

# **GMS STATEMENT OF FINANCIAL ENTITLEMENTS 2013/14**

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## 1. Introduction

1.1 Scottish Ministers, in exercise of the powers conferred upon them by section 17M and 105(6) of the National Health Service (Scotland) Act 1978<sup>1</sup>, and of all other powers enabling them in that behalf, after consulting in accordance with section 17M(4) of the 1978 Act both with the bodies appearing to them to be representative of persons to whose remuneration these directions relate and with such other persons as they think appropriate, gives the directions set out in this Statement of Financial Entitlements (“SFE”).

1.2 This SFE relates to the payments to be made by Health Boards to a contractor under a general medical services (“GMS”) contract. It replaces the Statement of Financial Entitlements, signed on 22 November 2012 and effective from 1 April 2012. Previous SFE’s continue to have effect in relation to claims for payments that relate to the relevant financial years.

1.3 The directions set out in this SFE are subordinate legislation for the purposes of section 23 of the Interpretation Act 1978, and accordingly, in this SFE, unless the context otherwise requires—

- (a) words or expressions used here and the 1978 Act bear the meaning they bear in the 1978 Act;
- (b) references to legislation (i.e. Acts and subordinate legislation) are to that legislation as amended, extended or applied, from time to time;
- (c) words importing the masculine gender include the feminine gender, and *vice versa* (words importing the neuter gender also include the masculine and feminine gender); and
- (d) words in the singular include the plural, and *vice versa*.

1.4 This SFE is divided into Parts, Sections, paragraphs, sub-paragraphs and heads. A Glossary of some of the words and expressions used in this SFE is provided in Annex A. Words and expressions defined in that Annex are generally highlighted by initial capital letters.

1.5 The directions given in this SFE apply to Scotland only. They were authorised to be given, and by an instrument in writing, on behalf of Scottish Ministers, by David Thomson, a member of the Senior Civil Service, on 11 September 2013 and came into force with effect from 1 April 2013.

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<sup>1</sup> Section 17M was inserted by section 4 of the Primary Medical Services (Scotland) Act 2004.

1.6 This SFE may be revised at any time, in certain circumstances with retrospective effect.<sup>2</sup> For the most up-to-date information, contact the Scottish Government, Directorate for Health and Social Care Integration, Primary Medical Services Branch, Area 1.ER, St Andrew's House, Regent Road, EDINBURGH, EH1 3DG.

signed by authority of the Scottish Ministers

A handwritten signature in black ink, appearing to be 'D Thomson', written over a horizontal dashed line.

David Thomson  
Scottish Government Health and Social Care Integration Directorate: A member of the Senior  
Civil Service  
11 September 2013

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<sup>2</sup> See section 17M(3)(e) of the NHS (Scotland) Act 1978

## **PART 1**

# **GLOBAL SUM AND MINIMUM PRACTICE INCOME GUARANTEE**

## **2. Global Sum Payments**

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

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

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

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

2.3 The Scottish Allocation Formula, a summary of which is included in Annex B of this SFE, determines how the total Global Sum amount for Scotland is to be distributed to all practices in Scotland. Once the contractor's CRP has been established, this number is to be adjusted by the Scottish Allocation Formula. The resulting figure is the contractor's Contractor Weighted Population for the Quarter. It is on the basis of the Contractor Weighted Population for the Quarter, relative to the Scotland-wide Weighted Population for the Quarter, that the practice is allocated its share of the Scotland-wide global sum, not including the sums allocated for Temporary Patients Adjustments or Organisational Core Standard Services. From 1 April 2013 the global sum amount for Scotland is increased to £409 million reflecting an uplift in the global sum, the increase in aggregate contractor registered populations from 1 April 2012 to 31 March 2013 and the Organisational Core Standard Payment (OCSP).

2.4 For comparative purposes only, this figure should correspond to the Contractors Weighted Population for the Quarter multiplied by approximately £74. This figure is calculated by taking the total global sum amount for Scotland (£408.9 million), subtracting the total sum allocated for Annual Temporary Patients Adjustments and Annual Organisational Core Standard Payment then dividing by the Scotland-wide registered population for the Quarter.<sup>3</sup>

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<sup>3</sup> The figure of £408.9m takes effect with this SFE on 1 April 2013 and includes non-GMS practices. The equivalent figure prior to 1 April 2013 was £389.7m. The new figure reflects an uplift in the Global Sum, the change in Scotland's registered populations for the period 01 April 2012 to 31 March 2013 and the Organisational Core Standard Payment.



The resulting amount is then to be divided by twelve, and the resulting amount from that calculation with the addition of one twelfth of the contractor’s Temporary Patient Adjustment and one twelfth of the contractors Organisational Core Standard Payment is the contractor’s first Initial GSMP for the financial year.

***Calculation of Adjusted Global Sum Monthly Payments.***

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

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

**TABLE**

<i>Column 1</i>	<i>Column 2</i>
<b>Additional or Out-of-Hours Services</b>	<b>Percentage of Initial GSMP (Excluding the OCSP)</b>
Cervical Screening Services	1.1
Child Health Surveillance	0.7
Minor Surgery	0.6
Maternity Medical Services	2.1
Contraceptive Services	2.4
Childhood immunisations and pre-school boosters	1.0
Vaccines and immunisations	2.0
Out-of-Hours Services	6.0

***First Payable Global Sum Monthly Payment.***

2.6 Once the first value of a contractor's Initial GSMP, and where appropriate Adjusted GSMP have been calculated, the Health Board must determine the gross amount of the contractor's Payable GSMP. This, is its Initial GSMP or, if it has one, its Adjusted GSMP. The net amount of a contractor's Payable GSMP, i.e. the amount actually to be paid each month, is the gross amount of its Payable GSMP minus any monthly deductions in respect of superannuation determined in accordance with Section 22 (see paragraph 22.6).

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

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

***Revision of Payable Global Sum Monthly Payments.***

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

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

2.9 Whenever the Payable GSMP needs to be revised, the Health Board will first need to calculate a new Initial GSMP for the contractor (unless this cannot have changed). This is to be calculated in the same way as the contractor's first Initial GSMP (as outlined in paragraphs 2.3 and 2.4 above), but using the most recently established CRP of the contractor (the number is to be established quarterly).

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

2.11 Once any new values of the contractor's Initial GSMP and Adjusted GSMP have been calculated, the Health Board must determine the gross amount of the contractor's new

Payable GSMP. This is its (new) Initial GSMP or, if it has one, its (new or possibly first) Adjusted GSMP. The net amount of a contractor's Payable GSMP, i.e. the amount actually to be paid each month, is the gross amount of its Payable GSMP minus any monthly deductions in respect of superannuation determined in accordance with Section 22 (see paragraph 22.6).

2.12 Payment of the new Payable GSMP must (until it is next revised) be made monthly, and it is to fall due on the last day of each month. However, if a change is made to the Additional or Out-of-Hours Services that a contractor is under an obligation to provide and that change takes effect on any day other than the first day of the month, the contractor's Payable GSMP for that month is to be adjusted accordingly. Its amount for that month is to be the total of—

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

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

***Conditions attached to Payable Global Sum Monthly Payments.***

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

- (a) the contractor must make available to the Health Board any information which the Health Board does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's Payable GSMP;
- (b) the contractor must make any returns required of it (whether computerised or otherwise) to Practitioner Services Division (PSD) of NHS National Services Scotland, and do so promptly and fully;

- (c) the contractor must immediately notify the Health Board if for any reason it is not providing (albeit temporarily) any of the services it is under an obligation to provide under its GMS contract; and
- (d) all information supplied to the Health Board pursuant to or in accordance with this paragraph must be accurate.

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

2.16 It is also a condition of every contractor's Payable GSMPs that it achieves, in relation to each financial year in which it receives Payable GSMPs, an Achievement Points Total of at least 500, whether or not it participated in the Quality and Outcomes Framework. If it breaches this condition, the Health Board must withhold from the contractor the amount produced by multiplying—

- (a) 500, by
- (b) the amount specified in paragraph 6.6 as the value of each Achievement Point in a calculation of an Achievement Payment for the financial year to which the Achievement Points Total relates, by
- (c) the contractor's Contractor Population Index that is, or would be, used for the calculation of any Achievement Payment due to the contractor in respect of that financial year (the contractor will, in any event, receive an Achievement Payment in respect of the points it does score for that financial year, pursuant to section 6).

2.17 However, if the contractor's GMS contract either takes effect during, or is terminated before the end of, that financial year, the amount to be withheld pursuant to paragraph 2.16 is to be adjusted by the fraction produced by dividing the number of days during which the financial year for which its GMS contract had effect by 365 (or 366 where the financial year includes 29<sup>th</sup> February).

2.18 The contractor's global sum monthly payment may also be reduced where the contractor has not fulfilled the requirements of the organisational core standard payment as described in Section 3 of Annexe E and evidenced as part of a post payment verification review undertaken in that contract year.

***Contractor Population Index.***

2.19 The Contractor Population Index (CPI) of a contractor, mentioned in paragraph 2.16, is the contractor's most recently established CRP divided by 5212.<sup>4</sup> Where reference is made in this SFE to a contractor's CPI, that reference, unless the context otherwise requires, is to the most up-to-date version of the contractor's CPI at the time that the payment which is being adjusted in accordance with a calculation using the contractor's CPI falls due.

***Vaccines and Immunisations.***

2.20 The reference to –

- (a) childhood immunisations and pre-school boosters; and
- (b) vaccines and immunisations,

in column 1 of the Table in paragraph 2.5 are to the vaccines and immunisations of the type specified and given in circumstances which are referred to in Table 1 and Table 2 in Annex J.

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<sup>4</sup> The figure of 5212 takes effect with this SFE from 01 April 2013. The equivalent figure prior to 01 April 2013 was 5198. The new figure reflects the change in Scotland's registered population for the period 01 April 2012 to 31 March 2013. As at 1 April 2013 registered population was 5,543,698 – an increase of 14,427 from 2012.

### **3. Minimum Practice Income Guarantee**

3.1 The Minimum Practice Income Guarantee (MPIG) is based on the historic revenue of a contractor's GPs from the list in Annex D of the 2004/5 SFE, essentially of Red Book fees and allowances, and is essentially designed to protect those income levels. A one year aggregate of these protected income amounts is the contractor's Initial Global Sum Equivalent (GSE), which is then adjusted to produce first its Adjusted GSE and then its Final GSE.

3.2 MPIG calculations are one-off calculations made in respect of contractors whose GMS contracts took effect, or which are treated as taking effect for payment purposes, on 1st April 2004. Nevertheless, an explanation of how MPIG calculations were originally undertaken has been retained in this SFE for reference purposes. The basis of an MPIG calculation was one year aggregate of the protected income amounts mentioned in paragraph 3.1, which produced the contractor's Initial Global Sum Equivalent (GSE), which was then adjusted to produce first its Adjusted GSE and then its Final GSE.

#### ***Calculation of Global Sum Equivalent.***

3.3 In respect of contracts which took effect, or which are treated as taking effect for payment purposes, on 1st April 2004, in order to calculate a contractor's GSE, a calculation was first made of its Initial and Adjusted GSE. This was done by the Health Board—

- (a) on the basis of information obtained by it from the contractor about payments to the contractor (or the GPs comprising the contractor) under the Red Book, and in particular in the year preceding 1st July 2003;
- (b) in accordance with the Scottish Government Health Directorate (SGHD) guidance reproduced in Annex D of the 2004/5 SFE; and
- (c) Details of GSE allocations for previous Inducement Practitioners are at Annex D part 2 of the 2004/5 SFE.

