DIRECTIONS

NATIONAL HEALTH SERVICE, ENGLAND

General Medical Services Statement of Financial Entitlements (No. 2) Directions 2021

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Introduction

1.—(1) The Secretary of State for Health and Social Care gives the following directions as to payments to be made under general medical services contracts in exercise of the powers conferred by sections 87, 272(7) and (8) and 273(1) of the National Health Service Act 2006(**a**). In accordance with section 87(4) of that Act, the Secretary of State for Health and Social Care has consulted with the bodies appearing to the Secretary of State to be representative of persons to whose remuneration these directions relate and with such other persons as the Secretary of State for Health and Social Care thinks appropriate.

(2) The Statement of Financial Entitlements (No. 2) Directions 2021 (the "SFE") replaces the Statement of Financial Entitlements Directions 2021, signed on 31st March 2021 (the "2021 (No. 1) SFE"). The 2021 (No. 1) SFE replaced the Statement of Financial Entitlements 2013 (the "2013 SFE"), signed on 27th March 2013, as amended by the Directions set out in Annex J. The 2021 (No. 1) SFE and the 2013 SFE continue to have effect in relation to the matters set out in Section 22 (Revocation and saving provision) of the SFE.

(3) The 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 the SFE is provided in Annex A.

Citation, extent, application and commencement

2.—(1) These Directions may be cited as the General Medical Services Statement of Financial Entitlements Directions 2021 and are referred to in the following Sections and Annexes as the SFE.

(2) These directions extend to England and Wales, but apply to England only.

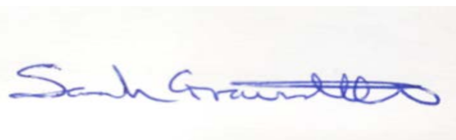
(3) The SFE may be revised at any time, in certain circumstances with retrospective effect(**b**).

(4) These directions are given to the National Health Service Commissioning Board(**c**). The SFE relates to the payments to be made by the National Health Service Commissioning Board to a contractor under a general medical services contract.

(5) The SFE comes into force on 1st October 2021.

(6) The SFE is authorised to be given on behalf of the Secretary of State for Health and Social Care, by a member of the Senior Civil Service and is signed on 1st October 2021.

Signed by authority of the Secretary of State for Health and Social Care.



Sarah Gravenstede, Deputy Director General Practice
A member of the Senior Civil Service
Department of Health and Social Care

Date: 1st October 2021

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a 2006 (c.4); Section 87 is amended by section 55 of, and paragraph 33 of Schedule 4 to the Health and Social Care Act 2012 (c.7) ("the 2012 Act"). By virtue of section 271(1) of the 2006 Act, the powers conferred by these sections are excisable by the Secretary of State only in relation to England.

b See section 87(3) of the 2006 Act.

c The National Health Service Commissioning Board (known as "NHS England") is established by section 1H of the 2006 Act. Section 1H as inserted by section 9(1) of the 2012 Act.

PART 1

GLOBAL SUM

GLOBAL SUM PAYMENTS

Global Sum Payments: General

3.—(1) Global Sum Payments are a contribution towards the contractor's costs in delivering Essential Services and minor surgery, 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.

(2) The vaccines and immunisations which are paid under the Global Sum Payment are set out in Part 2 of Annex B.

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

(3) 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, the Board 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) (see paragraph 19(15))—

(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.

(4) 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 the SFE. The resulting figure, which is the contractor's Contractor Weighted Population for the Quarter, is then to be multiplied by £96.78. If the home addresses of any of the contractor's registered patients are within the Greater London Authority area([**a**]), a London Adjustment is to be added, which is the count of registered patients whose postcodes([**b**]) are within the Greater London Authority area multiplied by 2.18.

(5) Then, the Board will need to add the total produced by paragraph (4) (with or without the London Adjustment, as appropriate) to the annual amount of the contractor's Temporary Patients Adjustment. The method of calculating contractors' Temporary Patients Adjustments is set out in Annex C. The resulting amount is then to be divided by twelve, and the resulting amount from that calculation is the contractor's first Initial GSMP for the financial year.

Calculation of Adjusted Global Sum Monthly Payments

(6) 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 minor surgery or out of hours services listed in column 1 of the Table in this paragraph, the Board is to calculate an Adjusted GSMP for that contractor as follows. If the contractor is not going to provide—

(a) one of the minor surgery or out of hours services listed in column 1 of the Table, the contractor's Adjusted GSMP will be its Initial GSMP reduced by the percentage listed opposite the service it is not going to provide in column 2 of the Table;

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

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a See sections 1 and 2 of the Greater London Act 1999 (c.29) and article 2 of the Greater London Authority (Assembly Constituencies and Returning Officers) Order 1999 (S.I.1999/3380) for the London Boroughs within the Greater London Authority area.

b On a quarterly basis, the postcodes of a practice's registered patients will be analysed to determine which Lower Super Output Area ("LSOA") they fall within. LSOAs are geographical areas created by the Office for National Statistics ("ONS"). It will then be determined whether the relevant LSOAs fall within the Greater London Authority area using the most recent boundary information published by ONS.

Table

Minor surgery or out of hours services	*Percentage of Initial GSMP*
Minor surgery	0.6
Out of hours services	4.75

First Payable Global Sum Monthly Payments

(7) Once the first value of a contractor's Initial GSMP, and where appropriate Adjusted GSMP have been calculated, the Board 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 21 (superannuation contributions – see paragraphs 21(6) 21(7) and 21(12)).

(8) The Board 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

(9) 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 minor surgery or out of hours services opt-outs (whether temporary or permanent);
- (c) if the contractor is to start or resume providing minor surgery that it has not been providing; or
- (d) if either of the amounts specified in paragraph (4) (being £96.78 and the London Adjustment) is changed.

(10) Whenever the Payable GSMP needs to be revised, the Board 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 (3) to (5) above), but using the most recently established CRP of the contractor (the number is to be established quarterly).

(11) Any deductions for minor surgery or out of hours services opt-outs are then to be calculated in the manner described in paragraph (6). If the contractor starts or resumes providing minor surgery 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 minor surgery or out of hours services) is the contractor's new (or possibly first) Adjusted GSMP.

(12) Once any new values of the contractor's Initial GSMP and Adjusted GSMP have been calculated, the Board 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 21 (superannuation contributions - see paragraphs 21(6), 21(7) and 21(12)).

(13) 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 minor surgery or out of hours services that a contractor is under an obligation to provide and that change takes effect on any day other than the first day of the month, the contractor's Payable GSMP for that month is to be adjusted accordingly.

Its amount for that month is to be the total of the appropriate proportion of its previous Payable GSMP and the appropriate proportion of its new Payable GSMP. These are to be calculated as follows—

(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 GSM: 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.

(14) Any overpayment of Payable GSMP in that month as a result of the Board 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

(15) Payable GSMPs, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must make available to the Board any information which the Board 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 registration system approved by the Board(**a**), and do so promptly and fully;

(c) the contractor must immediately notify the Board 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 Board pursuant to or in accordance with this paragraph must be accurate.

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

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

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

(a) 150; by

(b) the amount specified in Section 6(8) (calculation of Achievement Payments) as the value of each Achievement Point in a calculation of an Achievement Payment for the financial year to which the Achievement Points Total relates; by

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

(18) However, if the contractor's GMS contract either takes effect during or is terminated before the end of, that financial year, the amount to be withheld pursuant to paragraph (17) is to be adjusted by the

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a The registration system is an NHS database of all patients who are registered with an NHS GP practice in England.

fraction produced by dividing the number of days during which the financial year for which its GMS contract had effect by 365 (or 366 where the financial year includes 29th February).

Contractor Population Index

(19) The CPI of a contractor, mentioned in paragraph (17)(c), is the contractor's most recently established CRP divided by the national average for England of the number of registered patients of contractors on the 1st January in the year immediately before the commencement of the financial year to which the Achievement Payment relates as calculated using the registered lists of contractors held on the registration system approved by the Board. For the financial year ending 31st March 2022, the national average practice population figure is 9,085(**a**).

PART 2

QUALITY AND OUTCOMES FRAMEWORK

GENERAL PROVISIONS RELATING TO THE QUALITY AND OUTCOMES FRAMEWORK

Background

4.—(1) The Quality and Outcomes Framework (QOF) is set out in Annex D to the SFE.

(2) Participation in the QOF is voluntary. Information on what is required to accomplish the task or achieve the outcome included in each indicator is set out in Annex D. Additional Guidance on the rationale for indicators, best practice, establishing evidence and verification is published by NHS England and can be obtained on https://www.england.nhs.uk/wp-content/uploads/2021/03/B0456-update-on-quality-outcomes-framework-changes-for-21-22-.pdf.

(3) This Section explains the types of payments in relation to the QOF and sets out the mechanism for measuring Achievement Payments in respect of indicators for the financial year commencing on 1st April 2021 and ending on 31st March 2022 – see paragraphs (7) to (20).

Types of payments in relation to the QOF

(4) Essentially, there are two types of payments that are made in relation to the QOF: Aspiration Payments (see also Section 5 (Aspiration Payments: calculation, payment arrangements and conditions of payments)) and Achievement Payments (see also Section 6 (Achievement Payments: calculation, payment arrangements and conditions of payments)).

Aspiration Payments

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

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

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

(6) If a contractor is to have an Aspiration Points Total, this is to be agreed between the contractor and the Board—

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

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

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a The national average practice population figure is taken from the Calculating Quality Reporting Service (CQRS) on 1st January 2021.

Achievement Payments

(7) Achievement Payments are payments based on the points total that the contractor achieves under the QOF – as calculated, generally speaking (see Section 6(2) (assessment of Achievement Payments)), on the last day of the financial year or the date on which its contract terminates (see Section 6(Achievement Payments: calculation, payment arrangements and conditions of payments)) – this points total is its Achievement Points Total. The payments are to be made in respect of all Achievement Points actually achieved, whether or not the contractor was seeking to achieve those points, but the final amount also takes into account the deduction of the Aspiration Payments that the contractor has received in respect of the same financial year.

The principal domains of the QOF

(8) The QOF is divided into the following domains, which are—

(a) the clinical domain;

(b) the public health domain; and

(c) the Quality Improvement Domain.

Calculation of points in respect of the domains

(9) Each domain contains areas for which there are a number of indicators set out in tables in Section 2 (summary of all indicators) of Annex D. These indicators contain standards (tasks or thresholds) against which the performance of a contractor will be assessed. An explanation of these standards and the calculation relating to these standards are set out in paragraphs (10) to (20).

Calculation common to all domains

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

Calculations in respect of the clinical domain and the public health domain

(11) Other indicators relating to the clinical and public health domain have designated Achievement Thresholds. The contractor's performance against the standards set out in these indicators is assessed by a percentage – generally of the patients suffering from a particular disease in respect of whom a specific task is to be performed or a specific outcome recorded (referred to as "fraction" indicators – see for example paragraph D.12 of Section 1 (introduction) of Annex D). Two percentages are set in relation to each indicator—

(a) a minimum percentage of patients, which represents the start of the scale; and

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

(12) If a contractor has achieved a percentage score in relation to a particular indicator that is between the minimum and the maximum set for that indicator, it achieves a proportion of the points available in relation to that indicator. The proportion is calculated as follows.

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

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

(b) the number produced by subtracting from the total number of patients registered with the contractor with the relevant medical condition (B), the total number of patients who have a

personalised care adjustment recorded and the total number of patients who fall within the meaning of excluded patients (C).

(14) For the purposes of paragraph (13)—

(a) "personalised care adjustment" means an appropriate variation in the care of a registered patient in consequence of which such patients fall within the criteria for personalised care adjustment as set out in paragraphs D.12 to D.22 of Section 1 (introduction) Annex D; and

(b) "excluded patients" means patients who are on the relevant disease register or target group and are referred to in paragraph D.13 of Section 1 (introduction) of Annex D but are not included in an indicator denominator for the clinical area concerned.

(15) The fraction derived from the calculation in paragraph (11) is then multiplied by 100 for the percentage score. The calculation can be expressed as—

$$\frac{A}{(B-C)} \times 100 = D$$

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

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

(17) The result (H) is the number of points to which the contractor is entitled in relation to that indicator.

Thresholds

(18) Maximum thresholds are intended to be set based on evidence of the maximum practically achievable level to deliver clinical effectiveness. This is to ensure that QOF supports continuous quality improvement year on year up to the level that is practically achievable and will enable more patients to benefit, therefore improving health and saving more lives. Evidence of the maximum practically achievable is to be provided by data available on achievement in previous years.

(19) The percentages for the achievement threshold levels for the fraction indicators included in QOF for the financial year commencing on 1st April 2021 and ending on 31st March 2022 are set out in Annex D.

(20) The percentages for the threshold levels for fraction indicators for the period commencing on 1st April 2021 to 31st March 2022 and the following financial years are to be set according to the following principles—

(a) the thresholds for all continued fraction indicators in the QOF are intended to be reviewed by the Board each year to decide the level of thresholds for these indicators, following the method set out in subparagraphs (b) to (e);

(b) the maximum thresholds are to be set at the same percentage as that achieved by the 75th percentile of contractors in the latest year for which data is available. This is two financial years before the year in question. For example, for the financial year commencing on 1st April 2021 and ending on 31st March 2022 the achievement data is published at end October 2021 and this will be used to set the new thresholds for "continued fraction indicators" for the period commencing on 1st April 2022 and ending on 31st March 2023;

(c) the minimum threshold is set 40 percentage points lower than the new maximum threshold. For example, if the new maximum threshold is proposed to be 93% the new minimum threshold would be proposed as 53%;

(d) "continued fraction indicators" means fraction indicators that remain in QOF with substantially the same clinical meaning (not necessarily the same points or thresholds) for at least three years – i.e. they were included in the year to which the achievement data relates and they continue in the QOF into the year in which the thresholds are to be amended. For example, for thresholds set for the period commencing on 1st April 2025 and ending on 31st March 2026, to be a

continued fraction indicator, an indicator would have had to remain substantially the same in QOF during the three financial years from 1st April 2021 to 31st March 2024; and

(e) a fraction indicator remains "substantially the same" where the clinical meaning remains substantially unchanged in the opinion of the Secretary of State, after seeking advice from the Board. Where only minor changes to the wording in respect of an indicator is made and the underlying clinical meaning remains the same, then the indicator will be regarded as remaining substantially the same and is a "continued fraction indicator".

ASPIRATION PAYMENTS: CALCULATION, PAYMENT ARRANGEMENTS AND CONDITIONS OF PAYMENTS

Calculation of Monthly Aspiration Payments: General

5.—(1) At the start of each financial year (or if a GMS contract starts after the start of the financial year, the date on which the GMS contract takes effect), subject to sub-paragraph (2)(b), the Board must calculate for each contractor that has agreed to participate in the QOF the amount of the contractor's Monthly Aspiration Payments for that, or for the rest of that, financial year.

(2) As indicated in Section 4(5) (Aspiration Payments) above, there are two methods by which a contractor's Monthly Aspiration Payments may be calculated. Each contractor may choose the method by which its Monthly Aspiration Payments are calculated, if it is possible to calculate Monthly Aspiration Payments in respect of the contractor by both methods. However—

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

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

Calculation of Monthly Aspiration Payments: the 70% method

(3) Where—

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

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

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

(4) To calculate a contractor's Monthly Aspiration Payments by the 70% method, the contractor's Unadjusted Achievement Payment for the previous year needs to be established (that is, the total established under paragraph 6.10 of the 2013 SFE as in force on 31st March 2021 or Section 6(9) (calculation of Achievement Payments) of the SFE). Generally, this will not be possible in the first quarter of the financial year, and so a Provisional Unadjusted Achievement Payment will need to be established by the Board. The amount of this payment is to be based on the contractor's return submitted in accordance with paragraph 6.4 of the 2013 SFE as in force on 31st March 2021 or Section 6(4) (returns in respect of Achievement Payments) of the SFE.

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

(6) Once an annual amount for the contractor's Provisional Unadjusted Achievement Payment has been determined, this is to be multiplied by the Quality and Outcomes Framework Uprating Index for the financial year. The Quality and Outcomes Framework Uprating Index is to be determined by dividing—

(a) the amount set out in Section 6(8) (calculation of Achievement Points) as the value of each Achievement Point for the financial year in respect of which the claim for Monthly Aspiration Payments is being made; by

(b) the amount set out in Section 6(8) (calculation of Achievement Points) or, as the case may be in accordance with paragraph 6.8 of the 2013 SFE, as the value of each Achievement Points for the previous financial year,

and the resultant figure is to be multiplied by the CPI. For the purposes of calculating the CPI, the national average practice population figure for the financial year ending 31st March 2022 is 9,085(**a**).

