SUBORDINATE LEGISLATION

2019 No. 34

THE NATIONAL HEALTH SERVICE (WALES) ACT 2006

Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2019

Made - - - - 30 September 2019

Coming into force in accordance with direction 1(3)

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

Title, application and commencement

1.—(1) The title of these Directions is the Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2019.

(2) These Directions are given to Local Health Boards.

(3) These Directions are made on 30 September 2019 and come into force on 01 October 2019.

Amendments to the Statement of Financial Entitlements

2. The Directions to Local Health Boards as to the Statement of Financial Entitlements Directions 2013(**2**) which came into force on 11 June 2013, as amended by the Directions listed in Annex J at Schedule 5 to these Directions, are further amended.

Amendment to the Table of Contents

3. For the Table of Contents substitute the Table of Contents at Schedule 1.

Amendment of Part 1, Section 2 – Global Sum Payments

4.—(1) In paragraph 2.3, for "From 1 July 2019, the resulting figure which is the contractor's Weighted Population for the quarter, is to be multiplied by £90.00. At the end of July 2019, a backdated Global Sum monthly payment of £3.25 is to be applied per weighted patient for the period from 1 April 2019 to 30 June 2019." substitute "From 1 October 2019, the resulting figure which is the contractor's Weighted Population for the quarter, is to be multiplied by £91.19. At the end of October 2019, a backdated Global Sum monthly payment of £1.19 is to be applied per weighted patient for the period from 1 April 2019 to 30 September 2019."

(**1**) 2006 (c.42).
(**2**) Directions to Local Health Boards as to the Statement of Financial Entitlements Directions 2013 (2013 No.8).

(2) After paragraph 2.15., insert—

"**Contractor Population Index**

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

2.17. On and from 1 October 2020, the value of a QAIF point for QA and QI will be recalculated each year after the NARP has been established and will apply to the current QAIF (QA and QI) year for QA and QI, subject to any uplift that may or may not be applied.

2.18. The revised QAIF point value is to be calculated by multiplying the previous QAIF point value by the fraction produced by dividing the newly established NARP that will apply for the forthcoming QAIF (QA and QI) year by the NARP that applied to the previous QAIF (QA and QI) year. The calculation can be expressed as:

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

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

QAIF Point Value 2019/20

2.19. For 2019/20 the QAIF point value for QAIF QA, QI and Access will be £179.00 and paragraphs 2.17 and 2.18 will not apply."

Insertion of Part 2, Quality Assurance and Improvement Framework

5. After paragraph 3.44 of Section 3: Minimum Practice Income Guarantee, insert—

"PART 2 – QUALITY ASSURANCE AND IMPROVEMENT FRAMEWORK

Section 4: GENERAL PROVISIONS

Background

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

4.2. Participation in the QAIF is voluntary. Information on what is required to accomplish the task or achieve the outcome included in each indicator is set out in Annex D.

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

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

The three principal domains of the QAIF

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

(a) the Quality Assurance ("QA") Domain comprising of two sub-domains

(i) Clinical—

(aa) Active[1], and

(bb) Inactive[2]; and

(ii) Cluster Network[3] ("CN");

(b) the Quality Improvement ("QI") Domain[4]; and

(c) the Access Domain[5].

Types of payments in relation to the QAIF

4.6. There are two types of payments that are made in relation to the QA and QI domains of QAIF: Aspiration Payments (see section 5) and Achievement Payments (see section 6).

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

Aspiration Payments – QA and QI for QAIF (QA and QI) year 1 October 2019 to 30 September 2020

4.8. Aspiration payments will be paid to GMS contractors at 70% of the 2018/19 QOF Achievement Payment, divided into 12 instalments and paid on a monthly basis from 1 October 2019 to 30 September 2020.

Aspiration Payments – QA and QI for QAIF (QA and QI) years from 1 October 2020

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

4.10. Aspiration payments 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 ("the 70% method") based on the Unadjusted Achievement Payment at 30 September of the previous QAIF (QA and QI) year; or

(b) a calculation based on the total number of points that a contractor has agreed with the LHB that it is aspiring to achieve under the QAIF during the QAIF (QA and QI) year in respect of which the Aspiration payment is made ("the Aspiration Points Total method"). The total points agreed with the LHB is the contractor's Aspiration Points Total. The number of points available for particular indicators are set out in the QAIF indicators in Annex D.

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

(a) 1 October of the forthcoming QAIF (QA and QI) year, or

(b) if the contractor's GMS contract takes effect after 1 October in any QAIF (QA and QI) year, no later than the date on which the contractor's GMS contract takes effect.

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1 See paragraphs 4.16-24
2 See paragraphs 4.25-29
3 See paragraph 4.30
4 See paragraphs 4.31-34
5 See paragraphs 4.35-36

Achievement Payments – QA and QI

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

(a) on the 30 September[1] each year, or

(b) the date on which its contract terminates[2],

and this points total will be the contractor's achievement points Total.

4.13. Achievement Payments will be made in respect of all achievement points actually achieved, whether or not the contractor was seeking to achieve those points, but the final amount also takes into account the deduction of the Aspiration Payments that the contractor has received for the period 1 October to 30 September of the same QAIF year.

Calculation of points in respect of the domains

4.14. Each domain contains areas for which there are a number of indicators which are set out in Annex D. These indicators contain standards (tasks or thresholds) against which the performance of a contractor will be assessed. An explanation of these standards and the calculation relating to these standards are set out in paragraphs 4.15 to 4.24.

Calculation common to all domains

4.15. Some of the indicators simply require particular tasks to be accomplished (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 completely. What is required to accomplish these tasks and the evidence the LHB may request is set out in Sections 2 and 4 of Annex D[3].

Calculations in respect of the Clinical Active Sub-domain

4.16. If the disease registers are produced, the point value set for those disease registers is awarded[4]. The indicators for Influenza and Dementia have designated achievement thresholds[5]. The contractor's performance against the standards set out in these indicators is assessed by a percentage (referred to as "Fraction" indicators). Two percentages are set in relation to each indicator—

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

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

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

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

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

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1 Subject to paragraph 6.2

2 See paragraph 6.4

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

4 See Annex D, paragraphs D.19 to D.21.

5 See Annex D, Section 2 – Clinical Sub-Domain Active Registers and Indicators

patients who fall within the meaning of excepted patients (C). The calculation can be expressed as—

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

4.18. For the purposes of paragraph 4.17—

"excepted patients" means patients who fall within the criteria for exception reporting as set out in Annex D, Section 1, paragraphs D.26 – D.33.