3.4 Whether or not any adjustments are in fact necessary to Initial GSE, the final total produced as a result of the calculation in accordance with Annex D of the 2004/5 SFE was known as the contractor's Adjusted GSE. That amount was then subject to three further adjustments—

- (a) the amount was increased by 2.85% to bring prices in respect of the year ending 30th June 2003 up to 31st March 2004 levels (i.e. rebasing for the financial year 2003 to 2004); then
- (b) the sub-paragraph (a) amount was increased by 1.47% to take account of projected price increases in respect of the financial year 2004 to 2005 (i.e. rebasing for the financial year 2004 to 2005);
- (c) the sub-paragraph (b) amount was added to the contractor's GSE Superannuation Adjustment. This was an adjustment to take account of the additional employer's superannuation contributions in respect of GPs and practice staff as a result of the Treasury transfer. The contractor's GSE

Superannuation Adjustment was calculated by adjusting its total amount of superannuation contributions up to a level equating to 14% contributions.

The resulting amount was the contractor's Final GSE.

***Calculation of Correction Factor Monthly Payments.***

3.5 The contractor's Final GSE was then compared to the paragraph 2.3 total in respect of the contractor. In the financial year 2004 to 2005, a contractor's paragraph 2.3 total was the annual amount of its first Initial Global Sum Payment, excluding its Temporary Patients Adjustment and minus the following two adjustments in that financial year which have since been discontinued: a Superannuation Premium and an Appraisal Premium. From that paragraph 2.3 total was subtracted any Historic Opt-Outs Adjustment to which the contractor was entitled.

3.6 A contractor was entitled to the Historic Opt-Outs Adjustment if–

- (a) between 1<sup>st</sup> July 2002 and 1<sup>st</sup> April 2004, the GPs comprising the contractor have not been providing, within GMS services, services which as far as possible were equivalent to one or more of the Additional or Out-of-Hours Services listed in the Table in paragraph 2.5; and
- (b) the contractor would not be providing those services in the financial year 2004 to 2005.

3.7 The amount of the contractor's Historic Opt-Outs Adjustment was calculated as follows. If the contractor is claiming an Historic Opt-Outs Adjustment in respect of–

- (a) one of the Additional or Out-of-Hours Services listed in column 1 of the Table in paragraph 2.5, the value of the contractor's Historic Opt-Outs Adjustment was the amount by which its paragraph 2.3 total would be reduced if it was reduced by the percentage listed opposite that service in column 2 of the Table;
- (b) more than one of the Additional or Out-of-Hours Services listed in column 1 of the Table in paragraph 2.5, the value of the contractor's Historic Opt-Outs Adjustment was to include an amount in respect of each service. The value of the amount for each service was the amount by which the contractor's paragraph 2.3 total would be reduced if it was reduced by the percentage listed opposite that service in column 2 of the Table, without any other deductions from the paragraph 2.3 total first being taken into account. The total of all the amounts in respect of each service was then aggregated to produce the final amount of the contractor's Historic Opt-Outs Adjustment.

3.8 Accordingly, a contractor's paragraph 2.3 total, minus any Historic Opt-Outs Adjustment to which it was entitled, was its Global Sum Comparator.

3.9 If the contractor's Final GSE was less than its Global Sum Comparator, a Correction Factor was not payable in respect of that contractor. However, if its Final GSE was greater than its Global Sum Comparator, Correction Factor Monthly Payments ("CFMPs") had to be

paid by the Health Board to the contractor under its GMS contract. The amount of the CFMPs payable was the difference between the contractor's Final GSE and its Global Sum Comparator, divided by twelve.

***Review and revision of Correction Factor Monthly Payments in respect of financial year 2013/14 and financial years thereafter.***

- 3.10 At the start of each financial year, Health Boards must determine which of their contractors are entitled to CFMPs. Generally, these will be:
- a) the contractors to which CFMPs were payable at the end of the previous financial year and which are still in existence at the start of the new financial year; and
  - b) any contractors affected by a partnership merger or split whose contract takes effect at the start of the financial year and who, by virtue of the paragraphs 3.16 to 3.19 below, is entitled to receive CFMPs calculated in accordance with those paragraphs.
- 3.11 The baseline monthly figure amount for the calculation of a contractor's CFMP for a new financial year is established as follows:
- a) in the case of a contractor affected by a partnership merger or split that takes effect at the start of the financial year, if, by virtue of paragraphs 3.16 to 3.19 below, the contractor becomes entitled to CFMPs, or the amount of its CFMPs is to change, a calculation must first be made of the amount to which it would have been entitled as a CFMP in the previous financial year, had the merger or split taken effect then, and that amount is to be the baseline monthly figure amount for the calculation of its CFMPs for the new financial year;
  - b) in all other cases, the baseline monthly amount for the calculation of the contractor's CFMPs for the new financial year will be the monthly figure for any CFMP that was payable at the end of the previous financial year.
- 3.12 Once the baseline monthly figure amount of a contractor's CFMPs has been established, that amount is to be updated
- (a) for the financial year 2013 to 2014 by 2%;
  - (b) for the financial year 2014 to 2015 and subsequent financial years, - the CFMP will continue to be paid monthly, although it may be subject to retrospective adjustment once any uplift to the global sum and reduction in the corrector factor have been calculated, CFMPs are to fall due on the last day of each month.
- 3.14 Thereafter, throughout the new financial year, unless the contractor is subject to a partnership merger or split, the amount of the contractor's CFMPs is to remain unchanged, even if the amount of the contractor's Payable GSMP changes.



***Practice mergers or splits.***

3.15 Except as provided for in paragraphs 3.16 to 3.20, a contractor with a GMS contract which takes effect, or is treated as taking effect for payment purposes, after 1st April 2004 will not be entitled to CFMPs.

3.16 If-

- (a) a new contractor comes into existence as the result of a merger between one or more other contractors; and
- (b) that merger led to the termination of GMS contracts and the agreement of a new GMS contract,

the new contractor is to be entitled to a CFMP that is the total of any CFMPs payable under the terminated GMS contracts.

3.17 If-

- (a) a new contractor comes into existence as the result of a partnership split of a previous contractor (including a split in order to reconstitute as a company limited by shares);
- (b) at least some of the members of the new contractor were members of the previous contractor; and
- (c) the split led to the termination of the previous contractor's GMS contract,

the new contractor will be entitled to a proportion of any CFMP payable under the terminated contract. The proportions are to be worked out on a *pro rata* basis, based upon the number of patients registered with the previous contractor (i.e. immediately before its contract is terminated) who will be registered with the new contractor when its new contract takes effect.

3.18 However, where a contractor that is a company limited by shares becomes entitled to CFMPs as a consequence of a partnership split in order to reconstitute as a company limited by shares, that entitlement is conferred exclusively on that company and is extinguished if that company is dissolved. Following such a dissolution, discretionary payments under section 17Q of the 1978 Act, equivalent to correction factor payments, could be made by the Health Board to a new contractor to whom the extinguished company's patients are transferred. Such payments may be appropriate, for example, where a group of providers in a partnership become a company limited by shares and then again a partnership, but all the while they continue to provide essentially the same services to essentially the same number of patients.

3.19 If-

- (a) a new GMS contract is agreed by a contractor which has split from a previously established contractor; but

- (b) the split did not lead to the termination of the previously established contractor's GMS contract,

the new contractor will not be entitled to any of the previously established contractor's CFMP unless, as a result of the split, an agreed number, or a number ascertainable by the Health Board(s) for the contractors, of patients have transferred to the new contractor at or before the end of the first full quarter after the new GMS contract takes effect.

3.20 If such a transfer has taken place, the previously established contractor and the new contractor are each to be entitled to a proportion of the CFMP that has been payable under the previously established contractor's GMS contract. The proportions are to be worked out on a *pro rata* basis. The new contractor's fraction of the CFMP will be—

- (a) the number of patients transferred to it from the previously established contractor; divided by
- (b) the number of patients registered with the previously established contractor immediately before the split that gave rise to the transfer.

and the old contractor's CFMP is to be reduced accordingly.

***Conditions attached to payment of Correction Factor Monthly Payments.***

3.21 CFMPs, or any part thereof, are only payable if the contractor satisfies the following conditions—

- (a) the contractor must make available any information which the Health Board does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's CFMP; and
- (b) all information supplied pursuant to or in accordance with this paragraph must be accurate.

3.22 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any or any part of a CFMP that is otherwise payable.

## PART 2

### QUALITY AND OUTCOMES FRAMEWORK

#### 4. Quality and Outcomes Framework: General

4.1 The Quality and Outcomes Framework (QOF) is set out in Annex E to this SFE. Participation in the QOF is voluntary.

##### *Types of payments in relation to the QOF.*

4.2 Essentially, there are two types of payments that are made in relation to the QOF: Aspiration Payments and Achievement Payments. Aspiration Payments are, in effect, a part payment in advance in respect of achievement under the QOF, and may be calculated using one of two different methods—

- (a) a calculation based on 70% of the contractor's previous year's Unadjusted Achievement Payment. This figure is then further multiplied by the figure which is the product of the maximum number of points available under QOF for the financial year in respect of which calculation is being made, divided by the maximum number of points available under the QOF in the previous financial year; or
- (b) a calculation based on the total number of points that a contractor has agreed with a Health Board that it is aspiring towards under the QOF during the financial year in respect of which the Aspiration Payment is made. This total is its Aspiration Points Total. The points available are set out in the QOF indicators in the QOF, which have numbers of points attached to particular performance indicators (negative points totals in relation to indicators are always to be disregarded).

4.3 If a contractor is to have an Aspiration Points Total, this is to be agreed between it and the Health Board—

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

4.4 Achievement Payments are payments based on the points total that the contractor achieves under the QOF – as calculated, generally speaking (see paragraph 6.2), on the last day of the financial year or the date on which its contract terminates (this points total is its Achievement Points Total). The payments are to be made in respect of all Achievement Points actually achieved, whether or not the contractor was seeking to achieve those points, but the final amount also takes into account the deduction of the Aspiration Payments that the contractor has received in respect of the same financial year.

***The seven principal domains of the QOF.***

4.5 The QOF is divided into seven principal domains, which are: the clinical domain; the medicines management domain; the public health domain; quality and productivity domain, the patient experience domain; the quality improvement domain and the additional services domain.

***Calculation of points in the clinical domain.***

4.6 The clinical domain contains 23 clinical areas, for each of which there are a number of indicators set out in tables in Section 2 of the QOF. These indicators contain standards against which the performance of the contractor will be assessed.

4.7 Some of the indicators simply require particular tasks to be accomplished (i.e. the production of disease registers), and the standards contained in the indicators do not have, opposite them in the tables of indicators, percentage figures for Achievement Thresholds. The points available in relation to these indicators are only obtainable (and then in full) if the task is accomplished. Guidance on what is required to accomplish these tasks is given in Section 3 of the Scottish QOF Guidance.

4.8 Other indicators have designated Achievement Thresholds. The contractor's performance against the standards set out in these indicators is assessed by a percentage – generally of the patients suffering from a particular disease in respect of whom a specific task is to be performed or a specific outcome recorded. 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.