(7) The total produced by paragraph (6) is then to be multiplied by 70%. This figure is then further multiplied by the figure which is the product of the maximum number of points available under the QOF for the financial year in respect of which the calculation is being made divided by the maximum number of points available under the QOF in the previous financial year. By way of example—

(a) the figures used for this element of the calculation in the financial year commencing on 1st April 2013 and ending on 31st March 2014 were 900 and 1000 respectively, 900 points being the maximum number of points available under the QOF for that financial year and 1000 being the maximum number of points available under the QOF for the financial year commencing on 1st April 2012 and ending on 31st March 2013. The resulting figure is the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to paragraphs (8), (9) and (10), is to be the contractor's Monthly Aspiration Payment as calculated by the 70% method.

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

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

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

Calculation of Monthly Aspiration Payments: the Aspiration Points Total method

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

(12) If the contractor is to have its Monthly Aspiration Payments calculated by this method, at the start of each financial year – or if a GMS contract starts after the start of the financial year, on the date on which the GMS contract takes effect – an Aspiration Points Total is to be agreed between the contractor and the Board. As indicated in Section 4(5)(b) (Aspiration Payments) above, an Aspiration Points Total is the total number of points that the contractor has agreed with the Board that it is aspiring towards under the QOF during the financial year in respect of which the Aspiration Payment is made.

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a The national average practice population figure is taken from the Calculating Quality Reporting Service (CQRS) on 1st January 2021.

(13) If the Board and the contractor have agreed an Aspiration Points Total for the contractor, that total is to be divided by three. The resulting figure is to be multiplied by £201.16 and then by the contractor's CPI, which produces the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to Section 6(12) (recovery where Aspiration Payments have been too high), is to be the contractor's Monthly Aspiration Payment, as calculated by the Aspiration Points Total method.

Payment arrangements for Monthly Aspiration Payments

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

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

- (a) the number of days during the month in which the contractor was participating in the QOF; by
- (b) the total number of days in that month.

(16) The amount of a contractor's Monthly Aspiration Payments is thereafter to remain unchanged throughout the financial year, even when the contractor's CPI changes and as a consequence is less likely to achieve the Aspiration Points Total that has been agreed.

Conditions attached to Monthly Aspiration Payments

(17) Monthly Aspiration Payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

- (a) as regards Monthly Aspiration Payments which are, or are to be, calculated by the Aspiration Points Total method—
  - (i) the contractor's Aspiration Points Total on which the Payments are based must be realistic and agreed with the Board, and
  - (ii) the contractor must make any returns required of it (whether computerized or otherwise) to the Board in such manner as the Board may reasonably require, and do so promptly and fully;
- (b) the contractor must make available to the Board any information which the Board does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's Monthly Aspiration Payments;
- (c) a contractor utilising computer systems approved by the Board must make available to the Board aggregated monthly returns relating to the contractor's achievement of the standards contained in the indicators in the QOF, and in the standard form provided for by such systems;
- (d) a contractor not utilising computer systems approved by the Board must make available to the Board similar monthly returns, in such form as the Board may reasonably request (for example, the Board may reasonably request that a contractor fill in manually a printout of the standard spreadsheet in a form specified by the Board); and
- (e) all information supplied pursuant to or in accordance with this paragraph must be accurate.

(18) If the contractor breaches any of the conditions referred to in paragraph (17), the Board may, in appropriate circumstances, withhold payment of any or any part of a Monthly Aspiration Payment that is otherwise payable.

ACHIEVEMENT PAYMENTS: CALCULATION, PAYMENT ARRANGEMENTS AND CONDITIONS OF PAYMENTS

Basis of Achievement Payments

6.—(1) Achievement Payments are to be based on the Achievement Points to which a contractor is entitled each financial year, as calculated in accordance with this Section and Section 3 (Global Sum payments).

Assessment of Achievement Payments

(2) Subject to paragraph (3), the date in respect of which the assessment of Achievement Points is to be made is the last day of the financial year.

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

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

Returns in respect of Achievement Payments

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

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

Calculation of Achievement Payments

(6) The parts of the Achievement Payment that relate to the domains referred to in Section 4(8)(a) and 4(8)(b) (the principal domains of the QOF) are calculated in a different way from the part relating to the Quality Improvement Domain referred to in Section 4(8)(c). As regards—

(a) the cervical screening indicators, the Achievement Points Total is to be assessed in accordance with Annex E, and a calculation is to be made of the cash total in respect of those indicators in the manner set out in that Annex; and

(b) the clinical domain and the public health domain in a case where there is a disease register, first a calculation needs to be made of an Adjusted Practice Disease Factor for each disease area. The sum from this calculation is then multiplied by £201.16 and by the contractor's Achievement Points Total in respect of the disease area to produce a cash amount for that disease area. Then the cash totals in respect of all the individual disease areas in the domain are to be added together to give the cash total in respect of the domain.

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

(7) The part of the Achievement Payment that relates to—

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

(b) indicator 004 in the smoking area of the public health domains; and

(c) indicator BP002 in the blood pressure area of the public health domain,

must be calculated by multiplying the total number of Achievement Points gained by the contractor in respect of the palliative care area referred to in sub-paragraph (a) above or, as the case may be, in respect of the indicators referred to in sub-paragraphs (b) and (c) above by £201.16.

(8) As regards all the other Achievement Points gained by the contractor, the total number of Achievement Points is to be multiplied by £201.16.

(9) The cash totals produced under paragraphs (6), (7) and (8) are then added together and multiplied by the contractor's CPI, calculated in accordance with the provisions of Section 3(190) (Contractor Population Index)—

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

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

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

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

(10) If the contractor's GMS contract had effect—

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

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

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

Recovery where Aspiration Payments have been too high

(12) If the resulting amount from the calculation under paragraph (11) is a negative amount, that negative amount, expressed as a positive amount ("the paragraph (11) amount"), is to be recovered by the Board from the contractor in one of two ways—

(a) to the extent that it is possible to do so, the paragraph (11) amount is to be recovered by deducting one twelfth of that amount from each of the contractor's Monthly Aspiration Payments for the financial year after the financial year to which the paragraph (9) amount relates. In these circumstances—

(i) the gross amount of its Monthly Aspiration Payments for accounting and superannuation purposes in the financial year after the financial year to which the paragraph (11) amount relates is to be the amount to which the contractor is otherwise entitled under Section 5(3) to 5(10) (calculation of Monthly Aspiration Payments: the 70% method) or Section 5(11) to 5(13) (calculation of Monthly Aspiration Payments: the Aspiration Points Total method), and

(ii) the paragraph (11) amount is to be treated for accounting and superannuation purposes as an overpayment in respect of the contractor's Monthly Aspiration Payments for the financial year to which the paragraph (9) amount relates; or

(b) if it is not possible to recover all or part of the paragraph (11) amount by the method described in sub paragraph (a) (for example, because of the termination of the GMS contract after a partnership split), the amount that cannot be so recovered is to be treated as an overpayment in respect of the contractor's Monthly Aspiration Payments for the year to which the paragraph (9) amount relates, and is to be recovered accordingly (i.e. in accordance with Section 20(1) (overpayments and withheld amounts)).

Accounting arrangements and due date for Achievement Payments

(13) The contractor's Achievement Payment, as calculated in accordance with paragraph (11) is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial

year into which the date in respect of which the assessment of Achievement Points on which the Achievement Payment is based ("the relevant date") falls and the Achievement Payment is to fall due —

(a) where the GMS contract terminates before the end of the financial year into which the relevant date falls (see paragraph (3)), at the end of the quarter after the quarter during which the GMS contract was terminated, and

(b) in all other cases, at the end of the first quarter of the financial year after the financial year into which the relevant date falls (see paragraph (2)).

Conditions attached to Achievement Payments

(14) Achievement Payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must make the return required of it under paragraph (4);

(b) the contactor must ensure that all the information that it makes available to the Board 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 Board 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 Board on request;

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

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

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

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

PART 3

DIRECTED ENHANCED SERVICES

NETWORK PARTICIPATION PAYMENTS FOR THE PERIOD 1st APRIL 2021 TO 31st MARCH 2022

Primary Care Networks

7.—(1) Direction 3(1)(a) of the Primary Medical Services (Directed Enhanced Services) Directions 2021 makes provision for the Board to establish, operate and, as appropriate, revise a scheme for the registration and regulation of Primary Care Networks ("PCNs") which are established by contractors in a Network Area which has been approved by the Board. The registration of a PCN will entitle a contractor within it to a Network Participation Payment ("NPP") provided the requirements of the Network Contract Directed Enhanced Service Scheme as set out in the DES Directions are satisfied.

(2) A contractor, whose practice is a member of a PCN which has been registered and who continues to meet the requirements of the Network Contract Directed Enhanced Service Scheme, will be entitled to a NPP calculated in accordance with this Section.

Network Participation Payment

(3) If, as a part of a GMS contract, a contractor participates in the Network Contract Directed Enhanced Service Scheme, the Board must pay the contractor under the GMS contract, a NPP calculated and paid

in accordance with paragraph (4) in respect of the period during which the contractor satisfies the conditions in paragraph (5).

(4) The calculation and payment of the NPP required by paragraph (3) is as follows—

(a) the NPP is the sum of £0.147 multiplied by the number of the Contractor Weighted Population(**a**) as calculated on the 1st January in the year immediately before the commencement of the financial year to which the NPP relates;

(b) the NPP is payable in respect of all or any part of the period as follows—

(i) in respect of a contractor who applies to participate in the Network Contract Directed Enhanced Service Scheme on or before 30th April 2021, from 1st April 2021 up to and including 31st March 2022, during which period or part of it, the contractor satisfies the conditions in paragraph (5);

(ii) in respect of a contractor who applies to participate in the Network Contract Directed Enhanced Service Scheme after 30th April 2021, from such later date as the Board determines is appropriate after 1st April 2021 up to and including 31st March 2022, during which period or part of it, the contractor satisfies the conditions in paragraph (5); and

(c) the NPP will be paid monthly, in arrears, by no later than the last day in the month that immediately follows the last day in the month in respect of which the NPP applies, except—

(i) in relation to the first payment which will be made in the month following confirmation of the contractor's participation in the Network Contract Directed Enhanced Service Scheme and where paragraph (4)(b)(i) applies, the first payment must include monthly payments from 1 April 2021; and

(ii) where paragraph (7) applies,

(5) The NPP, or any part of such payments, are only payable if the contractor satisfies the following conditions—

(a) the contractor is a Core Network Member of a PCN approved by the Board in accordance with the Board's Network Contract Directed Enhanced Services Specification(**b**) for all or part of the financial year ending 31st March 2022;

(b) the contractor's participation in the Network Contract Directed Enhanced Service Scheme has been confirmed by the Board for all or part of the financial year ending 31st March 2022;

(c) the contractor fulfils the requirements of the Network Contract DES Scheme as set out in the Network Agreement and Network Contract DES Specification referred to in direction 4 of the Primary Medical Services (Directed Enhanced Services) Directions 2021(**c**);

(6) If the contractor breaches any of these conditions, the Board may, in appropriate circumstances, withhold payment of all or any part of the NPP that is otherwise payable.

(7) If the contractor ceases to be a Core Network Member of an approved PCN on or after 1st April 2021 in the financial year ending 31st March 2022, it shall no longer be entitled to receive an NPP with effect from the first day of the month following the month in which the contractor ceased to be a Core Network Member of an approved PCN.

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a The Contractor Weighted Population (CWP) for the Quarter is defined in Part 2 of Annex A and paragraph B.25 of Annex B, and calculated quarterly, which means the figure is variable. The most accurate figure for the CWP used to calculate the NPP is that calculated on the 1st January in the year preceding the financial year for which the calculation is made. See further: Network Contract DES guidance available from https://www.england.nhs.uk/publication/network-contract-des-guidance-2021-22/ or hard copies can be obtained from NHS England, Area 2D, Skipton House, 80 London Road, London, SE1 6LH.

b Specification at: https://www.england.nhs.uk/publication/network-contract-des-specification-2021-22/.

c The Primary Medical Service (Directed Enhanced Services) Directions 2021 were signed on 31st March 2021.

Learning Disabilities Health Check Scheme

8.—(1) Direction 3(1)(b) of the DES Directions requires the Board to establish, operate and as appropriate, revise a Learning Disabilities Health Check Scheme. This Section applies to arrangements entered into in accordance with the Learning Disabilities Health Check Scheme provided for in directions 3(1)(b) and 5 of the DES Directions in respect of the financial year or any part of that year. In this Section, "financial year" means the period commencing on 1st April 2021 and ending 31st March 2022.

Learning Disabilities Health Check Scheme: Health Check Completion Payments

(2) If, as part of a GMS contract—

(a) a contractor and the Board have agreed arrangements in respect of a Learning Disabilities Health Check Scheme in respect of all or any part of the financial year in accordance with the DES Directions;

(b) the contractor compiles a health check learning disabilities register using coded information held on a registered patient's medical record in accordance with direction 5(7)(a) of the DES Directions; and

(c) the contractor informs the Board in writing of the number of patients on the Register who received a compliant health check undertaken by the contractor in accordance with the arrangements during that monthly period before the last day in the month that immediately follows the last day in the monthly period in respect of which the claim for payment relates,

the Board must pay the contractor under the GMS contract, a Health Check Completion Payment in respect of the monthly period which is to be calculated in accordance with paragraph (3).

(3) A Health Check Completion Payment for each monthly period is calculated as follows—

(a) £140.00 multiplied by

(b) the number of compliant health checks undertaken by the contractor in respect of patients recorded as being on the Register during the monthly period to which the payment refers, as notified to the Board in accordance with paragraph (2).

(4) As regards payments of a Health Check Completion Payment—

(a) no more than one payment is to be made to the contractor in the respect of any individual patient irrespective of the number of compliant health checks undertaken by the contractor in respect of that patient during the financial year; and

(b) no payment shall be made to a contractor in respect of any individual patient in the case where that patient's name was added to the Register after it had been agreed and the Board required the contractor to remove that name.

Learning Disabilities Health Check Scheme: the Register

(5) If a contractor had agreed arrangements in respect of a Learning Disabilities Health Check Scheme in accordance with the Primary Medical Services (Directed Enhanced Services) (No.2) Directions 2020, as in force immediately before 1st April 2021, and those arrangements are in place on 31st March 2021 and a Health Check Learning Disabilities Register was agreed in respect of those arrangements—

(a) that Health Check Learning Disabilities Register—

(i) may continue to be the agreed Register in respect of the financial year, and

(ii) must also have effect for the purpose of identifying those registered patients aged 14 years or over with learning disabilities who are to be invited for an annual health check; and

(b) there is no requirement to agree a further register.

(6) Paragraph (7) applies in the case where any additions are made or proposed additions of the names of patients to the Register after it has been agreed (including where the Register is the Health Check Learning Disabilities Register previously agreed as a consequence of the DES Directions).

(7) In respect of names being added to the Register—

(a) unless sub-paragraph (b) applies, no name may be added to the Register during any monthly period and no entitlement to a Health Check Completion Payment arises in respect of any proposed additions of the names of patients to the Register in any monthly period; and

(b) a contractor may only add a patient's name to the Register where the contractor complies with the requirements in paragraph (8) and the Board agrees to that name being added. In such a case, the contractor is entitled to a quarterly Health Check Completion Payment in respect of that patient.

(8) The requirements referred to in paragraph (7) are—

(a) the contractor must notify the Board in writing of the patient's name and reasons for including that name on the Register within 7 days of adding that name to the Register; and

(b) if the Board requests information it reasonably needs in order to assist it in its consideration of whether the name in question should be retained on the Register, the contractor must provide such information within 7 days of the Board's request.

(9) If the Board instructs the contractor in writing to remove a patient's name from the Register which the contractor has added, the contractor must remove that name and—

(a) no entitlement to a Health Check Completion Payment arises in respect of that patient; and

(b) any Health Check Completion Payment already paid in respect of that patient must be treated as an overpayment and may be recovered by the Board in accordance with Section 19 (administrative provisions) of the SFE.

(10) If a contractor and the Board have agreed arrangements in respect of a Learning Disabilities Health Check Scheme in respect of all or any part of the financial year but have not concluded an agreement on a Register before 31st March 2022, agreement must be concluded in order to qualify for a Health Check Completion Payment.

Accounting arrangements and due payment dates for Health Check Completion Payments

(11) Health Check Completion Payments are to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year during which the compliant health check takes place.

(12) The amount calculated as the Health Check Completion Payment is payable on the last day in the month which immediately follows the month during which the Board received details of the number of registered patients on the Register who received a compliant health check under the arrangements.

(13) Health Check Completion Payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must make available to the Board any information which the Board does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order for the Board to establish whether the contractor has fulfilled the contractor's obligations under the Learning Disabilities Health Check Scheme arrangements;

(b) the contractor must make any returns required of it (whether computerized or otherwise) to the registration system approved by the Board, and must do so promptly and fully; and

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

(14) If the contractor breaches any of the conditions referred to in paragraph (13), the Board may, in appropriate circumstances, withhold payment of any, or any part of a, Health Check Completion Payment that is otherwise payable.

