in paragraph 8, the Local Health Board may, in appropriate circumstances, withhold payment of all or any part of any payment otherwise payable under this Section.

Professional expenses supplement annual payment

16A.10. The Local Health Board must pay to an eligible contractor under its GMS contract an annual lump sum payment under the GP Retention Scheme in respect of a professional expenses supplement of any doctor who becomes a member of the Scheme in respect of any employment with or engagement by the contractor.

16A.11. For the purposes of this paragraph, an "eligible contractor" is a contractor to whom paragraph 6 (payments in respect of sessions undertaken by members of the Scheme) applies.

16A.12. The professional expenses supplement is to be calculated by the Local Health Board by reference to the number of sessions which a doctor described in paragraph 10 is contracted to perform for the contractor in each week, up to a maximum of four sessions per week, on the following basis, depending on whether the doctor is contracted to perform an annualised number of sessions, or a number of sessions per week:

<i>Number of sessions per week</i>	<i>Annualised sessions(a)</i>	<i>Amount of professional expenses supplement per annum</i>
1-2	Fewer than 104	£1000
2	104	£2000
3	156	£3000
4(+)	208(+)	£4000

16A.13. Subject to paragraph 14, the Local Health Board must pay to the contractor the professional expenses supplement—

- (a) "Annualised sessions" are the number of sessions per week which a performer is contracted to work for a contractor averaged out over the period of a year. They include any sessions which a member of the GP Retention Scheme is employed or engaged by the contractor to undertake but which the member does not actually undertake because it falls on a statutory holiday or because the member is absent by reason of annual leave or any requirement to undertake continuing professional development.

- (a) on the date on which the doctor becomes a member of the GP Retention Scheme; and
- (b) on the anniversary of that date in each subsequent year in respect of which the payment is due.

16A.14. The Local Health Board must not pay a professional expenses supplement in respect of any doctor where an eligible contractor has not provided sufficient information to the Local Health Board about the number of sessions per week for which that doctor is employed or engaged by the contractor.

16A.15. Where the Local Health Board pays a professional expenses supplement to an eligible contractor in respect of a doctor, the contractor must pass on the payment to that doctor, net of any applicable deductions payable by that doctor in respect of income tax and national insurance contributions, within one calendar month from the date on which the contractor received the payment on the understanding that the payment is to be applied towards meeting the cost of the doctor's professional indemnity cover, continuing professional education requirements and other professional expenses.”.

Section 17: DISPENSING

Dispensing: General

17.1 Some contractors are authorised or required to provide dispensing services to specific patients. The arrangements for this are set out in Part 6 (Applications by doctors for inclusion in or amendment to dispensing doctor lists) of the National Health Service (Pharmaceutical Services) (Wales) Regulations 2020 (“the 2020 Regulations”) and paragraph 51 (provision of drugs, medicines and appliances for immediate treatment or personal administration) of Part 3 of Schedule 6 to the 2004 Regulations.

Costs in respect of which reimbursement is payable

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

- (a) in accordance with the arrangements under which a dispensing doctor undertakes to provide pharmaceutical services referred to in regulation 26 (Arrangements for the provision of pharmaceutical services by doctors) of the 2020 Regulations;
- (b) for personal administration, in accordance with paragraph 51(1)(b) in Part 3 of Schedule 6 to the 2004 Regulations,

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

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

- (a) the basic price of the drug or appliance, which is the price as calculated in accordance with Part II Clause 8 (Basic Price), clause 10 (A and B) (Quantity to be Supplied), clause 11 (Broken Bulk), clause 13 (Reconstitution of Certain Oral Liquids) and Part VIIA Basic Prices of Drugs) of the Drug Tariff, less a discount calculated in accordance with Part 1 of Annex G;
- (b) the appropriate dispensing fee, as set out in Part 2 of Annex G (in respect of contractors authorised or required to provide dispensing services in accordance with Part 6 of the 2020 Regulations) or Part 3 of Annex G (in respect of all other contractors);
- (c) an allowance to cover the VAT payable on the purchase of any products listed in paragraph 17.4(a) to (e) and which are provided in accordance with paragraph 51(1)(b) in Part 3 of Schedule 6 to the 2004 Regulations. The allowance is to be calculated by applying the rate

of VAT applying at the time of a claim to the basic price of the product after the discount has been calculated in accordance with Part 1 of Annex G has been deducted;

- (d) exceptional expenses, as provided for in Part II, clause 12 (Out of Pocket Expenses), of the Drug Tariff; and
- (e) professional fees, as provided for in Part IIIA, clause 2A (additional fees for unlicensed medicines), of the Drug Tariff.

Personally administered drugs and appliances and those used for diagnosis

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

- (a) vaccines, anaesthetics and injections;
- (b) the following diagnostic reagents: Dick Test; Schick Test; Protein Sensitisation Test Solutions; and Tuberculin Tests (i.e. Koch Test, Mantoux Test, Patch Test and Diagnostic Jelly);
- (c) intrauterine contraceptive devices (including drug-releasing IUCDs, contraceptive caps and diaphragms);
- (d) pessaries which are appliances; and
- (e) sutures (including skin closing strips).

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

Products not covered by this Section

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

- (a) MMR (Measles, Mumps and Rubella);
- (b) BCG (Bacillus Calmette-Guerin);
- (c) Tuberculin Purified Protein Derivative;
- (d) Meningococcal C conjugate vaccine (for children under 5 and persons entering the first year of higher education);
- (e) DTaP/IPV/HiB/HepB(Diphtheria/Tetanus/Pertussis/Inactivated Polio/Haemophilus influenza type B/Hepatitis B);
- (f) dTaP/IPV (low dose Diphtheria/Tetanus/Pertussis/Inactivated Polio);
- (g) DTaP/IPV (Diphtheria/Tetanus/Pertussis/Inactivated Polio);
- (h) Td/IPV(Diphtheria/Tetanus/Inactivated Polio);
- (i) Hib/MenC (Haemophilus influenzae type B/meningitis C), PCV (pneumococcal); and
- (j) HPV (human papillomavirus types 16 and 18) in the case where the course of immunisation has commenced and is not complete before 19th October 2012;
- (k) HPV (human papillomavirus types 6, 11, 16 and 18) in the case where the course of immunisation commences on or after 19th October 2012; or

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

17.8 Payments are payable under this Section—

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

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

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

Deductions in respect of charges

17.10 Payment in respect of prescriptions shall be subject to any deduction required to be made under the National Health Service (Free Prescriptions and Charges for Drugs and Appliances)(Wales)Regulations 2007(a) in respect of charges required to be made and recovered by the dispensing practitioner.

Contractors unable to obtain discounts

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

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

Contractors that are to receive special payments

17.13 If a contractor satisfies the LHB that—

- (a) by reason of the remoteness of the contractor’s practice premises or the small quantities of drugs and appliances that the contractor needs to buy, the contractor has had to pay more than the basic price for drugs and appliances it orders; and
- (b) its payments under paragraph 17.3(a) should be calculated at special payment levels rather than basic price levels,

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

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

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

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

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

Preconditions before payments under this Section are payable

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

- (a) noted, counted and sent all the prescriptions in respect of drugs or appliances in respect of which it wishes to claim reimbursement to the NHS Wales Shared Services Partnership – Primary Care Services, 4th Floor, Companies House, Crown Way, Cardiff, CF14 3UB, not later than the 5th of the month following the month to which the prescriptions relate; and
- (b) included all the claims under cover of a single claim form, and if the claim is in respect of the following high-volume personally administered vaccines – influenza, typhoid, hepatitis A, hepatitis B, Pneumococcal, and Meningococcal – it must be made in the form of bulk entries on the claim form.