4.9 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. 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.

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

- (a) the number of patients registered with the contractor in respect of whom the task has been performed or outcome achieved (A); by
- (b) the number produced by subtracting from the total number of patients registered with the contractor with the relevant medical condition (B) the number of patients to be excluded from the calculation on the basis of the provisions in the QOF on exception reporting (C).

The provisions on exception reporting are set out in Section 8 of the Scottish QOF Guidance. This fraction is then multiplied by 100 for the percentage score. The calculation can be expressed as:

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

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

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

4.12 The result is the number of points to which the contractor is entitled in relation to that indicator.

#### ***Calculation of points in the medicines management domain.***

4.13 This domain is itself split into 3 sub-domains: medicines management 001(S), medicines management 002(S) and medicines management 003(S). Section 2.4 of the QOF contains the detail of indicators for each of these sub-domains, which in turn contain standards against which the performance of the contractor will be assessed.

4.13.1 The standards set relate to the task performed or an outcome to be achieved. The points available in relation to the indicators are only obtainable in full if the task is in fact accomplished or the outcome achieved.

4.13.2 Guidance on what is required to accomplish the task or achieve the outcome is given in Section 6(iii) of the Scottish QOF Guidance.

#### ***Calculation of points in the public health domain.***

4.14 The public health domain contains 3 indicators (previous QOF organisational indicators records 11, records 17 and education 5). The new indicators are BP001 (Blood pressure - 15 QOF Points), replacing the previous records 11 and records 17, and SMOK003 replacing the previous information 5 (2 QOF Points). The 17 QOF points for these indicators will only be obtainable if the relevant outcomes recorded are achieved. Section 2.4 of the QOF contains the detail of indicators for each of these sub-domains, which in turn contain standards against which the performance of the contractor will be assessed.

NB: SMOK003 has been retained in the Smoking Cessation section of the Clinical Domain.

4.15 Guidance on what is required to gain the points set out in this domain is given in Section 6(iv) of the Scottish QOF guidance.

***Calculation of points in the quality and productivity domain.***

4.16 The quality and productivity domain contains 9 indicators which are set out in Section 2.3 of the QOF. The indicators associated with secondary care outpatient referrals and emergency care (QP001(S), QP002(S), QP003(S), ) continue partly as for 2013/14 and new indicators associated with improving care for patients at high risk of emergency admission (QP004(S), QP005(S), QP006(S), QP007(S), QP008(S), QP009(S) introduced for 2013/14 and 2014/15.

4.16.1 For those GP practices and Health Boards who have an existing or planned significant level of (pre-2013/14 contract year) Anticipatory Care Planning activity, those Health Boards and GP practices, the latter via their LMCs, can agree to revert to what was QOF QP 9 to QP14 inclusive in the QOF Guidance from 2012/13, in place of QOF QP004(S) to QP009(S) inclusive from 2013/14. The mechanism for payment for this would also be agreed, most likely by a manual year end adjustment by the Board.

4.17 Guidance on what is required to gain the points set out in this domain is given in Section 5 of the Scottish QOF guidance

***Calculation of points in the patient experience domain.***

4.18 The patient experience domain contains one indicator which is set out in Section 2.4 of the QOF and relates to the length of patient consultations. The points available for this indicator will only be obtainable (and then in full) if the relevant outcomes recorded are achieved.

4.19 Guidance on what is required to gain the points set out in this domain is given in Section 6(i) of the Scottish QOF guidance.

***Calculation of points in the additional services domain.***

4.20 The additional services domain relates to the following Additional Services: cervical screening services; child health surveillance; maternity services; and contraceptive services. For each of these services, there are a number of indicators, set out in tables in Section 2.2 of the QOF, which contain standards against which the performance of the contractor will be assessed.

4.21 The child health surveillance and maternity medical services indicators require particular services to be offered – and the points available in relation to these indicators will only be obtainable (and then in full) if the service is offered to the relevant target population.

4.22 The first contraceptive indicator (SH1) and all but one of the cervical screening services indicators require particular tasks to be performed in relation to a target population, and the points available in relation to these indicators will only be obtainable (and then in full) if the task is accomplished.

4.23 The second and third contraceptive indicators (SH2 and SH3) and one of the cervical screening services indicators (CS1) have designated achievement thresholds, and the method for calculating points in relation to these indicators is the same as the method for calculating points in relation to this type of indicator in the clinical domain.

4.24 Guidance on what is required to gain the points set out in this domain is given in Section 4 of the Scottish QOF guidance.

***Calculation of points in the quality improvement domain.***

4.25 The quality improvement domain contains two indicators (QI001(S) and QI002(S)) which is set out in Section 2.4 of the QOF.

4.26 Guidance on what is required to gain the points set out in this domain is given in Section 6(ii) of the Scottish QOF guidance.

## 5. Aspiration Payments

### *Calculation of Monthly Aspiration Payments: general.*

5.1 At the start of each financial year – or if a GMS contract starts after the start of the financial year, for the date on which the GMS contract takes effect – subject to paragraph 5.2(b), Health Boards must calculate for each contractor that has agreed to participate in the QOF the amount of its Monthly Aspiration Payments for that, or for the rest of that, financial year.

5.2 As indicated in paragraph 4.2 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 Payments in respect of the contractor by basing the calculation on an Aspiration Points Total, that is the method which is to be used; and
- (b) if the contractor's GMS contract is to take effect on or after 2nd February but before 1st April, no Aspiration Points Total is to be agreed for the financial year into which that 2nd February falls, so the contractor will not be able to claim Monthly Aspiration Payments in that financial year. However, the contractor will nevertheless be entitled to Achievement Payments under the QOF if it participates in the QOF.

### *Calculation of Monthly Aspiration Payments: the 70% method.*

5.3 If–

- (a) the contractor's GMS contract took effect before the start of the financial year in respect of which the claim for Monthly Aspiration Payments is made; and
- (b) in respect of the previous financial year the contractor was entitled to an Achievement Payment, under this SFE,

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

5.4 To calculate a contractor's Monthly Aspiration Payments by the 70% method, the contractor's Unadjusted Achievement Payment for the previous year needs to be established that is, the total established under paragraph 5.39 of the 2004/5 SFE or paragraph 6.7 of this SFE. Generally, this will not be possible in the first quarter of the financial year, and so a Provisional Achievement Payment will need to be established by the Health Board. The amount of this payment is to be based on the contractor's return submitted in accordance with paragraph 5.35 of the 2004/5 SFE or paragraph 6.3 of this SFE.

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



5.6 Once an annual amount for the contractor's Provisional Achievement Payment has been determined, this is to be multiplied by the QOF Uprating Index for the financial year. The QOF Uprating Index is to be determined by dividing—

- (a) the amount specified in paragraph 6.6 as the value of each Achievement Point for the financial year in respect of which the claim for Monthly Aspiration Payments is being made; by
- (b) the amount that was specified in paragraph 6.6 in respect of the previous financial year,

and rounding the resulting figure to fifteen decimal places.

5.7 The total produced by paragraph 5.6 is then to be multiplied by 70%. This figure is then further multiplied by the figure which is the product of the maximum number of points available under the QOF for the financial year in respect of which the calculation is being made divided by the maximum number of points available under the QOF in the previous financial year. (By way of example, the figures used for this element of the calculation in the financial year 2013/14 are 923 and 1000 respectively, 923 points being the maximum number of points available under the QOF for the financial year 2013/14 and 1000 being the maximum number of points available under the QOF for the financial year 2012/13.) The resulting figure is the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to paragraphs 5.9, 5.10 and 6.10, is to be the contractor's Monthly Aspiration Payment, as calculated by the 70% method.

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

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

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

***Calculation of Monthly Aspiration Payments: the Aspiration Points Total method.***

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

5.12 If the contractor is to have its Monthly Aspiration Payments calculated by this method, at the start of each financial year – or if a GMS contract starts after the start of the financial year, for the date on which the GMS contract takes effect – an Aspiration Points Total is to be agreed between the contractor and the Health Board. As indicated in paragraph 4.2(b) above, an Aspiration Points Total is the total number of points that the contractor has agreed with a Health Board that it is aspiring towards under the QOF during the financial year in respect of which the Aspiration Payment is made.

5.13 If the Health Board and the contractor have agreed an Aspiration Points Total for the contractor, that total is to be divided by three. The resulting figure is to be multiplied by £133.47, 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 6.10, is to be the contractor's Monthly Aspiration Payment, as calculated by the Aspiration Points Total method.

***Payment arrangements for Monthly Aspiration Payments.***

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

5.15 The Health Board must thereafter pay the contractor under its 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, its Monthly Aspiration Payment in respect of that first part month (which will have been calculated by the Aspiration Points Total method) is to be adjusted by the fraction produced by dividing–

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

5.16 The amount of a contractor's Monthly Aspiration Payments is thereafter to remain unchanged throughout the financial year, even when its 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.***

5.17 Monthly Aspiration Payments, or any part thereof, are only payable if the contractor satisfies the following conditions–

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

5.18 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any or any part of a Monthly Aspiration Payment that is otherwise payable.

## 6. Achievement Payments

### *Basis of Achievement Payments.*

6.1 Achievement Payments are to be based on the Achievement Points to which a contractor is entitled at the end of the financial year, as calculated in accordance with this Section and Section 4.

6.2 The date in respect of which the assessment of achievement points is to be made is the last day of the financial year, subject to the following exceptions—

- (a) if a contractor is under an obligation, under its GMS contract, to provide an additional service for part of the financial year but ceases providing that service before the end of the financial year—
  - (i) permanently; or
  - (ii) temporarily, but does not then resume providing the service before the end of the financial year;

the assessment of the Achievement Points to which it is entitled in respect of that service is to be made in respect of the last date in the financial year on which it was under an obligation, under its GMS contract, to provide that service; and

- (b) if a GMS contract terminates before the end of the financial year, the assessment of the Achievement Points to which it is entitled is to be made in respect of the last date in the financial year on which it was under an obligation, under its GMS contract, to provide essential services.

### *Returns in respect of Achievement Payments.*

6.3 In order to make a claim for an Achievement Payment, a contractor must make a return in respect of the information required of it by the Health Board in order for the Health Board to calculate its Achievement Payment. Where a GMS contract terminates before the end of the financial year, a contractor may make a return at that stage in respect of the information necessary to calculate the Achievement Payment to which it is entitled in respect of that financial year.

6.4 On the basis of that return but subject to any revision of the Achievement Points totals that the Health Board may reasonably see fit to make—

- (a) to correct the accuracy of any points total; or
- (b) having regard to any guidance issued by SGH&SCID;

the Health Board is to calculate the contractor's Achievement Payment as follows.

### ***Calculation of Achievement Payments.***

6.5 The parts of the Achievement Payment that relate to the clinical domain (other than the area relating to palliative care and indicators 1 and 4 in the area relating to smoking) and the additional services domain are calculated in a different way from the parts relating to the other domains. As regards—

- (a) the clinical domain (other than the area relating to palliative care and indicators 1 and 4 in the area relating to smoking), first a calculation needs to be made of an Adjusted Practice Disease Factor for each disease area. (In the case of a GMS contract that only has effect for part of a financial year, there are specific provisions, set out in more detail in Annex G, as to the Adjusted Practice Disease Factor that is to be taken into account in calculating the contractor's Achievement Payment.) This is then multiplied by £133.47 and by the contractor's Achievement Points total in respect of the disease area to produce a cash amount for that disease area. Then the cash totals in respect of all the individual disease areas in the domain are to be added together to give the cash total in respect of the domain. A fuller explanation of the calculation of Adjusted Practice Disease Factors, and of the provisions that apply in the case of a GMS contract that only has effect for part of a financial year, is given in Annex G; and
- (b) the additional services domain, the Achievement Points total in respect of each additional service is to be assessed in accordance with the guidance in Annex F, and a calculation is thereafter to be made of the cash total in respect of the domain in the manner set out in that guidance.