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

$$D \times 100 = E$$

4.20. If a contractor has achieved a percentage score in relation to a particular indicator that is the minimum set for that indicator, or is below that minimum, it achieves no points in relation to that indicator.

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

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

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

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

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

General Provisions relating to the inactive indicators of the clinical sub-domain

4.25. The Inactive Clinical indicators can be found at Section 2 of Annex D. The calculation of achievement points for the Inactive Clinical indicators will be based on the full point value.

4.26. The contractor must provide any information which the LHB may reasonably request in relation to the Inactive Clinical indicators for monitoring purposes. Information from GP systems will be made available via the portal.

4.27. The contractor must engage with the national clinical audits that are undertaken in Wales.

Payments in relation to the inactive indicators of the clinical sub-domain

4.28. 4.28 Contractors will be entitled to the full achievement points value and therefore payment in full for the Inactive Clinical indicators.

4.29. 4.29 Points for the Inactive Clinical indicators will be calculated in the same way as for the Active Clinical indicators[1].

General Provisions relating to the Cluster Network Domain

4.30. The Cluster Network Engagement indicators can be found at Section 3 of Annex D. Within the Cluster Network domain, 200 points are available with the focus on outputs on a network/cluster basis. Achievement payments for the Cluster Network sub-domain will be calculated in accordance with section 6, paragraphs 6.11-18.

General Provisions relating to the Quality Improvement Domain

4.31. The QI domain is based on a "basket" of quality improvement projects to be delivered at a cluster level. The detail can be found at Section 4 of Annex D. The basket of projects available during the 2019/20 QAIF cycle are—

(a) Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the cluster population.

(b) Reducing stroke risk through improved management of Atrial Fibrillation for the cluster population.

(c) Ceilings of care / Advanced Care planning.

(d) Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20.

4.32. The cluster of which a contractor is a part of must agree which 2 QI projects they will implement at cluster level for the 2019-20 QAIF (QA and QI) year.

4.33. The Patient Safety Programme for the 2019-20 year is mandatory and so the cluster of which a contractor is part of must choose one other project from b, c, d set out in paragraph 4.31 above.

4.34. In QAIF (QA and QI) year 2019/2020 a total of 60 points will be available for contractors who undertake QI training.

General Provisions relating to the Access Domain

4.35. There are two groups of access standards within the Access Domain. Group 1 contains five standards and Group 2 contains three standards. Contractors will be paid annually for the standards completed during a QAIF (Access) year. Contractors are expected to achieve all eight of the standards by 31 March 2021. The standards can be found at Section 5 of Annex D.

4.36. Achievement Payments will be calculated in accordance with paragraphs 6.8 to 6.10.

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

Aspiration Payments – QA and QI 1 October 2019 to 30 September 2020

5.1. Aspiration Payments will be paid to GMS contractors at 70% of the 2018/19 QOF Achievement Payment and will be divided into 12 instalments and paid on a monthly basis from 1 October 2019 to 30 September 2020.

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1 See paragraphs 4.16– 4.24

Calculation of Monthly Aspiration Payments QA and QI each QAIF (QA and QI) year commencing 1 October 2020: General

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

5.3. As indicated in paragraph 4.10 above, there are two methods by which a contractor's Monthly Aspiration Payments may be calculated. Each contractor may choose the method by which its Monthly Aspiration Payments are calculated, if it is possible to calculate Monthly Aspiration Payments in respect of the contractor by both methods. However—

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

(b) if the contractor's GMS contract is to take effect on or after 2 August but before 1st October in the same calendar year, no Aspiration Points Total is to be agreed for the QAIF (QA and QI) year into which that 2 August falls, so the contractor will not be able to claim Monthly Aspiration Payments in that QAIF (QA and QI) year. However, the contractor will nevertheless be entitled to Achievement Payments under the QAIF if that contractor participates in the QAIF.

Calculation of Monthly Aspiration Payments QA and QI each QAIF (QA and QI) year commencing 1 October 2020: the 70% method

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

(a) the contractor's GMS contract took effect before the 1 October of a QAIF (QA and QI) year in respect of which the claim for Monthly Aspiration Payments is made; and

(b) in respect of the previous QAIF (QA and QI) year the contractor was entitled to an Achievement Payment under this SFE.

5.5. To calculate a contractor's Monthly Aspiration Payments by the 70% method, the contractor's Unadjusted Achievement Payment for the previous QAIF (QA and QI) year needs to be established (that is, the total established in accordance with Section 6 of this SFE). Generally, this will not be possible in the first quarter of the QAIF (QA and QI) year, and so a Provisional Unadjusted Achievement Payment will need to be established by the LHB. The amount of this payment is to be based on the contractor's return submitted in accordance with paragraph 6.6 and 6.7 (returns in respect of Achievement Payments) of this SFE.

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

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

(a) the amount set out in paragraph 6.14 as the value of each Achievement Point for the QAIF (QA and QI) year in respect of which the claim for Monthly Aspiration Payments is being made, by

(b) the amount which was previously set out in paragraph 6.14 as the value of each achievement point for the previous QAIF (QA and QI) year,

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

5.8. The total produced by paragraph 5.7 is then to be multiplied by 70%. This figure is then further multiplied by the figure which is the product of the maximum number of points available under the QAIF for the QAIF (QA and QI) year in respect of which the calculation is being made divided by the maximum number of points available under the QAIF (QA and QI) in the previous QAIF (QA and QI) year.

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

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

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

Calculation of Monthly Aspiration Payments QA and QI each QAIF year commencing 1 October 2020: the Aspiration Points Total method

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

5.13. If the contractor is to have its Monthly Aspiration Payments calculated by this method, at the start of each QAIF (QA and QI) year – or if a GMS contract starts after the start of the QAIF (QA and QI) year, on the date on which the GMS contract takes effect – an Aspiration Points Total is to be agreed between the contractor and the LHB. As indicated in paragraph 4.10(b) above, an Aspiration Points Total is the total number of points that the contractor has agreed with the LHB that it is aspiring towards under the QAIF (QA and QI) during the QAIF (QA and QI) year in respect of which the Aspiration Payment is made.