Provisions relating to contractors whose contracts terminate or who withdraw from the arrangements prior to 31st March 2022 (subject to the provisions below for terminations attributable to a practice split or merger)

(15) Where a contractor and the Board have agreed arrangements in respect of a Learning Disabilities Health Check Scheme for any part of the 12 month period ending on 31st March 2022 and the contractor's contract subsequently terminates or the contractor withdraws from the arrangements prior to 31st March 2022, the contractor is entitled to a Health Check Completion Payment in respect of any compliant health checks undertaken by the contractor during the monthly period during which the contract terminates or the contractor withdraws from the scheme.

(16) The Board must pay the contractor for the monthly period in which the contract terminates or the contractor withdraws from the arrangements, an amount calculated in accordance with paragraphs (3) and (4) and paragraphs (5) to (14) apply.

Provisions relating to contractors whose practices merge

(17) Paragraphs (18) to (21) apply where two or more GMS contractors merge ("a contractual merger") and as a result two or more patient lists are combined, resulting in either a new or a varied GMS contract.

(18) Assessment of any entitlement to a Health Check Completion Payment will depend on whether or not the contractor under a new or varied GMS contract enters into new written arrangements following the date on which the new or varied GMS contract commenced.

(19) Where there is a contractual merger and the contractor under a new or varied GMS contract does not enter into new written arrangements in respect of a Learning Disabilities Health Check Scheme before the last day in the monthly period in which the new or varied GMS contract commenced, entitlement to any Health Check Completion Payment arising under the original contracts will be assessed, on the basis that those contracts are treated as having terminated, in accordance with the provisions of this Section relating to contracts that terminate as set out in paragraphs (15) and (16).

(20) Where the contractor under a new or varied GMS contract subsequently enters into arrangements in respect of a Learning Disabilities Health Check Scheme during the monthly period in which the new or varied GMS contract commenced, the entitlement of the contractor under such new arrangements to a Health Check Completion Payment will be calculated on the basis that—

(a) any previous Registers if retained by the contractor under a new or varied GMS contract may be the new agreed Register; and

(b) any additional names to, or removal of names from, the Register in a monthly period for the remaining financial year must be made in accordance with paragraphs (7) to (9),

and in such circumstances, the Board must pay the contractor under the new or varied GMS contract a Health Check Completion Payment in respect of the quarter period, an amount calculated in accordance with paragraphs (3) and (4) and paragraphs (10) to (14) apply.

(21) The Board is not obliged to make payment in respect of any compliant health check undertaken by the contractor in respect of any patient if payment has already been made or is payable to one of the contractors whose contracts are subject to the merger in respect of a compliant health check undertaken in respect of that patient.

Provisions relating to contractors whose practices split

(22) Paragraphs (23) to (27) apply where a GMS contractor splits ("a contractual split"), and as a result the contractor's patient list is divided between two or more GMS contractors, resulting in either new GMS contracts or varied GMS contracts or a combination of both.

(23) Where there is a contractual split, the GMS contract that splits will be treated as having terminated on the date the contract splits and any entitlement to a Health Check Completion Payment arising under the original contract will be assessed in accordance with the provisions of this Section relating to contracts that terminate as set out in paragraphs (15) and (16).

(24) Where the contractor under a new or varied GMS contract subsequently enters into arrangements in respect of a Learning Disabilities Health Check Scheme during the monthly period in which the new

or varied GMS contract commenced, assessment of entitlement of the contractor under the new arrangements to a Health Check Completion Payment will be calculated on the basis that—

(a) any previous Registers if retained by the contractor under a new or varied GMS contract is to be the new agreed Register; and

(b) any additional names to, or removal of names from, the Register in a monthly period for the remaining financial year must be made in accordance with paragraphs (7) to (9),

and in such circumstances, the Board must pay the contractor under the new or varied GMS contract a Health Check Completion Payment in respect of the month an amount calculated in accordance with paragraphs (3) and (4) and paragraphs (10) and (14) apply.

(25) The Board is not obliged to make payment in respect of any compliant health check undertaken by the contractor in respect of any patient if payment has already been made or is payable to one of the contractors whose contracts are subject to the split in respect of a compliant health check undertaken in respect of that patient.

(26) Where a contractor under any new or varied GMS contract subsequently enters into arrangements in respect of a Learning Disabilities Health Check Scheme after the last day in the monthly period during which the new or varied GMS contract commenced, assessment of entitlement to a Health Check Completion Payment under the new arrangements, will be calculated on the basis of the number of compliant health checks undertaken by the contractor during the monthly period in which the date of the new or varied GMS contract commenced and the Board must pay the contractor an amount calculated in accordance with paragraphs (3) and (4) and paragraphs (5) to (14) apply in respect of that month.

(27) The Board is not obliged to make payment in respect of any compliant health check undertaken in respect of any patient if payment has already been made or is payable to the previous contract in respect of a compliant health check undertaken in respect of that patient during the financial year.

Provisions relating to non-standard splits and mergers

(28) Where the GMS contract of a contractor who has entered into Learning Disabilities Health Check arrangements with the Board 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 Board, lead to an inequitable result; or

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

the Board may, in consultation with the contractor or contractors concerned, agree to such payments as, in the Board's opinion, are reasonable in all the circumstances

PART 4

PAYMENTS FOR SPECIFIC PURPOSES

PAYMENTS FOR GP PERFORMERS COVERING MATERNITY, PATERNITY, ADOPTION LEAVE AND SHARED PARENTAL LEAVE

General

9.—(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.

(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 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) to maintain the level of services that it normally provides. Even if the

Board is not directed in the SFE to pay for such cover, it may do so as a matter of discretion. However, if—

(a) the performer is a GP performer; and

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

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

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

(3) In any case where a contractor actually and necessarily engages a 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 for the absence of a GP performer on ordinary or additional maternity leave, paternity leave or ordinary or additional adoption leave or shared parental leave and—

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

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

(i) statute;

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

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

(c) the GP performer who is a party to the contract or who is already employed or engaged by the contractor is not employed full time; and

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

then subject to the following provisions of this Section, the Board must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that cover (which may or may not be the maximum amount payable, as set out in paragraph (5)).

(4) The Board must consider whether or not it is necessary for the contractor to engage, or continue to engage, a 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 (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 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 (or more than one such person), if the performer on leave had a right to return but that right has been extinguished; and

(b) it should not normally be considered necessary for the contractor to employ a locum 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 (or more than one such person), 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.

Amounts payable

(5) The maximum amount payable under this Section by the Board in respect of cover for a GP performer is—

(a) in respect of the first two weeks for which the Board provides reimbursement, £1,143.06 per week; and

(b) in respect of any week thereafter for which the Board provides reimbursement in respect of cover, £1,751.52 per week.

(6) Any amounts payable by way of reimbursement 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 paragraph (5).

Payment arrangements

(7) The contactor is to submit claims for costs actually incurred after they have been incurred, at a frequency to be agreed between the Board 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

(8) 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 Board 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 Board 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 Board with a letter written by the GP performer confirming the date of the adoption and the name of the main care provider, countersigned by the appropriate adoption agency;

(d) if the leave of absence is for shared parental leave, the contractor must supply the Board 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([a]) and countersigned by the practice;

(e) the contractor must, on request, provide the Board 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

(f) once the arrangements are in place, the contractor must inform the Board—

(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 Board is to determine whether it still considers the cover necessary.

(9) If the contractor breaches any of these conditions, the Board may, in appropriate circumstances, withhold payment of any sum otherwise payable under this Section.

PAYMENTS FOR LOCUMS OR GP PERFORMERS COVERING SICKNESS LEAVE

General

10.—(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.

(2) If an employee or partner who takes any sickness leave is a performer under a GMS contract, the contractor may need to employ a locum, or a salaried GP on a fixed term contract or use the services of

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a Further information on eligibility requirements can be found in the Protocol in respect of cover or GP performer payments for parental and sickness leave which is published by the Board and is available at http://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/.

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 maintain the level of services that it normally provides. Even if the Board is not directed in the 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 who are returning from sickness leave or for those who are at risk of needing to go on sickness leave. It should in particular consider exercising its discretion—

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

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

Entitlement to payments for covering sickness leave

(3) In any case where a contractor actually and necessarily engages a 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) to cover for the absence of a GP performer on sickness leave, and—

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

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

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

(b) if the GP performer's absence is as a result of an accident, the contractor must be unable to claim any compensation from whoever caused the accident towards meeting the cost of engaging a locum or salaried GP on a fixed term contract to cover for the GP performer during the performer's absence. But if such compensation is payable, the Board may loan the contractor the cost of cover, 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 cover, in which case the loan is to be considered a reimbursement by the Board of the costs of the locum which is subject to the following provisions of this Section; or

  (ii) only part of the compensation paid is referable to the cost of 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 locum was successful;

(c) the GP performer who is a party to the contract or who is already employed or engaged by the contractor is not employed full time,

(d) the contractor is not already claiming another payment for cover in respect of the performer on leave pursuant to Part 4 (payments for specific purposes),

then subject to the following provisions of this Section, the Board must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that cover (which may or may not be the maximum amount payable, as set out in paragraph (5)).

(4) It is for the Board to determine whether or not it was in fact necessary for the contractor to engage cover, or to continue to engage cover, but it is to have regard to the following principles—

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

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

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

Ceilings on the amounts payable

(5) The maximum amount payable under this Section by the Board in respect of cover for a GP performer is £1,751.52 per week.

(6) Any amounts payable by way of reimbursement 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 paragraph (5).

(7) No reimbursement under this Section will be paid in respect of the first two weeks period of each period of 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 in respect of any such period are—

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

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

- (a) if it is 26 weeks or less, is then to be deducted from the period referred to in paragraph (7)(a); or
- (b) if it more than 26 weeks, then 26 weeks of it is to be deducted from the period referred to in paragraph (7)(a) and the balance is to be deducted from the period referred to in paragraph (7)(b).

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

Payment arrangements

(10) The contractor is to submit to the Board 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

(11) 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 Board to the engagement of the locum or salaried GP on a fixed term contract (but its request to do so must be determined as quickly as possible by the Board), including agreement as to the amount that is to be paid for the cover;
- (b) the contractor must, without delay, supply the Board with medical certificates 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 Board 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 Board—
    - (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 on leave,

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

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

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

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

(12) If any of these conditions are breached, the Board may, in appropriate circumstances, withhold payment of any sum otherwise payable under this Section.

PAYMENTS FOR LOCUMS TO COVER SUSPENDED DOCTORS

General

11.—(1) The Board has powers to suspend GP performers from the medical performers list.

(2) A GP performer who is suspended from the medical performers list may be entitled to payments directly from the Board. This is covered by a separate determination made under regulation 13(1) of the Performers Lists Regulations.

Eligible cases

(3) In any case where a contractor—

(a) either —

(i) is a sole practitioner who is suspended from the Board's medical performers list and is not in receipt of any financial assistance from the Board under section 96 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 (ii)(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 (payments for specific purposes),

then subject to the provisions in this Section, the Board 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 (5)).

(4) It is for the Board 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

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

Payment arrangements

(6) The contractor is to submit claims for costs actually incurred after they have been incurred, at a frequency to be agreed between the Board 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

(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 Board 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 Board—

(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 Board is to determine whether it still considers the locum cover necessary.

(8) If the contractor breaches any of these conditions, the Board may, in appropriate circumstances, withhold payment of any such sum otherwise payable under this Section.

PAYMENTS IN RESPECT OF PROLONGED STUDY LEAVE

General

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

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

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

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

(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 Health Education England or a committee or person recognised by Health Education England, having regard to any guidance on Prolonged Study Leave that has been agreed nationally; and

(c) the Board 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

(3) Where the criteria set out in paragraph (2) are met, in respect of each week for which the GP performer is on Prolonged Study Leave, the Board 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 Board of that change in circumstances.

(4) If the contractor breaches the condition set out in paragraph (3), the Board 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

(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 Board 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 (7)).

(6) It is for the Board 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.

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

Payment arrangements

(8) The contractor is to submit to the Board 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

(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 Board to the engagement of the locum (but its request to do so must be determined as quickly as possible by the Board), 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 Board 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 Board—

(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 Board is to determine whether it still considers the locum cover necessary.

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

General

13.—(1) This Scheme is a package of financial and educational support designed to help keep doctors working in general practice.

(2) This Scheme applies, from 1st April 2017, 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 licence to practise; and

(b) the medical performers list which the Board is required to prepare, maintain and publish under regulation 3 of the National Health Service (Performers Lists) (England) Regulations 2013(**b**),

and where paragraphs (3) and (4) apply to that doctor.

(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

(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 Board considers to be acceptable for the purposes of this Scheme.

(4) This paragraph applies where a doctor to whom this Scheme applies—

(a) is not able to undertake a regular part-time role by working in short clinics or on annualised sessions(**c**); and

(b) there is a need for additional educational supervision.

Payments in respect of sessions under the Scheme

(5) Subject to paragraph (3), where—

(a) a contractor who the 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 arranged and approved by the Board,

the 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.

Provisions in respect of leave arrangement

(6) The Board must pay to the contractor under its GMS contract any payment payable under paragraph (5) 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;

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. 2013/335.

c Annualised sessions are the number of sessions per week which a performer is required to work for a contractor averaged out over the period of a year. They include any sessions which a performer is contracted to undertake but where the performer 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.

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

(f) other pressing personal or family reasons where the contractor and the Board agree that the absence of the member of the GP Retention Scheme is necessary and unavoidable.

Payment conditions

(7) 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 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 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 Board in accordance with sub-paragraph (6)(a) to (f) above, the contractor must make available to the Board any information which the 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 Board;

(d) the contractor must inform the Board if the doctor in respect of whom the payment is made ceases to be a member of the GP Retention Scheme.

(8) If a contractor breaches any of these conditions, the 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

(9) The 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 on or after 1st April 2017 in respect of any employment with or engagement by the contractor.

(10) For the purposes of this paragraph, an "eligible contractor" is a contractor to whom paragraph (5) (payments in respect of sessions under the Scheme) applies.

(11) The professional expenses supplement is to be calculated by the Board by reference to the number of sessions which a doctor described in paragraph (2), (3) or (4) above 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:

Number of sessions per week	*Annualised sessions*(**a**)	*Amount of professional expenses supplement per annum*
1-2	Fewer than 104	£1000

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 des 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.

2	104	£2000
3	156	£3000
4	208	£4000

(12) Subject to paragraph (13), the Board must pay to the contractor the professional expenses supplement—

(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.

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

(14) Where the 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.

CQC FEES REIMBURSEMENT SCHEME

General

14.—(1) This Scheme is established on 1st April 2017 and enables the Board to reimburse the amount of any fees paid by a contractor, as a provider of NHS primary medical services, by virtue of provision contained in the Provision for Fees Scheme which is made and published by the Care Quality Commission under section 85(1) of the Health and Social Care Act 2008(**a**) ("CQC registration fees").

(2) The Board must pay to a contractor under its GMS contract a payment which represents the total amount of CQC registration fees which the contractor has paid to the Care Quality Commission under the Provision for Fees Scheme in respect of any year.

(3) The Board must not make any payment to a contractor under this Section unless an invoice or other suitable evidence of payment has been presented to it by the contractor as evidence of the amount which the contractor has paid to the Care Quality Commission in respect of CQC registration fees in any year.

Payment of reimbursement of CQC Registration Fees

(4) Payments under this Section must be made by the Board to a contractor as part of the next Global Sum Monthly Payment which falls due to the contractor following the date on which the Board receives evidence, in accordance with paragraph (3), of the amount that the contractor has paid by way of CQC registration fees.

FLEXIBLE CAREERS SCHEME

General

15.—(1) This is an established Scheme for certain part-time doctors. It is managed by Health Education England and is for employed doctors only. Contractors are eligible for contractor payments under this Scheme, but will also receive payments to be forwarded to doctors.

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a 2008 c.14. The Provision for Fees Scheme is made and published annually by the Care Quality Commission under section 85(1) of the Health and Social Care Act 2008. Information about the Scheme is available at: http://www.cqc.org.uk/organisations-we-regulate/registered-services/fees Further information about the Provision for Fees Scheme can be obtained from the CQC National Customer Service Centre, Gallowgate, Newcastle Upon Tyne, NE1 4PA.

Flexible Careers Scheme Contractor Payments

(2) The Board must pay to a contractor under its GMS contract a Flexible Career Scheme ("FCS") Contractor Payment if—

(a) it employs a part-time doctor who is a member of the FCS; and

(b) that FCS doctor performs primary medical services under its GMS contract, as a general practitioner, with a working commitment that generates a Time Commitment Fraction of at least one fifth but not more than five ninths, except that the doctor may also work—

(i) an additional 28 hours, during the membership year, of funded education time for personal and professional development; and

(ii) a limited amount of additional time in the National Health Service, with the approval of Health Education England.