The part of the Achievement Payment that relates to the palliative care area and to indicators 1 and 4 in the smoking area of the clinical domain will be calculated in accordance with paragraph 6.6.

6.6 As regards all the other Achievement Points gained by the contractor, the total number of them is to be multiplied by £133.47.<sup>5</sup>

6.7 The cash totals produced under paragraphs 6.5 and 6.6 are then added together and multiplied by the contractor's CPI, calculated in accordance with the provisions of paragraph 2.18 –

- (a) at the start of the final quarter of the financial year to which the Achievement Payment relates;
- (b) if its GMS contract takes effect after the start of the final quarter of the financial year to which the Achievement Payment relates, on the date its GMS contract takes effect; or
- (c) if its GMS contract has been terminated, its CPI at the start of the quarter during which its GMS contract was terminated.

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<sup>5</sup> The amount specified in paragraph 6.6 in respect of the financial year 1 April 2012 to 31 March 2013 was £133.47.

6.8 If the contractor's GMS contract had effect –

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

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

***Recovery where Aspiration Payments have been too high.***

6.10 If the resulting amount from the calculation under paragraph 6.9 is a negative amount, that negative amount, expressed as a positive amount (“the paragraph 6.9 amount”), is to be recovered by the Health Board from the contractor in one of two ways–

- (a) to the extent that it is possible to do so, the paragraph 6.9 amount is to be recovered by deducting one twelfth of that amount from each of the contractor's Monthly Aspiration Payments for the financial year after the financial year to which the paragraph 6.9 amount relates. In these circumstances –
  - (i) the gross amount of its Monthly Aspiration Payments for accounting and superannuation purposes in the financial year after the financial year to which the paragraph 6.9 amount relates is to be the amount to which the contractor is otherwise entitled under paragraphs 5.7 to 5.10 or paragraph 5.13; and
  - (ii) the paragraph 6.9 amount is to be treated for accounting and superannuation purposes as an overpayment in respect of the contractor's Monthly Aspiration Payments for the financial year to which the paragraph 6.9 amount relates; or
- (b) if it is not possible to recover all or part of the paragraph 6.9 amount by the method described in sub-paragraph (a) (for example, because of the termination of the GMS contract after a partnership split), the amount that cannot be so recovered is to be treated as an overpayment in respect of the contractor's Monthly Aspiration Payments for the year to which the paragraph 6.9 amount relates, and is to be recovered accordingly (i.e. in accordance with paragraph 21.1).

- 6.11 Where the resulting amount from the calculation under paragraph 5.40 of the 2004/5 SFE is a negative amount, that negative amount, expressed as a positive amount (“the paragraph 5.40 amount”), is to be treated as an overpayment in respect of the contractor’s Payable GSMPs for the financial year 2005 to 2006, and is to be recovered accordingly (i.e. in accordance with paragraph 21.1).

***Accounting arrangements and due date for Achievement Payments.***

6.12 The contractor’s Achievement Payment, as calculated in accordance with paragraph 6.9, is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year into which the date in respect of which the assessment of Achievement Points on which the Achievement Payment is based (“the relevant date”) falls, and the Achievement Payment is to fall due–

- (a) where the GMS contract terminates before the end of the financial year into which the relevant date falls, at the end of the quarter after the quarter during which the GMS contract was terminated; and
- (b) in all other cases, at the end of the first quarter of the financial year after the financial year into which the relevant date falls.

***Conditions attached to Achievement Payments.***

6.13 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 6.3;
- (b) the contractor must ensure that all the information that it makes available to the Health Board in respect of the calculation of its Achievement Payment is based on accurate and reliable information, and that any calculations it makes are carried out correctly;
- (c) the contractor must ensure that it is able to provide any information that the Health Board may reasonably request of it to demonstrate that it is entitled to each Achievement Point to which it says it is entitled, and the contractor must make that information available to the Health Board on request;
- (d) the contractor must make any returns required of it (whether computerised or otherwise) to PSD of NHS National Services Scotland, and do so promptly and fully;
- (e) the contractor must co-operate fully with any reasonable inspection or review (including the Health Board’s QOF annual review) that the Health Board or another relevant statutory authority wishes to undertake in respect of the Achievement Points to which it says it is entitled; and
- (f) all information supplied pursuant to or in accordance with this paragraph must be accurate.

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



## PART 3

### DIRECTED ENHANCED SERVICES

#### 7. NOT ALLOCATED

#### 8. Childhood Immunisations Scheme

8.1 Childhood Immunisation and Pre-school Booster Services are classified as Additional Services. If contractors are providing these services to patients registered with them, Health Boards are to seek to agree a Childhood Immunisations Scheme plan with them, as part of their GMS contract. This plan will be the mechanism under which the payments set out in this Section will be payable.

##### *Childhood Immunisations Scheme plans.*

8.2 Childhood Immunisations Scheme plans are to cover the matters set out in direction 4(2)(a) to (g) of the DES Directions.

##### *Target payments in respect of two-year-olds.*

8.3 Health Boards must pay to a contractor under its GMS contract a Quarterly Two-Year-Olds Immunisation Payment (“Quarterly TYOIP”) if it qualifies for that payment. A contractor qualifies for that payment if, on the first day of a quarter—

- (a) the contractor has, as part of its GMS contract, a Childhood Immunisations Scheme plan which has been agreed with its Health Board; and
- (b) subject to paragraph 8.3A, as regards the cohort of children, established on that day, who are registered with the contractor and who are aged two (i.e. who have passed their second birthday but not yet their third), by the end of that quarter at least 70%, for the lower payment, or at least 90%, for the higher payment, have completed the recommended immunisation courses (ie those that have been recommended nationally and by the World Health Organisation) for protection against—
  - (i) diphtheria, tetanus, poliomyelitis, pertussis and Haemophilus influenzae type B (HiB);
  - (ii) measles/mumps/rubella; and
  - (iii) Meningitis C (Men C).

8.3A In establishing whether the required percentage of the cohort of children referred to in paragraph 8.3 have completed the recommended immunisations courses referred to in that paragraph, the Health Board is not required to determine whether any of that cohort have

received the HiB/MenC Booster, recommended in the provisions set out at Annex I to this SFE, for administration around the age 12 - 13 months. The administration of that HiB/MenC Booster vaccination is not a requirement for payment under this Section.

***Calculation of Quarterly Two-Year-Olds Immunisation Payment.***

8.4 Health Boards will first need to determine the number of completed immunisation courses that are required over the three disease groups in paragraph 8.3(b) in order to meet either the 70% or 90% target. To do this the contractor will need to provide the Health Board with the number of two-year-olds (**A**) whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which the contractor is seeking payment (this is the cohort of children in respect of whom the calculation is to be made), and then the Health Board must make the following calculations—

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

8.5 Health Boards will then need to calculate which, if any, target was achieved. To do this, a Health Board will also need from the contractor the number of children in the cohort of children in respect of whom the calculation is to be made who, by the end of the quarter to which the calculation relates, have completed immunisation courses in each of the three disease groups (**C1** + **C2** + **C3**). In this section 8, **C1** is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 8.3(b)(i); **C2** is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 8.3(b)(ii) and **C3** is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 8.3(b)(iii). Only completed immunisation courses (whether or not carried out by the contractor) are to count towards the determination of whether or not the targets are achieved. No adjustment is to be made for exception reporting. A calculation (which provides for an additional weighting factor of 2 to be given to immunisation courses in respect of the diseases referred to in paragraph 8.3(b)(i)) is then to be made of whether or not the targets are achieved—

- (a) if  $(\mathbf{C1} \times 2) + \mathbf{C2} + \mathbf{C3} \geq \mathbf{B}^1$ , then the 70% target is achieved; and
- (b) if  $(\mathbf{C1} \times 2) + \mathbf{C2} + \mathbf{C3} \geq \mathbf{B}^2$ , then the 90% target is achieved.

8.6 Next the Health Board will need to calculate the number of the completed immunisation courses, notified under paragraph 8.11(b)(ii), that the contractor can use to count towards achievement of the targets (**D**). To do this, the contractor will need to provide the Health Board with a breakdown of how many immunisation courses in each disease group were completed before the end of the quarter to which the calculation relates by a completing immunisation administered, within the NHS (and not necessarily during the quarter to which the calculation relates), by-

- (a) the Contractor;

- (b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “GMS contractor” includes a contractor providing services under section 28Q of the 1977 Act, a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “PMS Contractor ” includes a contractor providing services under section 28C of the 1977 Act, a contractor providing services under section 17C of the National Health Services (Scotland) Act 1978 and a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (d) an Alternative Provider Medical Services contractor (“APMS contractor”) as part of primary medical services to a patient who was at that time registered with that contractor (where the term “APMS contractor” includes a contractor providing services under arrangements made under section 16CC(2)(b) of the 1977Act, a contractor providing services under arrangements made under section 2C(2) of the National Health Services (Scotland) Act 1978 and a contractor providing services under arrangements made under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or
- (e) a Primary Care Trust Medical Services practice (“PCTMS practice”) as part of primary medical services to a patient who was at that time registered with that practice (where the term “a PCTMS practice” includes a practice providing services under arrangements made under section 16CC(2)(a) of the 1977Act and a practice providing services under arrangements made under Article 56(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 (such arrangements in Northern Ireland being referred to as Health and Social Services Board Medical Services)).

For the purposes of this paragraph 8.6 and paragraph 8.7, an immunisation course is considered as being completed when the final immunisation needed to complete the immunisation course (the “completing immunisation”) is administered.

8.7 Once the Health Board has that information, **(D)** is to be calculated as follows—

$$\begin{array}{r}
 \mathbf{C1} \times 2 \text{ minus } \mathbf{E1} \times 2 \\
 + \quad \mathbf{C2} \text{ minus } \mathbf{E2} \\
 + \quad \mathbf{C3} \text{ minus } \mathbf{E3} \\
 \hline
 = \quad \quad \quad \mathbf{D}
 \end{array}$$

For these purposes—

- (a) **(E<sup>x</sup>)** is the number of completed immunisation courses in each disease group where the completing immunisation was carried out other than by a contractor or practice of the type specified in, and under the circumstances specified in,

any of the paragraphs 8.6(a) to (e) (e.g. for the diseases referred to in paragraph 8.3(b)(i), **E1**);

- (b) (**C<sup>X</sup>**) is the number of children in the cohort of children in respect of whom the calculation is to be made who have completed the immunisation course in respect of a particular disease group (e.g. for the diseases referred to in paragraph 8.3(b)(i), **C1**);
- (c) in the case of the disease group referred to in paragraph 8.3(b)(i), the value of  $(C1 \times 2) - (E1 \times 2)$  can never be greater than  $(A \times 2) \times 0.7$  or  $0.9$  (depending on which target is achieved); where it is, it is treated as the result of  $(A \times 2) \times 0.7$  or, as the case may be,  $0.9$ ; and
- (d) in any other case the value of **C<sup>X</sup>-E<sup>X</sup>** can never be greater than **A x 0.7** or **0.9** (depending on which target achieved); where it is, it is treated as the result of: **A x 0.7** or as the case may be **0.9**.