5.14. If the LHB and the contractor have agreed an Aspiration Points Total for the contractor, that total is to be divided by three. The resulting figure is to be multiplied by £179.00 and then by the contractor's CPI, which produces the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to paragraph 6.19 (recovery where Aspiration Payments have been too high), is to be the

contractor's Monthly Aspiration Payment, as calculated by the Aspiration Points Total method.

Payment arrangements for Monthly Aspiration Payments QA and QI each QAIF year commencing 1 October 2020

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

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

(a) the number of days during the month in which the contractor was participating in the QAIF (QA and QI) year, by

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

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

Conditions attached to Monthly Aspiration Payments

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

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

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

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

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

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

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

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

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

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

Basis of Achievement Payments

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

(a) QA and QI during the QAIF (QA and QI) year (1 October to 30 September), and

(b) Access during each financial year (1 April to 31 March),

as calculated in accordance with this Section and Section 4.

Assessment of Achievement Payments

6.2. Subject to paragraph 6.4, the date in respect of which the assessment of achievement points is to be made is—

(a) 30 September for QA and QI; or

(b) the last day of the financial year for Access.

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

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

6.4. In a case where a GMS contract terminates prior to 30 September during a QAIF (QA and QI) year, the assessment of the achievement points to which the contractor is entitled is to be made in respect of the last date in the QAIF (QA and QI) year on which that contractor is required under the contractor's GMS contract to provide essential services.

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

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

Returns in respect of Achievement Payments

6.6. In order to make a claim for an Achievement Payment, a contractor must make a return in respect of the information required by the LHB in order for the LHB to calculate the contractor's Achievement Payment. Where a GMS contract terminates before 30 September during a QAIF (QA and QI) year, or before the end of the financial year for QAIF Access, a contractor may make a return at the time the contract terminates in respect of the information necessary to calculate the Achievement Payment to which the contractor is entitled in respect of that QAIF (QA and QI) year or financial year.

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

Calculation of Achievement Payments for QAIF Access 2019/20

6.8. All achievement points gained by the contractor under the Access Domain are to be multiplied by £179.00.

6.9. The cash total produced under paragraph 6.8 will be multiplied by the contractor's CPI as at—

(a) 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, the date its GMS contract takes effect; or

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

Calculation of Achievement Payments for QAIF Access 2020/21 and future financial years

6.10. The QAIF Access points value for Achievement Payments will made at the QAIF (QA and QI) point value calculated for QAIF (QA and QI) year in which the QAIF Access year ends and for QAIF (QA and QI) year 2020/21, using the contractor's registered patient list size at 1 January 2020 and again at 1 January 2021 against the mean average of contractor registered patients also taken at 1 January 2020 and again at 1 January 2021.

Calculation of Achievement Payments for QAIF (QA and QI)

6.11. For the Achievement Payment that relates to the Clinical Active and Inactive Sub-domains, (other than the palliative care indicator), where there is a disease register in respect of an indicator, 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 £179.00 and by the contractor's achievement points Total in respect of the disease area to produce a cash amount for that disease area. Then the cash totals in respect of all the individual disease areas in the domain are to be added together to give the cash total in respect of the domain.

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

6.13. The part of the Achievement Payment that relates to the palliative care indicator in the clinical inactive sub-domain must be calculated by multiplying the total number of achievement points gained by the contractor by £179.00.

6.14. For all of the other achievement points gained by the contractor under the Clinical Active sub-domain, the Cluster Network sub-domain and the QI domain, the total number of achievement points is to be multiplied by £179.00.

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

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

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

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

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

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

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

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

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

Recovery where Aspiration Payments have been too high

6.19. If the resulting amount from the calculation under paragraph 6.18 is a negative amount, that negative amount, expressed as a positive amount ("the paragraph 6.18 amount"), is to be recovered by the LHB from the contractor in one of two ways—

(a) to the extent that it is possible to do so, the paragraph 6.18 amount is to be recovered by deducting one twelfth of that amount from each of the contractor's Monthly Aspiration Payments for the QAIF (QA and QI) year after the QAIF (QA and QI) year to which the paragraph 6.10 amount relates. In these circumstances—

(i) the gross amount of the contractor's Monthly Aspiration Payments for accounting and superannuation purposes in the QAIF (QA and QI) year after the QAIF (QA and QI) year to which the paragraph 6.18 amount relates is to be the amount to which the contractor is otherwise entitled under paragraphs 5.4 to 5.11 or paragraph 5.12 to 5.14, and

(ii) the paragraph 6.18 amount is to be treated for accounting and superannuation purposes as an overpayment in respect of the contractor's Monthly Aspiration Payments for the QAIF (QA and QI) year to which the paragraph 6.17 amount relates; or

(b) if it is not possible to recover all or part of the paragraph 6.18 amount by the method described in sub paragraph (a) (for example, because of the termination of the GMS contract after a partnership split), the amount that cannot be so recovered is to be treated as an overpayment in respect of the contractor's Monthly Aspiration Payments for the QAIF (QA and QI) year to which the paragraph 6.17 amount relates, and is to be recovered accordingly (i.e. in accordance with paragraph 19.1).

Accounting arrangements and due date for Achievement Payments

6.20. The contractor's Achievement Payment, as calculated in accordance with paragraph 6.18 is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year into which the date in respect of which the assessment of achievement points on which the Achievement Payment is based ("the relevant date") falls and the Achievement Payment is to fall due –

(a) where the GMS contract terminates before the end of the financial year into which the relevant date falls (see paragraph 6.4 and 6.5), at the end of the quarter after the quarter during which the GMS contract was terminated, and

(b) in the case of achievement payments for Access, at the end of the first quarter of the financial year after the financial year into which the relevant date falls (see paragraph 6.2). and

(c) in the case of achievement payments for QAIF (QA and QI), at the end of the first quarter of the QAIF (QA and QI) year after the QAIF (QA and QI) year into which the relevant date falls (see paragraph 6.2).

Conditions attached to Achievement Payments

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

(a) the contractor must make the return required of it under paragraph 6.6;

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

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

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

(e) the contractor must engage with the national clinical audits that are undertaken in Wales.

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

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

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

Amendment of Part 3, Section 7 - Childhood Immunisations

6. After paragraph 7.20, insert—

"**7.20A** Paragraph 7.20 applies from 1 July 2019.".

