STATEMENT OF FINANCIAL ENTITLEMENTS AMENDMENT (WALES)
DIRECTIONS 2005

The National Assembly for Wales, in exercise of the powers conferred on it by sections 28T and 126(4) of the National Health Service Act 1977\(^a\), after consulting in accordance with section 28T(4) of that Act both with the bodies appearing to it to be representative of persons to whose remuneration these directions relate and with such other persons as it thinks appropriate, gives the following directions.

1.- (1) These Directions apply to Local Health Boards in Wales, may be cited as the Statement of Financial Entitlements Amendment (Wales) Directions 2005, shall come into force on the day after they are made and shall have effect as from 1st April 2004.

(2) The Schedule to the directions as to the Statement of Financial Entitlements given to Local Health Boards which came into force on 19 April 2004 is amended in accordance with the Schedule to these directions.

Signed on behalf of the National Assembly for Wales

Brian Gibbons
Minister for Health and Social Services

Date: 6th April 2005

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\(^a\) 1977 c.49. Section 28T was inserted by section 171 of the Health and Social Care (Community Health and Standards) Act 2003 (c.43).
Amendments to the SFE Schedule

(1) In paragraph 2.4 (which relates to the calculation of the Adjustments added into a contractor’s Initial Global Sum Monthly Payment)—

   (a) in sub-paragraph (b), for “£0” substitute “£0.21”; and

   (b) delete sub-paragraph (c) and sentence below it in brackets.

(2) In paragraph 2.8(c), delete the words “or Out of Hours”.

(3) Amend the numbering of paragraph “3.9” to read “3.8”.

(4) In paragraph 3.12, after “If” insert the word “either”

(5) After paragraph 3.12 (c) insert the word “or” and new sub-paragraphs (d) and (e):-

   “(d) if a new contractor comes into existence or there is a variation of one or more existing contracts as the result of the termination by a LHB of its direct management of a contract; or

   (e) if a new contractor comes into existence or there is a variation of one or more existing contracts as the result of the termination of a contract held by a sole practitioner or a contract where all GP Performers in a contract resign or retire simultaneously and the new or varied contracts come into force the day following such termination,”

(6) In the paragraph after 3.12(e), in the first line after the word “contractor” insert the following words “or the holder of a contract varied as mentioned in (d) or (e) above,” and at the end of the paragraph for “when its new contract takes effect “ substitute the following words “or the holder of a contract varied as mentioned in (d) or (e) above when its new contract or the variation of the contract takes effect, as the case maybe.”

(7) In paragraph 5.26, in the first line amend “paragraph 6.1” to read “paragraph 6.1(a)”.

(8) In paragraph 5.31, reletter the sub-paragraphs from (a) to (f) and in sub-paragraph (e), in the last line amend “paragraph 6.1” to read “paragraph 6.1(a)”.

(9) In paragraph 5.37, delete sub-paragraph (a) and substitute with-
“(a) the clinical domain, first a calculation needs to be made of an Adjusted Practice Disease Factor for each disease area, and this is then multiplied by £77.50 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 is given in Annex G; and"

(10) In paragraph 5.37, in sub-paragraph (b), in the third line delete the words “thereafter”, and in the fourth line amend the first “the” to “that”.

(11) In paragraph 5.38 (which relates to the calculation of the part of the Achievement Payment that relates to the other domains) for “[£75]” substitute “£77.50”.

(12) Delete paragraph 6 and substitute with the following:-

“6. Improved Access Scheme

6.1 Direction 3(1)(a) of the DES Directions requires each LHB to establish (if it has not already done so), operate and as appropriate, revise an Improved Access Scheme for its area, the underlying purpose of which is to improve patient access to primary medical services, and which may comprise or include-

(a) arrangements for improving access for patients requiring routine appointments working towards the target of patients being able to consult with a member of the primary care team within 24 hours of requesting an appointment and sooner in an emergency, as set out in the Welsh Supplement to the UK Directed Enhanced Service for Access agreed with GPC Wales dated September 2003 and issued in October 2003. An additional 50 quality points are available in 2004/05 for those practices that achieve the target.

(b) arrangements to address specific local health needs or requirements in respect of access to primary medical services locally.