(3) For the purposes of the calculation of time commitment in paragraph (2)(b), the following periods of leave are discounted—

(a) annual leave up to a maximum of six weeks pro rata (compared to full-time);

(b) maternity, paternity, parental, adoption leave and shared parental leave endorsed by the Board;

(c) sickness leave endorsed by the Board;

(d) special leave in an emergency, which is granted in accordance with employment law and guidance issued by the Department of Business, Energy and Industrial Strategy; and

(e) other special leave for pressing personal or family reasons, endorsed by the Board.

Amount of FCS Contractor Payments

(4) The Board will need to obtain from the contractor at the end of each quarter a return of the actual cost to the contractor, rounded to the nearest pound, of it employing the FCS doctor while that doctor is a member of the scheme. This is—

(a) to include salary, national insurance contributions and NHS Pension Scheme employer's superannuation contributions (where these are paid by the contractor); and

(b) not to include costs relating to any additional work the FCS doctor is permitted, with the approval of Health Education England, to undertake outside the FCS.

(5) A percentage of that amount is then payable as the contractor's FCS Contractor Payment, as calculated (subject to the following provisions of this Section) in accordance with the following Table—

Table

In respect of	FCS doctors
Year 1	50%
Year 2	25%
Year 3	10%

(6) For these purposes—

(a) the qualifying date for the first payment, and so the start of the doctor's first year in the Scheme, is the date the doctor joins the Scheme;

(b) if, in relation to any period of leave referred to in paragraph (3), Health Education England reasonably determines that, for exceptional reasons, the year of membership of the FCS in which the period of leave started should be extended, that year of membership shall not be taken to have elapsed until a full year has elapsed from the start of that year of membership, discounting the period of leave, and that doctor's qualifying date for payments must be adjusted accordingly; and

(c) if the quarterly return relates to costs incurred in respect of different years of membership of the FCS, the contractor must specify which costs relate to which year of membership of the Scheme.

Amount of FCS Doctor Payments

(7) Subject to the following provisions in this Section, if a contractor is eligible for a FCS contractor payment, the Board must also pay to the contractor under its GMS contract, in respect of the doctor who is a member of the FCS—

(a) an annual FCS Doctor Payment of £1,050; and

(b) a payment to cover the amount of any employer's national insurance contributions which are payable by the contractor in respect of that FCS Doctor Payment.

Payments in respect of part years

(8) If—

(a) an FCS doctor's membership of the FCS ceases during a year of membership; or

(b) an FCS doctor moves to a new employer during a year of membership of the FCS scheme but remains a member of the scheme,

the amount of the FCS Doctor Payment payable to the contractor is to be adjusted by multiplying the amount of the payment otherwise payable by the following fraction: the number of days for which the FCS doctor is contracted to work for the contract during the membership year, divided by 365 (or 366 where the membership year includes 29th February) – and any payment of employer's national insurance contributions under paragraph (7)(b) is to be adjusted accordingly.

Payments in respect of educational sessions

(9) In respect of each of up to eight educational sessions attended in a year of membership of the FCS by an FCS doctor, and on the basis of a return from the contractor at the end of each quarter, the Board must reimburse the contractor who employs the FCS doctor under its GMS contract for—

(a) the actual cost of employing the FCS doctor during those sessions; and

(b) any expenses claimed by and paid to the FCS doctor by the contractor to cover the cost of the FCS doctor's actual travel and subsistence in attending those sessions, if these costs are reasonable in the opinion of the Board.

Payment arrangements

(10) FCS Doctor Payments to the contractor are to fall due on the last day of the month during which that contractor qualifying date falls, taking account of any adjustment of the qualifying date in accordance with paragraph (6).

(11) The other payments under this Section are to fall due on the last day of the month following the quarter in respect of the quarterly return is made.

Conditions attached to Flexible Career Scheme payments and overpayments

(12) FCS Contractor Payments and payments or any part of a payment under paragraph (9)(a) is only payable if the contractor satisfies the following conditions—

(a) the contractor must make available to the Board any information which the Board does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the payment. In particular, the contractor must, on request, provide the Board with written records demonstrating the actual costs it is seeking to recover; and

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

(13) FCS Doctor Payments, or any part thereof, are only payable if the following conditions are satisfied—

(a) a contractor that receives an FCS Doctor Payment in respect of a doctor 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 doctor, subject to any lawful deduction of income tax, national insurance and superannuation contributions,

once it has secured from the doctor an enforceable undertaking that that doctor will repay to the contractor any amount repayable by the contractor to the Board under this Section in respect of that doctor;

(b) the contractor must inform the Board if the doctor in respect of whom the payment is made ceases to be a member of the FCS.

(14) Payments in respect of expenses under paragraph (9)(b) are only payable if the following conditions are satisfied—

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

(b) all information provided pursuant to or in accordance with sub-paragraph (a) must be accurate.

(15) If a contractor breaches the conditions set out in paragraph (12) or (14), the Board may in appropriate circumstances withhold payment of any or any part of a payment to which the conditions relate that is otherwise payable.

(16) If a contractor breaches the conditions in paragraph (13) the Board may require repayment of any payment paid to which the condition relates, or may withhold payment of any other sum payable to the contractor under the SFE, to the value of the payment paid.

(17) If as a result of the doctor leaving the FCS, the Board has paid a larger amount to the contractor in respect of a FCS Doctor Payment than the amount to which the contractor is entitled, the Board may require repayment of the excess paid, or may withhold payment of any other sum payable to the contractor under the SFE, to the value of the excess paid.

(18) Where, pursuant to paragraph (16) or (17), a contractor is required to repay any or any part of a FCS Doctor Payment, the arrangements by which the contractor may seek to enforce the undertaking referred to in paragraph (13)(a) as a consequence of that repayment are a matter for the contractor.

DISPENSING

General

16.—(1) Some contractors are authorised or required to provide dispensing services to specific patients. The arrangements for this are set out in Part 8 (dispensing doctors) of the Pharmaceutical Regulations 2013 and regulation 65 (provision of drugs, medicines and appliances for immediate treatment or personal administration) of the 2015 Regulations.

Costs in respect of which reimbursement is payable

(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 47 (terms of service of dispensing doctors: general) of the Pharmaceutical Regulations 2013; or

(b) for personal administration, in accordance with regulation 65(1)(b) of the 2015 Regulations,

then subject to the following provisions of this Section, the Board must pay to the contractor under its GMS contract the payments listed in paragraph (3), as calculated in accordance with this Section.

(3) The amounts payable in relation to the provision of drugs and appliances are—

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

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

(c) an allowance to cover the VAT payable on the purchase of any products listed in paragraph (4)(a) to (4)(e) and which are provided in accordance with regulation 65(1)(b) of the 2015 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

(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 (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).

(5) In respect of these products, subject to the provisions of this Section, the Board must pay to all contractors under their GMS contracts the payments listed in paragraph (3), as calculated in accordance with this Section – if the products are provided in accordance with regulation 65(1)(b) of the 2015 Regulations.

Products not covered by this Section

(6) No payments are payable under this Section in respect of the products listed in this paragraph, which are centrally supplied as part of Childhood Immunisations—

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

(b) BCG (Bacillus Calmette-Guerin);

(c) Tuberculin Purified Protein Derivative;

(d) Meningococcal C conjugate vaccine or Hib/MenC vaccine (for children under 5 years of age). The Meningococcal element will end on 1st July 2016;

(e) MenACWY vaccine for adolescents and persons entering the first year of higher education;

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

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

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

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

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

(k) 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;

(l) 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

(m) Rotavirus vaccine.

(7) In addition, no payments are payable under this Section in respect of—

(a) the Shingles vaccine which is centrally supplied by the Department of Health and Social Care as part of its shingles immunisation programme against the Shingles virus; or

(b) any other product which may be centrally supplied by the Department of Health and Social Care.

(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.

(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

(10) Payment in respect of prescriptions shall be subject to any deduction required to be made under the National Health Service (Charges for Drugs and Appliances) Regulations 2015(**a**) in respect of charges required to be made and recovered by the dispensing practitioner.

Contractors unable to obtain discounts

(11) If a contractor satisfies the Board, 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 Board under this Section (and the Board 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 Board 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 Board 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.

(12) Where the Board approves such an exemption, it must inform the NHS Prescription Services part of the NHS Business Services Authority of the exemption and of the period for which it is to apply.

Contractors that are to receive special payments

(13) If a contractor satisfies the Board 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 (3)(a) should be calculated at special payment levels rather than basic price levels,

(and the Board 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 Board must agree to reimburse the contractor on the basis of the special payment levels, instead of the basic price levels, of the drugs and appliances it supplies, as set out in the Table below.

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

a S.I. 2015/570 as amended by S.I 2015/1879, S.I. 2016/325, 696, 1077, S.I. 2017/408, 457, S.I. 2018/48, 201, 1114, S.I. 2019/248, 287, 990, 1094, The Sentencing Act 2020 c. 17, S.I. 2020/201, 885, 1126 and S.I. 2021/178.

(14) Where a contractor is reimbursed on the basis of special payment levels (see paragraph (13)) any VAT allowance payable (see paragraph (3)(c)) shall be calculated as a percentage of the special payment level.

(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 Board that its payments under paragraph (3)(a) should be calculated at special payment levels rather than basic price levels.

Preconditions before payments under this Section are payable

(16) The payments listed in paragraph (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 Prescription Services part of the NHS Business Services Authority, Bridge House, 152 Pilgrim Street, Newcastle-upon-Tyne, NE1 6SN, 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 divided all the prescriptions into two bundles (for the calculation of the dispensing fee), and

(i) one of these two bundles must be prescription forms in respect of which no charge is payable, because—

(aa) the patient is entitled to an exemption;

(bb) the drugs or appliances were no-charge contraceptives, or

(cc) the drugs or appliances were personally administered items, and are in the list in paragraph (4), and

(ii) the other of these two bundles must be of prescription forms in respect of which a charge is payable, whether or not the charge has been collected (if the prescription form is for more than one item, at least one of which is chargeable, it should be included in this bundle),

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) Where a contractor has satisfied the conditions in paragraph (16), the Board 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 Prescription Services part of the NHS Business Services Authority, an amount that represents 80% of the amount that the Board reasonably estimates is likely to be due to the contractor in respect of the claim, once it 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 Board 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 Prescription Services part of the NHS Business Services Authority, the balance of the amount due in respect of the claim, having had that amount certified by that that Authority, 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

(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 Board pursuant to this Section, and collected from patients in accordance with the National Health Service (Charges for Drugs and Appliances) Regulations 2015, are brought "gross" into its contractor accounts as "income".

DISPENSARY SERVICES QUALITY SCHEME

General

17.—(1) Contractors who are authorised or required to provide dispensing services to specific patients either in accordance with the provisions of Part 8 of the Pharmaceutical Regulations 2013 or in accordance with the provisions of regulation 65 of the 2015 Regulations (the provision of such dispensing services being referred to in this Section as having "consent to dispense"), may choose to participate in the Dispensary Services Quality Scheme.

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

Eligibility for Dispensary Services Quality Payments

(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 (4) (read with paragraphs (5) and (6)); and

(c) the Board is satisfied, following review of the contractor's arrangements (which the Board 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 Board 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 Board 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 Board considers it necessary to undertake one.

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

(a) it must provide the Board, 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 (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 Board, 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 Board 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 Board in reviewing its Dispensary Services Quality Scheme arrangements.

(5) The contractor must provide the written undertaking referred to in paragraph (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.

(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

(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 (3),

the Board 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 registration system approved by the Board) on 1st January of that financial year in respect of whom the contractor has consent to dispense.

(8) If, as regards a GMS contract which is in existence on 1st April but to which paragraph (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 (3),

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

(9) The Dispensary Services Quality Payment payable under paragraph (8) above is calculated as follows—

£2.58 multiplied by—

the number of patients on the contractor's list (as measured by the registration system approved by the Board) 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 (4)(b), whichever is the shorter period.

(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 (3),

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

(11) The Dispensary Services Quality Payment payable under paragraph (10) above is calculated as follows—

£2.58 multiplied by—

the number of patients on the contractor's list (as measured by the registration system approved by the Board) 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 (4)(b), whichever is the shorter period.

Conditions attached to Dispensary Services Quality Payments

(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 Board any information which the Board 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 registration system approved by the Board, and do so promptly and fully; and

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

(13) If the contractor breaches any of the conditions referred to in paragraph (12), the Board 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

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

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

(b) if, on the due date provided for in sub-paragraph (a), the Board does not have the information it needs in order to be satisfied that the contractor has met the eligibility criteria in paragraph (3) (all reasonable efforts to obtain the information having been undertaken), on the last day of the month during which the Board obtains the information it needs in order to be so satisfied.

(15) In the case of a contract merger or split of a type described in paragraphs (18) to (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

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

(a) the contract terminates;

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

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

the contractor may nevertheless be entitled to payment of a Dispensary Services Quality Payment, calculated in accordance with the provisions of paragraph (17) of this Section.

(17) The calculation of the payment—

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

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

Provisions relating to contactors whose practices merge

(18) Paragraphs (19) and (19) 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.

(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.

(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

(21) Paragraphs (21) and (22) 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.

(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.

(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

(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 Board, 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 Board should consider, in consultation with the contractor or contractors concerned, making payments under section 96 of the 2006 Act.

(25) It may be that the circumstances of a contract termination, or of a split or merger as described in paragraphs (18) to (23), have rendered it practicably speaking impossible for a contractor to have complied with all of the entitlement conditions in paragraph (3). In these circumstances, the Board may, where it is equitable to do so, set aside the considerations with which the contractor is no longer able to comply.

PART 5

VACCINES AND IMMUNISATIONS

PAYMENTS FOR VACCINES AND IMMUNISATIONS

General

18.—(1) A Contractor must offer to administer and provide vaccine and immunisation services of the type, and in the circumstances, specified in Annex I.

Payment

(2) The Board must pay a Contractor an item of service ("IoS") fee of £10.06 in respect of each dose of vaccine or immunisation administered to a patient who—

(a) is registered with the Contractor;

(b) meets the defined eligible cohort and age criteria for the vaccination and immunisation programme, in accordance with Annex I; and

(c) has received the required dose of vaccination or immunisation.

(3) Notwithstanding paragraph (2), the Board may not make any payment to the Contractor until the information in paragraph (14) has been provided.

(4) The Contractor must comply with best practice on call or recall and opportunistic offers for vaccinations and immunisations as set out in guidance: https://www.england.nhs.uk/publication/update-on-vaccination-and-immunisation-changes-for-2021-22/.

Eligibility for payment

(5) A Contractor is eligible for the IoS fee referred to in paragraph (2) if—

(a) the vaccination or immunisation was administered on or after 1st April 2021 but before 1st April 2022; and

(b) the IoS fee is claimed for vaccination or immunisation which was administered to a patient who was on the Contractor's list of registered patients and:

  (i) the Contractor administered the vaccine or immunisation to the patient; and

  (ii) the Contractor does not receive any payment from any other source in respect of the vaccination and immunisation.

(6) If the Contractor receives any payment from any other source, having also received the IoS fee, it must inform the Board. The Board must consider recovering any payment made under this Section in respect of that patient pursuant to Section 20(1) and 20(2) (overpayments and withheld amounts).

(7) Where a Contractor fails to achieve the performance level of 80% coverage, at year-end, on routine childhood vaccination and immunisation, in relation to the number of children in the eligible cohort registered with the Contractor, the Board may, if it considers appropriate, reduce the Contractor's annual payment, in respect of childhood vaccines and immunisations, by 50% of the number of children in the eligible cohort, multiplied by the IoS fee.

(8) For the purposes of paragraph (7), the Board must have regard to whether a Contractor has met the core standards as set out in the 2015 Regulations and whether the Contractor has made reasonable efforts to vaccinate all eligible children, when considering whether to reduce the Contractor's annual payment.

Claims for payment

(9) A Contractor must use reasonable endeavours to submit a claim to the Board for payment of the IoS fee before the end of the period of 1 month beginning on the date of administration of the dose of vaccine and immunisation to which the payment relates.

(10) Without prejudice to paragraph (9) and subject to paragraph (11), a Contractor must submit a claim to the Board for payment of the IoS fee by no later than the period of 6 months beginning on the date of administration of the dose of vaccine and immunisation to which the payment relates.

(11) The Board may accept a claim made outside of the 6 months' period, if it considers it reasonable to do so.

(12) The Board must agree the value of the claim submitted by the Contractor before the IoS fee is paid. Any IoS fee payable falls due on the next day, following the expiry of 14 days after the claim is submitted, when the Contractor's GSMO falls due, unless the claim remains under dispute.