Amendment of Part 4, Section 15 – Seniority Payments

7. Under the heading "General", after paragraph 15.1 insert—

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

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

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

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

15.1E GPs currently within the Seniority Payment Scheme who move to a different practice in Wales and do not migrate to the Partnership Premium Scheme can remain within the Seniority Payment Scheme.

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

(a) not in the Seniority Payment Scheme; or

(b) in the Seniority Payment Scheme but joins the Partnership Premium Scheme.".

Insertion of Section 15A – The Partnership Premium Scheme

8. After Section 15 insert—

"Section 15A: THE PARTNERSHIP PREMIUM SCHEME

General

15A.1. The Partnership Premium Scheme (PPS) is available in relation to all GP providers who are partners in a partnership that holds a GMS Contract (each such partner being a "GP Partner" in this Section 15A), irrespective of length of service. The amount of partnership premium payable is linked to the GP Partner's average sessional commitment and not the number of contracts a partnership holds. Where a GP Partner holds more than one contract and undertakes clinical sessions under each contract, the GP Partner must notify the LHB of every such contract. Each clinical session will, for PPS purposes, count towards the contract under which it was undertaken and the Partnership Premium payment will be split between those contractors based on the average number of clinical sessions undertaken for each contract.

15A.2. The PPS will provide an annual payment, in relation to each GP Partner in Wales who opts to participate in the scheme, based on the number of clinical sessions performed by the GP Partner per week on average over the financial year. The level of the annual payment will be £1,000 multiplied by their average number of clinical sessions per week (up to a maximum of 8 sessions per week or £8,000 per annum).

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

(a) is in receipt of Partnership Premium, and

(b) has 16 years or more Reckonable Service as a GP performer (calculated in accordance with paragraphs 15.3 to 15.9 of this SFE),

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

Clinical Session

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

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

15A.6. When calculating a GP Partner's average number of clinical sessions per week, any more than 2 sessions a day, or 8 sessions a week, will not be counted for PPS purposes.

Annual Leave

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

Sickness Absence

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

(a) actually and necessarily engages a locum or a salaried GP on a fixed term contract; or

(b) uses the services of a GP performer—

(i) who is a party to the contract, or

(ii) who is already employed or engaged by the contractor (or more than one such person)

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

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

Maternity, Paternity, Adoption and Shared Parental Leave

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

Data

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

Payments

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

15A.13. The payment will be made on a pro rata basis according to the GP Partner's average number of clinical sessions per week for the quarter (subject to the maximum thresholds in section 15A.6 above). Subject to section 15A.16(a) below, the maximum payment in relation to a GP Partner per quarter shall therefore be £2,000 (or £2,400 where the senior premium applies). Payments will be made as follows—

— Quarter 1 – June

Quarter 2 – September

Quarter 3 – December

Quarter 4 – March

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

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

Condition attached to payment of Quarterly Partnership Premium Payments

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

(a) if a GP Partner receives a PPS Payment from more than one contractor, those payments taken together must not amount to more than £8,000 (or (£9,600 where the senior premium applies) per annum or £2,000 (or £2,400 where the senior premium applies) per quarter;

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

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

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

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

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

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

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

Amendment of Annex A, Part 1 Acronyms

9.—(1) In Annex A – Glossary, Part 1 – Acronyms, in the list—

(a) after the acronym "MPIG" insert—

"NARP – National Average of Registered Patients";

(b) after the acronym ""NHSPD" insert—

"PPS – Partnership Premium Scheme";

(c) after the acronym "PSMP" insert—

"QA – Quality Assurance

QAIF – Quality Assurance and improvement Framework contained in Annex D

QI – Quality Improvement".

Amendment of Annex A, Part 2 Definitions

10.—(1) In Annex A, Part 2 – Definitions, for the definition—

(a) "Aspiration Points Total" substitute—

""Aspiration Points Total" is to be construed in accordance with paragraph 4.10(b) and 5.12;",

(b) "Adjusted Practice Disease Factor" substitute—

""Adjusted Practice Disease Factor" is to be construed in accordance with paragraph 6.11, 6.12 and Annex F;",

(c) "Monthly Aspiration Payment" substitute—

""Monthly Aspiration Payment" is to be construed in accordance with paragraph 5.7 and 5.12;",

(d) "The National Average of Registered Patients (NARP)" substitute—

""National Average of Registered Patients" means the aggregate CRP of contractors in Wales, as calculated using the number of patients recorded on the Primary Care Registration System administered by NHS Digital as being registered with contractors on the 1 July, divided by the number of contractors on 30 September, in the QAIF (QA and QI) year immediately before the commencement of the QAIF year (QA and QI) to which the relevant payment relates.",

(e) "Provisional Unadjusted Achievement Payment" substitute—

""Provisional Unadjusted Achievement Payment" is to be construed in accordance with 5.5 and 5.6;",

(f) "Unadjusted Achievement Payment" substitute—

""Unadjusted Achievement Payment" is to be construed in accordance with paragraph 5.5;".

(2) After the definition for "Provisional Unadjusted Achievement Payment" insert—

""QAIF (QA and QI) year" means the period 1 October to 30 September of any relevant year;

"QAIF (QA and QI) Uprating Index" is to be construed in accordance with paragraph 5.7;

"QAIF (Access) year" means the period 1 April to 31 March of any relevant year;

"QAIF point value" is to be construed in accordance with paragraphs 2.17 and 2.19;".

(3) Omit the definition "Quality and Outcomes Framework".

(4) Omit the definition "Quality and Outcomes Framework Uprating Index".

Insertion of Annex D - Quality Assurance and Improvement Framework

11. After Annex C – Temporary Patients Adjustment insert Annex D attached at Schedule 2 to these Directions.

Insertion of Annex F – Adjusted Practice Disease Factor Calculations

12. Insert Annex F attached at Schedule 3 to these Directions.

Amendment of Part 2, Annex G – Dispensing Payments

13. In Part 2 of Annex G (dispensing fee scale for contractors that are authorised or required to provide dispensing services)—

(1) For the words "To apply from 1 April 2019" substitute "To apply from 1 October 2019 up to and including 31 March 2020"; and

(2) For the Table substitute—

"Total prescriptions calculated separately for each individual dispensing practitioner, in bands	Prices per prescription in pence
Up to 456	198.5
457 - 570	195.7
571 - 686	193.1
687 - 799	190.7
800 - 914	188.4
915 - 1027	186.4
1028 - 1427	184.4
1428 - 1999	182.7
2000 - 2284	181.1
2285 - 2855	179.7
2856 - 3425	178.5
3426 - 3997	177.4
3998 - 4565	176.5
4566 and over	175.8