8.8 The maximum amounts payable to a contractor will depend on the number of children aged two whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 63. The maximum amounts payable to the contractor (**F**) are therefore to be calculated as follows–

- (a) where the 70% target is achieved:  $(F^1) = \frac{A}{63} \times \text{£}722.32$ ; or
- (b) where the 90% target is achieved:  $(F^2) = \frac{A}{63} \times \text{£}2,166.97$

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

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

8.10 The amount payable as a Quarterly TYOIP is to fall due on the last day of the quarter the contractor is seeking payment (i.e. at the end of the quarter after the last quarter in which immunisations were carried out that could count towards the targets). However, if the contractor delays providing the information the Health Board needs to calculate its Quarterly TYOIP beyond the Health Board's cut-off date for calculating quarterly payments, the amount is to fall due at the end of the next quarter (that is, just under nine months after the cohort was established. No Quarterly TYOIP is payable if the contractor provides the necessary information more than four months after the final date for immunisations which could count towards the payment. The following table summarises the timetable in accordance with which TYOIPs will be made, unless the information the Health Board needs to calculate the payment is supplied late.

<i>Quarter in respect of which the payment is made</i>	<i>Date the cohort of children is established</i>	<i>Final date for immunisations which count towards the payment</i>	<i>Final date for submitting returns to the Health Board</i>	<i>Date the payment falls due</i>
First quarter of the financial year	1 <sup>st</sup> April	31 <sup>st</sup> March	Date in September set by the Health Board	30 <sup>th</sup> June
Second quarter of the financial year	1 <sup>st</sup> July	30 <sup>th</sup> June	Date in December set by the Health Board	30 <sup>th</sup> September
Third quarter of the financial year	1 <sup>st</sup> October	30 <sup>th</sup> September	Date in March set by the Health Board	31 <sup>st</sup> December
Fourth quarter of the financial year	1 <sup>st</sup> January	31 <sup>st</sup> December	Date in June set by the Health Board	31 <sup>st</sup> March

***Conditions attached to Quarterly Two-Year-Olds Immunisation Payments.***

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

- (a) the contractor must meet its obligations under its Childhood Immunisations Scheme plan;
- (b) the contractor must make available to the Health Board sufficient information to enable the Health Board to calculate the contractor's Quarterly TYOIP. In particular, the contractor must supply the following figures—
  - (i) the number of two-year-olds whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which a payment is claimed;
  - (ii) how many of those two-year-olds have completed each of the recommended immunisation courses (i.e. that have been recommended nationally and by the World Health Organisation) for protection against the disease groups referred to in paragraph 8.3(b) by the end of the quarter in respect of which a payment is claimed; and
  - (iii) of those completed immunisation courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 8.6 (a) to (e)); and
- (c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

8.12 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of all or part of a Quarterly TYIOP that is otherwise payable.

***Target payments in respect of five-year-olds.***

8.13 Health Boards must pay to a contractor under its GMS contract a Quarterly Five-Year-Olds Immunisation Payment (“Quarterly FYOIP”) if it qualifies for that payment. A contractor qualifies for that payment if–

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

***Calculation of Quarterly Five-Year-Olds Immunisation Payment.***

8.14 Health Boards will need to determine the number of completed 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 Health Board with the number of five-year-olds (**A**) whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which the contractor is seeking payment (this is the cohort of children in respect of whom the calculation is to be made), and then the Health Board must make the following calculations–

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

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

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

8.16 Next the Health Board will need to calculate the number of the completed courses, notified under paragraph 8.21(b)(ii), that the contractor can use to count towards achievement of the targets (**D**), the initial value of which is (**C**) minus the number of children whose completed courses were not carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the sub-paragraphs (a) to (e) below. To do this, the contractor will need to provide the Health Board with a breakdown of how many of the completed courses were carried out before the end of the quarter to which the calculation relates by a completing course administered, within the NHS (and not necessarily during the quarter to which the calculation relates), by-

- (a) the Contractor;
- (b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “GMS contractor” includes a contractor providing services under section 28Q of the 1977 Act, a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “PMS Contractor” includes a contractor providing services under section 28C of the 1977 Act, a contractor providing services under section 17C of the National Health Services (Scotland) Act 1978 and a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (d) an Alternative Provider Medical Services contractor (“APMS contractor”) as part of primary medical services to a patient who was at that time registered with that contractor (where the term “APMS contractor” includes a contractor providing services under arrangements made under section 16CC(2)(b) of the 1977 Act, a contractor providing services under arrangements made under section 2C(2) of the National Health Services (Scotland) Act 1978 and a contractor providing services under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or
- (e) a Primary Care Trust Medical Services practice (“PCTMS practice”) as part of primary medical services to a patient who was at that time registered with that practice (where the term “a PCTMS practice” includes a practice providing services under arrangements made under section 16CC(2)(a) of the 1977 Act and a practice providing services under Article 56(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 (such arrangements in Northern Ireland being referred to as Health and Social Services Board Medical Services).

8.17 If  $D > B^1$  or  $B^2$  (depending on the target achieved), then (**D**) is adjusted to equal the value of ( $B^1$ ) or ( $B^2$ ) as appropriate.

8.18 The maximum amounts payable to a contractor will depend on the number of children aged five whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 58. The maximum amounts payable to the contractor (**E**) are therefore to be calculated as follows–

- (a) where the 70% target is achieved:  $E^1 = \frac{A}{58} \times \text{£}223.73$  or
- (b) where the 90% target is achieved:  $E^2 = \frac{A}{58} \times \text{£}671.21$

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

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

8.20 The amount payable as a Quarterly FYOIP is to fall due on the last day of the quarter the contractor is seeking payment (ie at the end of the quarter after the last quarter in which completed courses were carried out that could count towards the targets). However, if the contractor delays providing the information the Health Board needs to calculate its Quarterly FYOIP beyond the Health Board's cut-off date for calculating quarterly payments the amount is to fall due at the end of the next quarter (that is, just under nine months after the cohort was established). No Quarterly FYOIP is payable if the contractor provides the necessary information more than four months after the final date for immunisations which could count towards the payment. The table in paragraph 8.10 summarises the timetable in accordance with which FYOIPs will be made, unless the information the Health Board needs to calculate the payment is supplied late.

***Conditions attached to Quarterly Five-Year-Olds Immunisation Payments.***

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

- (a) the contractor must meet its obligations under its Childhood Immunisation Scheme plan;
- (b) the contractor must supply to the Health Board with sufficient information to enable the Health Board to calculate the contractor's Quarterly FYOIP. In particular, the contractor must supply the following figures–
  - (i) the number of five-year-olds whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter in respect of which a payment is claimed;
  - (ii) how many of those five-year-olds have received the complete course of recommended reinforcing doses (ie that have been recommended nationally and by the World Health Organisation) for protection against diphtheria, tetanus, pertussis and poliomyelitis by the end of the quarter in respect of which a payment is claimed; and



- (iii) of those completed courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 8.16 (a) to (e); and
- (c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

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

8.23 Contractors may use the data held on SIRS, or any equivalent system, when providing relevant information to Health Boards.

## PART 4

### PAYMENTS FOR SPECIFIC PURPOSES

#### **8A. Pneumococcal Vaccination, HiB/MenC Booster Vaccination and Rotavirus Vaccination**

8A.1 Changes were introduced to the routine childhood immunisation programme with effect from 1 June 2013. Details of those changes, which relate to the introduction of rotavirus into the routine childhood immunisation programme, changes to the schedule for the Meningitis C (Men C) vaccinations, were set out in a letter dated 7 May 2013 from the Chief Medical Officer, the Chief Nursing Officer and the Chief Pharmaceutical Officer; SGH&SCID/CMO(2013) 6. The Scottish Immunisation Programme – General Practice Elements is set out in Annex I to this SFE.

8A.2 Childhood immunisation and pre-school booster services are classified as Additional Services. This Section makes provision in respect of payments to be made in respect of the administration by a contractor, which is contracted to provide the childhood immunisation and pre-school booster Additional Service, of the pneumococcal conjugate vaccine (PCV) and the combined HiB and Men C booster vaccine (HiB/MenC) as part of the routine childhood immunisation schedule and in certain non-routine cases.

8A.3 The provisions of this section apply with effect from 1 June 2013.

8A.4 References in this Section to the age of a child expressed in months are references to calendar months. Where reference is made to a vaccination being administered at or around a certain age, this is an indication of the recommended schedule for administration of the vaccine contained in the provisions as set out in Annex I to this SFE. The specific timing of the administration of the vaccination, which should be within the parameters of the recommended schedule, is a matter for the clinical judgement of the relevant health care professional.

#### ***Payment for administration of PCV vaccinations and HiB/MenC vaccinations as part of the routine childhood immunisation schedule.***

8A.5 The Health Board must pay to a contractor who qualifies for the payment, a payment of £15.02 in respect of each child registered with the contractor—

- (a) who has received, as part of their routine childhood immunisation schedule, all four of the vaccinations set out in the table at paragraph 8A.7, namely the series of three PCV vaccinations to be administered at two months, four months and around 12 - 13 months, and the HiB/MenC booster vaccination which is to be administered at around 12 – 13 months; and
- (b) in respect of whom the contractor administered the final completing vaccination.

8A.6 For the purpose of paragraph 8A.5(b), the final completing vaccination means the third in the series of three PCV vaccinations which is scheduled, in the table at paragraph 8A.7, to be administered at around 13 months.

8A.7 The table below sets out the schedule for the administration of the PCV and the Hib/MenC vaccinations as part of the routine childhood immunisation schedule.

When to immunise	What is given	How vaccine is given
Two months old	Pneumococcal (PCV)	One injection
Four months old	Pneumococcal (PCV)	One injection
Around 12 months	Haemophilus influenzae type b, Meningitis C (HiB/MenC)	One injection
Around 13 months	Pneumococcal (PCV)	One injection

***Payment for administration of PCV vaccinations other than as part of the routine childhood immunisation schedule.***

8A.8 The Health Board must pay to a contractor who qualifies for the payment, a payment of £15.02 in respect of each child registered with the contractor who has received the PCV vaccination in any of the circumstances set out in paragraphs 8A.10 to 8A.14 and in respect of whom the contractor administered the final completing vaccination..

***Children at increased risk of pneumococcal infection.***

8A.9 The table below sets out what are, for the purposes of this Section, the specific pneumococcal clinical risk groups for children<sup>6</sup>.

Clinical risk group	Examples (decision based on clinical judgement)
Asplenia or dysfunction of the spleen	This includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
Chronic respiratory disease	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neuromuscular disease (e.g. cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless <b>so severe as to require</b> continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below).
Chronic heart disease	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.