Payment arrangements

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

- (a) on the first day of the month after the month on which the contractor submitted its claim to the NHS Wales Shared Services Partnership – Primary Care Services, an amount that represents 80% of the amount that the LHB reasonably estimates is likely to be due to the contractor in respect of the claim, once the NHS Wales Shared Services Partnership – Primary Care Services has certified the amount due in respect of the claim (having taken into account the charges that are required to be made and recovered), although the LHB may pay less than 80% if the contractor's claims each month in respect of prescriptions vary significantly; and
- (b) on the first day of the second month after the month on which the contractor submitted its claim to the NHS Wales Shared Services Partnership – Primary Care Services, the balance of the amount due in respect of the claim, having had that amount certified by NHS Wales Shared Services Partnership – Primary Care Services and taking into account—
 - (i) the charges that are required to be made and recovered; and
 - (ii) the amount already paid out in respect of the claim pursuant to sub-paragraph (a).

Accounting obligations

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

- (a) its actual expenditure on drugs and appliances (i.e. the amount it pays its suppliers) is shown “gross” on its practice accounts; and
- (b) its payments from the LHB pursuant to this Section, and collected from patients in accordance with the National Health Service (Free Prescriptions and Charges for Drugs and Appliances)(Wales) Regulations 2007, are brought “gross” into its contractor accounts as “income”.

Section 18: DISPENSARY SERVICES QUALITY SCHEME

Dispensary Services Quality Scheme: General

18.1 Contractors who are authorised or required to provide dispensing services to specific patients in accordance with the provisions of Part 6 (Applications by doctors for inclusion in or amendment to dispensing doctor lists) of the National Health Service (Pharmaceutical Services) (Wales) Regulations 2020 and paragraph 51 (provision of drugs, medicines and appliances for immediate treatment or personal administration) of Part 3 of Schedule 6 to the 2004 Regulations (in this Section the provision of such dispensing services is referred to as having “consent to dispense” and the specific patients receiving dispensing services are referred to as “dispensing patients”), may choose to participate in the Dispensary Services Quality Scheme.

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

Eligibility for Dispensary Services Quality Payments

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

- (a) the contractor participates in the Dispensary Services Quality Scheme;
- (b) the contractor satisfies the eligibility conditions set out in paragraph 18.4 (read with paragraphs 18.5 and 18.6); and
- (c) the LHB is satisfied, following review of the contractor’s arrangements (which the LHB is to undertake between 1st January and 31st March inclusive of the financial year to which the payment relates or, where the provision of the service terminates before 1st January for any reason, on such other date as the LHB may, in consultation with the contractor, consider reasonable) that the contractor is providing the required level of service and is achieving the required standards, as set out in Annex H. This eligibility condition will only be satisfied if the contractor—
 - (i) complies with any reasonable requirement imposed on it, as part of that review, to provide documentary evidence of matters the LHB needs to consider in order to satisfy itself as to compliance with the standards and levels of service set out in Annex H; and
 - (ii) co-operates with a practice inspection, if the LHB considers it necessary to undertake one.

18.3 A Where the contractor has satisfied paragraphs 18.3(a) and 18.3(b) for the financial year ending with 31 March 2021 the contractor shall be deemed to have also satisfied paragraph 18.3(c) for that financial year.

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

- (a) it must provide the LHB, in respect of each financial year during which it proposes to participate in the Dispensary Services Quality Scheme, with a written undertaking, within the time limits set out in paragraph 18.5, that it will, during the financial year to which the written undertaking relates—
 - (i) perform the services identified in Annex H; and
 - (ii) achieve the standards identified in Annex H;
- (b) it must indicate in the written undertaking provided in accordance with sub-paragraph (a) the date during the financial year to which the written undertaking relates (that is, 1st April at the start of that financial year or a later date) with effect from which it either has been carrying out or proposes to carry out the services identified in Annex H;

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

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

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

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

Calculation of Dispensary Services Quality Payments

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

- (a) had consent to dispense on 1st April of that financial year;
- (b) had been participating in the Dispensary Services Quality Scheme immediately prior to 1st April of that financial year; and
- (c) satisfies the eligibility conditions set out in paragraph 18.3,

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

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

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

- (a) either had consent to dispense on 1st April of that financial year or has, on the date the contract takes effect, consent to dispense; and
- (b) satisfies the eligibility conditions set out in paragraph 18.3,

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

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

£2.58 multiplied by—

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

- (a) 1st January of that financial year; or
- (b) where the contract takes effect between 2nd January and 31st January inclusive of that financial year, the date upon which the contract takes effect,
then multiplied by X/365 (or X/366 where the financial year includes 29th February), where X is either the number of days left in the financial year from when the contract took effect or the number of days left in the financial year starting from (and including) the date specified by the contractor in his written undertaking pursuant to paragraph 18.4(b), whichever is the shorter period.

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

- (a) either did not have consent to dispense on 1st April of that financial year or, on the date the contract takes effect, did not have consent to dispense;
- (b) obtains consent to dispense between 2nd April and 31st January inclusive of that financial year; and
- (c) satisfies the eligibility conditions set out in paragraph 18.3,

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

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

£2.58 multiplied by—

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

- (a) 1st January of that financial year; or
- (b) where the consent to dispense is obtained between 2nd January and 31st January inclusive of that financial year, the date upon which the consent to dispense is obtained,
then multiplied by X/365 (or X/366 where the financial year includes 29th February), where X is either the number of days left in the financial year from when the contract took effect or the number of days left in the financial year starting from (and including) the date specified by the contractor in his written undertaking pursuant to paragraph 18.4(b), whichever is the shorter period.

Conditions attached to Dispensary Services Quality Payments

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

- (a) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor has fulfilled its obligations under the Dispensary Services Quality Scheme;
- (b) the contractor must make any returns required of it (whether computerized or otherwise) to the Exeter Registration System, and do so promptly and fully; and
- (c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

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

Accounting arrangements and date payment is due

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

- (a) subject to sub-paragraph (b), at the end of the first month of the financial year after the financial year to which the payment relates or, in the case of a contract that terminates prior to the end of the financial year or in respect of which the contractor ceases to have consent to dispense or to provide the service in Annex H prior to the end of the financial year, on the date the contract terminates or the consent to dispense ceases or the provisions of the service in Annex H ceases, as the case may be; or
- (b) if, on the due date provided for in sub-paragraph (a), the LHB does not have the information it needs in order to be satisfied that the contractor has met the eligibility criteria in paragraph 18.3 (all reasonable efforts to obtain the information having been undertaken), on the last day of the month during which the LHB obtains the information it needs in order to be so satisfied.

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

Part payment of Dispensary Services Quality Payments in special circumstances

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

- (a) the contract terminates;
- (b) the contractor ceases to have consent to dispense; or
- (c) the contractor ceases to provide the services in Annex H before 1 January 2021,

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

18.17 The calculation of the payment—

- (a) will be on the basis of the number of patients in respect of whom the contractor has consent to dispense at the start of the quarter in which the contract terminates, the contractor ceases to have consent to dispense or the contractor ceases to provide the service in Annex H, as the case may be; and
- (b) will be on the basis that in any calculation involving X/365, or X/366, “X” will be the number of days during the relevant financial year starting on the date when the contractor’s participation during that financial year in the Dispensary Services Quality Scheme began and ending on the date on which the contract terminates, the contractor ceases to have consent to dispense or the contractor ceases to provide the services in Annex H, as the case may be.

Provisions relating to contractors whose practices merge

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

18.19 If any of the contractors in a contractual merger which takes place

before 1st February in any financial year were participating in the Dispensary Services Quality Scheme during that financial year, any Dispensary Services Quality Payment relating to that participation is to be

calculated on the basis that their original GMS contract terminated on the date of the merger. The merged contract is to be treated for the purposes of this Section as a new contract coming into force on the date of the merger. If the new contractor (for these purposes) wants to participate in the Dispensary Services Quality Scheme it should seek to do so in accordance with the provisions of this Section.