To apply from 1 April 2020

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	Prices per prescription in pence
Up to 456	221.0
457 - 570	217.9
571 - 686	215.0
687 - 799	212.3

800 - 914	209.7
915 - 1027	207.5
1028 - 1427	205.3
1428 - 1999	203.4
2000 - 2284	201.6
2285 - 2855	200.0
2856 - 3425	198.7
3426 - 3997	197.5
3998 - 4565	196.5
4566 and over	195.7”

Amendment to Part 3 of Annex G – Dispensing Payments

14. In Part 3 of Annex G (dispensing fee scale for contractors that are not authorised or required to provide dispending services)—

(1) For the words “To apply from 1 April 2019” substitute “To apply from 1 October 2019 up to and including 31 March 2020”; and

(2) For the Table substitute—

“Total prescriptions calculated separately for each individual dispensing practitioner, in bands	Prices per prescription in pence
Up to 456	206.9
457 - 570	204.0
571 - 686	201.5
687 - 799	199.0
800 - 914	196.8
915 - 1027	194.7
1028 - 1427	192.7
1428 - 1999	191.0
2000 - 2284	189.4
2285 - 2855	188.0
2856 - 3425	186.8
3426 - 3997	185.7
3998 - 4565	184.8
4566 and over	184.1

To apply from 1 April 2020

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	Prices per prescription in pence
Up to 456	230.3
457 - 570	227.1
571 - 686	224.3
687 - 799	221.5
800 - 914	219.1
915 - 1027	216.8
1028 - 1427	214.6
1428 - 1999	212.7
2000 - 2284	210.9
2285 - 2855	209.3
2856 - 3425	207.9
3426 - 3997	206.8
3998 - 4565	205.7
4566 and over	205.0”

Amendment of Annex I - Routine childhood vaccines and immunisations

15. For Annex I substitute Annex I attached at Schedule 4 to these Directions.

Amendment of Annex J – Amendments

16. For Annex J substitute Annex J attached at Schedule 5 to these Directions.

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

Date: 30 September 2019

SCHEDULE 1

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SCHEDULE 2

ANNEX D

QUALITY ASSURANCE AND IMPROVEMENT FRAMEWORK

Part 1: Introduction

General

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

D.2 The QAIF consists of three domains; **Quality Assurance (QA)**, **Quality Improvement (QI)** and the new domain of **Access**.

Quality Assurance (QA)

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

D.4 The clinical indicators for 2019-20 consist of **active** and **inactive** indicators, a concept retained from the Quality and Outcomes Framework (QOF) in 2018-19. This will allow Welsh Government and LHBs to look further at the data behind the inactive indicators during the QAIF (QA and QI) year and to evaluate activity.

D.5 **Clinical active** indicators are made up of the disease registers, the two flu indicators FLU001W and FLU002W, and the dementia indicator DEM002. These active clinical indicators account for 81 points.

D.6 **Clinical inactive** indicators are made up of a further ten clinical indicators. They will be reported on for 2019-20 QAIF cycle and paid at full point value (101 points). All other clinical indicators from the former QOF have been retired.

D.7 The total points available for clinical indicators under QA is 182.

D.8 **Cluster network** under QA enables the maintenance of a clear link between activity and financial reward through reformed cluster output/activity indicators related to engagement (5 meetings equals 40 points), contributing information to cluster IMTPs due for completion by September each year (80 points) and the delivery of outcomes for relevant services (80 points).

D.9 The total points for cluster network under QA is 200.

Quality Improvement (QI)

D.10 The QI domain is based on QI projects the practice will complete.

D.11 In 2019/20, GP providers will undertake the mandatory Patient Safety Project plus another project from the basket of QI projects. To assist in the QI activity, practices will be rewarded for completing an accredited QI training course.

D.12 In 2020/21, GP providers will undertake a new mandatory patient safety project plus two projects from the basket of QI projects.

D.13 The total points available for the QI domain is 185.

Access

D.14 The Access domain is based on the Access to In-Hours GMS Services Standards announced by the Minister for Health and Social Services on 20 March 2019. Underpinned by clear measurable expected achievements by March 2021, these standards are the subject of a national delivery milestone for the Primary Care Model for Wales; the standards set clear requirements on GP providers in terms of expectations relating to access including an increased digital offering.

D.15 The standards have been separated into two groups. Each Access Standard is a QAIF indicator; they have been grouped as follows:

Group 1

Less than 3 standards = no payment (0 points)

3 standards = 60% payment (30 points)

4 standards = 80% payment (40 points)

All standards in Group 1 = 100% payment (50 points)

Group 2

GP providers will be required to undertake all three standards in order to receive payment (50 points total).

Quality Payment

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

D.16 The total points available for the Access domain is 125.

General information on the Quality Assurance Clinical Domain

D.17 Indicators have been prefixed by an abbreviation of the category to which they belong, as per their description under the QOF scheme. For the purposes of calculating Achievement Payments, contractor achievement against QAIF (QA) indicators is measured on a cycle of:

(a) 1st October to 30th September.

(b) in cases where a GMS contract terminates mid- QAIF (QA and QI) year, the last day on which the contract subsists.

D.18 In the case of a GMS contract that has come to an end before 30 September in any QAIF (QA and QI) year, the reference to periods of time are still calculated on the basis that the period ends on 30 September in the QAIF (QA and QI) year to which the achievement payment relates. The SFE sets out the rules that apply to measuring achievement for contracts that end before the end of the QAIF (QA and QI) achievement year.

Disease registers

D.19 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 health board may also compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations.

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

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

Verification

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

Business rules

D.23 The Dataset and Business Rules that support the reporting requirements of the QAIF are based on Read codes (version 2 and Clinical Terms Version 3) and associated dates. Read codes are an NHS standard. Contractors using proprietary coding systems and/or local/practice specific codes will need to be aware that these codes will not be recognised within QAIF reporting. Contractors utilising such systems may need to develop strategies to ensure that they are using appropriate Read codes in advance of producing their achievement report. During 2019/20 NHS Wales expect to move to SNOMED clinical terms as the NHS standard for coding, in line with the NHS in the rest of the UK.

Exception reporting

D.24 Exception reporting applies to those indicators in the clinical domain of QAIF QA where the achievement is determined by the percentage of patients receiving the specified level of care.