<sup>6</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/147977/Green-Book-Chapter-25-v4\\_0.pdf.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147977/Green-Book-Chapter-25-v4_0.pdf.pdf)

Chronic kidney disease	This includes nephrotic syndrome, chronic kidney disease at stages 4 and 5 and those on kidney dialysis or with kidney transplantation.
Chronic liver disease	This includes cirrhosis, biliary atresia, chronic hepatitis.
Diabetes	This includes diabetes mellitus requiring insulin or oral hypoglycaemic drugs. This does not include diabetes that is diet controlled.
Immunosuppression	Due to disease or treatment, including asplenia or splenic dysfunction and HIV infection at all stages. Patients undergoing chemotherapy leading to immunosuppression. Individuals on or likely to be on systemic steroids for more than a month at a dose equivalent to prednisolone 20mg or more per day (any age), or for children under 20kg, a dose of $\geq 1$ mg/kg/day. Some immunocompromised patients may have a suboptimal immunological response to the vaccine.
Individuals with cochlear implants	It is important that immunisation does not delay the cochlear implantation. Where possible, pneumococcal vaccination should be completed at least 2 weeks prior to surgery to allow a protective immune response to develop. In some cases it will not be possible to complete the course prior to surgery. In this instance, the course should be started at any time prior to or following surgery and completed according to the immunisation schedule.
Individuals with Cerebrospinal fluid leaks	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery.

8A.10 Where a child who is in any of the pneumococcal clinical risk groups set out in the table in paragraph 8A.9 presents late for vaccination (that is, not in accordance with the routine schedule set out in paragraph 8A.7), and -  
this

- (a) consequently cannot receive, and has not received, the four vaccinations referred to in paragraph 8A.5(a) in accordance with the routine schedule set out in the table in paragraph 8A.7; but
- (b) who nevertheless still presents in time to enable him to receive, and did receive, two doses of PCV before the age of around 12 months, the HiB/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months,

the Health Board must pay to the contractor administering the final completing vaccination a payment of £15.02 in respect of that child. The third dose of PCV is considered the final completing vaccination for this purpose.

8A.11 Where a child over the age of around 12 months but under the age of 5 years and who is in any of the clinical risk groups set out in the table in paragraph 8A.9 presents late for vaccination (that is, not in accordance with the routine schedule set out in paragraph 8A.7), and—

- (a) consequently cannot receive, and has not received, two doses of PCV before the age of around 12 months, the HiB/Men C booster at around the age of around 12 months and a third dose of PCV at around the age of around 13 months; but
- (b) who nevertheless receives either a single dose of PCV or, if he has asplenia, splenic dysfunction or is immunocompromised, two doses of PCV, the second of which is administered two months after the first dose<sup>7</sup>,

the Health Board must pay to the contractor administering the final completing vaccination a payment of £15.02 in respect of that child. The single dose of PCV or, in the case of a child where a second dose of PCV is required, the second dose of PCV is considered the final completing vaccination for this purpose.

***Children over the age of 13 months but under 5 years who have previously had invasive pneumococcal disease.***

8A.12 Where a child who is over 13 months but under 5 years and who has previously had invasive pneumococcal disease receives a single dose of PCV in accordance with the recommendation contained in paragraph 6 of Annex 1 of the provisions set out at Annex I to this SFE, the Health Board must pay to the contractor administering the final completing vaccination a payment of £15.02 in respect of that child, unless a payment is otherwise payable for that same final completing vaccination under paragraph 8A.11, or 8A.14. The single dose of PCV is considered the final completing vaccination for this purpose.

***Children with an unknown or incomplete vaccination status.***

8A.13 Where a child who has an unknown or incomplete vaccination status receives vaccinations sufficient to ensure that he has received two doses of PCV before the age of 12 months, the HiB/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months, the Health Board must pay to the contractor administering the final completing vaccination a payment of £15.02 in respect of that child. The third dose of PCV is considered the final completing vaccination for this purpose.

8A.14 Where a child who has an unknown or incomplete vaccination status and is too old to be able to receive two doses of PCV before the age of around 12 months, the HiB/MenC booster at around the age of 12 months and a third dose at around the age of 13 months, receives a single dose of PCV prior to the age of 24 months, the Health Board must pay to the contractor who administers the final completing vaccination a payment of £15.02 in respect of that child. The single dose of PCV is considered the final completing vaccination for this purpose.

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<sup>7</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/147977/Green-Book-Chapter-25-v4\\_0.pdf.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147977/Green-Book-Chapter-25-v4_0.pdf.pdf) ( page 304 table for details).

***Eligibility for payment.***

8A.15 A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met—

- (a) the contractor is contracted to provide the childhood immunisation and pre-school booster Additional Service;
- (b) the child in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the final completing vaccination was administered;
- (c) the contractor administers the final completing vaccination to the child in respect of whom the payment is claimed;
- (d) subject to sub-paragraph (e), the child in respect of whom the payment is claimed is aged around 13 months when the final completing vaccination is administered;
- (e) in the case of payments in respect of vaccinations administered in accordance with paragraphs 8A.11 or 8A.12, the child must be under 5 years when the final completing vaccination is administered and in the case of vaccinations administered in accordance with paragraph 8A.14, the child must be under 2 years when the final completing vaccination is administered;
- (f) the contractor does not receive any payment from any other source in respect of any of the series of three PCV vaccinations and the HiB/MenC booster vaccination set out in the table at paragraph 8A.7 or in respect of any vaccination administered under any of the circumstances set out in paragraphs 8A.10 to 8A.14 of this Section (if he does receive any such payment in respect of any child from any other source, the Health Board must give serious consideration to recovering any payment made under this Section in respect of that child pursuant to paragraph 21.1(a)); and
- (g) the contractor submits the claim within 6 months of administering the final completing vaccination.

8A.16 The Health Board may set aside the requirement that the contractor submit the claim within 6 months of administering the final completing vaccination if it considers it reasonable to do so.

8A.17 The contractor is not entitled to payment of more than £15.02 in respect of an child under this Section, other than where—

- (a) the contractor claims for payment for a final completing vaccination administered under the circumstances set out in paragraph 8A.12; and
- (b) by virtue of that paragraph, the contractor is entitled to a payment under that paragraph, irrespective of any previous payment made in respect of that child under the provisions of this Section.

***Claims for payment.***

8A.18 The contractor is to submit claims in respect of final completing vaccinations after they have been administered. The amount payable is to fall due quarterly on the last day of the quarter after the last quarter in which the vaccinations were carried out, in-line with the target Childhood Immunisations.

8A.19 Health Boards must ensure that the receipt and payment in respect of any claims are properly recorded and that each such claim has a clear audit trail.

***Conditions attached to payment.***

8A.20 A payment under the provisions of this Section is only payable if the contractor satisfies the following conditions—

- (a) the contractor must supply the Health Board with the following information in respect of each child for which a payment is claimed—
  - (i) the name of the child;
  - (ii) the CHI number of the child;
  - (iii) subject to paragraph (iv) below, confirmation that the child has received three doses of PCV and one dose of HiB/MenC in accordance with the table at paragraph 8A.7;
  - (iv) if the claim is made in the circumstances set out in paragraph 8A.11, 8A.12 or 8A.14, confirmation that all required vaccinations have been administered; and
  - (v) the date of the final completing vaccination, which must have been administered by the contractor, but where a parent or carer objects to details of the child's name being supplied to the Health Board, the contractor need not supply such information to the Health Board but must supply the child's CHI number;
- (b) the contractor must provide appropriate information and advice to the parent or carer of the child, and, where appropriate, also to the child, about pneumococcal vaccinations and the HiB/MenC booster vaccination;
- (c) the contractor must record in the child's records, kept in accordance with paragraph 66 of Schedule 5 to the 2004 Regulations, any refusal of an offer of a pneumococcal vaccination or a HiB/MenC Booster vaccination;
- (d) where a pneumococcal vaccination or a HiB/MenC booster vaccination is administered, the contractor must record in the child's records, kept in accordance with paragraph 66 of Schedule 5 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 1 to the 2004 Regulations;
- (e) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable him to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;

- (f) the contractor must make available to the Health Board any information which the Health Board does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;
- (g) the contractor must make any returns required of it (whether computerised or otherwise) to the Practitioner Services Division (PSD) of NHS National Services Scotland, and do so promptly and fully; and
- (h) all information provided pursuant to or in accordance with this paragraph must be accurate.

8A.21 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any, or any part of, the payment due under this Section.

***Rotarix (Rotarix) Vaccine.***

***Payment for administration of rota virus vaccinations as part of the routine childhood immunisation schedule.***

8A.22 The Health Board must pay to a contractor who qualifies for the payment, a payment of £7.67 (This payment for 2 doses of vaccine is agreed as part of a reduction in the requirement for men C vaccine of one vaccine per child) in respect of each child registered with the contractor;

- (a) who has received, as part of their routine childhood immunisation schedule, both of the vaccinations, the first dose of 1.5 ml of Rotarix® vaccine at 2 months (approximately 8 weeks) of age and the second dose of 1.5 ml at least 4 weeks after the first dose;
- (b) in respect of whom the contractor administered both doses of the vaccination, vaccines will be provided within the recommended timescale (SGHD/CMO/2013/4).

***Eligibility for payment.***

8A.23 A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met;

- (a) the contractor is contracted to provide the childhood immunisation and pre-school booster Additional Service;
- (b) the child in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the second, completing, vaccination was administered;
- (c) the child in respect of whom the payment is claimed is aged under 24 weeks when the second, completing, vaccination is administered;



- (d) the contractor submits the claim within 6 months of administering the second, completing, vaccination.

8A.24 The Health Board may set aside the requirement that the contractor submit the claim within 6 months of administering the second, completing, vaccination if it considers it reasonable to do so.

8A.25 The contractor is entitled to payment of £3.84 in respect of—

- (i) any child under this sub-section, where the contractor has administered the first vaccination and the child does not attend for the second vaccination and the contractor makes a claim 6 months after the first does or at the end of the financial year; or
- (ii) where the contractor provides only the second, completing vaccination.

***Claims for payment.***

8A.26 The contractor is to submit claims in respect of the second, completing, vaccinations after they have been administered. The amount payable is to fall due quarterly on the last day of the quarter after the last quarter in which the vaccinations were carried out, in-line with the target Childhood Immunisations.

8A.27 The contractor is to submit claims in respect of incomplete vaccination courses six month after the first dose was administered. The amount payable is to fall due quarterly on the last day of the quarter in which the claim has been submitted.

8A.28 Health Boards must ensure that the receipt and payment in respect of any claims are properly recorded and that each such claim has a clear audit trail.

***Conditions attached to payment.***

8A.29 A payment under the provisions of this sub-Section is only payable if the contractor satisfies the following conditions—

- (a) the contractor must supply the Health Board with the following information in respect of each child for which a payment is claimed—
- (i) the name of the child;
- (ii) the CHI number of the child;
- (iii) confirmation that the child has received two doses of Rotarix® vaccine in accordance with paragraph 8A.22;
- (iv) the date of the final completing vaccination, which must have been administered by the contractor or their employed staff, or attached staff where this has been agreed with the Health Board,

but where a parent or carer objects to details of the child's name being supplied to the Health Board, the contractor need not supply such information to the Health Board but must supply the child's CHI number;

- (b) the contractor must provide appropriate information and advice to the parent or carer of the child, about rota virus vaccinations;
- (c) the contractor must record in the child's records, kept in accordance with paragraph 66 of Schedule 5 to the 2004 Regulations, any refusal of an offer of a rotavirus vaccination;
- (d) where a rota virus vaccination is administered, the contractor must record in the child's records, kept in accordance with paragraph 66 of Schedule 5 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 1 to the 2004 Regulations;
- (e) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable them to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;
- (f) the contractor must make available to the Health Board any information which the Health Board does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this sub-Section;
- (g) the contractor must make any returns required of it (whether computerised or otherwise) to the Practitioner Services Division (PSD) of NHS National Services Scotland, and do so promptly and fully; and
- (h) all information provided pursuant to or in accordance with this paragraph must be accurate.