(13) The Board must ensure that the receipt and payment of claims is recorded accurately and that each claim has a clear audit trail.

Information needed by the Board to consider a claim

(14) The IoS fee is only payable if the Contractor—

(a) supplies the Board with the following information, subject to paragraph (16) and any applicable data protection legislation, in respect of each registered patient for which an IoS fee 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) details of informed consent, including, where consent is given on behalf of the patient, the name of the person giving consent and their relationship with the patient;

(v) where an offer of vaccination and immunisation is accepted;

(vi) any refusal of an offer of vaccination and immunisation;

(vii) the injection site where the vaccine is administered;

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

(ix) when two or more vaccines are administered in close succession, the route of the administration and the injection site of each vaccine;

(x) the date of administration of the vaccine;

(xi) any contraindication to the vaccine or immunisation; and

(xii) any adverse reactions to vaccine or immunisation, where known;

(b) provides appropriate clinical information and advice to the patient, or where the patient is a child, to their parent or carer;

(c) uses nationally specified clinical coding for use in electronic health records (SNOMED codes), details of which can be found on the NHS Digital website https://digital.nhs.uk/services/terminology-and-classifications/snomed-ct, to record this activity and to return performance data to UK Health Security Agency;

(d) makes available any information to the Board, which it reasonably requests and 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; and

(e) makes any returns reasonably required of it (whether computerised or otherwise) to the registration system approved by the Board, and does so promptly and fully.

(15) The Contractor must ensure that all information provided pursuant to or in accordance with paragraph (14) is accurate to the best of the Contractor's knowledge and belief.

(16) If the patient, or where the patient is a child, a parent or carer, objects to their name or date of birth being supplied to the Board, the Contractor need not supply such information to the Board but must supply the patient's NHS number.

(17) If the Contractor fails to comply with a requirement of this Section, the IoS fee is not due and the Board can withhold its payment to the Contractor until any necessary information is provided to the satisfaction of the Board.

(18) Where the vaccination or immunisation is administered, the Contractor must record in the patient's records, kept in accordance with regulation 67 of the 2015 Regulations, the immunisation information as defined in regulation 3 of the 2015 Regulations.

PART 6

REVIEW OF CORONAVIRUS VACCINATION AND TESTING EXEMPTION CONFIRMATION REQUESTS

PAYMENTS FOR THE REVIEW OF CORONAVIRUS VACCINATION AND TESTING EXEMPTION CONFIRMATION REQUESTS

General

19.—(1) This Part relates to the payment for a Contractor providing services under Regulation 22A of the 2015 Regulations.

Payment

(2) The Board must pay a Contractor an IoS fee of £44.00 in respect of each response to a valid exemption confirmation request(**a**) that the Contractor makes.

(3) The Board must make the payment referred to in paragraph (2) by the end of the calendar month following the calendar month in which the Contractor responded to a valid exemption confirmation request.

Eligibility for payment

(4) A Contractor is eligible for the IoS fee referred to in paragraph (2) if the Contractor responds to the valid exemption confirmation request by recording its response on the SCRa in relation to the relevant patient.

PART 7

SUPPLEMENTARY PROVISIONS

ADMINISTRATIVE PROVISIONS

Overpayments and withheld amounts

20.—(1) Without prejudice to the specific provisions elsewhere in the SFE, if the Board makes a payment to a contractor under its GMS contract pursuant to the 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 Board 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 Board is entitled to repayment of all or part of the money paid,

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

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a A confirmation exemption request is valid if it is made in accordance with the process approved by the Secretary of State. Full details of the process will be made available on www.gov.uk before 1st October 2021.

(2) Where the Board is entitled pursuant to the SFE to withhold all or part of a payment because of a breach of a payment condition, and the Board does so or recovers the money by deducting an equivalent amount from another payment in accordance with paragraph (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

(3) Without prejudice to the specific provisions elsewhere in the SFE relating to underpayments of particular payments, if the full amount of a payment that is payable pursuant to the 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)

(c) it must be paid promptly (see regulation 23 of the 2015 Regulations).

(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 Board must—

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

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

(5) However, if a contractor has—

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

(b) claimed a payment to which it is entitled pursuant to the SFE but the Board 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 Board obtains the information or computer software it needs in order to calculate the payment.

Payments on account

(6) Where the Board and the contractor agree (but the Board's agreement may be withdrawn where it is reasonable to do so and if it has given the contractor reasonable notice thereof), the Board 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 the 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 the SFE,

and if that payment results in an overpayment in respect of the payment, paragraph (1) applies.

Payments to or in respect of suspended doctors whose suspension ceases

(7) 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 the SFE and payment was made to the GP pursuant to a determination made under regulation 13(1) 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 the SFE.

Effect on periodic payments of termination of a GMS contract

(8) If a GMS contract under which a periodic payment is payable pursuant to the 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.

(9) Paragraph (8) 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

(10) 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 (5)).

(11) Paragraph (10) does not apply to any claims for payments which fall due under a provision of the SFE in respect of which an alternative time limit for making claims for such payments is imposed unless, in the opinion of the Board, exceptional circumstances exist which make it reasonable for that time limit to be disapplied.

Protocol in respect of locum cover payments

(12) Part 4 sets out a number of circumstances in which the Board is obliged to pay a maximum amount per week for locum cover in respect of an absent performer. However, even where the Board is not directed pursuant to the 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.

(13) As a supplementary measure, the Board 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 10 (payments for locums or GP performers covering sickness leave). In determining the amounts than may be appropriate in these circumstances, the expectation of the Department of Health and Social Care is that they would not exceed the half rate payable in the second period of 26 weeks under Section 10(7)(b), or the amount that would be payable under the NHS Pension Scheme Regulations if the performer retired on ground of permanent incapacity, whichever is the lower; and

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

(14) Where the Board—

(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

(15) The starting point for the determination of a contractor's Contractor Registered Population (CRP) is the number of patients recorded in the registration system approved by the Board 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. For the purposes of making adjustments in accordance with paragraphs (16) and (17), the abolition of PCTs by section 34 of the Health and Social Care Act 2012 does not affect the continuing operation of those provisions and the operation of the registration system approved by the Board which, but for that abolition, would be capable of having effect after 31 March 2013.

(16) However, in respect of any quarter, this number may be adjusted as follows—

(a) if a contractor satisfies the Board that a patient who registered with it before the start of a quarter was not included in the number of patients recorded in the registration system approved by the Board as being registered with it at the start of that quarter, and the Board 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 CRP 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 CRP for that quarter;

(b) if, included in the number of patients recorded in the registration system approved by the Board 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 Board until after the second day of the previous quarter,

those patients are not treated as part of the contractor's CRP at the start of that quarter; or

(c) if a patient is not recorded in the registration system approved by the Board 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 CRP at the start of that quarter.

(17) If a contractor wishes its CRP to be adjusted in accordance with paragraph (16), it must—

(a) within 10 days of receiving from the Board a statement of its patient list size for a quarter, request in writing that the Board makes the adjustment; and

(b) within 21 days of receiving that statement, provide the Board with the evidence upon which it wishes to rely in order to obtain the adjustment,

and the Board must seek to resolve the matter as soon as is practicable. If there is a dispute in connection with the adjustments, paragraphs (11) and (19) apply.

Dispute resolution procedures

(18) Any dispute arising out of or in connection with the SFE between the Board and a contractor is to be resolved as a dispute arising out of or in connection with the contractor's GMS contract (see Part 12 of the 2015 Regulations).

(19) Part 12 of the 2015 Regulations requires the contractor and the Board to make reasonable efforts to communicate and co-operate with each other with a view to resolving the dispute between themselves before referring it for determination in accordance with the NHS dispute resolution procedure (or, where applicable, before commencing court proceedings).

SUPERANNUATION CONTRIBUTIONS

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

21.—(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 Board, which act as their employer for superannuation purposes. In this Section, a reference to a "specialist trainee" means a GP Registrar.

(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 which is part of the NHS Business Services Authority (NHSP) 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 Board 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 Board must thereafter forward these contributions to the NHSP. The detail of all these arrangements is set out in the NHS Pension Scheme Regulations.

(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 "Board" is the "Host Board", as defined in the NHS Pension Scheme Regulations (**a**).

(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 the 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 Board 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 Board is obliged to forward to the NHSP or an Additional Voluntary Contributions Provider on the contract's, or its Pension Scheme Contributors' behalf.

(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 Board from any money the Board pays, pursuant to the SFE, to the contractor that is the employing authority of the Pension Scheme Contributor.

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a "Host Board" is defined in regulation A2 of the National Health Service Pensions Scheme Regulations 1995 (S.I. 1995/300), regulation 2.A.1 of the National Health Service Pension Scheme Regulations 2008 (S.I. 2008/653), and Schedule 15 to the National Health Service Pensions Scheme Regulations 2015 (S.I. 2015/94).

Monthly deductions in respect of superannuation contributions

(6) The deductions are to be made in two stages. First, the Board, 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.

(7) Before determining the monthly amount to be deducted, the Board 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.

(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 Board and the contractor may agree that the payment is to be made net of any superannuation contributions that the Board is responsible for collecting on behalf of the NHSP 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.

(9) An amount equal to the monthly amount that the Board deducts must be remitted to the NHSP 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 (6).

End-year adjustments

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

(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 the 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 Board—

- (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.

(12) Once a contractor's Pension Scheme Contributor's superannuable earnings in respect of a financial year have been agreed, the Board must—

- (a) if its deductions from the contractor's Payable GSMPs during that financial year relating to the superannuation contributions in respect of those earnings—
    - (i) did not cover the cost of all the employer's and employee's superannuation contribution that are payable by the contractor or the Pension Scheme Contributors in respect of those earnings—

(aa) deduct the amount outstanding from any payment payable to the contractor under its GMS contract pursuant to the 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 the SFE that a contractor that is an employing authority of a Pension Scheme Contributor must pay to the Board the amount outstanding; or

(ii) were in excess of the amount payable by the contractor and the Pension Scheme Contributor to the NHSP 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 NHSP 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

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

(14) Where contributions are payable by a locum practitioner under paragraph (13) 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.

(15) Where employer's superannuation contributions are payable in respect of a locum practitioner under paragraph (14), those contributions must be paid to the Board.

(16) 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

(17) Paragraph (18) 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.

(18) The Board may recover the amount of any unpaid contributions referred to in paragraph (17)—

(a) where an employing authority has ceased to exist and paragraph (17)(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 Board: 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, regulation 2.J.14 of the National Health Service Pension Scheme Regulations 2008 or paragraph 6 of Schedule 12 to the National Health Service Pension Scheme Regulations 2015; 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.

(19) The provisions of paragraph (18) are without prejudice to any other method of recovery the Secretary of State may have.

PART 8

REVOCATION AND SAVINGS

Revocation and saving provision

22.—(1) Subject to paragraph (2), the 2021 (No. 1) SFE is revoked.

(2) Notwithstanding the revocation is paragraph (1), without prejudice to section 16 of the Interpretation Act 1978, the 2021 (No. 1) SFE as in force immediately before 1 October 2021 continues to apply (including its saving provisions in respect of the 2013 SFE)—

(a) In respect of the requirement, under paragraph 21(11), on a contractor to identify any Seniority Payments in the General Medical Practitioner's Annual Certificate of Pensionable Profits; and

(b) To the extent necessary to assess any entitlement to payment or recovery of payment or to process any payment, adjustment or reconciliation (including a reconciliation of Seniority Payments) arising under the terms of the 2021 (No. 1) SFE or the 2013 SFE, as appropriate.

ANNEX A

Glossary

PART 1
ACRONYMS

The following acronyms are used in this document:

CPI – Contractor Population Index

CRP – Contractor Registered Population

FCS – Flexible Careers Scheme

GMS – General Medical Services

GSMP – Global Sum Monthly Payment

NHS– National Health Service

NHSP– NHS Pensions which is part of the NHS Business Services Authority

QOF – Quality and Outcomes Framework

SHA – Strategic Health Authority

PART 2
DEFINITIONS

Unless the context otherwise requires, words and expressions used in the SFE and the 2015 Regulations bear the meaning they bear in the 2015 Regulations.

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

"2006 Act" means the National Health Service Act 2006(**a**);

"2015 Regulations" means the National Health Service (General Medical Services Contracts) Regulations 2015(**b**);

"2013 SFE" means the Statement of Financial Entitlement made under section 87 of the 2006 Act and signed on 27th March 2013;

"Achievement Payment" is to be construed in accordance with Section 4 (general provisions relating to the Quality and Outcomes Framework);

"Aspiration Payment" is to be construed in accordance with Section 4 (general provisions relating to the Quality and Outcomes Framework);

"Aspiration Points Total" is to be construed in accordance with Section 4(5)(b) (Aspiration Payments) and Section 5 (Aspiration Payments: calculation, payment arrangements and conditions of payments);

"Adjusted Global Sum Monthly Payment" is to be construed in accordance with Section 3(3) – (5) (calculation of a contractor's first Initial Global Sum Monthly Payment) and 3(12) (revision of Payable Global Sum Monthly Payments);

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a 2006 c. 42.
b S.I. 2015/1862.

"Adjusted Practice Disease Factor" is to be construed in accordance with Section 6(6) (calculation of Achievement Payments) and Annex F;

"the Board" means the National Health Service Commissioning Board(**a**);

"Board's cut-off date for calculating quarterly payments" means the date in the final month of a quarter, determined by the Board, 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;

"Childhood Immunisations" is to be construed as a reference to the Childhood Vaccines and Immunisations essential service referred to in the 2015 Regulations;

"Contractor" means a person entering into, or who has entered into, a GMS contract with the Board in accordance with section 84 of the 2006 Act or as a consequence of a property transfer scheme made under section 300 of the Health and Social Care Act 2012;

"Contractor Population Index" is to be construed in accordance with Section 3(19) (Contractor Population Index);

"Contractor Registered Population", in relation to a contractor, means (subject to any adjustment made in accordance with Section 20(15) (adjustment of Contractor Registered Populations)) the number of patients recorded in the registration system approved by the Board 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 2021 signed on 31st March 2021;

"Dispensary Services Quality Payment" is to be construed in accordance with the provisions of Section 17 (Dispensary Services Quality Scheme);

"Dispensary Services Quality Scheme" is to be construed in accordance with the provisions of Section 17 (Dispensary Services Quality Scheme) 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 127(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;

"Essential Services" means the services referred to in regulation 17 of the 2015 Regulations;

"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;

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a The Board is established by section 1H of the 2006 Act. Section 1H is inserted by section 9 of the Health and Social Care Act 2012 (c.7).

"GMS Contract" means a general medical services contract entered into in accordance with section 84 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 list which is prepared, maintained and published by the Board in accordance with regulation 3(1)(a) of the Performers Lists Regulations; 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 Specialty 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 Section 3(5) (calculation of a contractor's first Initial Global Sum Monthly Payment) and 3(11) (revision of Payable Global Sum Monthly Payments);

"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, otherwise than in pursuance of a commercial agreement, 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) minor surgery;

(iii) enhanced services;

(iv) dispensing services;

(v) out of hours services;

(vi) commissioned services;

(vii) certification services; or

(viii) collaborative services;

"London Adjustment" is to be construed in accordance with Section 3(4) (calculation of a contractor's first Initial Global Sum Monthly Payment);

"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;

a S.I 2000/619.

"Monthly Aspiration Payment" is to be construed in accordance with Section 5(7) (calculation of Monthly Aspiration Payments: the 70% method) and 5(12) (calculation of Monthly Aspiration Payments: the Aspiration Points Total method);

"NHS Pension Scheme Regulations" means the National Health Service Pension Scheme Regulations 1995(**a**), the National Health Service Pension Scheme Regulations 2008(**b**) and the National Health Service Pensions Scheme Regulations 2015(**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) (England) Regulations 2013(**d**);

"Pharmaceutical Regulations 2013" means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013(**e**);

"Provisional Unadjusted Achievement Payment" is to be construed in accordance with Section 5(4) and 5(5) (calculation of Monthly Aspiration Payments: the 70% method);

"Quality and Outcomes Framework" is the framework reproduced at Annex D;

"Quality and Outcomes Framework Uprating Index" is to be construed in accordance with Section 5(6) (calculation of Monthly Aspiration Payments: the 70% method);

"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;

"Seniority Payments" means the payments for years of reckonable service to reward experience made pursuant to section 23 of the 2013 SFE;

"SCRa" means the Summary Care Record Application, which is operated by NHS Digital;

"SHA" means a Strategic Health Authority which was established and which subsisted immediately before the coming into force of section 33 (abolition of Strategic Health Authorities) of the Health and Social Care Act 2012;

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

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

"Target Population Factor" is to be construed in accordance with E.2 and E.3 of Annex E;

"Temporary Patients Adjustment" is to be construed in accordance with Section 3(5) (calculation of a contractor's first Initial Global Sum Monthly Payment) and Annex C;

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

"Unadjusted Achievement Payment" is to be construed in accordance with Section 5(4) (calculation of Monthly Aspiration Payments: the 70% method).