6.2 As part of its Improved Access Scheme, a LHB must, each financial year, offer to enter into arrangements with each contractor in its area (unless it already has such arrangements with the contractor in respect of that financial year), thereby affording the contractor a reasonable opportunity to participate in the scheme during that financial year. However, before entering into any such arrangements, the LHB must satisfy itself of the matters set out in direction 3(2)(a) and (b) of the DES Directions.

6.3 The plan setting out any arrangements that the LHB enters into, or has entered into, with a particular contractor (“an IAS plan) must
cover the matters set out in direction 4(2) (a) to (d) of the DES Directions.

**Improved Access Scheme Payments**

6.4 If a contractor and a LHB have agreed an IAS plan the LHB must in respect of the financial year 2004 to 2005 pay to the contractor under its GMS contract an Improved Access Scheme Implementation Payment of £5,161.25 which payment is to fall due—

(a) if the plan was agreed on or before 1st April 2004, on 30th April 2004; and

(b) if the plan is agreed after 1st April 2004, on the first date after the plan is agreed on which one of the contractor's Payable GSMPs falls due.

6.5 Improved Access Scheme Preparation Payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must make available to the LHB any information which the LHB does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to form its opinion on whether the contractor has fulfilled its obligations under the IAS plan.

(b) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully;

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

6.6 If the contractor breaches any of these conditions, the LHB may, in appropriate circumstances, withhold payment of any or any part of an Improved Access Scheme Preparation Payment that is otherwise payable.

6.7 The payment is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year 2004 to 2005."

(13) Delete Paragraph 7 and substitute with the following:-

“7. Quality Information Preparation Scheme

7.1 Direction 3(1)(b) of the DES Directions requires each LHB to establish (if it has not already done so), operate and, as
appropriate, revise a Quality Information Preparation Scheme (QuIPS) for its area, the underlying purpose of which is to summarise and improve the quality of medical records held by contractors in its area. QuIPSs are to come to an end on 31 March 2005.

7.2 As part of its QuIPS, a LHB must, in respect of the financial year 2004 to 2005 offer to enter into arrangements with each contractor in its area (unless it already has such arrangements with the contractor), thereby affording the contractor a reasonable opportunity to participate in the Scheme. However, before entering into any such arrangements, the LHB must satisfy itself of the matters set out in direction 3(2)(a) and (b) of the DES Directions.

7.3 The plan setting out the arrangements that the LHB enters into with a particular contractor (a QuIPs Plan) must cover the matters set out in direction 5(2)(a) and (b) of the DES Directions.

Quality Information Preparation Scheme Payments

7.4 If, as part of a GMS contract a contractor and a LHB have agreed a QuIPS plan under which payment is due in respect of the financial year 2004 to 2005, the LHB must in respect of the financial year 2004 to 2005 pay to the contractor under the GMS contract a QuIPS Payment. The amount of this payment is to be £2,580.62 multiplied by the practice’s CPI.

7.5 The payment is to fall due–

(a) if the plan was agreed on or before 1st April 2004, or takes effect on 1st April 2004, on 30th April 2004; and

(b) if the plan is agreed after 1st April 2004, on the first date after the plan is agreed on which one of the contractor’s Payable GSMPs falls due.”

(14) In paragraph 8.3 of the SFE, delete sub-paragraph (b) and substitute with-

“(b) on the first day of the quarter to which the payment relates, at least 70%, for the lower payment, or at least 90%, for the higher payment, of the children aged two (i.e. who have passed their second birthday but not yet their third) registered with the contractor have completed the recommended immunisation courses (i.e. those that have been recommended nationally and by the World Health Organisation) for protection against –

(i) diphtheria, tetanus and poliomyelitis,

(ii) pertussis,

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(iii) measles/mumps/rubella, and

(iv) Haemophilus influenzae type B (HiB).”.

(15) In paragraph 8.4, in the second line delete the words “recommended by the Green Book”.

(16) Delete paragraph 8.10 and substitute with-

“The amount payable as a Quarterly TYOIP is to fall due on the last day of the quarter in respect of which the contractor is seeking payment (i.e. at the end of the quarter after the last quarter in which immunisations were carried out that count towards the targets). However, if the contractor delays providing the information the LHB needs to calculate its Quarterly TYOIP beyond the middle of the quarter, the amount is to fall due at the end of the next quarter. No Quarterly TYOIP is payable if the contractor provides the necessary information more than four months after the date to which the information relates”.