8A.30 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any, or any part of, the payment due under this sub-Section.

## **9. Payments for locums covering maternity, paternity and adoption leave**

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

9.2 If an employee or partner who takes any such leave is a performer under a GMS contract, the contractor may need to employ a locum to maintain the level of services that it normally provides. Even if the Health Board is not directed in this SFE to pay for such cover, it may do so as a matter of discretion. However, if–

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

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

### ***Entitlement to payments for covering ordinary maternity, paternity and ordinary adoption leave.***

9.3 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 ordinary maternity leave, paternity leave or ordinary adoption leave, and–

- (a) the leave of absence is for more than one week (the maximum periods are: 26 weeks for ordinary maternity leave and for ordinary adoption leave for the parent who is the main care provider; and 2 weeks for paternity leave and for adoption leave for the parent who is not the main care provider);
- (b) the performer on leave is entitled to that leave either under–
  - (i) statute;
  - (ii) a partnership agreement or other agreement between the partners of a partnership; or
  - (iii) a contract of employment, provided that the performer on leave is entitled under their contract of employment to be paid their full salary by the contractor during their leave of absence;
- (c) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer; and
- (d) the contractor is not also claiming another payment for locum cover in respect of the performer on leave pursuant to this Part;

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

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

- (a) it should not normally be considered necessary to employ a locum if the Health Board has offered to provide the locum cover itself and the contractor has refused that offer without good reason;
- (b) it should not normally be considered necessary to employ a locum if the performer on leave had a right to return but that right has been extinguished; and
- (c) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on his return.

***Ceilings on the amounts payable.***

9.5 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is-

- (a) in respect of the first two weeks for which the Health Board provides reimbursement in respect of locum cover, £982.92 per week; and
- (b) in respect of any week thereafter for which the Health Board provides reimbursement in respect of locum cover, £1506.15 per week.

***Payment arrangements.***

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

***Conditions attached to the amounts payable.***

9.7 Payments under this Section, or any part thereof, are only payable if the contractor satisfies the following conditions—

- (a) if the leave of absence is maternity leave, the contractor must supply the Health Board with a certificate of expected confinement as used for the purposes of obtaining statutory maternity pay, or a private certificate providing comparable information;

- (b) if the leave of absence is for paternity leave, the contractor must supply the Health Board with a letter written by the GP performer confirming prospective fatherhood and giving the date of expected confinement;
- (c) if the leave of absence is for adoption leave, the contractor must supply the Health Board with a letter written by the GP performer confirming the date of the adoption and the name of the main care provider, countersigned by the appropriate adoption agency;
- (d) the contractor must, on request, provide the Health Board with written records demonstrating the actual cost to it of the locum cover;
- (e) once the locum arrangements are in place, the contractor must inform the Health Board—
  - (i) if there is to be any change to the locum arrangements; or
  - (ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the performer on leave;

at which point the Health Board is to determine whether it still considers the locum cover necessary.

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

## 10. Payments for locums covering sickness leave

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

10.2 If an employee or partner who takes any sickness leave is a performer under a GMS contract, the contractor may need to employ a locum to maintain the level of services that it normally provides. Even if the Health Board is not directed in this SFE to pay for such cover, it may do so as a matter of discretion – and indeed, it may also provide locum support for performers who are returning from sickness leave or for those who are at risk of needing to go on sickness leave. It should in particular consider exercising its discretion—

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

### *Entitlement to payments for covering sickness leave.*

10.3 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 sickness leave, and—

- (a) the leave of absence is for more than one week;
- (b) if the performer on leave is employed by the contractor, the contractor must—
  - (i) be required to pay statutory sick pay to that performer; or
  - (ii) be required to pay the performer on leave his full salary during absences on sick leave under his contract of employment.
- (c) if the GP performer's absence is as a result of an accident, the contractor must be unable to claim any compensation from whoever caused the accident towards meeting the cost of engaging a locum to cover for the GP performer during the performer's absence. But if such compensation is payable, the Health Board may loan the contractor the cost of the locum, on the condition that the loan is repaid when the compensation is paid unless—
  - (i) no part of the compensation paid is referable to the cost of the locum, in which case the loan is to be considered a reimbursement by the Health Board of the costs of the locum which is subject to the following provisions of this Section; or
  - (ii) only part of the compensation paid is referable to the cost of the locum, in which case the liability to repay shall be proportionate to the extent

to which the claim for full reimbursement of the costs of the locum was successful;

- (d) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer; and
- (e) the contractor is not already claiming another payment for locum cover in respect of the performer on leave pursuant to this Part;

then subject to the following provisions of this Section, the Health Board must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging a locum (which may or may not be the maximum amount payable, as set out in paragraph 10.5).

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

- (a) it should not normally be considered necessary if the Health Board has offered to provide the locum cover itself and the contractor has refused that offer without good reason;
- (b) it should not normally be considered necessary to employ a locum if the performer on leave had a right to return but that right has been extinguished; and
- (c) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on his return;
- (d) it should not normally be considered necessary for a contractor with two or more GP performers to engage a locum to replace a GP performer, unless the absence of the performer on leave leaves each of the other GP performers (*not including members of the Doctor's Retainer Scheme*) with average numbers of patients as follows—

<i>Absences lasting or expected to last</i>	<i>Full-time GP</i>	<i>Three-quarter-time GP</i>	<i>Half-time GP</i>
Not more than 2 weeks	3600+ patients	2700+ patients	1800+ patients
Not more than 6 weeks	3100+ patients	2325+ patients	1550+ patients
Longer than 6 weeks	2700+ patients	2025+ patients	1350+ patients

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

***Ceilings on the amounts payable.***

10.5 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is £982.92 per week.

10.6 However, the maximum periods in respect of which payments under this Section are payable in relation to a particular GP performer are—

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

10.7 In order to calculate these periods, a determination is to be made in respect of the first day of the GP performer's absence as to whether, in the previous 52 weeks, any amounts have been payable in respect of him under this Section or Section 10 of the 2004/5 SFE. If any amounts have been payable in those 52 weeks, the periods in respect of which they were payable are to be aggregated together. That aggregate period (whether or not it fact relates to more than one period of absence)—

- (a) if it is 26 weeks or less, is then to be deducted from the period referred to in paragraph 10.6(a); or
- (b) if it is more than 26 weeks, then 26 weeks of it is to be deducted from the period referred to paragraph 10.6(a) and the balance is to be deducted from the period referred to in paragraph 10.6(b).

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

***Payment arrangements.***

10.8 The contractor is to submit to the Health Board claims for costs actually incurred during a month by the 10<sup>th</sup> of the following month, and any amount payable is to fall due on the same day of the following month that the contractor's Payable GSMP falls due.

***Conditions attached to the amounts payable.***

10.9 Payments under this Section, or any part thereof, are only payable if the following conditions are satisfied—

- (a) the contractor must obtain the prior agreement of the Health Board to the engagement of the locum (but its request to do so must be determined as quickly as possible by the Health Board), including agreement as to the amount that is to be paid for the locum cover;



- (b) the contractor must, without delay, supply the Health Board with medical certificates in respect of each period of absence for which a request for assistance with payment for locum cover is being made;
- (c) the contractor must, on request, provide the Health Board with written records demonstrating the actual cost to it of the locum cover;
- (d) once the locum arrangements are in place, the contractor must inform the Health Board—
  - (i) if there is to be any change to the locum arrangements; or
  - (ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the performer on leave;at which point the Health Board is to determine whether it still considers the locum cover necessary;
- (e) if the locum arrangements are in respect of a performer on leave who is or was entitled to statutory sick pay, the contractor must inform the Health Board immediately if it stops paying statutory sick pay to that employee;
- (f) the performer on leave must not engage in conduct that is prejudicial to his recovery; and
- (g) the performer on leave must not be performing clinical services for any other person, unless under medical direction and with the approval of the Health Board.

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

## 11. Payments for locums to cover for suspended doctors

11.1 This section applies where a GP performer is on 1 April 2004 suspended from a medical or supplementary medical list or, on or after that day, is suspended from a performers list.

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 performers list,

may be entitled to payments directly from the Health Board that suspended him. This is covered by a separate determination under regulation 15 (1) of the Performers List Regulations

### *Eligible cases.*

11.3 In any case where a contractor–

- (a) either–
  - (i) is a sole practitioner who is suspended from his Health Board's medical performers list and is not in receipt of any financial assistance from his Health Board under section 17Q of the 1978 Act as a contribution towards the cost of the arrangements to provide primary medical services under his GMS contract during his suspension,
  - (ii) is paying a suspended GP performer–
    - (aa) who is a partner in the contractor, at least 90% of his normal monthly drawings (or a *pro rata* amount in the case of part months) from the partnership account; or
    - (bb) who is an employee of the contractor, at least 90% of his normal salary (or a *pro rata* amount in the case of part months);  
or
  - (iii) paid a suspended GP performer the amount mentioned in paragraph (ii)(aa) or (bb) for at least six months of his suspension, and the suspended GP performer is still a partner in or employee of the contractor;
- (b) actually and necessarily engages a locum (or more than one such person) to cover for the absence of the suspended GP performer;
- (c) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the absent performer is a job-sharer; and

- (d) the contractor is not also claiming a payment for locum cover in respect of the absent performer under another Section in this Part;

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

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

- (a) it should not normally be considered necessary to employ a locum if the Health Board has offered to provide the locum cover itself and the contractor has refused that offer without good reason;
- (b) it should not normally be considered necessary to employ a locum if the absent performer had a right to return but that right has been extinguished; and
- (c) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the absent performer and it is not carrying a vacancy in respect of another position which the absent performer will fill on his return.

***Ceilings on the amounts payable.***

11.5 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is £982.92 per week.

***Payment arrangements.***

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

***Conditions attached to the amounts payable.***

11.7 Payments under this Section, or any part thereof, are only payable if the contractor satisfies the following conditions—

- (a) the contractor must, on request, provide the Health Board with written records demonstrating—
- (i) the actual cost to it of the locum cover; and
- (ii) that it is continuing to pay the suspended GP performer at least 90% of his normal income before the suspension (i.e. his normal monthly

drawings from the partnership account, his normal salary or a *pro rata* amount in the case of part months); and

- (b) once the locum arrangements are in place, the contractor must inform the Health Board—
  - (i) if there is to be any change to the locum arrangements; or
  - (ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the absent performer;

at which point the Health Board is to determine whether it still considers the locum cover necessary.

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

## **12. Payments in respect of Prolonged Study Leave**

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

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

### ***Types of study in respect of which Prolonged Study Leave may be taken.***

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

- (a) the study leave is for at least 10 weeks but not more than 12 months;
- (b) the educational aspects of the study leave have been approved by the local Director of Postgraduate GP Education, having regard to any guidance on Prolonged Study Leave that Directors of Postgraduate GP Education have agreed nationally; and
- (c) the Health Board has determined that the payments to the contractor under this Section in respect of the Prolonged Study Leave are affordable, having regard to the budgetary targets it has set for itself.