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

Provisions relating to contractors whose practices split

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

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

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

Discretionary matters

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

- (a) the application of the provisions set out in this Section in respect of splits or mergers would, in the reasonable opinion of the LHB, lead to an inequitable result; or
- (b) the circumstances of the split or merger are such that the provisions set out in this Section cannot be applied,

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

18.25 It may be that the circumstances of a contract termination, or of a split or merger as described in paragraphs 18.18 to 18.23, have rendered it practicably speaking impossible for a contractor to have complied with all of the entitlement conditions in paragraph 18.3. In these

circumstances, the LHB may, where it is equitable to do so, set aside the considerations with which the contractor is no longer able to comply.

PART 5 – SUPPLEMENTARY PROVISIONS

Section 19: ADMINISTRATIVE PROVISIONS

Overpayments and withheld amounts

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

- (a) the contractor was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment or because the payment was calculated incorrectly (including where a payment on account overestimates the amount that is to fall due);
- (b) the LHB was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money has already been paid; or
- (c) the LHB is entitled to repayment of all or part of the money paid,

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

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

Underpayments and late payments

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

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

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

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

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

19.5 However, if a contractor has—

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

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

Payments on account

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

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

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

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

- (a) the Average Adjusted Superannuable Income for that financial year has been established; and
- (b) the GP provider's pensionable earnings from all sources for that financial year, excluding—
 - (i) pensionable earnings which do not appear on that provider's certificate submitted to the LHB in accordance with paragraph 20.10; and
 - (ii) any amount in respect of Seniority Payments,

have been established.

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

Payments to or in respect of suspended doctors whose suspension ceases

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

Effect on periodic payments of termination of a GMS contract

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

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

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

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

Time limitation for claiming payments

19.12 - (1) Payments are only payable if claimed before the end of the period of six years beginning with the date on which they could first have fallen due (albeit that the due date has changed pursuant to paragraph 19.5).

(2) Sub-paragraph (1) does not apply to any claims for payments which fall due under a provision of this SFE in respect of which an alternative timing limit for making claims for such payments is imposed unless, in the opinion of the LHB, exceptional circumstances exist which make it reasonable for that time limit to be disapplied.

Dispute resolution procedures

19.13 Any dispute arising out of or in connection with this SFE between the LHB and a contractor is to be resolved as a dispute arising out of or in connection with the contractor's GMS contract, i.e. in accordance with the NHS dispute resolution procedures or by the courts (see Part 7 of Schedule 6 to the 2004 Regulations).

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

Protocol in respect of locum cover payments

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

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

- (a) how they are likely to exercise their discretionary powers to make payments (including top-up payments) in respect of locum cover, having regard to the budgetary targets they have set for themselves, where they are not obliged to make such payments;
- (b) where they are obliged to make payments in respect of locum cover pursuant to Part 4, the circumstances in which they are likely to make payments in respect of locum cover of less than the maximum amount payable (for example where the locum cover is in respect of a part-time GP performer who normally works three days per week);
- (c) how they are likely to exercise their discretionary powers to make payments in respect of cover for absent GP performers which is provided by nurses or other health care professionals;
- (d) how they are likely to exercise their discretionary powers to make payments to a partner or shareholder in a contractor, or an employee of a contractor, who is providing locum cover for an absent GP performer who is also a partner or shareholder in, or an employee of, the contractor;
- (e) how they are likely to exercise their discretionary powers to make payments in respect of a GP performer who is on a long term sickness leave, where locum cover payments are no longer payable in respect of that performer under Section 12. In determining the amounts that may be appropriate in these circumstances, the expectation of the Welsh Government is that they would not exceed the half rate payable in the second period of 26 weeks under paragraph 12.6(b), or the amount that would be payable under the NHS Pension Scheme Regulations if

- the performer retired on ground of permanent incapacity, whichever is the lower;
- (ea) how they are likely to exercise their discretionary powers to make payments in the circumstances outlined in paragraph 12.3ZA; and
- (f) where they are not obliged to make payment in respect of locum cover pursuant to Part 4, how they are likely to exercise their discretionary powers to make payments in respect of a sole practitioner who is absent for the purposes of attending an accredited postgraduate educational course, in circumstances where, because of the nature of the locality in which the contractor's premises are situated, locum cover arrangements (i.e. arrangements other than cover provided by a neighbouring practice) are essential to meet the needs of patients in that locality for primary medical services.

19.17 Where the LHB—

- (a) intends to depart from that protocol in any individual case, it must consult the Local Medical Committee (if any) for the area in which the applicant affected by the departure from that protocol provides primary medical services; and
- (b) departs from that protocol in any individual case and refuses an application for funding in respect of locum cover, this must be duly justified to the unsuccessful applicant.

Adjustment of Contractor Registered Populations

19.18 The starting point for the determination of a contractor's Contractor Registered Population is the number of patients recorded in the Primary Care Registration System administered by NHS Digital as being registered with the contractor, initially when its GMS contract takes effect and thereafter at the start of each quarter, when a new number must be established.

19.19 However, in respect of any quarter, this number may be adjusted as follows—

- (a) if a contractor satisfies the LHB that a patient who registered with it before the start of a quarter was not included in the number of patients recorded in the Primary Care Registration System administered by NHS Digital as being registered with it at the start of that quarter, and the LHB received notification of a new registration within 48 hours of the start of that quarter, that patient—
- (i) is to be treated as part of that contractor's Contractor Registered Population at the start of that quarter; and
 - (ii) if that patient was registered with another contractor at the start of that quarter, is not to be counted as part of that other contractor's Contractor Registered Population for that quarter;
- (b) if, included in the number of patients recorded in the Primary Care Registration System administered by NHS Digital as being registered with a contractor at the start of a quarter, there are patients who—
- (i) transferred to another contractor in the quarter before the previous quarter (or earlier); but
 - (ii) notification of that fact was not received by the LHB until after the second day of the previous quarter,
- those patients are not treated as part of the contractor's Contractor Registered Population at the start of that quarter; or
- (c) if a patient is not recorded in the Primary Care Registration System administered by NHS Digital as being registered with a contractor at the start of a quarter, but that patient—
- (i) had been removed from a contractor's patient list in error; and
 - (ii) was reinstated in the quarter before the previous quarter (or earlier),
- that patient is to be treated as part of the contractor's Contractor Registered Population at the start of that quarter.

19.20 If a contractor wishes its Contractor Registered Population to be adjusted in accordance with paragraph 19.19, it must—

- (a) within 10 days of receiving from the LHB a statement of its patient list size for a quarter, request in writing that the LHB makes the adjustment; and
- (b) within 21 days of receiving that statement, provide the LHB with the evidence upon which it wishes to rely in order to obtain the adjustment,

and the LHB must seek to resolve the matter as soon as is practicable. If there is a dispute in connection with the adjustments, paragraphs 19.13 and 19.14 apply.

Section 20: SUPERANNUATION CONTRIBUTIONS

The LHB's responsibilities in respect of contractors' employer's and employee's superannuation contributions

20.1. Employer's superannuation contributions in respect of GP Registrars in general practice – who are subject to separate funding arrangements from those in respect of other GP performers – are the responsibility of the LHB, which act as their employer for superannuation purposes. In this section, a reference to a “specialist trainee” means a GP Registrar.

20.2. Under the NHS Pension Scheme Regulations, contractors continue to be responsible for paying the employer's superannuation contributions of practice staff who are members of the NHS Pension Scheme, and for collecting and forwarding to the NHS Pensions Division which is part of the NHS Business Services Authority (NHSPD) both employer's and employee's superannuation contributions in respect of their practice staff. Contractors are responsible, as the “employing authority” and are required to pay the LHB both the employer's and employee's superannuation contributions for—

- (a) non-GP providers; and
- (b) GP performers who are not specialist trainees in general practice,

who are members of the NHS Pension Scheme. The LHB must thereafter forward these contributions to the NHSPD. The detail of all these arrangements is set out in the NHS Pension Scheme Regulations.