D.25 "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Patients are removed from the denominator and numerator for an indicator if they have been both excepted **and** they have not received the care specified in the indicator wording. If the patient has been excepted, but the care has subsequently been carried out within the relevant time period, the patient will be included in both the denominator and the numerator, i.e. achievement will always override an exception.

Exception reporting criteria

D.26 Patients may be excepted if they meet the following criteria for exception reporting:

(a) Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the QAIF (QA and QI) year to which the achievement payments relate.

(b) Disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail.

(c) Patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards

(d) Where a patient does not agree to treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.

(e) Where the patient has a supervening condition which makes treatment of their condition inappropriate.

D.27 Contractors should report the number of exceptions for each indicator set and individual indicator. Contractors will not be expected to report why individual patients were exception reported. However, contractors may be called on to explain why they have 'excepted' patients from an indicator and contractors must ensure the reasons are identifiable in the patient record.

Principles

D.28 The overriding principles to follow in the decision to except a patient are:

(a) A duty of care remains for all patients, irrespective of exception reporting arrangements.

(b) It is good practice for clinicians to review from time to time those patients who are excepted from treatment, e.g. to have continuing knowledge of health status and personal health goals.

(c) The decision to exception report should be based on clinical judgement, relevant to the patient, with clear and auditable reasons coded or entered in free text on the patient record.

(d) There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

D.29 In each case where a patient is exception reported, in addition to recording what should be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the clinical reason for the exception is fully recorded in a way that can facilitate an audit in the patient record. This is both in order to manage the care of that particular patient and for the purpose of verification.

D.30 Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. For the purposes of managing the care of the patient and for subsequent audit and verification, it is important that the reason the patient meets one or more of the exception reporting criteria and any underlying clinical reason for this is recorded in the patient's clinical record.

D.31 Invitations to attend a review should be made to the individual patient and can be in writing or by telephone. This can include a note at the foot of the patient's prescription requesting that they attend for review.

D.32 The three invitations need to have taken place within the QAIF (QA and QI) year in question. There should be three separate invitations at three unique periods of time. The telephone call invitation may lead to the application of exception criteria 'informed dissent' if the patient refuses to take up the invitation to attend.

D.33 The following are examples that are not acceptable as an invitation:

(a) A generic invitation on the right hand side of the script to attend a clinic or an appointment e.g. influenza immunisation.

(b) A notice in the waiting room inviting particular groups of patient to attend clinics or make appointments (e.g. influenza immunisation).

Guidance

D.34 Further information on QAIF can be accessed via the following links –

http://www.wales.nhs.uk/sites3/Documents/480/Guidance%20for%20GMS%20Contract%20Wales%20-%20Quality%20and%20Improvement%20Framework%202019-20.pdf

http://www.wales.nhs.uk/sites3/Documents/480/Guidance%20for%20the%20GMS%20Contract%20Wales%20-%20Access%20to%20In-Hours%20GMS%20Services%202019-20%20%28vA54536518%29.pdf

Part 2: Clinical Sub-Domain Active and Inactive Registers and Indicators

Clinical Sub-Domain Active Registers and Indicators

Atrial fibrillation (AF)

Indicator	Points
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	2

Secondary prevention of coronary heart disease (CHD)

Indicator	Points
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	2

Heart failure (HF)

Indicator	Points
HF001. The contractor establishes and maintains a register of patients with heart failure	2

Hypertension (HYP)

Indicator	Points
HYP001. The contractor establishes and maintains a register of patients with established hypertension	2

Stroke and transient ischaemic attack (STIA)

Indicator	Points
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2

Diabetes mellitus (DM)

Indicator	Points
DM001. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	2

Asthma (AST)

Indicator	Points
AST001. The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	2

Chronic Obstructive Pulmonary Disease (COPD)

Indicator	Points
COPD001. The contractor establishes and maintains a register of patients with COPD	2

Dementia (DEM)

Indicator	Points
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	2

Mental Health (MH)

Indicator	Points
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	2

Cancer (CAN)

Indicator	Points
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'	2

Epilepsy (EP)

Indicator	Points
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
LD001. The contractor establishes and maintains a register of patients with learning disabilities	2

Osteoporosis: secondary prevention of fragility fractures

Indicator	Points
OST001. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012	2

Rheumatoid Arthritis (RA)

Indicator	Points
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1

Palliative Care (PC)

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

Obesity (OB)

Indicator	Points
OB001. The contractor establishes and maintains a register of patients aged 16 or over with a BMI of 30 in the preceding 15 months.	2

Influenza (FLU)

Indicator	Points	Threshold
FLU001W. The percentage of the registered population aged 65 years of more who have had influenza immunisation in the preceding 1 August to 31 March	5	55-75%
FLU002W. The percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March	15	45-65%

Dementia (DEM)

Indicator	Points	Threshold
DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face to face review in the preceding 15 months.	28	55-75%

Total Clinical Sub-Domain Active QAIF Points	**81**

Clinical Sub-Domain Inactive Indicators

Atrial Fibrillation (AF)

Indicator	Points
AF006. The percentage of patient with atrial fibrillation in whom stroke risk has been assessed using CHA2DS2-VASx score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more) and a record of counselling regarding the risks and benefits of anticoagulation therapy has been made	12
AF007. In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy.	12

Diabetes Mellitus (DM)

Indicator	Points
DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	8
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less	10
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months	17
DM012 The percentage of patients with diabetes , on the register , with a record of a foot examination and risk classification; 1) low risk (normal sensation, palpable pulse) , 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months	4
DM014 The percentage of patients newly diagnoses 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	11

Chronic Obstructive Pulmonary Disease (COPD)

Indicator	Points
COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months	9

Mental Health (MH)

Indicator	Points
MH011W. The percentage of patients with Schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure, BMI, smoking status and alcohol consumption in the preceding 15 months and in addition to those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 months.	12

Palliative Care (PC)

Indicator	Points
PC002W. The contractor has regular (at least 2 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed	6

Total Clinical Sub-Domain Inactive QAIF Points	**101**

Part 3: Clusters Network Engagement

Indicator	Points
CND014W –. The GP Cluster Network will meet on 5 occasions during the year; the timing of meetings should be agreed around the planning of the HB and ideally, to avoid the period of winter pressure.	**40**
CND015W Contributing relevant cluster information to the Primary Care Cluster IMTP which will include information on the demand and capacity tool and also the workforce development plan.	**80**
CND016W Delivering specific cluster determined outcomes which includes engagement in planning of local initiatives, Completion of the 2 Quality Improvement initiatives at a cluster level where agreed by the GMS practices (as per section 4). Active participation as evidence of operating an effective system of clinical governance (quality assurance) in the practice e.g. through completion of CGSAT and IG toolkit.	**80**

Part 4: Quality Improvement (QI)

Overview

4.1 The QI domain is based on the introduction of a "basket" of quality improvement projects which are to be delivered at cluster level. The basket of projects available for 2019-20 will be:

(c) Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the cluster population.