(17) Delete paragraph 8.11(b) (ii) and substitute with-

“(ii) how many of those two-year-olds have completed each of the recommended immunisation courses (i.e. that have been recommended nationally and by the World Health Organisation) for protection against the disease groups referred to in paragraph 8.3(b), and”.

(18) Delete paragraph 8.13 (b) and substitute with-

“(b) on the first day of the quarter to which the payment relates, at least 70%, for the lower payment, or at least 90% for the higher payment, of the children aged five (i.e. who have passed their fifth birthday but not yet their sixth) registered with the contractor have received the recommended reinforcing doses (i.e. those that have been recommended nationally and by the World Health Organisation) for protection against diphtheria, tetanus, acellular pertussis and poliomyelitis.”.

(19) Delete paragraph 8.14 and substitute with –

“8.14 LHBs will need to determine the number of complete immunisation courses that are required in order to meet either the 70% or the 90% target. To do this, the contractor will need to provide the LHB with the number of five year olds (A) whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which the contractor is seeking payment and then the LHB must make the following calculations-

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

(20) Delete paragraph 8.20 and substitute with:-

“8.20 The amount payable as a Quarterly FYOIP is to fall due on the last day of the first month of the quarter in respect of which the contractor is seeking payment (i.e. at the end of the quarter after the last quarter in which booster courses were carried out that count towards the targets). However, if the contractor delays providing the information the LHB needs to calculate its Quarterly FYOIP beyond the middle of the quarter, the amount is to fall due at the end of the next quarter. No Quarterly FYOIP is payable if the contractor provides the necessary information more than four months after the date to which the information relates.”.

(21) Delete paragraph 8.21(b)(ii) and substitute with:-

“(ii) how many of those five-year olds have received the complete course of recommended reinforcing doses (i.e. that have been recommended nationally and by the World Health Organisation) for protection against diphtheria, tetanus, acellular pertussis and poliomyelitis, and”.

(22) Delete the paragraph after paragraph 9.3 (d) and substitute with:-

“then subject to the following provisions of this Section, the LHB must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 9.5).”.

(23) In sub-paragraph 10.3(b)(ii) after the word “employment” delete the following words – “and the performer on leave must have been employed for at least three months by the contractor”.

(24) Delete the paragraph after paragraph 10.3(e) and substitute with:-

“Then subject to the following provisions of this Section, the LHB must provide financial assistance to the contractor under its GMS contract in respect of the costs of engaging that locum (which may or may not be the maximum amount payable as set out in paragraph 10.5).”.

(25) Delete paragraph 11.1 and substitute with –

“11.1 LHBs have powers to suspend GP performers from their medical performers’ list. They may also on 1st April 2004, still be considering cases of GP performers who are on but suspended from their medical performers' list because prior to 1st April 2004 they were suspended from a medical list or a supplementary list.”.

(26) Delete paragraph 11.2 and substitute with –
“11.2 A GP performer who is suspended from a medical performers’ list either-

(a) on or after 1st April 2004; or
(b) by virtue of being suspended from a medical list or a supplementary list,

may be entitled to payments directly from the LHB that suspended him or her. This is covered by a separate determination under regulation 13(17) of the Performers List Regulations.”.

(27) Delete the paragraph after paragraph 11.3(d) and substitute with:-

“Then subject to the following provisions of this Section, the LHB must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 11.5).”.

(28) Delete paragraph 12.5 and substitute with:-

“12.5 In any case where a contractor actually and necessarily engages a locum (or more than one such person) to cover for the absence of a GP performer on Prolonged Study Leave, then subject to the following provisions of this Section, the LHB must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 12.7).”.

(29) In paragraph 13.3 (Service that is Reckonable Service)–

(a) in sub-paragraph (a)–

(i) after “doctor within the” insert “public service”, and

(ii) after “EEA Member State” add “(including service in that system pre-Accession)”;

(b) for sub-paragraph (e), substitute the following sub-paragraph–

“(e) it comprises up to a maximum of four years clinical service in a country or territory outside the United Kingdom–

(i) which followed the date of first registration of the GP provider in that country or territory, and

(ii) in circumstances where–

(aa) on 31st March 2003, that period of clinical service was counted by a LHB as a period of registration for the purposes of a
calculation of the annual rate of the GP Provider’s Seniority Payment under the Red Book, and

(bb) that period of clinical service is not counted as reckonable service by virtue of any of the preceding sub-paragraphs in this paragraph.”