20.3. In this Section—

- (a) non-GP providers and GP performers who are not specialist trainees in general practice are together referred to as “Pension Scheme Contributors”; and
- (b) the “LHB” is the “host LHB”, as defined in the NHS Pension Scheme Regulations(a).

20.4. The cost of paying Pension Scheme Contributors' employer's and employee's superannuation contributions relating to the income of Pension Scheme Contributors which is derived from the revenue of a GMS contract has been or will be included in the national calculations of the levels of the payments in respect of services set out in this SFE. It is also to be assumed that—

- (a) any other arrangements that the contractor has entered into to provide services which give rise to pensionable earnings for the purposes of the NHS Pension Scheme Regulations will have included provision for all the payable superannuation contributions in respect of its Pension Scheme Contributors in the contract price; and
- (b) the payments from the LHB to the contractor in respect of services under the GMS contract, together with the contract price of any other contract to provide services which gives rise to pensionable earnings for the purposes of the NHS Pension Scheme Regulations that the contractor has entered into, also cover the cost of any additional voluntary contributions that the LHB is obliged to forward to the NHSPD or an Additional Voluntary Contributions Provider on the contract's, or its Pension Scheme Contributors' behalf.

(a) “Host Board” is defined in regulation 2.A.1 of the National Health Service Pension Scheme Regulations 2008 (S.I. 2008/653).

20.5. Accordingly, the costs of paying the employer's and employee's superannuation contributions of a contractor's Pension Scheme Contributors under the NHS Pensions Scheme in respect of their pensionable earnings from all sources – unless superannuated for the purposes of the NHS Pension Scheme elsewhere – are all to be deducted by the LHB from any money the LHB pays, pursuant to this SFE, to the contractor that is the employing authority of the Pension Scheme Contributor.

Monthly deduction in respect of superannuation contributions

20.6. The deductions are to be made in two stages. First, the LHB, as part of the calculation of the net amount (as opposed to the gross amount) of a contractor's payable GSMPs, deduct an amount that represents a reasonable approximation of a monthly proportion of—

- (a) the contractor's liability in the financial year to which the Payable GSMPs relate in respect of the employer's superannuation costs under the NHS Pension Scheme relating to any of the contractor's Pension Scheme Contributors (i.e. a reasonable approximation in respect of their total NHS Pension Scheme pensionable earnings which are not superannuated elsewhere) who are members of the NHS Pension Scheme;
- (b) those Pension Scheme Contributors' related employee's superannuation contributions; and
- (c) any payable additional voluntary contributions in respect of those Pension Scheme Contributors.

20.7. Before determining the monthly amount to be deducted, the LHB must take all reasonable steps to agree with the contractor what that amount should be, and it must duly justify to the contractor the amount that it does determine as the monthly deduction.

20.8. Superannuation contributions in respect of payments for specific purposes which are paid after the start of the financial year will, for practical reasons, need to be handled slightly differently. The LHB and the contractor may agree that the payment is to be made net of any superannuation contributions that the LHB is responsible for collecting on behalf of the NHSPD or an Additional Voluntary Contributions Provider. In the absence of such an agreement, the default position is that a reasonable proportion of the total amount of those contributions will need to be deducted from the remaining Payable GSMPs that are due to the contractor before the end of the financial year.

20.9. An amount equal to the monthly amount that the LHB deducts must be remitted to the NHSPD and any relevant Money Purchase Additional Voluntary Contributions Providers no later than—

- (a) the 19th day of the month in respect of which the amount was deducted; or
- (b) in the case of Money Purchase Additional Voluntary Contributions, 7 days after an amount in respect of them is deducted pursuant to paragraph 20.6.

End-year adjustments

20.10. After the end of any financial year, the final amount of each Pension Scheme Contributor's superannuable income in respect of the financial year will need to be determined. For these purposes, the superannuable income of a Pension Scheme Contributor is the contractor's total pensionable earnings, as determined in accordance with the NHS Pension Scheme Regulations, which are not superannuated elsewhere.

20.11. As regards contractors that are partnerships, sole practitioners or companies limited by shares, it is a condition of all the payments payable pursuant to Parts 1 to 3 of this SFE – if any of the contractor's Pension Scheme Contributors are members of the NHS Pension Scheme – that the contractor ensures that its Pension Scheme Contributors (other than those who are neither members of the NHS Pension Scheme nor due Seniority Payments) prepare, sign and forward to the LHB—

- (a) an accurately completed certificate, the General Medical Practitioner's Annual Certificate of Pensionable Profits, in the standard format provided nationally; and

(b) no later than one month from the date on which the GP was required to submit the HM Revenue & Customs return on which the certificates must be based.

20.12. Seniority payments have to be separately identifiable in the certificate for the purposes of the calculation of Average Adjusted Superannuable Income, which is necessary for the determination of the amount of GP providers' Seniority payments. Seniority Payment figures in the certificates forwarded to the LHB will necessarily be provisional (unless they are submitted too late for the information they contain to be included in the national calculation of Average Adjusted Superannuable Income), but the forwarding of certificates must not be delayed simply because of this. Pension Scheme Contributors who are not members of the NHS Pension Scheme but in respect of whom a claim for a Quarterly Seniority Payment is to be made must nevertheless prepare, sign and forward the certificate to the LHB so that the correct amount of their Seniority Payments may be determined.

20.13. Once a contractor's Pension Scheme Contributor's superannuable earnings in respect of a financial year have been agreed, the LHB must—

(a) if its deductions from the contractor's Payable GSMPs during that financial year relating to the superannuation contributions in respect of those earnings—

(i). did not cover the cost of all the employer's and employee's superannuation contributions that are payable by the contractor or the Pension Scheme Contributors in respect of those earnings—

(aa). deduct the amount outstanding from any payment payable to the contractor under its GMS contract pursuant to this SFE (and for all purposes the amount that is payable in respect of that payment is to be reduced accordingly); or

(bb). obtain payment (where no such deduction can be made) from the contractor of the amount outstanding, and it is a condition of the payments made pursuant to this SFE that a contractor that is an employing authority of a Pension Scheme Contributor must pay to the LHB the amount outstanding; or

(ii). were in excess of the amount payable by the contractor and the Pension Scheme Contributor to the NHSPD or a relevant Money Purchase Additional Voluntary Contributions Provider in respect of those earnings, repay the excess amount to the contractor promptly (unless, in the case of an excess amount in respect of Money Purchase Additional Voluntary Contributions, the Contributor elects for that amount to be a further contribution and he is entitled to so elect); and

(b) forward any outstanding employer's and employee's superannuation contributions due in respect of those earnings to the NHSPD or any relevant Additional Voluntary Contributions Provider (having regard to the payments it has already made on account in respect of those Pension Scheme Contributors for that financial year).

Locum practitioners

20.14. Under the NHS Pensions Schemes Regulations, locum practitioners must pay employee's superannuation contributions to the LHB in respect of pensionable locum work undertaken.

20.15. Where contributions are payable by a locum practitioner under paragraph 20.14 in respect of pensionable locum work carried out for an employing authority, that employing authority (within the meaning of the Pension Schemes Regulations) must pay employer's superannuation contributions in respect of that work.

20.16. Where employer's superannuation contributions are payable in respect of a locum practitioner under paragraph 20.15, those contributions must be paid to the LHB.

20.17. It is to be assumed that a GMS contractor who enters into an arrangement with a locum practitioner which give rise to pensionable earnings for the purposes of the NHS Pension Scheme Regulations will have included provision in that arrangement for

all the payable superannuation contributions in respect of that locum practitioner in the contract price.