(d) Reducing stroke risk through improved management of Atrial Fibrillation for the cluster population.

(e) Ceilings of care / Advanced Care planning.

(f) Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20

GMS contractors will be required to agree at cluster level and implement two QI projects in 2019-20:

(i) Patient Safety Programme – mandatory

(ii) Quality Improvement – choice from b, c, d set out above

Further details on each of the projects are detailed at http://www.wales.nhs.uk/sites3/Documents/480/Guidance%20for%20GMS%20Contract%20Wales%20-%20Quality%20and%20Improvement%20Framework%202019-20.pdf

QI Training

4.2 To enable GP providers to develop their approach to quality improvement, the health board will also act in a supportive role, with a focus on quality improvement and development.

The Bronze IQT packages are available for all GP providers, and can be accessed through Public Health Wales and the '1000 Lives Improvement' initiative, which supports the development of the programme for primary care by providing guidance, training and advice for local, regional and national health teams across Wales.

Further information on how to access the IQT programme is available from a designated IQT facilitator within each health board.
http://www.1000livesplus.wales.nhs.uk/primary-care/

https://learning.wales.nhs.uk

The Royal College of General Practitioners (RCGP) also offers the innovative online tool *QI Ready*. *QI Ready* prepares and supports GPs and practice staff to carry out QI activities in their practice. The tool is comprised of an online learning network, which contains complex case studies, a self-accreditation system and QI e-learning modules.

RCGP Wales has three faculties that host educational courses and networking events throughout the regions and North, South West and South East Wales. Many of these events contribute to CPD and professional development. Each health board has an RCGP advocate to promote the values of professional GP practice, and to highlight the resources available through the UK College.

4.3 Points available in the Quality Improvement domain

- Patient safety project = 65
- QI project 1 = 60
- QI training (year 1 only) = 60

Total = 185

Part 5: Access

Access Standards

Indicator	Points
Group 1 1. Appropriate telephony and call handling systems are in place which support the needs of callers and avoids the need for people to call back multiple times. Systems also provide analysis data to the practice. A planned two year programme of implementation of appropriate systems resulting in: • A practice has a recording function for incoming and outgoing lines. • A practice has the ability to stack calls and are utilising this fully. • A practice can interrogate their phone systems and analyse the data provided. 2. People receive a prompt response to their contact with a practice via telephone. • 90% of calls are answered within 2 minutes of the recorded message ending. • Less than 20% of calls are abandoned (REPORTED BUT NOT MONITORED) • Data to be taken from analysis capability of telephony system. 3. A practice has a recorded bilingual introductory message in place, which includes signposting to other local services and to emergency services for clearly identified life threatening conditions. • A practice has a recorded bilingual introductory message that usually lasts no longer than 2 minutes. (A national standardised message will be developed with the option of local development). 4. A practice has in place appropriate and accessible alternative methods of contact, including digital solutions such as SMS text messaging and email, as well as face-to-face. • By end of March 2021: • 25% of all pre-bookable appointments are bookable through a digital solution (e.g. MHOL). This includes appointments with other healthcare professionals. • A practice offers access to repeat prescriptions through a digital solution (e.g. MHOL). • A practice offers care homes access to repeat prescription ordering	Less than 3 Standards = 0 3 Standards = 30 4 Standards = 40 5 Standards = 50

service through a digital solution. 5. People are able to request a non-urgent consultation, including the option of a call back via email, subject to the necessary national governance arrangements being in place. • A practice is contactable via email for patients to request non-urgent appointments or prescriptions. • A practice has in place the necessary governance arrangements for this process, which could include standardised and bilingual auto-responses.	
Group 2 6. People are able to access information on the different ways of requesting a consultation with a GP and other healthcare professionals. Practices will display information relating to these standards. • A practices displays information on requesting a consultation in the surgery, in practice leaflets and on the practice website. • A practice publicises how people can request a consultation (urgent and routine). • A practice displays information on standards of access. 7. People receive a timely, co-ordinated and clinically appropriate response to their needs. • Appropriate triaging (with relevant training undertaken) and appointment systems in place: • All children under 16 years of age with acute presentations are offered a same-day consultation. • URGENT – people who are clinically triaged as requiring an urgent assessment are offered a same day consultation (could be face to face, telephone, video call or a home visit). • PRE-BOOKABLE – the offer of a pre-bookable consultation must be available and should routinely be within 2-3 weeks. However, it could be available up to 6 weeks in advance. • Active signposting for appropriate queries to alternative cluster based services, health board-wide and national services. 8. All practices have a clear understanding of patient needs and demands within their practice and how these can be met. • An annual audit and subsequent plan to be discussed at cluster level and submitted to the health board.	Less than 3 Standards = 0 3 Standards = 50

• Annual participation in the All Wales Patient Survey and reflection on findings. Discussion on findings and subsequent action plans to be held at a cluster level and shared with the health board. • A practice to undertake a demand and capacity audit on an annual basis. Findings are then to be considered. These will support the identification of how extended roles could support the delivery of care. • A practice participates in the annual All Wales Patient Survey and consider and act upon the findings.	
Achievement Quality Payment A bonus of 25 points will be awarded to a contractor for achievement of all Group 1 and Group 2 standards	25

SCHEDULE 3

ANNEX F

ADJUSTED PRACTICE DISEASE FACTOR CALCULATIONS

ADJUSTED PRACTICE DISEASE FACTOR

Calculations

F.1 The calculation involves three steps—

(a) the calculation of the contractor's Raw Practice Disease Prevalence. There will be a Raw Practice Disease Prevalence in respect of each indicator in the active and inactive clinical domains other than the indicator for palliative care;

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

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

F.2 The above three steps are explained below. The register to be used to calculate the Raw Practice Disease Prevalence is the register 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. 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, a register in respect of that specific disease area or indicator should be maintained based on the indicator specified in the relevant part of Section 2 relating to that disease.