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a S.I. 1995/ 300.
b S.I. 2008/653.
c S.I. 2015/94.
d S.I. 2013/335.
e S.I. 2013/349.

ANNEX B

Global Sum

PART 1

The Global Sum Allocation Formula

Introduction

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

B.2 The formula consists of the following components—

(a) an adjustment for the age and sex structure of the population;

(b) an adjustment for the additional needs of the population, relating to morbidity and mortality;

(c) an adjustment for list turnover;

(d) a nursing and residential homes index; and

(e) adjustments for the unavoidable costs of delivering services to the population, including a Market Forces Factor and rurality index.

Age and sex adjustment

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

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

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

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

Nursing and Residential Homes

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

Needs adjustment

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 and 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.

B.8 The Global Sum Allocation Formula relates these variables to workload by the following formula—

Practice list *(48.1198 + (0.26115 *SLLI) + (0.23676 * SMR<65)).

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

List turnover adjustment

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

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

Unavoidable costs adjustment

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

Staff Market Forces

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

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

Rurality

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

(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 registered as residing in area and not under regulation 30 of the 2015 Regulations to practice). If a practice has more than one surgery, the average distance is assessed from the practice's principal surgery, which is defined as the surgery which the greatest number of the practice's patients could reasonably be expected to attend.

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

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

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

References to PCT in paragraphs B.20 to B.28

B.17 For the purposes of paragraphs B.20 to B.28, "PCT" means a Primary Care Trust established and which subsisted immediately before the coming into force of section 34 (abolition of Primary Care Trusts) of the Health and Social Care Act 2012.

B.18 The abolition of a PCT does not affect the operation of any provision in paragraphs B.20 to B.28.

B.19 Notwithstanding paragraph B.18, where a provision requires action by a PCT, it is to be treated, so far as the provision falls to be applied to any act or omission, as referring to the Board.

Normalising the adjustments

B.20 At each stage of the calculation, the weighted practice populations are normalized (scaled back) to the PCT 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.21 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:

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

B.22 The PCT normalized weighted population used above is the PCT's registered population for the current quarter multiplied by its latest Quarterly PCT Normalising Index. The Quarterly PCT Normalising Index is a quarterly updated index derived by the registration system approved by the Board 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 PCT's population, relative to the PCT's in the country, are reflected in its practices' global sum payments.

B.23 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.21.

B.24 The normalised weighted practice populations for each adjustment are then divided by the practice's normalized list size to generate a practice index for each adjustment used in the Global Sum Allocation Formula. The formula for calculating the practice's normalized list size is as follows—

Practice normalized list size = CRP * Quarterly PCT Normalising Index

B.25 Using the age and sex adjustment as an example, the formula for then calculating the practice index for each adjustment is as follows—

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

B.26 Indices are produced for each of the other five adjustments in the Global Sum Allocation Formula in the same manner as outlined in B.25.

Combining the adjustments

B.27 Each of the six indices are then applied simultaneously to the practice's normalised list size to calculate the overall weighted practice, as follows—

Overall weighted practice population =

Practice normalised list size *age and sex index* nursing and residential homes index* additional needs index *MFF index* rurality index

B.28 This overall weighted practice population is then normalised to the national registered population to calculate the Contractor Weighted Population for the Quarter as follows—

Contractors Weighted Population =

$$\frac{\text{overall weighted practice population}}{\text{sum of PCT overall weighted practice populations}} * \text{PCT normalised weighted population}$$

PART 2

Vaccines and Immunisations

CHAPTER 1

Introduction

B.29 Part 2 of Annex B sets out types of vaccines and immunisations and the circumstances in which Contractors are to offer and give such vaccines and immunisations under the terms of their GMS contract.

B.30 The vaccines and immunisations set out in this Annex are paid under the Global Sum Payment provisions (Part 1 of the SFE) and are not eligible for an item of service ("IoS") fee.

CHAPTER 2

VACCINES AND IMMUNISATIONS WHICH ARE NOT REQUIRED FOR THE PURPOSE OF FOREIGN TRAVEL

General

B.31 Contractors are to offer vaccines and immunisations in respect of the diseases listed in column 1 of Table 1 (whether or not there is any localised outbreak of any of the diseases mentioned in Chapter 4) to persons who do not intend to travel abroad and provide such immunisations in the circumstances set out in column 2 of that Table.

B.32 Contractors who offer and provide the vaccines and immunisations referred to in Table 1 must have regard to the guidance and information on vaccinations and immunisations procedures set out in "Immunisation against infectious diseases – The Green Book" which is published by the Department of Health and available on https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book.

Table 1

VACCINES AND IMMUNISATION IN RESPECT OF DISEASES	*CIRCUMSTANCES IN WHICH VACCINE OR IMMUNISATION IS TO BE OFFERED AND GIVEN*
1. Anthrax	Four doses of the vaccine (plus an annual reinforcing dose) are to be offered to persons who are exposed to an identifiable risk of contracting anthrax. Those who are exposed to an identifiable risk will mainly be those persons who come into contact with imported animal products that could be contaminated with anthrax.
2. Hepatitis A	(a) A course of immunisation is to be offered to persons who are resident— (i) in residential care; or (ii) in an educational establishment, who risk exposure to infection and for whom immunisation is recommended by the local Director of Public Health. (b) The number of doses of vaccine required will be dependent upon the chosen vaccine and should be sufficient to provide satisfactory long-term protection against the disease.
3. Paratyphoid[1]	No vaccine currently exists for the immunisation of paratyphoid.
4. Rabies (pre-exposure)	(a) Three doses of Rabies vaccine are to be offered to the following persons—

	(i) laboratory workers handling rabies virus; (ii) bat-handlers; (iii) persons who regularly handle imported animals, for example, those— (aa) at animal quarantine stations; (bb) at zoos; (cc) at animal research centres and acclimatization centres; (dd) at ports where contact with imported animals occurs and this may include certain HM Revenue and Custom Officers; (ee) persons carrying agents of imported animals; and (ff) who are veterinary or technical staff in animal health. (iv) animal control and wildlife workers who regularly travel in rabies enzootic areas; and (v) health workers who are at risk of direct exposure to body fluids or tissue from a patient with confirmed or probable rabies. (b) Reinforcing doses are to be provided at recommended intervals to those at continuing risk[2]
5. Typhoid	a) a course of typhoid vaccine is to be offered to the following persons— (i) hospital doctors, nurses and other staff likely to come into contact with cases of typhoid; and (ii) laboratory staff likely to handle material contaminated with typhoid organisms. The number of doses (including reinforcing doses) required will be dependent on the chosen vaccine and is to be offered so as to provide satisfactory protection against the disease.

[1] No vaccine is currently available for paratyphoid. Should a vaccine subsequently become available a review of this Table would be considered and consultation on any proposed amendments to this Table would be required in accordance with section 87 of the National Health Service Act 2006.

[2] See 'Immunisation against infectious diseases – The Green Book'.

CHAPTER 3
VACCINES AND IMMUNISATIONS REQUIRED FOR THE PURPOSES OF FOREIGN TRAVEL

B.33 Vaccines and immunisations in respect of the diseases listed in column 1 of Table 2 must only be offered in the case of a person who intends to travel abroad, and if the offer is accepted, given in the circumstances set out in column 2 of the Table.

B.34 Contractors who offer and provide the vaccines and immunisations referred to in Table 2 must have regard to—

(a) the guidance and information on vaccines and immunisations procedures set out in "Immunisation against infectious diseases – The Green Book"; and

(b) the information on travel medicine and travel health issues provided and published by the National Travel Health Network and Centre([a]).

a Routine vaccination is not appropriate and no vaccine is available for use in general practice. Should it become appropriate to vaccinate, a review of the Table would be considered and consultation on any proposed amendments to this Table would be required in accordance with section 87 of the National Health Service Act 2006.

Table 2

VACCINES AND IMMUNISATIONS IN RESPECT OF DISEASES	*CIRCUMSTANCES IN WHICH VACCINE OR IMMUNISATION IS TO BE OFFERED AND GIVEN*
1. Cholera	(a) A course of immunisation is to be offered to persons travelling— (i) to an area where they may risk exposure to infections as a consequence of being in that area; or (ii) to the country where it is a condition of entry to that country that persons have been immunised. (b) The appropriate course of immunisation is dependent on age and will consist of an initial course and a subsequent reinforcing course of immunisation. If more than two years have elapsed since the last course of immunisation, a new course of immunisation should be commenced.
2. Hepatitis A	(a) A course of immunisation is to be offered to persons travelling to areas where the degree of exposure to infections is believed to be high[1] (b) Persons who may be at a higher risk of infection include those who— (i) intend to reside in an area for at least three months and may be exposed to Hepatitis A during that period; or (ii) if exposed to Hepatitis A, may be less resistant to infection because of a pre-existing disease or condition or who are at risk of developing medical complications from exposure. (c) The number of doses (either two or three) of the vaccine required will be dependent upon the chosen vaccine and should be sufficient to provide satisfactory long-term protection against the disease.
3. Poliomyelitis (or Polio)	(a) A course of immunisation (using an age appropriate combine vaccine) is to be offered to persons travelling— (i) to an area where they may risk exposure to infection as a consequence of being in that area; or

VACCINES AND IMMUNISATIONS IN RESPECT OF DISEASES	*CIRCUMSTANCES IN WHICH VACCINE OR IMMUNISATION IS TO BE OFFERED AND GIVEN*
	(ii) to a country where it is a condition of entry to that country that persons have been immunised. (b) Children under the age of 6 years are to be offered immunisation, in accordance with the routine childhood immunisation schedule in Annex I. (c) Persons aged 6 years and over who have not had the full course of immunisation or whose immunisations history is incomplete or unknown are to be offered, either— (i) a primary course of three doses plus two reinforcing doses at suitable time intervals; or (ii) as many doses as required to ensure that a full schedule has been administered at the appropriate intervals as clinically appropriate.
5. Typhoid	(a) A course of typhoid vaccine is to be offered to persons travelling— (i) to an area where they may risk exposure to infection as a consequence of being in that area; or (ii) to a country where it is a condition of entry to that country that persons have been immunised. (b) The number of doses (including reinforcing doses) required will be dependent on the chosen vaccine and is to be offered so as to provide satisfactory protection against the disease.

(1) See up to date details of travel information on http://www.nathnac.org/

CHAPTER 4

VACCINES AND IMMUNISATIONS WHICH ARE REQUIRED IN THE CASE OF A LOCALISED OUTBREAK

B.35 In the event of a localised outbreak of any of the diseases listed in paragraph B.36, the Board must consider its response to that localised outbreak and contractors must offer and provide vaccines and immunisations in accordance with any directions given by the Board in response to the outbreak, and those directions may make recommendations as to additional categories of persons who should be offered immunisation.

B.36 The diseases referred to in paragraph B.35 are—

(a) Anthrax;

(b) Diphtheria;

(c) Meningococcal Group C or MenACWY as appropriate;

(d) Poliomyelitis;

(e) Rabies;

(f) Tetanus; and

(g) Typhoid.

B.37 Contractors who offer and provide vaccines and immunisations in respect of the diseases mentioned in paragraph B.36 must have regard to the guidance and information on vaccines and immunisations procedures set out in “Immunisation against infectious diseases – “The Green Book”

which is published by the Department of Health.

B.38 Contractors who offer immunisation in the circumstances set out in paragraph B.35, are not required, by virtue of this Annex, to carry out a contact tracing or trace back exercise.

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 Board 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 Board 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 Board 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 Board must discuss the matter with the contractor.

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

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

ANNEX D

Quality and Outcomes Framework

SECTION 1: Introduction

General

D.1 The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary.

D.2 The percentages for the achievement threshold levels for the fraction indicators included in QOF for the financial year commencing on 1st April 2021 and ending on 31st March 2022 are set out in this Annex.

Glossary of terms used in Annex D

Abbreviation	*Definition*
ACE-Inhibitor or ACE-I	Angiotensin Converting Enzyme Inhibitor
AF	Atrial Fibrillation
ARB	Angiotensin Receptor Blocker
AST	Asthma
BMI	Body Mass Index
BP	Blood Pressure
CAN	Cancer
CHD	Coronary Heart Disease
$CHADS_2$	Congestive (HF) Hypertension Age (75 and over) Diabetes Stroke
CKD	Chronic Kidney Disease
CON	Contraception
COPD	Chronic Obstructive Pulmonary Disease
CS	Cervical Screening
CVD	Cardiovascular Disease
CVD-PP	CVD Primary Prevention
DEM	Dementia
DEP	Depression
DM	Diabetes Mellitus
DXA	Dual-energy X-ray Absorptiometry
EP	Epilepsy
FEV_1	Forced Expiratory Volume in One Second
GP	General Practitioner
GPPAQ	GP Physical Activity Questionnaire
HbA1c	Glycated Haemoglobin
HF	Heart Failure
HYP	Hypertension
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
LD	Learning Disabilities
LVSD	Left Ventricular Systolic Dysfunction
MH	Mental Health
mmHg	Millimetres of Mercury
mmol/l	Millimoles per Litre
NICE	National Institute for Health and Care Excellence
OB	Obesity
OST	Osteoporosis

Abbreviation	*Definition*
PAD	Peripheral Arterial Disease
PC	Palliative Care
PE	Patient Experience
QI	Quality Improvement
RA	Rheumatoid Arthritis
SMOK	Smoking
STIA	Stroke and Transient Ischemic Attack
TIA	Transient Ischemic Attack

Interpretation of words and expressions used in Annex D

D.3 In this Annex, unless the context otherwise requires, words and expressions have the following meaning—

(a) "currently treated" in respect of a patient is to be construed as a patient who has been prescribed a specified medicine within a period of six months which ends on the last day of the financial year to which the Achievement Payment relates;

(b) "exclusions" means persons who fall within the description of patient in paragraph D.13;

(c) "financial year" means the period of 12 months commencing on 1st April and ending on 31st March; and

(d) "personalised care adjustment" means an appropriate variation in the care of a registered patient that is recorded in the patient record in consequence of which such patients fall within the criteria for personalised care adjustment set out in paragraphs D.12 to D.22 (personalised care adjustment).

Indicators: general

D.4 For the purposes of calculating Achievement Payments, contractor achievement against QOF indicators is measured—

(a) on the last day of the financial year (31st March); or

(b) in the case where the contract terminates mid-year, on the last day on which the contract subsists.

D.5 For example, for payments relating to the financial year 1st April 2021 to 31st March 2022, unless the contract terminates mid-year, achievement is measured on 31st March 2022. If the GMS contract ends on 30th June 2022, achievement is measured on 30th June 2022.

D.6 Indicators generally set out the target, intervention or measurement to be recorded within a specified time period to establish eligibility for Achievement Payments. Unless otherwise stated, time periods referred to mean the period which ends on the last day of the financial year to which the Achievement Payment relates. For example—

(a) in indicator HYP003, "the percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less," the phrase "the preceding 12 months" means the period of 12 months which ends on 31st March in the financial year to which the Achievement Payments relate;

(b) in indicator CAN003, "the percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis", the phrase "within the preceding 15 months" means the period of 15 months which ends on 31st March in the financial year to which the Achievement Payments relate;

(c) in indicator DM014 the percentage of patients newly diagnosed with diabetes, on the register in the preceding 1st April to 31st March who have a record of being referred to a structured education programme within 9 months after entry in the diabetes register; and

(d) in indicator CS005, “the proportion of women eligible for screening and in the age range from 25 to 49 years at the end of the reporting period whose notes record that an adequate cervical screening test has been performed in the preceding 3 years and 6 months”, the phrase “in the preceding 3 years and 6 months” means the period of 3 years and 6 months which ends on 31st March in the financial year to which the Achievement Payments relate.

D.7 In the case of a contract that has come to an end before 31 March in any relevant financial year, the reference to periods of time must be calculated on the basis that the period ends on 31st March in the financial year to which the Achievement Payments relate.

Disease registers

D.8 An important feature of the QOF is the establishment of disease registers. These are lists of patients registered with the contractor who have been diagnosed with the disease or risk factor described in the register indicator. While it is recognised that these may not be completely accurate, it is the responsibility of the contractor to demonstrate that it has systems in place to maintain a high-quality register. Verification may involve asking how the register is constructed and maintained. The Board may compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations.