Recovery of unpaid contributions

- 20.18.** Paragraph 20.19 applies where, despite the provisions of this section—
- (a) a Pension Scheme Contributor or locum practitioner has failed to pay employee's superannuation contributions;
 - (b) a Pension Scheme Contributor has failed to pay employer's superannuation contributions; or
 - (c) an employing authority has failed to deduct employee's superannuation contributions.

- 20.19.** The LHB may recover the amount of any unpaid contributions referred to in paragraph 20.18—
- (a) where an employing authority has ceased to exist and paragraph 20.18(a) applies, by adding the amount of those unpaid contributions to the amount of employee's superannuation contributions the Pension Scheme Contributor or locum practitioner in question is due to pay the LHB: that Pension Scheme Contributor is to record that amount of those unpaid contributions in a certificate referred to in paragraph 23 of Schedule 2 to the National Health Service Pension Scheme Regulations 1995 or regulation 2.J.14 of the National Health Service Pension Scheme Regulations 2008; or
 - (b) by deduction from any payment of a benefit to, or in respect of, the member entitled to that benefit, such a deduction must be to the member's advantage and is subject to the member's consent.

- 20.20.** The provisions of paragraph 20.19 are without prejudice to any other method of recovery the Secretary of State may have.

PART 6 - TRANSITIONAL, REVOCATION AND SAVING PROVISIONS

Section 21: Transitional provisions

Transitional provisions

21.1. Where it is necessary for the contractor or the LHB—

- (a) to take account of a period of time; or
- (b) to calculate a period of time which is required in accordance with this SFE,

any period of time that occurred before 1st April 2013 and which is relevant to the matter under consideration is to be taken into account or used in order to calculate any time period for the purposes of that consideration or applying provisions in this SFE on or after 1st April 2013 only if that period of time could have been taken into account or used in a calculation of a time period in respect of those mirror provisions as in force immediately before 1st April 2013.

Revocations

21.2. Subject to paragraph 21.3, the 2005 SFE and the amendments to the 2005 SFE, as listed in Annex J are revoked,

Savings

21.3. Notwithstanding the revocation provided for in paragraph 21.2, the 2005 SFE and the amendments to those Directions as in force immediately before 1st April 2013—

- (a) continue to apply to the extent necessary in respect of establishing entitlement to a Seniority Payment and the calculation of the full annual rate of such a payment as provided for in paragraph 15.13 (calculation of seniority payments for the period until 31st March 2009);
- (b) continue to apply to the extent necessary in respect of the application of Annex B; and
- (c) continue to apply to the extent necessary to assess any entitlement to payment or recovery of payment arising under the terms of GMS contract.

21.4. For the purposes of paragraph 21.3 and for the resolution of any matter which is pending as at 31st March 2013 the LHB may do or continue to do anything which it could have done in relation to the 2005 SFE.

ANNEX A - GLOSSARY

PART 1 - ACRONYMS

The following acronyms are used in this document:

AWLR – All Wales Locum Register

CPI – Contractor Population Index

CRP – Contractor Registered Population

FYOIP – Five-Year-Olds Immunisation Payment

GMS – General Medical Services

GSE – Global Sum Equivalent

GSMP – Global Sum Monthly Payment

LHB – Local Health Board

LMC – Local Medical Committee

NARP – National Average of Registered Patients

NHS – National Health Service

NHSPD – NHS Pensions Division which is part of the NHS Business Services Authority

PSMP – Practice Support Monthly Payment

QI – Quality Improvement

QIF – Quality and Improvement Framework

“QI year” means the period 1 October to 30 September of any relevant year

TYOIP – Two-Year-Olds Immunisation Payment

PART 2 - DEFINITIONS

Unless the context otherwise requires, words and expressions used in this SFE and the 2004 Regulations bear the meaning they bear in the 2004 Regulations.

The following words and expressions used in this SFE have, unless the context otherwise requires, the following meaning—

“2006 Act” means the National Health Service (Wales) Act 2006(a);

“2004 Regulations” means the National Health Services (General Medical Services Contracts) (Wales) Regulations 2004(b);

“2005 SFE” means the Statement of Financial Entitlement made under section 45 of the 2006 Act which came into force on 30th April 2005;

“Achievement Payment” is to be construed in accordance with Section 5 and 6;

(a) 2006 c. 42.

(b) S.I 2004/478 (W.48) as amended

“Aspiration Payment” is to be construed in accordance with Section 5 and 6;

“Additional Services”, in the context of the additional services domain, means the following services: cervical screening services, child health surveillance, maternity medical services and contraceptive services. In other contexts, it also includes: minor surgery, childhood vaccines and immunisations including pre-school boosters, and vaccinate and immunisations;

“Additional or Out of Hours Services” means all the services listed in the definition of Additional Services above, together with out of hours services provided under arrangements made pursuant to regulation 30 of the 2004 Regulations;

“Adjusted Global Sum Monthly Payment” is to be construed in accordance with paragraph 2.5 and 2.10.

“the LHB” means the Local Health Board;

“Childhood Immunisations” is to be construed as a reference to the Childhood Vaccines and Immunisations additional service referred to in the 2004 Regulations;

“Contractor” means a person entering into, or who has entered into, a GMS contract with the LHB in accordance with section 42 of the 2006 Act;

“Contractor Population Index” is to be construed in accordance with paragraph 2.16 and 2.17.

“Contractor Registered Population”, in relation to a contractor, means (subject to any adjustment made in accordance with paragraph 2.16 and 2.17) the number of patients recorded in the Primary Care Registration System administered by NHS Digital as being registered with the contractor, initially when its GMS contract takes effect and thereafter at the start of each quarter, when a new number must be established;

“Contractor Weighted Population for the Quarter” is a figure set for each contractor arrived at by the Global Sum Allocation Formula in Part 1 of Annex B;

“DES Directions” means the Primary Medical Services (Directed Enhanced Services) Directions 2007 which came into force on 12th December 2007;

“Dispensary Services Quality Payment” is to be construed in accordance with the provisions of Section 18;

“Dispensary Services Quality Scheme” is to be construed in accordance with the provisions of Section 18 and Annex H;

“Drug Tariff” means the publication known as the Drug Tariff which is published by the Secretary of State and which is referred to in section 81(4) (arrangements for additional pharmaceutical services) of the 2006 Act;

“Employing authority” has the same meaning as in the NHS Pension Scheme Regulations.

“Employed or engaged”, in relation to a general practitioner’s relationship with a contractor, includes –

- (a) a sole practitioner who is the contractor;
- (b) a general practitioner who is a partner in a partnership and that partnership is the contractor; and
- (c) general practitioner who is a shareholder in a company limited by shares and that company is the contractor;

“financial year” means the period of 12 months commencing on 1st April and ending on 31st March;

“Full-time” means, in relation to a performer of primary medical services with a contract of employment, a contractual obligation to work for at least 37 ½ hours per normal working week. The hours total may be made up of surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services;

“General Practitioner” means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

“GMS Contract” means a general medical services contract entered into in accordance with section 42 of the 2006 Act;

“GMS contractor” means a contractor who provides primary medical services under a GMS contract;

“GP performer” means a general practitioner—

(a) whose name is included in the medical performers of a Local Health Board; and

(b) who performs primary medical services under a GMS contract, and who is—

(i) a contractor (i.e. a sole practitioner);

(ii) an employee of a contractor; or

(iii) a partner in a partnership or a shareholder in a company limited by shares and that partnership or, as the case may be, that company is the contractor;

“GP provider” means a GP who is—

(a) a contractor (i.e. a sole practitioner);

(b) a partner in a partnership and that partnership is the contractor; or

(c) a shareholder in a company limited by shares and that company is the contractor;

“GP Registrar” means a medical practitioner who is being trained in general practice by a medical practitioner who is approved under section 34I(1)(c) of the Medical Act 1983 for the purpose of providing training under that Act;

“Initial Global Sum Monthly Payment” is to be construed in accordance with paragraphs 2.4 and 2.9;