(30) In paragraph 13.8, amend the reference to “paragraph 13.3(c)” to “paragraph 13.3(d)”.

(31) Delete paragraph 13.13 and substitute with :-

“13.13 If, for any GP provider, the full annual rate payable in respect of him/her, as calculated above, is less than the total amount due to him/her-

(a) on 31st March 2003 as the full annual rate of his/her Seniority Payment under the Red Book; plus
(b) on 31st March 2004, his/her Golden Thanks payment under the Red Book,

that GP provider is entitled to at least that total amount as the full annual rate of his/her Seniority Payments in the financial year 2004 to 2005.”.

(32) In paragraph 13.21(c) (conditions attached to payment of Quarterly Seniority Payments), for “sub-paragraph (a)” substitute “sub-paragraph (b)”.

(33) In paragraph 13.23 (which relates to the sanctions to be imposed if the conditions attached to payment of Quarterly Seniority Payments are breached), for “13.21(c)” substitute “13.21 (d)”.

(34) In paragraph 14.2 (standard payments under the Golden Hello Scheme)—

(a) for paragraph (i) in sub-paragraph (d) substitute—

“(i) been included in the medical performers list, services list or medical list of any Health Authority or LHB, unless this was—

(aa) because of temporary arrangements made by a LHB for the provision of general medical services or the performance of primary medical services following the suspension of a doctor, or

(bb) solely related to employment as a locum or as a GP registrar (or employment as both),”;

and
(b) in sub-paragraphs (d)(ii) and (d)(iii) for “(except as a locum)”, at each place where it occurs, substitute “(except as a locum or a GP registrar)”.

(35) In paragraph 14.3 (which relates to an exception to the eligibility criteria in paragraph 14.2(d)), for “(except as a locum)” substitute “(except as a locum or a GP registrar)”.

(36) After paragraph 14.5, insert the following paragraph-

“Payment of employer’s superannuation contributions in respect of Golden Hello Payments

14.5A The amounts in the above table are net of any employer’s superannuation contributions that are payable in respect of Golden Hello Payments. Where such contributions are payable, the LHB must forward a payment to cover the amount of those contributions to the pension provider (for example, the NHS Pensions Agency), and the amount of that payment must be notified to the contractor to whom the net amount of the Golden Hello Payment is paid”.

(37) After paragraph 14.10 (which relates to payment of further payments), insert the following paragraph–

“14.10A Subject to the following provisions of this Section, LHBs must pay to contractors, in respect of doctors who are eligible for a standard, additional or further payment under this Section, a payment to cover the amount of any employer’s national insurance contributions which are payable by the contractor in respect of that standard, additional or further payment.”.

(38) In paragraphs 15.2 and 15.3 delete “Regional Dean” and substitute “Dean of General Practice, University Wales College of Medicine”.

(39) In paragraph 15.2 (b) delete the words “local Director of Postgraduate GP Education” and substitute “Dean of General Practice, University Wales College of Medicine”.

(40) In paragraph 16.2(a) amend “paragraph 47” to read “paragraph 49”.

(41) In paragraph 16.12 after “agree” insert “to”.

(42) Delete the sub-heading “Default contracts” and paragraph 19.9 and substitute with:–

“Default contracts and payments to persons not able to enter into default contracts
19.9 If a contractor’s GMS contract was agreed after 1st April 2004 but the contract takes effect for payment purposes on 1st April 2004, that contractor has received a payment under a default contract or pursuant to article 41(1) of the 2004 Order and that payment could have been made-

(a) as a payment on account under the contractor’s GMS contract pursuant to paragraph 19.6 or 19.7, it shall be treated as a payment on account pursuant to paragraph 19.6 or 19.7 (and for these purposes a payment of one twelfth of a final global sum equivalent under a default contract or under article 41(1) of the 2004 Order shall be treated as a payment on account in respect of a Payable GSMP); and

(b) as a payment under the contractor’s GMS contract pursuant to Part 4 or 5 of this SFE, it shall be treated as a payment under the contractor’s GMS contract pursuant to Part 4 or 5 of this SFE,

and accordingly, any condition that attaches to such a payment by virtue of this SFE is attached to that payment.”.

(43) Delete the full-stop after sub-paragraph 19.20(b) and add a comma.

(44) After 19.20(b) begin on a new line and add “and the LHB must seek to resolve the matter as soon as is practicable. If there is a dispute in connection with the adjustment, paragraphs 19.14 and 19.15 apply”.