D.9 The purpose of a register in QOF is to define a cohort of patients with a particular condition or risk factor. In some cases, this register then informs other indicators in that disease area. QOF registers must not be used as the sole input for the purposes of individual patient care and clinical audit, i.e. the call and recall of patients for check-ups, treatments etc. There are patients for whom a particular treatment activity is clinically appropriate but they might not meet the criteria as defined by the QOF register and therefore would not be picked up by a search based solely on the QOF register. As such, although QOF registers can be used to supplement clinical audit, they should be supported by appropriate clinical judgement to define which patients should be reviewed, invited for consultation etc. to ensure patients do not miss out on appropriate and sometimes critical care.

D.10 For some indicators, there is no disease register, but instead there is a target population group. For example, for cervical screening the target population group is women who have attained the age of 25 years or over and who have not attained the age of 65 years. Indicators in the Clinical and Public Health Domain are arranged in terms of clinical areas. Most of these areas either relate to a register or to a target population group.

D.11 Some areas in the clinical domain and the public health domain do not have a register indicator, or there may be more than one register to calculate the Adjusted Practice Disease Factor for different indicators within the area. For all relevant areas, the register population used to calculate the Adjusted Practice Disease Factor are set out in the summary of indicators.

Personalised care adjustment (formerly Exception reporting) and exclusions

D.12 Personalisation of care applies to those indicators in any domain of QOF where the achievement is determined by the percentage of patients receiving the specified level of care (fraction indicators), unless otherwise stated in the QOF Guidance.

D.13 Some indicators refer to a sub-set of patients on the relevant disease register, or in the target population group of a particular indicator. Patients who are on the disease register or target group, but not included in an indicator denominator for the clinical area concerned for definitional reasons are called “exclusions”.

D.14 A personalised care adjustment may be applied to the care of a registered patient who is in the relevant disease register or target group and would ordinarily be included in the indicator denominator if they meet one or more of the criteria set out below. Patients are removed from the denominator if their care has been personalised and also the care specified in the indicator has not been carried out. If the patient has had a reason for the personalisation of care added to their record but the care has been carried out in the relevant time period then the patient will be included in both the denominator and the numerator.

D.15 A personalised care adjustment cannot remove a patient from the underpinning register or target group and the patient must be included in the calculation of the Adjusted Practice Disease Factor.

D.16 Care may be personalised for the following reasons, listed in the order in which they will be applied in the Business rules—

(a) The investigative or secondary care service is unavailable. This will apply to the following indicators only: HF005, AST006, COPD008 and DM014. Discrete codes which indicate the concept of a service not being available should be used to record this;

(b) The intervention described in the indicator is clinically unsuitable for the patient. This may be due to specific reasons such as the patient being on maximum tolerated doses of medication, allergies, contraindications or other medication intolerances or broader reasons such as it being clinically inappropriate to review disease parameters due to particular circumstances such as being at the end of their life or having a supervening condition against which QOF interventions need to be balanced;

(c) The patient has chosen not to receive the intervention described in the indicator and this has been recorded in their patient record following a discussion with the patient;

(d) The patient has not responded to a minimum of two invitations for the intervention during the financial year to which the Achievement Payments relate except in the case of indicators CS005 and CS006, where the patient should have been invited on at least three occasions during the period specified in the indicator during which the achievement is to be measured (i.e. the preceding 3 years and 6 months or 5 years and 6 months ending on 31st March in the financial year to which Achievement Payments relate). Any and all invitations should be recorded in the patient record when they are made. There should be a minimum of seven days between the first and second invitation; and

(e) Patients newly diagnosed or recently registered with the contractor, should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure measurements within target levels.

D.17 Criteria (b) and (c) will be supported by both specific i.e. indicator specific and generic codes i.e. those which record the concept of patient unsuitability and informed dissent. Specific codes will remove the patient from the denominator for individual indicators where these criteria apply e.g. a record of a medication allergy would remove the patient from the denominator of an indicator related to the prescribing of that drug and not all the other clinical indicators in a set. Generic codes will remove the patient from the denominator for all the indicators in that set.

D.18 Criterion (a) will apply to the indicators specified above only and will only remove patients from the denominator of those indicators.

D.19 Only criterion (b) will apply to the following indicators: VI001, VI002 and VI003.

D.20 Criteria (d) and (e) will remove patients from all indicators in a given set unless the care has subsequently been carried out within the relevant time period as described in paragraph D.6(a) to (d) above.

D.21 Contractors should report the number of patients with a personalised care adjustment recorded for each indicator set and individual indicator. Contractors will not be expected to provide reasons for inclusion of a personalised care adjustment in an individual patient's record.

D.22 Additional guidance on the personalised care adjustment is included in the guidance published by NHS England and can be obtained on https://www.england.nhs.uk/gp/gpfv/investment/gp-contract.

Verification

D.23 The contractor must ensure that it is able to provide any information that the Board 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 Board on request. In verifying that an indicator has been achieved and information correctly recorded, the Board may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample

of patient records relevant to the indicator.

SECTION 2: Summary of all indicators

Section 2.1: Clinical domain (401 points)

2.1 Section 2.1 applies to all contractors participating in QOF.

Atrial fibrillation (AF)

Indicator	*Points*	*Achievement thresholds*
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	
Ongoing Management		
AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VAS_c score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous $CHADS_2$ or CHA_2DS_2-VAS_c score of 2 or more) *(NICE 2014 menu ID: NM81)*	12	40-90%
AF007. In those patients with atrial fibrillation with a record of a CHA_2DS_2-VAS_c score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy *(NICE 2014 menu ID: NM82)*	12	40-70%

For AF007, patients with a previous score of 2 or above using $CHADS_2$, recorded prior to 1 April 2015 will be included in the denominator.

Secondary prevention of coronary heart disease (CHD)

Indicator	*Points*	*Achievement thresholds*
Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	4	
Ongoing Management		
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken *(NICE 2015 menu ID: NM88)*	7	56–96%
CHD008. The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less *(NICE 2013 menu ID: NM68)*	12	40-77%
CHD009. The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less *(NICE 2019 menu ID: NM191)*	5	46-86%

Heart Failure (HF)

Indicator	*Points*	*Achievement thresholds*
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	4	
Initial diagnosis		
HF005. The percentage of patients with a diagnosis of heart failure on or after 1 April 2021 which: (a) Has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or (b) If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration. *(based on NM171*)	6	50–90%
Ongoing management		
HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB *(NICE 2019 menu ID: NM172)*	6	60–92%
HF006. The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure *(NICE 2019 menu ID: NM173)*	6	60-92%
HF007. The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses *(Based on NM174)*	7	50-90%

Disease registers for heart failure

There are two disease registers used for the HF indicators for the purpose of calculating APDF (practice prevalence):

1. a register of patients with HF is used to calculate APDF for HF001, HF005, and HF007,
2. a register of patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003 and HF006.

Register 1 is defined in indicator HF001. Register 2 is a sub-set of register 1 and is composed of patients with a diagnostic code for LVSD as well as for HF.

Hypertension (HYP)

Indicator	*Points*	*Achievement thresholds*
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	
Ongoing management		
HYP003. The percentage of patients aged 79 years or	14	40-77%

under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less *(NICE 2012 menu ID: NM53)*		
HYP007. The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less *(NICE 2012 menu ID: NM54)*	5	40-80%

Peripheral arterial disease (PAD)

Indicator	*Points*	*Achievement thresholds*
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease *(NICE 2011 menu ID: NM32)*	2	

Stroke and transient ischaemic attack (STIA)

Indicator	*Points*	*Achievement thresholds*
Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	
Ongoing management		
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti- coagulant is being taken *(NICE 2015 menu ID: NM94)*	4	57–97%
STIA010. The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less *(NICE 2013 menu ID: NM69)*	3	40-73%
STIA011. The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less *(NICE 2019 menu ID: NM192)*	2	46-86%

Diabetes Mellitus (DM)

Indicator	*Points*	*Achievement thresholds*
Records		
DM017. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed *(NICE 2011 menu ID: NM41)*	6	
Ongoing management		
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro- albuminuria who are currently treated with an ACE-I (or ARBs) *(NICE 2015 menu ID: NM95)*	3	57–97%

Indicator	*Points*	*Achievement thresholds*
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months *(NICE 2010 menu ID: NM13)*	4	50–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register *(NICE 2011 menu ID: NM27)*	11	40–90%
DM019. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less *(NICE 2018 menu ID: NM159)*	10	38-78%
DM020. The percentage of patients with diabetes, on the registers, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months *(NICE 2018 menu ID: NM157)*	17	35-75%
DM021. The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months *(NICE 2018 menu ID: NM158)*	10	52-92%
DM022. The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years) *(NICE 2018 menu ID: NM162)*	4	50-90%
DM023. The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin *(NICE 2018 menu ID: NM163)*	2	50-90%

Asthma (AST)

Indicator	*Points*	*Achievement thresholds*
Records		
AST005. The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been	4	

prescribed no asthma related drugs in the preceding 12 months *(based on NM165)*		
Initial diagnosis		
AST006. The percentage of patients with a diagnosis of asthma on or after 1 April 2021 with either: (a) a record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before or 6 months after diagnosis; or (b) if newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after 1 April 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration. *(based on NM166)*	15	45–80%
Ongoing management		
AST007. The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan *(based on NM167)*	20	45–70%
AST008. The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months *(based on NM168)*	6	45–80%

Chronic obstructive pulmonary disease (COPD)

Indicator	*Points*	*Achievement thresholds*
Records		
COPD009. The contractor establishes and maintains a register of: (a) Patients with a clinical diagnosis of COPD before 1 April 2021; (b) Patients with a clinical diagnosis of COPD on or after 1 April 2021 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV_1/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an FEV_1/FVC ratio below 0.7 recorded within 6 months of registration); and (c) Patients with a clinical diagnosis of COPD on or after 1 April 2021 who are unable to undertake spirometry *(based on NM169)*	8	

Ongoing management		
COPD010. The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale *(NICE 2019 menu ID: NM170)*	9	50–90%
COPD008. The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme) *(NICE 2012 menu ID: NM47)*	2	40-90%

Dementia (DEM)

Indicator	*Points*	*Achievement thresholds*
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	5	
Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months *(NICE 2015 menu ID: NM107)*	39	35–70%

Depression (DEP)

Indicator	*Points*	*Achievement thresholds*
Initial management		
DEP003. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis *(Based on NM50)*	10	45–80%

Disease register for depression

There is no register indicator for the depression indicator. The disease register for the depression indicator for the purpose of calculating the APDF is defined as all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

Mental health (MH)

Indicator	*Points*	*Achievement thresholds*
Records		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4	
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals,	6	40–90%

their family and/or carers as appropriate *(NICE 2015 menu ID: NM108)*		
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months *(based on NM17)*	4	50–90%
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months *(based on NM16)*	4	50-90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months *(based on NM15)*	4	50-90%
MH011. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or smoke, and/or are overweight (BMI of ≥23 kg/m2 or ≥25 kg/m2 if ethnicity is recorded as White) or preceding 24 months for all other patients *(based on NM129)*	8	50-90%
MH012. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months *(NICE 2015 menu ID: NM130)*	8	50-90%

Disease register for mental health

Due to the way repeat prescribing works in general practice, patients on lithium therapy are defined as patients with a prescription of lithium within the preceding six months.

Remission from serious mental illness

Making an accurate diagnosis of remission can be challenging. In the absence of strong evidence of what constitutes ‘remission’ from serious mental illness, clinicians should only consider using these codes if the patient has been in remission for at least five years, that is where there is:

(a) no record of anti-psychotic medication

(b) no mental health in-patient episodes; and

(c) no secondary or community care mental health follow-up for at least five years.

Where a patient is recorded as being ‘in remission’ they remain on the MH001 register (in case their condition relapses at a later date) but they are excluded from the denominator for indicators MH002, MH003, MH006, MH007, MH011 and MH012.

The accuracy of this coding should be reviewed on an annual basis by a clinician. Should a patient who has been coded as ‘in remission’ experience a relapse then this should be recorded as such in their patient record.

In the event that a patient experiences a relapse and is coded as such, they will again be included in all the associated indicators for schizophrenia, bipolar affective disorder and other psychoses and their care plan should be updated.

Where a patient has relapsed after being recorded as being in remission, their care plan should be updated subsequent to the relapse. Care plans dated prior to the date of the relapse will not be acceptable for QOF purposes.

Cancer (CAN)

Indicator	*Points*	*Achievement thresholds*
Records		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5	
Ongoing management		
CAN004. The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis *(NICE menu 2020 ID: NM205)*	6	50–90%
CAN005 The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and informed of the support available from primary care, within 3 months of diagnosis. *(based on NM204)*	2	70-90%

Chronic kidney disease (CKD)

Indicator	*Points*	*Achievement thresholds*
Records		
CKD005. The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5) *(NICE 2014 menu ID: NM83)*	6	

Epilepsy (EP)

Indicator	*Points*	*Achievement thresholds*
Records		
EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1	

Learning disability (LD)

Indicator	*Points*	*Achievement thresholds*
Records		
LD004. The contractor establishes and maintains a register of patients with learning disabilities *(NICE 2013 menu ID: NM73)*	4	

Osteoporosis: secondary prevention of fragility fractures (OST)

Indicator	*Points*	*Achievement thresholds*
Records		
OST004. The contractor establishes and maintains a register of patients: (a) Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after	3	

1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan; and (b) Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis *(NICE 2011 menu ID: NM29)*		

Disease register for osteoporosis

Although the register indicator OST004 defines two separate registers, the disease register for the purpose of calculating the APDF is defined as the sum of the number of patients on both registers.

Rheumatoid arthritis (RA)

Indicator	*Points*	*Achievement thresholds*
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis *(NICE 2012 menu ID: NM55)*	1	
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months *(NICE 2012 menu ID: NM58)*	5	40–90%

Palliative care (PC)

Indicator	*Points*	*Achievement thresholds*
Records		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	

Disease register for palliative care

There is no APDF calculation in respect of the palliative care indicators. In the rare case of a nil register at year end, if a contractor can demonstrate that it established and maintained a register during the financial year then they will be eligible for payment for PC001.

Non diabetic hyperglycaemia (NDH)

Indicator	*Points*	*Achievement thresholds*
Records		
NDH001. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months *(NICE 2017 menu: NM150)*	18	50–90%

Section 2.2: Public health domain (160 points)

Section 2.2 applies to all contractors participating in QOF.

Blood pressure (BP)

Indicator	*Points*	*Achievement thresholds*
Records		
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years *(based on NM61)*	15	50–90%

Obesity (OB)

Indicator	*Points*	*Achievement thresholds*
Records		
OB002. The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥30 in the preceding 12 months *(based on NM143)*	8	

Smoking (SMOK)

Indicator	*Points*	*Achievement thresholds*
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months *(NICE 2011 menu ID: NM38)*	25	50–90%
Ongoing management		
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months *(based on NM40)*	12	40–90%
SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months *(NICE 2011 menu ID: NM39)*	25	56–96%

Disease register for smoking

The disease register for the purpose of calculating the APDF for SMOK002 and SMOK005 is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicators. Any patient who has one or more co-morbidities e.g. diabetes and CHD, is only counted once on the register for SMOK002 and SMOK005.

There is no APDF calculation for SMOK004.

Requirements for recording smoking status

Smokers

For patients who smoke this recording should be made in the preceding 12 months for SMOK002.

Non-smokers

It is recognised that life-long non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 12 months for SMOK002 until the end of the financial year in which the patient reaches the age of 25.

Once a patient is over the age of 25 years (e.g. in the financial year in which they reach the age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:

- never smoked which is both after their 25th birthday and after the earliest diagnosis date for the disease which led to the patient's inclusion on the SMOK002 register (e.g. one of the conditions listed on the SMOK002 register).

Ex-smokers

Ex-smokers can be recorded as such in the preceding 12 months for SMOK002. Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years they are unlikely to restart.

Vaccines and Immunisations (VI)

Indicator	*Points*	*Achievement thresholds*	*Points at lower threshold*
VI001. The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months *(NICE 2020 menu ID: NM197)*	18	90-95%	3
VI002. The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months. *(NICE 2020 menu ID: NM198)*	18	90-95%	7
VI003. The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years. *(NICE 2020 menu ID: NM199)*	18	87-95%	7
VI004. The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years. *(based on NM201)*	10	50-60%	-

Cervical screening (CS)

Indicator	*Points*	*Achievement thresholds*
CS005. The proportion of women eligible for screening and aged 25-49 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months	7	45-80%

(NICE 2017 menu ID: NM154)		
CS006. The proportion of women eligible for screening and aged 50-64 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months *(NICE 2017 menu ID: NM155)*	4	45-80%

Section 2.3: Quality improvement domain (74 points)

Section 2.3 applies to all contractors participating in QOF.