“LHB’s cut-off date for calculating quarterly payments” means the date in the final month of a quarter, determined by the LHB, after which it is not in a position to accept new data in respect of payments to be made at the end of that quarter;

“Locum practitioner” means a general medical practitioner (other than a trainee practitioner)—

(a) who falls within the description of paragraph (a) of the definition of “GP Performer”; and

(b) who is engaged under a contract for services by a GMS contractor to deputise or assist temporarily in the provision of any one or a combination of any of the following—

(i) essential services;

(ii) additional services;

(iii) enhanced services;

(iv) dispensing services;

(v) commissioned services; or

(vi) certification services;

“Medical Performers List” is to be construed in accordance with regulation 3(1) of the Performers Lists Wales Regulations;

“Money Purchase Additional Voluntary Contributions Provider” means an insurance company providing what, for the purposes of the National Health Service Pension Scheme (Additional Voluntary Contributions) Regulations 2000(a), is a free-standing additional voluntary contributions scheme;

“Money Purchase Additional Voluntary Contributions” means contributions to a Money Purchase Additional Voluntary Contributions Provider in respect of what, for the purposes of the National Health Service Pension Scheme (Additional Voluntary Contributions) Regulations 2000, is a free-standing additional voluntary contributions scheme;

“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 January divided by the number of contractors on 31 March in the QIF QI year immediately before the commencement of the QIF QI year to which the relevant payment relates.

“NHS Pension Scheme Regulations” means the National Health Service Pension Scheme Regulations 1995(b) and the National Health Service Pension Scheme Regulations 2008(c);

“Part-time” means, in relation to a performer of primary medical services with a contract of employment, a contractual obligation to work for less than 37 ½ hours per normal working week. The hours total may be made up of surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services.

“Performers Lists Regulations” means the National Health Service (Performers Lists) (Wales) Regulations 2004(d);

“PMS agreement” means an agreement entered into in accordance with section 50 of the 2006 Act;

“PMS contractor” means a person who has entered into a PMS agreement;

“Practice Support Monthly Payment” is to be construed in accordance with paragraphs 3.30-3.34

“Quarter” means a quarter of the financial year and quarter period is to be construed as the period of 3 months ending on 31st March, 30th June, 30th September or 31st December;

“QIF (Access) Year” means the period 1 April to 31 March of any relevant year;

“QIF (QI) year” means the period 1 April to 31 March of any relevant year;

“Reckonable Service” is to be construed in accordance with paragraph 15.3;

“Red Book” means the Statement of Fees and Allowances under regulation 34 of the National Health Service (General Medical Services) Regulations 1992, as it had effect on 31st March 2004;

“Sole practitioner” means an individual GP performer who is also a GMS contractor;

“Suspended”, in relation to a GP performer, means suspended from the medical performers list;

(a) S.I. 2000/619.

(b) S.I. 1995/ 300.

(c) S.I. 2008/653.

(d) S.I. 2004/1020 (W.117).

“Target Population Factor is to be construed in accordance with paragraphs E3 and E4;

“Temporary Patients Adjustment” is to be construed in accordance with paragraph 2.4 and Annex C;

“Time Commitment Fraction” is the fraction produced by dividing a performer of primary medical services’ actual working commitment by 37 ½ hours. The hours total may be made up of surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services.

ANNEX B - GLOBAL SUM

PART 1 - THE GLOBAL SUM ALLOCATION FORMULA

Introduction

B.1 The global sum will be allocated using the Global Sum Allocation Formula. This formula aims to ensure that resources reflect more accurately the contractor's workload and the unavoidable costs of delivering high quality care to the local population.

B.2 The formula consists of the following components—

- an adjustment for the age and sex structure of the population;
- an adjustment for the additional needs of the population, relating to morbidity and mortality;
- an adjustment for list turnover;
- a nursing and residential homes index; and
- adjustments for the unavoidable costs of delivering services to the population, including a Market Forces Factor and rurality index.

Age and sex adjustment

B.3 The analysis supporting the formula estimates the relative workload, weighted by staff input cost, of providing general medical services to males and females of a number of age groups. The table below, based on analysis of the General Practice Research Database, shows these indices (expressed relative to a male patient aged 5-14), including an adjustment for the higher workload of treating patients through home visits.

Table: Age-sex workload indices (males aged 5-14=1)

	<i>0-4</i>	<i>5-14</i>	<i>15-44</i>	<i>45-64</i>	<i>65-74</i>	<i>75-84</i>	<i>85+</i>
Male	3.97	1	1.02	2.15	4.19	5.81	6.27
Female	3.64	1.04	2.19	3.36	4.9	6.56	6.72

B.4 Therefore, each male patient on a contractor's list aged over 85 will attract 6.27 times the resources for a male patient aged 5-14.

Nursing and Residential Homes

B.5 Patients in nursing and residential homes generate more workload than patients with otherwise similar characteristics who are not in homes. A factor of 1.43 is applied in respect of each patient in a nursing or residential home.

Needs adjustment

B.6. As well as the impact on contractors' workload generated by differing age and sex groups, the effect of indicators of mortality and morbidity on consultation frequency has been estimated, using the Health Survey for England.

B.7. Of all the variables tested by the supporting analysis, Standardised Limited Long- Standing Illness (SLLI) and the Standardised Mortality Ratio for those aged under 65 (SMR<65) were found to be best at explaining variations in workload.

B8. The Global Sum Allocation Formula relates these variables to workload by the following formula—

$$\text{Practice list} * (48.1198 + (0.26115 * \text{SLLI}) + (0.23676 * \text{SMR} < 65)).$$

In this formula, as in all other formulae in this Annex B, the symbol “*” is used as the sign for multiplication.

List turnover adjustment

B.9. Areas with high list turnover often have higher workload, as patients in their first year of registration in a practice tend to have more consultations than other patients.

B.10. Analysis of the workload implications revealed 40 – 50% more workload, as measured by aggregate consultation times, within the first year of registration. An average uplift factor, of 1.46, will be applied through the formula in respect of all new registrants in their first year of registration.

Unavoidable costs adjustment

B.11. Contractors are also likely to face differing costs of delivering primary care, particularly caused by geographic location. The global sum allocation formula reflects these costs through an explicit adjustment for ‘market forces’ and rurality. There is also an ‘off-formula’ adjustment for contractors whose qualify for the London adjustment.

Staff Market Forces

B.12. The staff Market Forces Factor has been informed by analysis of the New Earnings Survey, and reflects the geographical variation in contractors’ staff costs. The estimation methodology is the same as that used for general NHS allocations.

B.13. This element of the formula has been given a weighting of 48%, as this is the average proportion of the global sum accounted for by staff expenses.

Rurality

B.14. The cost of delivering services is likely to be affected by the rurality of the area the practice serves. Two measures designed to reflect rurality were used—

- (a) population density (as measured by persons per hectare in the wards from which a contractor draws its patients); and
- (b) population dispersion (as measured by the average distance from patients to practice). If a practice has more than one surgery, the average distance is assessed from the practice’s principal surgery, which is defined as the surgery which the greatest number of the practice’s patients could reasonably be expected to attend.

B.15. Using analysis of the HM Revenue & Customs information on GP expenses, rurality is linked to cost through the following adjustment to the formula—

$$\text{Practice List} * \text{average distance}^{0.05} * \text{population density}^{-0.06}$$

B.16. This adjustment is applied only to the expenses element of GMS expenditure, and therefore given an overall weighting of 58%.

Normalising the adjustments

B.17. At each stage of the calculation, the weighted practice populations are normalized (scaled back) to the LHB normalized weighted population. This is done so that the impact of each of the adjustments is equal, and ensures that one adjustment does not dominate the others.