(45) After paragraph 20.6 (which relates to monthly deductions in respect of superannuation contributions), insert the following paragraph-

“20.6A Employer’s 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. Golden Hello Payments will, in all cases, be paid net of the employer’s superannuation contributions – and in other cases of payments for specific purposes, the LHB and the contractor may agree that the payment is to be made net of employer’s superannuation contributions. 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”.

(46) In paragraph 20.7 after the words “any relevant” add the words “Money Purchase”.

(47) In paragraph 20.7 (a) delete the full stop and replace with a semi-colon followed by the word “or”.

(48) In paragraph 20.10 after the words “that the contractor ensures that its partner/GPs” insert the words “(other than those who are neither members of the NHS Pension Scheme nor due Seniority Payments)”.

(49) Delete sub-paragraph 20.12(b)(ii) and substitute with:-
“(ii) were in excess of the amount payable by the LHB and the partner/GP to the NHS Pensions Agency 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/she is entitled to so elect)”.

(50) In Part 2 of Annex A of the SFE (glossary – definitions)–

(a) after the definition of “Additional or Out-of Hours Services” delete the full stop and add the following – “provided under arrangements made pursuant to regulation 30 of the 2004 Regulations.”.

(b) delete the definition for “Default Contract” and substitute with- “means a contract entered into under article 13 of the 2004 Order.”.

(c) after the definition for “Default contract” insert the following new definitions-

“DES” Directions means the Primary Medical Services (Directed Enhanced Services) (Wales) Directions 2004.”

“Direct management of a contract” means where a LHB on or after 1st April 2004 managed a contract pending its transfer to one or more contractors.”

(d) For the definition of “General Practitioner” in sub-paragraph (a) after the word “Register” delete the words from “otherwise” to “Order”.

(e) For the definition of “General Practitioner” in sub-paragraph (b) (ii) after the word “paragraph” delete the words from “other” to “Order”.

(f) Delete the whole reference and definition for the “Green Book”.

(g) After the definition for “Initial Global Sum Monthly Payment” insert the following definition-

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

(h) in the definition of “Performers List Regulations”, for “(Performers List)” substitute “(Performers Lists)”; and

(i) in the definition of “Red Book”, after “31st March 2004”. add “However, for the purposes of paragraph 13.3(e)(ii)(aa) and 13.13(a), it means the Statement of Fees and Allowances under regulation 34 of the National Health Service (General Medical Services) Regulations 1992, as it had effect on 31st March 2003”.

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(51) In Annex D, MPIG Guidance, in D.1 delete the word “directed” and substitute with “agreed”.

(52) In Annex D, the heading for D.13 – “Staff vacancies during the baseline period” delete the words “during the baseline period”.

(53) In Section 2 of Annex E of the SFE (Quality and Outcomes Framework – Clinical Indicators) –

(a) in part 1 (general format), at the end of the final paragraph, which begins “For each indicator”, add “These have been replaced by the Logical Query Indicator Specification and the Dataset and Business Rules.”;

(b) after part 1.1 (rational) insert the following part –

“1.2 Use of Read codes

The Logical Query Indicator Specification and the Dataset and Business Rules that support the reporting requirements of the Quality and Outcomes Framework in each home country are based entirely on Read codes (4 byte, Version 2 and Clinical Terms Version 3) and associated dates. Read codes are an NHS standard. Practices using proprietary coding systems and/or local/practice specific codes need to be advised that these codes will not be recognised within QOF reporting. Practices utilising such systems should develop strategies to ensure that they are utilising appropriate Read codes in advance of producing their achievement report.”;

(c) renumber the other part 1.2 (reporting and verification) part 1.3;


(e) in part 2 (exception reporting), at the end of the final paragraph, which begins “Practices should report”, replace from “An IT solution is” to “were exception reported.” with “Exception codes have been added to systems by suppliers. Practices will not be expected to report why individual patients were exception-reported.”;

(f) in the part headed “Summary of all Clinical Indicators” –

(i) in the first table, which is headed “Secondary Prevention in Coronary Heart Disease (CHD)” –
(aa) in the first column, in the entry for Indicator CHD 3, for “need be recorded only once” substitute “should be recorded at least once since diagnosis”, and

(bb) in the third column, opposite the entry in the first column for Indicator CHD 4, for “25-70%” substitute “25-90%”,