F.3 The Raw Practice Disease Prevalence is calculated by dividing the number of patients on the relevant disease register at 30th September in the QAIF (QA and QI) year to which the Achievement Payment relates by the contractor's CRP for the relevant date. For these purposes, the "Relevant date" is the date in respect of which the value of the contractor's CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the QAIF (QA and QI) year to which the Achievement Payment relates, but see paragraph 6.16 (calculation of Achievement Payments).

F.4.1 The Adjusted Practice Disease Factor is calculated by—

(a) the calculation of the contractor's Raw Practice Disease Prevalence. There will be a Raw Practice Disease Prevalence in respect of each indicator in the active and inactive clinical QA domains (other than the indicator for palliative care);

(b) dividing the contractor figures around the new national Welsh mean (available at the end of each month) to give the Adjusted Practice Disease Factor (APDF). For example, an APDF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The re-basing ensures that in the Relevant year, the average contractor (that is a contractor with an APDF of 1.00) would receive, after adjustment, an amount per point equal to the amount specified in paragraph 6.14 of this SFE as in force on the 1st 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 AF in the period commencing 1 October 2019 and ending on 30 September 2020 would receive £214.80 per point scored on the AF indicators.

F.4.2 "Relevant year" in paragraph F.4.1(b) means the QAIF year (QA and QI) to which the calculation of Achievement Payments relates.

F.5 As a result of the calculation in F.1, each contractor will have a different "pounds per point" figure for each indicator area with a disease register (other than the area relating to palliative care), or may have a different "pounds per point" for individual indicators within an area (if more than one register is used for the area). It will then be possible to use these figures to calculate a cash total in relation to the points scored for each area (other than the area relating to palliative care).

F.6 This national prevalence figure and range of practice prevalence will be calculated on a Wales-only basis.

F.7 If the contractor's GMS contract terminates before 1st July in the financial year to which the Achievement Payment relates, the Adjusted Practice Disease Factor to be used in calculating the contractor's Achievement Payment should be the Adjusted Practice Disease Factor calculated for the contractor for the previous financial year.

F.8 If the contractor did not have an Adjusted Practice Disease Factor calculation for the previous financial year, then no Adjusted Practice Disease Factor should be used in calculating the contractor's Achievement Payment for that year.

F.9 Unless paragraph F.10 applies, if the contractor's GMS contract terminates on or after 1st July and before the end of the QAIF (QA and QI) year to which the Achievement Payment relates—

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

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

F.10 If the contractor's GMS contract commences after 1st July and terminates before the end of the QAIF (QA and QI) year in which the GMS contract commences, no Adjusted Practice Disease Factor is to be calculated for the contractor's Achievement Payment in respect of the period during which the contract subsisted.

SCHEDULE 4

ANNEX I

Routine childhood vaccines and immunisations

The Routine Childhood Immunisation Programme

Background

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

Routine Childhood Immunisation Schedule

I.2 All children starting the immunisation programme at 2 months of age will follow the schedule (often referred to as the "Childhood Immunisation Schedule") below as set out in the Table.

I.3 The latest information and guidance on vaccines and vaccine procedures for all the vaccines referred to in the Table, including completing the schedule of vaccines in the case of children with interrupted, incomplete or unknown immunisation status or in relation to premature infants is contained in the "Immunisations against infectious diseases – The Green Book".

Table

When to immunise	**What vaccine is given**	**How it is given**
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b (DTaP/IPV/HiB) and Hepatitis B	One injection
	Pneumococcal (PCV)	One injection
	Rotavirus (Rota)	One oral dose
	Meningococcal group B (Men B)	One injection
Three months old	Diphtheria, tetanus, pertussis (whooping cough) polio, Haemophilus influenza type b (DTaP/IPV/HiB) and Hepatitis B	One injection

	Rotavirus (Rota)	One oral dose

Four months old	Diphtheria, tetanus, pertussis (whooping cough) polio, Haemophilus influenza type b (DTaP/IPV/HiB) and Hepatitis B	One injection
	Pneumococcal (PCV)	One injection
	Menininggococcal group B (Men B)	One injection

Around twelve months	Haemophilus influenza type b, Men C (Hib/MenC)	One injection
	Measles, mumps and rubella (MMR)	One injection
	Pneumococcal (PCV)	One injection
	Meningococcal group B (Men B)	One injection

Two and three years of age on 31 August	Influenza	One nasal spray

Three years four months to five years old	Diphtheria, tetanus, pertussis (whooping cough) and polio (dTaP/IPV or DTap/IPV)	One injection
	Measles, mumps and rubella (MMR)	One injection

SCHEDULE 5

ANNEX J - AMENDMENTS

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

(c) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2013 (2013 No.60), which were made on 30 September 2013;

(d) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2014 (2014 No.3), which were made on 16 June 2014;

(e) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2014 (2014 No.17), which were made on 27 June 2014;

(f) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2014 (2014 No.24), which were made on 30 September 2014;

(g) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2015 (2015 No.7), which were made on 31 March 2015;

(h) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment No 2) Directions 2015 (2015 No.14), which were made on 01 April 2015;

(i) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment No 3) Directions 2015 (2015 No.15), which were made on 20 April 2015;

(j) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment No 4) Directions 2015 (2015 No.19), which were made on 25 June 2015;

(k) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.5) Directions 2015, which were made on 30 September 2015;

(l) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2016, which were made on 30 March 2016;

(m) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2016, which were made on 11 April 2016;

(n) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2016, which were made on 13 July 2016;

(o) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2016 (2016 No.19), which were made on 16 August 2016;

(p) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.5) Directions 2016 which were made on 15 December 2016;

(q) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 6) Directions 2017 which were made on 31 January 2017;

(r) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2017 which were made on 27 April 2017;

(s) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.2) Directions 2017 which were made on 9 August 2017;

(t) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.3) Directions 2017 which were made on the 28 September 2017;

(u) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2018 which were made on the 14 June 2018;

(v) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2018 which were made on 19 November 2018;

(w) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2019 which were made on 29 March 2019;

(x) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2019 which were made on 28 June 2019; and

(y) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2019 which were made on 29 August 2019.

(z) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2019 which were made on ?? September 2019.