B.18. Using the age and sex adjustment as an example, the formula for normalising weighted practice populations, for the specific Global Sum Allocation Formula adjustments, is as follows:

$$\frac{\text{age and sex weighted practice population}}{\text{sum of LHB age and sex weighted practice populations}} \quad \bullet \quad \text{LHB normalized weighted population}$$

B.19. The LHB normalized weighted population used above is the LHB’s registered population for the current quarter multiplied by its latest Quarterly LHB Normalising Index. The Quarterly LHB Normalising Index is a quarterly updated index derived by the Primary Care Registration System administered by NHS Digital from the data used in the previous quarter’s Global Sum Allocation Formula. Scaling back to this population ensures that the needs and costs of the LHB’s population, relative to the LHB’s in the country, are reflected in its practices’ global sum payments.

B.20. The other five weighted practice populations produced by the other adjustments in the Global Sum Allocation formula are normalized in the same manner as outlined in B.18.

B.21. The normalised weighted practice populations for each adjustment are then divided by the practice’s normalized list size to generate a practice index for each adjustment used in the Global Sum Allocation Formula. The formula for calculating the practice’s normalized list size is as follows—

$$\text{Practice normalized list size} = \text{CRP} * \text{Quarterly LHB Normalising Index}$$

B.22. Using the age and sex adjustment as an example, the formula for then calculating the practice index for each adjustment is as follows—

$$\frac{\text{Practice age and sex index} * \text{Normalised age and sex weighted practice population}}{\text{Practice normalised list size}}$$

B.23. Indices are produced for each of the other five adjustments in the Global Sum Allocation Formula in the same manner as outlined in B.22.

Combining the adjustments

B.24 Each of the six indices are then applied simultaneously to the practice’s normalised list size to calculate the overall weighted practice, as follows—

$$\text{Overall weighted practice population} = \text{Practice normalised list size} * \text{age and sex index} * \text{nursing and residential homes index} * \text{additional needs index} * \text{MFF index} * \text{rurality index}$$

B.25. This overall weighted practice population is then normalised to the national registered population to calculate the Contractor Weighted Population for the Quarter as follows—

$$\text{Contractors Weighted Population} = \frac{\text{overall weighted practice population}}{\text{sum of LHB overall weighted practice populations}} \quad * \quad \text{LHB normalised weighted population}$$

ANNEX C - TEMPORARY PATIENTS ADJUSTMENT

C.1 The need for this arises because of the contractors' obligations to provide emergency treatment to people who are not registered with their practice and to provide treatment to temporary residents. The Temporary Patients Adjustment will be calculated as follows.

C.2 All contractors are to receive a payment for unregistered patients as an element in their global sum allocation.

C.3 In the case of a contractor in respect of which a Temporary Patients Adjustment was calculated for the financial year prior to the current financial year in respect of which a calculation needs to be made, the Temporary Patients Adjustment for the current financial year will be the same amount as was calculated for the previous financial year.

C.4 However, there may be exceptional cases where a calculation pursuant to paragraph C.3 produces an amount that is clearly inappropriate as the basis for a payment in the financial year to which the payment relates. This may occur, for example, where the practice has faced a significant increase or decrease in the numbers of unregistered patients requiring treatment from it. In these cases, the LHB is instead to determine for the contractor, as the basis for its Temporary Patients Adjustment, a reasonable annual amount which is an appropriate rate for the area where the practice is located. Before making such a determination, the LHB must discuss the matter with the contractor.

C.5 In the case of a contractor in respect of which no Temporary Patients Adjustment was calculated for the financial year prior to the current financial year in respect of which a calculation needs to be made, the LHB is instead to determine for the contractor, as the basis for its Temporary Patients Adjustment for the current financial year, a reasonable annual amount which is an appropriate rate for the area where the practice is located. Before making such a determination, the LHB must discuss the matter with the contractor.

C.6 The amount calculated in accordance with paragraph C.3 to C.5 is the annual amount of the contractor's Temporary Patients Adjustment, which is the amount to be included in its Initial GSMP calculation.

C.7 Once a Temporary Patients Adjustment has been determined, it remains unchanged for the financial year to which the determination relates.

ANNEX D
(OMITTED)

ANNEX F
(OMITTED)

ANNEX G - DISPENSING PAYMENTS

PART 1
DISCOUNT SCALE

<i>Total basic price per month of the prescriptions submitted by the contractor - £ bandwidth</i>	<i>New discount rate (%)</i>
1-2000	3.17
2001 – 4000	5.93
4001 – 6000	7.21
6001 – 8000	8.06
8001 – 10 000	8.68
10 001 – 12 000	9.19
12 001 – 14 000	9.60
14 001 – 16 000	9.97
16 001 – 18 000	10.29
18 001 – 20 000	10.57
20 001 – 22 000	10.82
22 001 – 24 000	11.03
24 001 and above	11.18

PART 2
**DISPENSING FEESCALE FOR CONTRACTORS THAT ARE
AUTHORISED OR REQUIRED TO PROVIDE DISPENSING
SERVICES**

To apply from 1 October 2023 up to and including 31 March 2024

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	Prices per prescription, in pence
individual dispensing practitioner, in bands	
Up to 464	207.4
465 – 581	204.4
582 – 698	201.7

699 – 813	199.1
814 – 931	196.8
932 – 1045	194.7
1046 – 1453	192.6
1454 – 2034	190.8
2035 – 2324	189.2
2325 – 2906	187.7
2907 – 3485	186.4
3486 – 4067	185.3
4068 – 4646	184.3
4647 and over	183.6

To apply from 1 April 2024

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	Prices per prescription, in pence
Up to 464	235.0
465 – 581	231.6
582 – 698	228.6
699 – 813	225.7
814 – 931	223.0
932 – 1045	220.6
1045 – 1453	218.3
1454 – 2034	216.3
2035 – 2324	214.4
2325 – 2906	212.7
2907 – 3485	211.2
3486 – 4067	210.0
4068 – 4646	208.9
4647 and over	208.1

PART 3

DISPENSING FEESCALE FOR CONTRACTORS THAT ARE NOT AUTHORISED OR REQUIRED TO PROVIDE DISPENSING SERVICES

To apply from 1 October 2023 up to and including 31 March 2024

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	Prices per prescription, in pence
Up to 464	216.1
465 – 581	213.1
582 – 698	210.4
699 – 813	207.9
814 – 931	205.6
932 – 1045	203.4
1046 – 1453	201.3
1454 – 2034	199.5
2035 – 2324	197.9
2325 – 2906	196.4
2907 – 3485	195.1
3486 – 4067	194.0
4068 – 4646	193.0
4647 and over	192.3

To apply from 1 April 2024

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	Prices per prescription, in pence
Up to 464	244.8
465 – 581	241.5
582 – 698	238.5
699 – 813	235.5
814 – 931	233.0
932 – 1045	230.5
1046 – 1453	228.2
1454 – 2034	226.1
2035 – 2324	224.2
2325 – 2906	222.5
2907 – 3485	221.1
3486 – 4067	219.9
4068 – 4646	218.7
4647 and over	218.0

ANNEX H - DISPENSARY SERVICES QUALITY SCHEME

Governance of dispensary services

SOPs, clinical audit and risk management

H.1.1 The contractor must ensure that Standard Operating Procedures (SOPs) are in place and reflect both good professional practice, as well as the procedures that are actually performed by the practice. SOPs should be followed routinely for all dispensing related activities SOPs should be specific to the practice and should set out in writing what should be done, where, where and by whom.

H.1.2 Standard Operating Procedures must be reviewed and updated at least once every 12 months and whenever dispensing procedures are amended. A written audit trail of amendments should be maintained.

H.1.3 The contractor must participate in contractor lead clinical audit of dispensing services. Clinical audit seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and the implementation of change. Audit of dispensing services should include arrangements to assess the nature and quality of the advice provided to patients as part of the dispensing service.

H.1.4 The contractor must have a written policy for managing risks in providing dispensing services and must ensure that this policy is understood, and put into practice, by all staff involved in dispensing.