Early cancer diagnosis (QIECD)

Indicator	*Points*	*Achievement thresholds*
QIECD005. The contractor can demonstrate continuous quality improvement activity focused upon early cancer diagnosis as specified in the QOF guidance	27	NA
QIECD006. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings	10	NA

Care of people with Learning Disabilities (QILD)

Indicator	*Points*	*Achievement thresholds*
QILD007. The contractor can demonstrate continuous quality improvement activity focused on care of patients with a learning disability as specified in the QOF guidance	27	NA
QILD008. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on the care of patients with a learning disability as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10	NA

ANNEX E

Calculation of Cervical Screening Achievement Points

Achievement points

E.1 The cervical screening indicators do not apply to all of the contractor's registered population. Assessment of achievement is carried out in relation to particular target populations. The relevant target populations are women who have attained the age of 25 years but not yet attained the age of 65 years.

E.2 For cervical screening services, a Target Population Factor is to be calculated as follows—

(a) first the number of patients registered with the contractor in the relevant target population at the relevant date (A) is to be divided by the contractor's CRP at the relevant date (B);

(b) then the average number of patients registered with all contractors in England in the relevant target population at the relevant date (C) is to be divided by the average CRP for England (according to the registration system approved by the Board) at the relevant date (D); and

(c) the number produced by the calculation in sub-paragraph (a) is then to be divided by the number produced by the calculation in sub-paragraph (b) to produce the Target Population Factor for the cervical screening.

E.3 For the purposes of paragraph E.2, the "relevant date" is the date in respect of which the value of the contractor's CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the financial year to which the Achievement Payment relates, but see Section 6(6) to (11) (calculation of achievement payments).

E.4 The Target Population Factor for cervical screening services is to be multiplied by £201.16 and by the Achievement Points obtained in respect of cervical screening services (E) to produce the cash total in respect of cervical screening services (F).

E.5 This calculation could be expressed as—

$$\frac{(A \div B)}{(C \div D)} \times £201.16 \times E = F$$

ANNEX F

Adjusted Practice Disease Factor Calculations

Calculations

F.1 The calculation involves three steps—

(a) the calculation of the contractor's Raw Practice Disease Prevalence. There will be a Raw Practice Disease Prevalence in respect of each indicator in the clinical and public health domains (other than Achievement Points for cervical screening services where achievement is calculated in accordance with Annex E and the indicators in the palliative care area and indicators BP002 and 004);

(b) making an adjustment to give an Adjusted Practice Disease Factor; and

(c) applying the factor to the pounds per point figure for each disease area (other than the area relating to palliative care).

F.2 The above three steps are explained below. The register to be used to calculate the Raw Practice Disease Prevalence is usually the register as defined in the first indicator for the indicator area concerned ("the register indicator") in the summary of indicators set out in Section 2 of Annex D, except in a case where there is no register indicator or where the register to be used is not the register indicator to be used to calculate the Raw Practice Disease Prevalence. In the case where there is no register indicator or the register indicator is not the register to be used in respect of a specific disease area or indicator, the applicable register in respect of that specific disease area or indicator is specified in the relevant part of Section 2 of Annex D relating to that disease.

F.3 The Raw Practice Disease Prevalence is calculated by dividing the number of patients on the relevant disease register at 31st March in the financial year to which the Achievement Payment relates by the contractor's CRP for the relevant date. For these purposes, the "relevant date" is the date in respect of which the value of the contractor's CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the financial year to which the Achievement Payment relates, but see Section 6(6) to (11) (calculation of Achievement Payments).

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

(a) calculating the national range of Raw Practice Disease Prevalence's in England (the Board must use the national range established annually through the Calculating Quality Reporting Service (known as CQRS));

(b) re-basing the contractor figures around the new national English mean (available at the end of each month) to give the Adjusted Practice Disease Factor (APDF). For example, an APDF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The re-basing ensures that in the relevant year, the average contractor (that is a contractor with an APDF of 1.00) would receive, after adjustment, an amount per point equal to the amount specified in Section 6(6) to (11) (calculation of Achievement Payments) of the SFE as in force on the 1st April in that relevant year;

(c) thus, adjusting via the factor the contractor's average pounds per point for each disease, rather than the contractor's points score. For example, a contractor with an APDF of 1.2 for CHD in the period commencing on 1st April 2021 and ending on 31st March 2022 would receive £241.39 per point scored on the CHD indicators.

F.5 "Relevant year" in paragraph F.4(b) means the financial year to which the calculation of Achievement Payments relates.

F.6 As a result of the calculation in paragraph F.1, each contractor will have a different "pounds per point" figure for each indicator area with a disease register (other than the area relating to palliative care), or may have a different "pounds per point" for individual indicators within an area (if more than one register is used for the area). It will then be possible to use these figures to calculate a cash total in relation

to the points scored for each area (other than the area relating to palliative care, smoking indicator 004 or BP002).

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

F.8 If the contractor's GMS contract terminates before 1st January in the financial year to which the Achievement Payment relates, the Adjusted Practice Disease Factor to be used in calculating the contractor's Achievement Payment should be the Adjusted Practice Disease Factor calculated for the contractor for the previous financial year.

F.9 If the contractor did not have an Adjusted Practice Disease Factor calculation for the previous financial year, then no Adjusted Practice Disease Factor should be used in calculating the contractor's Achievement Payment for that year.

F.10 Unless paragraph F.11 applies, if the contractor's GMS contract terminates on or after 1st January and before the end of the financial year to which the Achievement Payment relates—

(a) the CRP to be used to calculate the Raw Practice Disease Prevalence is the CRP on 1st January; and

(b) the number of patients on the disease register is to be taken to be the number of patients on the register on the date nearest to the date on which the contract ends and on which there can be a calculation.

F.11 If the contractor's GMS contract commences after 1st January and terminates before the end of the financial year in which the GMS contract commences, no Adjusted Practice Disease Factor is to be calculated for the contractor's Achievement Payment in respect of the period during which the contract subsisted.

ANNEX G

Dispensing Payments

PART 1

DISCOUNT SCALE

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

PART 2

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

1st October 2020

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	*Prices per prescription in pence*
Up to 461	256.2
462 – 577	252.5
578 – 694	249.2
695 – 808	246.0
809 – 925	243.1
926 – 1039	240.5
1040 – 1444	238.0
1445 – 2022	235.8
2023 – 2310	233.7
2311 – 2888	231.9
2889 – 3465	230.3
3466 – 4044	228.9
4045 – 4618	227.7
4619 and over	226.9

From 1st April 2021

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	*Prices per prescription in pence*
Up to 461	230.7
462 – 577	227.4
578 – 694	224.4
695 – 809	221.5
810 – 925	218.9
926 – 1039	216.6
1040 – 1444	214.3
1445 – 2022	212.3
2023 – 2310	210.4
2311 – 2888	208.8
2889 – 3465	207.4
3466 – 4044	206.1
4045 – 4618	205.0
4619 and over	204.3

From 1st October 2021

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	*Prices per prescription in pence*
Up to 457	194.8
458 – 573	192
574 – 689	189.5
690 – 802	187.1
803 – 918	184.8

919 – 1031	182.9
1032 – 1433	180.9
1434 – 2006	179.3
2007 – 2292	177.7
2293 – 2866	176.3
2867 – 3438	175.1
3439 – 4012	174.1
4013 – 4583	173.1
4584 and over	172.5

From 1st April 2022

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	*Prices per prescription in pence*
Up to 457	224.5
458 – 573	221.3
574 – 689	218.4
690 – 802	215.6
803 – 918	213
919 – 1031	210.8
1032 – 1433	208.5
1434 – 2006	206.6
2007 – 2292	204.8
2293 – 2866	203.2
2867 – 3438	201.8
3439 – 4012	200.6
4013 – 4583	199.5
4584 and over	198.8

PART 3

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

From 1st October 2020

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	*Prices per prescription in pence*
Up to 461	266.9
462 – 577	263.3
578 – 694	260.0
695 – 808	256.8
809 – 925	254.0
926 – 1039	251.3
1040 – 1444	248.7
1445 – 2022	246.5
2023 – 2310	244.4
2311 – 2888	242.6
2889 – 3465	241.0
3466 – 4044	239.7
4045 – 4618	238.5
4619 and over	237.6

From 1st April 2021

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	*Prices per prescription in pence*
Up to 461	240.4
462 – 577	237.1
578 – 694	234.1
695 – 809	231.2
810 – 925	228.7
926 – 1039	226.3
1040 – 1444	224.0
1445 – 2022	222.0
2023 – 2310	220.1
2311 – 2888	218.5
2889 – 3465	217.0
3466 – 4044	215.8
4045 – 4618	214.7
4619 and over	214.0

From 1st October 2021

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	*Prices per prescription in pence*
Up to 457	202.9
458 – 573	200.2
574 – 689	197.6
690 – 802	195.2
803 – 918	193.1

919 – 1031	191
1032 – 1433	189.1
1434 – 2006	187.4
2007 – 2292	185.8
2293 – 2866	184.5
2867 – 3438	183.2
3439 – 4012	182.2
4013 – 4583	181.3
4584 and over	180.6

From 1st April 2022

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	*Prices per prescription in pence*
Up to 457	233.9
458 – 573	230.7
574 – 689	227.8
690 – 802	225
803 – 918	222.5
919 – 1031	220.2
1032 – 1433	217.9
1434 – 2006	216
2007 – 2292	214.2
2293 – 2866	212.6
2867 – 3438	211.2
3439 – 4012	210
4013 – 4583	209
4584 and over	208.2

ANNEX H

Dispensary Services Quality Scheme

Governance of dispensary services

SOPs, clinical audit and risk management

H.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.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.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.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.5 The contractor must ensure that all serious untoward incidents relating to dispensing are reported to the Board for the purpose of reviewing and learning from incidents.

Information

H.6 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.7 The contractor must inform the Board 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.8 The training and experience required in respect of dispensing staff is as follows.

H.9 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.10 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 Board, which should agree that the staff member concerned only has an occasional or limited role in dispensing. However, the contractor also needs to demonstrates that all staff who are working in the dispensary have evidence that they have the knowledge and competencies to perform the tasks and roles assigned to them, and staff who only have an occasional or limited role in dispensing are still required to have a certificate of competency signed by the practice manager (if any) and accountable GP in respect of the roles they occasionally undertake.

H.11 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.12 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.13 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.14 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.15 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.16 Where a dispenser is expected to enrol on a course, the relevant qualification should be completed within three years, although the Board 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.17 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.18 The contractor must assure a level of staffing that reflects that practice's dispensary's configuration and hours of opening, as agreed with the Board.

Duty of confidentiality

H.19 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.20 A review with patients (and, where appropriate, their carers) of compliance and concordance must be carried out, whether remotely or face to face. The review must be recorded in a patient's medical record

at least once in each financial year for at least 10% of the contractor's dispensing patients. Where the contractor is entitled to less than a full year's Dispensary Services Quality Payment in any financial year, the figure of 10% shall be reduced by an appropriate percentage. The practice should agree with the Board the types of patients that should be targeted for the review as part of its undertaking to carry out the services specified.

H.21 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.22 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.23 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 Vaccines and Immunisations

Background

I.1. Guidance and information on routine childhood and adult vaccines and immunisations are set out in "Immunisations against infection diseases – The Green Book" which is published by the Department of Health and Social Care.

I.2. The vaccines and immunisations listed in Tables 1 to 4 below are eligible for an item of service ("IoS") fee of £10.06.

Childhood Routine Immunisation Schedule

I.3. Table 1 lists the childhood routine vaccines and immunisations, which a Contractor should offer routinely to the cohorts of patients identified.

Table 1:

Age	Disease	Vaccine Given	Usual site
Eight weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and hepatitis B	DtaP/IPV/Hib/HepB	Thigh
	Meningococcal group b (MenB)	MenB	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Mouth
Twelve weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and hepatitis B	DtaP/IPV/Hib/HepB	Thigh
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Thigh
	Rotavirus	Rotavirus	Mouth
Sixteen weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and hepatitis B	DtaP/IPV/Hib/HepB	Thigh
	MenB	MenB	Left thigh
One year (on or after the child's first birthday)	Hib and MenC	Hib/MenC (combined vaccine)	Upper arm / thigh
	Pneumococcal	Pneumococcal conjugate vaccine (PCV booster)	Upper arm / thigh
	Measles, Mumps and Rubella	MMR	Upper arm / thigh
	MenB	MenB booster	Left thigh
Three years four months or soon after	Diphtheria, tetanus, pertussis and polio	DtaP/IPV	Upper arm
	Measles, Mumps and Rubella	MMR (check first dose given)	Upper arm
Fourteen years	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Upper arm

I.4. The latest information and guidance on vaccinations and immunisations, and relevant procedures for all the vaccines including completing the schedule of vaccines in the case of children with interrupted, incomplete or 'unknown' immunisation status or in relation to premature infants is contained in the "Immunisation against infectious diseases – The Green Book". Details of the wider UK Health and Security Agency's published routine childhood immunisation schedule are available at https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule.

I.5. Where additional doses of the vaccines specified above are required for medical reasons, the Board must also pay an IoS fee. The Board must also pay an IoS fee for each missed dose where clinically indicated.

Adult Routine Immunisation Schedule

I.6. Table 2 lists the adult routine vaccines and immunisations, which a Contractor should offer routinely to the cohorts of patients identified.

Table 2:

Age	Disease	Vaccine Given
2-64 years (in a clinical at risk group)	Pneumococcal (23 serotypes)	Pneumococcal Polysaccharide Vaccine (PPV)
65 years	Pneumococcal (23 serotypes)	Pneumococcal Polysaccharide Vaccine (PPV)
70 years (routine)	Shingles	Shingles
78-79 year (catch-up)	Shingles	Shingles

Selective Immunisation Schedule

I.7. Table 3 lists the vaccines and immunisations which are only required to be offered by the Contractor where applicable.

Table 3:

Age	Disease	Vaccine Given
At birth, four weeks	Babies born to hepatitis B infected mothers	Hepatitis B (Engerix B/HBvacPRO)
12 months	Babies born to hepatitis B infected mothers	Hepatitis B (Engerix B/HBvacPRO)
Pregnant women from 16 weeks of pregnancy	Pertussis	dTaP/IPV (Boostrix-IPV or Repavax)

Other Vaccination Programmes Schedule

I.8. All other vaccines and immunisations are listed in Table 4 and a Contractor should offer these routinely to the eligible cohorts of patients identified, as required.

Table 4:

Age	Disease	Vaccine Given
14 to 24 years (catch-up, where not administered under the schools programme)	Meningococcal groups A, C, W and Y disease (completing dose)	MenACWY

14 to 24 years (where the individual was eligible to receive the vaccine under routine schools immunisation programme but missed vaccination under the schools programme)	Human papillomavirus (HPV) types 16 and 18 (and genital warts cause by types 6 and 11) (completing dose)	HPV
16 years and over	Measles, Mumps and Rubella (MMR)	MMR

ANNEX J

Amendments to the General Medical Services Statement of Financial Entitlements 2013

(a) The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2013 which were signed on 18th September 2013.

(b) The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2014 which were signed on 28th March 2014.

(c) The General Medical Services Statement of Financial Entitlements (Amendment No. 2) Directions 2014 which were signed on 30 September 2014.

(d) The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2015 which were signed on 23 March 2015.

(e) The General Medical Statement of Financial Entitlements (Amendment No.2) Directions 2015 which were signed on 28th September 2015.

(f) The General Medical Services Statement of Financial Entitlements (Amendment No.3) Directions 2015 which were signed on 6th October 2015.

(g) The General Medical Services Statement of Financial Entitlements (Amendment No.4) Directions 2015 which were signed on 4th December 2015.

(h) The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2016 which were signed on 31st March 2016.

(i) The General Medical Services Statement of Financial Entitlements (Amendment No.2) Directions 2016 which were signed on 9th May 2016.

(j) The General Medical Services Statement of Financial Entitlements (Amendment No.3) Directions 2016 which were signed on 24th November 2016.

(k) The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2017 which were signed on 31st March 2017.

(l) The General Medical Services Statement of Financial Entitlement (Amendment No. 2) Directions which were signed on the 30th October 2017.

(m) The General Medical Services Statement of Financial Entitlements (Amendment) Directions which were signed on 29th March 2018.

(n) The General Medical Services Statement of Financial Entitlements (Amendment No.2) Directions which were signed on the 23rd October 2018.

(o) The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2019 which were signed on 29 March 2019.

(p) The General Medical Services Statement of Financial Entitlements (Amendment No.2) Directions 2019 which were signed on 1st October 2019.

(q) The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2020 which were signed on 26th February 2020.

(r) The General Medical Services Statement of Financial Entitlements (Amendment No. 2) Directions 2020 which were signed on 31st March 2020.

(s) The General Medical Services Statement of Financial Entitlements (Amendment) (No. 3) Directions 2020 which were signed on 30 November 2020.

(t) The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2021 which were signed on 3 March 2021.