(ii) in the second table, which is headed “Stroke and Transient Ischaemic Attacks”, in the first column, in the entry for Indicator STROKE 3, for “who have a record of smoking status in the last” substitute “whose notes record smoking status in the past”,

(iii) in the third table, which is headed “Hypertension”, in the first column, in the entry for Indicator BP 2, after “at least once” add “since diagnosis”,

(iv) in the fourth table, which is headed “Diabetes Mellitus (Diabetes)”, in the first column, in the entry for Indicator DM 3, for “in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status should be recorded once” substitute “whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status should be recorded at least once since diagnosis”, and

(v) in the fifth table, which is headed “Chronic Obstructive Pulmonary Disease (COPD)”, in the first column, in the entry for Indicator COPD 4, for “in whom there is a record of smoking status in the previous 15 months” substitute “whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status should be recorded at least once since diagnosis”, and

(vi) in the tenth table, which is headed “Asthma”, in the first column, in the entry for Indicator ASTHMA 4, after “at least once” add “since diagnosis”;

(g) in the part headed “Details of the rationale for indicators, and proposed methods of data collection and monitoring” in the table at the start of that part, which is headed “Secondary Prevention in Coronary Heart Disease (CHD)”–

(i) in the first column, in the entry for Indicator CHD 3, for “need be recorded only once” substitute “should be recorded at least once since diagnosis”, and
(ii) in the third column, opposite the entry in the first column for Indicator CHD 4, for “25-70%” substitute “25-90%”;  

(h) in the box, which describes CHD Indicator 3, before part CHD 3.1 (rationale), for “need be recorded only once” substitute “should be recorded at least once since diagnosis”;  

(i) in the table in the part headed “Stroke and Transient Ischaemic Attacks (TIA)”, in the first column, in the entry for Indicator STROKE 3, for “who have a record of smoking status in the last” substitute “whose notes record smoking status in the past”;  

(j) in the box, which describes Indicator STROKE 3, before the part headed “Stroke 3.1 Rationale”, for “who have a record of smoking status in the last” substitute “whose notes record smoking status in the past”;  

(k) in the part headed “Stroke 9.1 Rationale”, in the paragraph beginning “All patients who”, omit “and dipyridamole MR 200mg twice daily”;  

(l) in the part headed “Stroke 9.2 Reporting and Verification”, in the paragraph beginning “Practices should”, omit “, dipyridamole” and after “aspirin” add “updated in the last 15 months”;  

(m) in the table headed “Hypertension” before part BP 1.1 (rationale), in the entry for Indicator BP 2, after “at least once” add “since diagnosis”,  

(n) in the box, which describes Indicator BP 2, before part BP 2.1 (rationale), after “at least once” add “since diagnosis”,  

(o) in the table in the part headed “Diabetes Mellitus (Diabetes)”, in the first column, in the entry for Indicator DM 3, for “in whom there is a record of smoking status in the previous 15 months,, except those who have never smoked where smoking status should be recorded once” substitute “whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status should be recorded at least once since diagnosis”;  

(p) in the box, which describes Indicator DM 3, before part DM 3.1 (rationale), for “in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status should be recorded once” substitute “whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status should be recorded at least once since diagnosis”;
(q) in the table in the part headed “Chronic Obstructive Pulmonary Disease (COPD), in the first column, in the entry for Indicator COPD 4, for “in whom there is a record of smoking status in the previous 15 months” substitute “whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status should be recorded at least once since diagnosis”;

(r) in the box, which describes Indicator COPD 4, before part COPD 4.1 (rationale), for “in whom there is a record of smoking status in the previous 15 months” substitute “whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status should be recorded at least once since diagnosis”;

(s) in the table in the part headed “Asthma”, in the first column, in the entry for Indicator ASTHMA 4, after “at least once” add “since diagnosis”; and

(t) in the box, which describes Indicator ASTHMA 4, before the part headed “Asthma 4.1 Rationale”, after “at least once” add “since diagnosis”.

(54) In Section 3 of Annex E of the SFE (Quality and Outcomes Framework – Organisational Indicators), in the part headed “Organisational Indicators – Medicines Management (E), in the table at the start of that part, which is headed “Summary of Indicators”, in the second column, opposite the entry in the first column for Medicines Indicator 3, for “on at lea Basis” substitute “on at least an annual basis”.