H.1.5 The contractor must ensure that all serious untoward incidents relating to dispensing are reported to the LHB for the purpose of reviewing and learning from incidents.

Information

H.2.1 The contractor must provide information to their patients on—

- (a) the dispensing services provided by the contractor; and
- (b) how to obtain medicines urgently.

H.2.2 The contractor must inform their LHB (who will inform NHS Direct as for pharmacies) of the hours of availability of dispensing services provided by the contractor. The contractor must ensure that opening times are displayed prominently on the premises from which they carry out dispensing and that they are legible from outside the premises when they are shut.

Dispensing Staff

H.3.1 The training and experience required in respect of dispensing staff is as follows.

H.3.2 The Standard Operating Procedures for each dispensary must indicate the level of competency expected for each function performed by dispensers or staff working as dispensary assistants.

H.3.3 For staff employed by the contractor who are not doctors and whose normal working patterns do not involve dispensing but who are involved in dispensing on an occasional or limited basis, a flexible approach to the minimum competence requirement for dispensing assistants can be adopted. The contractor must identify such staff to the LHB, which should agree that the staff member concerned only has an occasional or limited role in dispensing. However, the contractor also needs to demonstrate that all staff who are working in the dispensary have evidence that they have the knowledge and competencies to perform the tasks and roles assigned to them, and staff who only have an occasional or limited role in dispensing are still required to have a certificate of competency signed by the practice manager (if any) and accountable GP in respect of the roles they occasionally undertake.

H.3.4 The contractor must have a written record of the qualifications of all staff engaged in dispensing and ensure that staff engaged in dispensing undertake continuing professional development. The contractor must carry out and complete a written record of an appraisal of all dispensing staff, and assess their competence in performing dispensary tasks at least annually.

H.3.5 Regarding existing staff employed by the practice on the date of the practice's first written undertaking to provide the service trainee dispensers—;

- (a) must be competent in the area in which they are working to a minimum standard equivalent to the Pharmacy Services Scottish/National Vocational Qualification (S/NVQ) level 2, or undertaking training towards this, or enrol in this training within three months of the practice's written undertaking towards this; and
- (b) must not work unsupervised until they have completed 1,000 hours work experience in the dispensary and have a certificate of competency signed by the practice manager (if any) and accountable GP. (A trained dispenser should supervise dispensing assistants until they have completed the work experience).

H.3.6 Other existing dispensing staff that work independently in the practice dispensary—

- (a) must have minimum work experience of 1,000 hours over the past five years in a GP dispensary or community pharmacy; and
- (b) must be competent in the area in which they are working to a minimum standard equivalent to the Pharmacy Services S/NVQ level 2, or undertaking training towards this, or enrol in this training within three months of the practice's written undertaking to provide the service.

H.3.7 However where an experienced dispenser's residual term of employment is not commensurate with the timeframe requirement of the specified course, the dispenser must have their knowledge and competence assessed and hold a certificate of competency signed by the practice manager (if any) and the accountable GP.

H.3.8 New dispensing staff employed by the practice after the date of the practice's first written undertaking to provide the service:

- (a) must be competent in the area which they are working, to a minimum standard equivalent to the Pharmacy Services S/NVQ level 2 qualification or enrol in training towards this within three months of the commencement of their employment; and
- (b) must have completed 1,000 hours of work experience in a GP dispensary or community pharmacy within the past five years before being able to work unsupervised. (A trained dispensing staff member should supervise new staff until they have completed the work experience).

H.3.9 Where a dispenser is expected to enrol on a course, the relevant qualification should be completed within three years, although the LHB has discretion to allow for additional time in the case of absence due, for example, to sickness or maternity leave.

Minimum level of staff hours

H.4.1 The contractor must ensure that a minimum level of staff hours is dedicated to dispensary services to ensure that patients' needs for dispensing services, and the time required to complete the underpinning systems and processes, can reasonably be expected to safeguard patient safety.

H.4.2 The contractor must assure a level of staffing that reflects that practice's dispensary's configuration and hours of opening, as agreed with the LHB.

Duty of confidentiality

H.5 All employee contracts for dispensing staff must include a duty of patient confidentiality as a specific requirement, with disciplinary procedures set out for non-compliance.

Review with patients of compliance and concordance with use of medicines

H.6.1 A contractor must carry out a review of compliance and concordance with the use of medicines of at least 10% of the contractor's dispensing patients at least once in each financial year. A review with a dispensing patient (and, where appropriate, the carers of those patients) may be conducted face-to-face in person or if clinically appropriate via telephone or remote video consultation, and the contractor must record the review in the medical record of each dispensing patient reviewed. Where the contractor is entitled to less than a full year's Dispensary Services Quality Payment in any financial year the figure of 10% shall be reduced by an appropriate percentage. The practice should agree with the LHB the types of patients that should be targeted for the review as part of their undertaking to carry out the services specified.

H.6.2 The review should normally be carried out by trained dispensing staff or by a registered health professional with appropriate competencies in review of medicines.

H.6.3 Arrangements must be in place to ensure that patients reviewed will be referred appropriately and in a timely manner to a doctor, nurse, pharmacist or other appropriate health professional working with the contractor, whenever clinically appropriate.

H.6.4 The reviewer should—

- (a) establish the patient's actual use, understanding and experience of taking medicines: referring potential side effects or adverse effects reported by patients;
- (b) identify discuss and resolve or refer poor or ineffective use of their medicines;
- (c) improve the clinical and cost effectiveness of prescribed medicines, referring where appropriate, and initiating appropriate action by using information from patients to recommend improvements in repeat dispensing and so reduce medicine wastage.

ANNEX I

Routine childhood vaccines and immunisations

The Routine Childhood Immunisation Programme

Background

I.1 Guidance and information on routine childhood vaccines and immunisations are set out in “Immunisation against infectious diseases – The Green Book” which is published by Public Health England.

Routine Childhood Immunisation Schedule

I.2 Children starting the immunisation programme at two months of age will follow the schedule (also known as the “Childhood Immunisation Schedule”), which include changes to the pneumococcal (PCV) dosing course for children born after 31 December 2019 to be administered in accordance with the table at Section 9ZA.5. The vaccinations listed in the table are part of the targeted childhood immunisations programme eligible for payment under the GMS contract. All children starting the immunisation programme at 2 months of age will follow the schedule (often referred to as the “Childhood Immunisation Schedule”) below as set out in the Table.

Table

Age	Vaccine	Dosage
Two months old (eight weeks)	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b, hepatitis B (DTaP/IPV/Hib/HepB)	One injection
	Pneumococcal (PCV) only for children born before 1 January 2020	One injection
	Rotavirus (Rota)	One oral dose
	Meningococcal B	One injection
Twelve weeks old	Pneumococcal (PCV) only for children born after 31 December 2019	One injection
Three months old (twelve weeks)	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b, hepatitis B (DTaP/IPV/Hib/HepB)	One injection
	Rotavirus (Rota)	One oral dose
Four months old (sixteen weeks)	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b, hepatitis B (DTaP/IPV/Hib, HepB)	One injection
	Pneumococcal (PCV) only for	One injection

	children born before 1 January 2020	
	Meningococcal B	One injection
Twelve to thirteen months old (on or after the child's first birthday)	Haemophilus influenzae type b, Meningococcal C (Hib/MenC)	One injection
	Pneumococcal (PCV) only for children born after 31 December 2019	One injection
Twelve to Thirteen months old	Meningococcal B	One injection
	Measles, mumps and rubella (MMR)	One injection
	Pneumococcal (PCV) only for children before 1 January 2020	One injection
Three years four months to five years old	Diphtheria, tetanus, pertussis (whooping cough) and polio (DTaP/IPV or DTaP/IPV)	One injection
	Measles, mumps and rubella (MMR)	One injection

ANNEX J – AMENDMENTS

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

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