(55) In Section 4 of Annex E of the SFE (Quality and Outcomes Framework – Patient Experience), in the first table in that section–

(a) beneath the heading “PE 1 Length of Consultations” insert the sub-heading “30 points”;

(b) beneath the heading “PE 2 Patient Surveys (1)” insert the sub-heading “40 points”;

(c) beneath the heading “PE 3 Patient Surveys (2)” insert the sub-heading “15 points”; and

(d) beneath the heading “PE 4 Patient Surveys (3)” insert the sub-heading “15 points”.

(56) In Section 4 of Annex E of the SFE (Quality and Outcomes Framework – Patient Experience), in part PE 2.1 (practical guidance) for the paragraph from “The aim of” to “50 questionnaires back.” substitute–
“If surveys are carried out in the surgery, these should be conducted on consecutive patients. If carried out by post, adult patients should be randomly sampled.”.

(57) Delete the whole of Annex F and replace with the following-

ANNEX F

CALCULATION OF ADDITIONAL SERVICES ACHIEVEMENT POINTS

F.1 The additional services 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–

- Cervical screening services: females aged 25 to 64 years
- Child health surveillance: children of both sexes aged 0 to 5 years
- Maternity medical services: females aged under 55 years
- Contraceptive services: females aged under 55 years

F.2 For example, to meet the requirements of the child health surveillance indicator, child health development checks will only need to be offered to the practice’s registered population of children aged 0 to 5 years.

F.3 Each of the additional services mentioned in paragraph F.1, 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 start of the final quarter (A) is to be divided by the contractor’s CRP at the start of the final quarter (B);

(b) then the average number of patients registered with contractors in Wales in the relevant target population at the start of the final quarter (C) is to be divided by the average CRP for Wales (according to the Exeter Registration System) at the start of the final quarter (D); and

(c) the number produced by the calculation in paragraph (a) is then to be divided by the number produced by the calculation in paragraph (b) to produce the Target Population Factor for the additional service in question.

F.4 The Target Population Factor for the additional service is to be multiplied by £77.50 and by the Achievement Points obtained in respect of the additional service (E) to produce the cash total in respect of the additional service (F).

F.5 This calculation could be expressed as–
\[
\frac{(A \div B)}{(C+D)} \times \£77.50 \times E = F
\]

F.6 If the contractor has not been under an obligation to provide an additional service for any period during the financial year 2004 to 2005 when the contractor's contract had effect, the adjusted total for that particular additional service to be further adjusted by the fraction produced by dividing—

(a) the number of days in the financial year during which the contract had effect and the contractor was under an obligation to provide the additional service; by

(b) the number of days in the financial year during which the contract had effect.

F.7 The resulting cash amounts, in respect of each additional service, are then to be added together for the total amount in respect of the additional services domain.

(58) Delete the whole of Annex G and replace with the following-

**ANNEX G**

**ADJUSTED PRACTICE DISEASE FACTOR CALCULATIONS**

G.1 The calculation involves three steps:

- first, the calculation of the contractor's Raw Practice Disease Prevalences. There will be a Raw Practice Disease Prevalence in respect of each disease area for which the contractor is seeking to obtain Achievement Points;

- secondly, making an adjustment to give an Adjusted Practice Disease Factor (APDF);

- thirdly, applying the factor to the pounds per point figure for each disease area.

G.2 These steps are explained below.

G.3 The Raw Practice Disease Prevalence is calculated by dividing the number of patients on the relevant disease register by the contractor's CRP for the last quarter.

G.4 The Adjusted Practice Disease Factor is calculated by:
(a) calculating the national range of Raw Practice Disease Prevalences in Wales and applying a 5% cut-off at the bottom of the range. Contractors below this will be treated as having the same prevalence as the cut-off point;

(b) once the cut-off has been applied, making a square root transformation to all the contractor prevalence figures. This means that the prevalence distribution will be compressed to a narrower range. It will prevent financial destabilisation of those with the lowest prevalence;

(c) after the transformation, rebasing the contractor figures around the new national Wales mean 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 rebasing ensures that the average contractor (i.e. one with an APDF of 1.0) receives £77.50 per point, after adjustment;

(d) 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 will receive £93 per point scored on the CHD indicators.

G.5 As a result of this calculation, each contractor will have a different ‘pounds per point’ figure for each disease area, and it will then be possible to use these figures to calculate a cash total in relation to the points scored in each disease area.

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