### ***The Educational Allowance Payment.***

12.3 Where the criteria set out in paragraph 12.2 are met, in respect of each week for which the GP performer is on Prolonged Study Leave, the Health Board must pay the contractor an Educational Allowance Payment of £133.68, subject to the condition that where the contractor is aware of any change in circumstances that may affect its entitlement to the Education Allowance Payment, it notifies the Health Board of that change in circumstances.

12.4 If the contractor breaches the condition set out in paragraph 12.3, the Health Board may, in appropriate circumstances, withhold payment of any or any part of an Educational Allowance Payment that is otherwise payable.

### ***Locum cover in respect of doctors on Prolonged Study Leave.***

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 Health Board must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 12.7).

12.6 It is for the Health Board to determine whether or not it was in fact necessary to engage the locum, or to continue to engage the locum, but it is to have regard to the following principles–

- (a) it should not normally be considered necessary to employ a locum if the Health Board has offered to provide the locum cover itself and the contractor has refused that offer without good reason;
- (b) it should not normally be considered necessary to employ a locum if the performer on leave had a right to return but that right has been extinguished; and
- (c) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on his return.

12.7 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is £982.92 per week.

***Payment arrangements.***

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

***Conditions attached to the amounts payable.***

12.9 Payments in respect of locum cover under this Section, or any part thereof, are only payable if the following conditions are satisfied–

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

at which point the Health Board is to determine whether it still considers the locum cover necessary.

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

## 13. Seniority Payments

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

### *Eligible posts.*

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

- (a) in case of posts held prior to 1st April 2004, if the post-holder provided unrestricted general medical services and was eligible for a basic practice allowance under the Red Book; or
- (b) in the case of posts held on or after 1st April 2004, if the post-holder performs primary medical services and is-
  - (i) himself a GMS contractor (i.e. a sole practitioner);
  - (ii) a partner in a partnership that is a GMS contractor; or
  - (iii) a shareholder in a company limited by shares that is a GMS contractor.

### *Service that is Reckonable Service.*

13.3 Work shall be counted as Reckonable Service if–

- (a) it is clinical service as a doctor within the NHS or service as a doctor in the public service health care system of another EEA Member State (including service in that system pre-Accession);
- (b) it is clinical service as a doctor or service as a medical officer within the prison service or the civil administration (which includes the Home Civil Service) of the United Kingdom, or within the prison service or the civil administration of another EEA Member State (including service in that prison service or the civil administration pre-Accession);
- (c) it is service as a medical officer–
  - (i) in the armed forces of an EEA Member State (including the United Kingdom) or providing clinical services to those forces in a civilian capacity(including service pre-Accession); or,
  - (ii) in the armed forces under the Crown other than the United Kingdom armed forces or providing clinical services to those forces in a civilian capacity;



if accepted by the Health Board or endorsed by Scottish Ministers as Reckonable Service;

- (d) it is service with the Foreign and Commonwealth Office as a medical officer in a diplomatic mission abroad, if accepted by the Health Board or endorsed by Scottish Ministers as Reckonable Service; or
- (e) it comprises up to a maximum of four years clinical service in a country or territory outside the United Kingdom—
  - (i) which followed the date of first registration of the GP provider in that country or territory; and
  - (ii) in circumstances where—
    - (aa) on 31st March 2003, that period of clinical service was counted by a Health Board 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.

***Calculation of years of Reckonable Service.***

13.4 Claims in respect of years of service are to be made to the Health Board, and should be accompanied by appropriate details, including dates, of relevant clinical service. Where possible, claims should be authenticated from appropriate records, which may in appropriate circumstances include superannuation records. If the Health Board is unable to obtain authentication of the service itself, the onus is on the GP provider to provide documentary evidence to support his claim (although payments may be made while verification issues are being resolved). Health Boards should only count periods of service in a calculation of a GP provider's Reckonable Service if they are satisfied that there is sufficient evidence to include that period of service in the calculation.

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

- (a) only clinical service is to count towards Reckonable Service;
- (b) only clinical service since the date on which the GP provider first became registered (be it temporarily, provisionally, fully or with limited registration) with the General Medical Council, or an equivalent authority in another EEA Member State, is to count towards Reckonable Service, with the exception of Reckonable Service prior to registration that is taken into account by virtue of paragraph 13.3(e);
- (c) periods of part-time and full-time working count the same; and

- (d) generally, breaks in service are not to count towards Reckonable Service, but periods when doctors were taking leave of absence (i.e. they were absent from a post but had a right of return) due to compulsory national service, maternity leave, paternity leave, adoption leave, parental leave, holiday leave, sick leave or study leave, or because of a secondment elective or similar temporary attachment to a post requiring the provision of clinical services, are to count towards Reckonable Service.

13.6 Claims in respect of clinical service in or on behalf of armed forces pursuant to paragraph 13.3(c), are to be considered in the first instance by the Health Board, and should be accompanied by appropriate details, including dates and relevant postings. If the Health Board is not satisfied that the service should count towards the GP provider's Reckonable Service as a doctor, it is to put the matter to Scottish Ministers, together with any comments it wishes to make.

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

13.8 Claims in respect of clinical service for or on behalf of diplomatic missions abroad pursuant to paragraph 13.3(d) are to be considered in the first instance by the Health Board, and should be accompanied by appropriate details, including dates and relevant postings. If the Health Board is not satisfied that the service should count towards the GP provider's Reckonable Service as a doctor, it is to put the matter to Scottish Ministers, together with any comments it wishes to make.

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

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

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

***Determination of the relevant dates.***

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

- (a) the date a GP provider's Reckonable service began, which is the date on which his first period of Reckonable Service started (his "Seniority Date"); and
- (b) the GP provider's qualifying date (see paragraph 13.2).

***Calculation of the full annual rate of Seniority Payments.***

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

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

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

**TABLE**

Years of Reckonable Service	Full annual rate of payment per practitioner
0	0
1	0
2	0
3	0
4	0
5	0
6	600
7	672
8	753
9	843
10	944
11	1,057
12	1,184
13	1,326
14	1,486
15	1,664
16	3,185
17	3,504
18	3,854
19	4,239
20	4,663
21	5,129
22	6,785
23	6,989
24	7,198
25	7,414
26	7,637
27	7,866
28	8,225
29	8,455
30	8,692
31	8,935
32	9,186
33	9,443
34	9,707
35	9,979
36	10,258
37	10,546
38	10,841
39	11,144
40	11,457
41	11,777
42	12,107
43	12,446
44	12,795
45	13,153
46	13,521
47	13,900

13.13 If immediately before 1st April 2013, any GP provider entitled to an amount under as the full annual rate of the Seniority Payment under paragraph 13.13 of the SFE 2004/2005 as in force on 31st March 2004, that GP provider continues to be entitled to that amount.

***Superannuable Income Fractions.***

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

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

- (a) NHS Superannuable profits from all sources for the financial year to which the Seniority Payment relates, as reported on his certificate submitted to the Health Board in accordance with paragraph 22.10, excluding any amount in respect of Seniority Payments; by
- (b) the Average Adjusted Superannuable Income.

Save that in a year when the GP provider retires and as a result his superannuable profits relate only to part of the year, then the Average Adjusted Superannuable Income should be adjusted so that it is pro-rata for the period to which the superannuable profits relate.

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

- (a) all the NHS profits, from the previous financial year, of the type mentioned in paragraph 13.15(a) of all the GP providers in Scotland who have submitted certificates to a Health Board in accordance with paragraph 22.10 by a date still to be fixed are to be aggregated; then
- (b) this aggregate is then to be divided by the number of GP providers in respect of which the aggregate was calculated; then
- (c) the total produced by sub-paragraph (b) is to be adjusted to take account of the shift towards less than full-time working. The index by which the amount is to be adjusted is to be the same as the index for the financial year to which the calculation of Average Adjusted Superannuable Income relates by which the uprating factor for pensions is to be adjusted to take account of the shift towards less than full-time working;

and the total produced by sub-paragraph (c) is the Average Adjusted Superannuable Income amount for the calculation in paragraph 13.15.

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

***Amounts payable.***

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

13.19 If, however, the GP provider's—

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

13.20 Payment of the Quarterly Seniority Payment is to fall due on the last day of the quarter to which it relates (but see paragraph 21.7).

***Conditions attached to payment of Quarterly Seniority Payments.***

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

- (a) if a GP provider receives a Quarterly Seniority Payment from more than one contractor, those payments taken together must not amount to more than one quarter of the full annual rate of Seniority Payment in respect of him;
- (b) the contractor must make available to the Health Board any information which the contractor does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the payment;
- (c) all information provided pursuant to or in accordance with sub-paragraph (b) must be accurate; and
- (d) a contractor who receives a Seniority Payment in respect of a GP provider must give that payment to that doctor—
  - (i) within one calendar month of it receiving that payment; and

- (ii) as an element of the personal income of that GP provider subject (in the case of a GP provider who is a shareholder in a contractor that is a company limited by shares) to any lawful deduction of income tax and national insurance.

13.22 If the conditions set out in paragraph 13.21(a) to (c) are breached, the Health Board may in appropriate circumstances withhold payment of any or any part of a payment to which the conditions relate that is otherwise payable.

13.23 If a contractor breaches the condition in paragraph 13.21(d), the Health Board 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.

## 14. Golden Hello Scheme

14.1 Under the Golden Hello Scheme, a lump sum “golden hello” payment is made to doctors who are starting out as GP performers in their first eligible post. All eligible doctors receive a standard payment and those starting work in specified Health Board areas also receive an additional payment.

### *Standard payments under the Golden Hello Scheme.*

14.2 A doctor will be eligible for a standard payment under the Golden Hello Scheme if, after 1st April 2005, he takes up a post as a GP performer and—

- (a) the post is as a GP performer employed or engaged by a contractor;
- (b) the post, if part-time—
  - (i) involves a working commitment that generates a Time Commitment Fraction of at least one fifth; or
  - (ii) with any other post held by the doctor that also entails performing primary medical services together involve working commitment that generates a Time Commitment Fraction of at least one fifth;
- (c) if the doctor is an employee of the contractor, he is on a contract—
  - (i) for an indefinite period (but not a fixed number of sessions); or
  - (ii) for a fixed term of more than two years;
- (d) subject to paragraph 14.3, prior to starting work in that post, he has not—
  - (i) been included in the performers list or medical list of any Health Board, except as a GP Registrar (unless this was because of temporary arrangements made by a Health Board for the provision of general medical services or the performance of primary medical services following the suspension of a doctor);
  - (ii) been employed or engaged (except as a locum) by a GP principal to assist, as a medical practitioner, in the provision of general medical services, or worked (except as a locum) as a GP performer—
    - (aa) either full-time, or part-time with a working commitment generating a Time Commitment Fraction of at least one quarter, if he took up post before 29th November 2002, or at least one fifth if he took up post on or after 29th November 2002; and
    - (bb) under a contract for an indefinite period (but not for a fixed number of sessions) or for a fixed term of more than two years; or



- (iii) been engaged (except as a locum) as a pilot scheme provider or an employee of a pilot scheme provider, or worked (except as a locum) as a medical practitioner performing primary medical services under a section 17C (formerly Personal Medical Services) contract—
  - (aa) either full-time, or part-time with a working commitment generating a Time Commitment Fraction of at least one quarter, if he took up the post before 29th November 2002 or at least one fifth, if he took up the post on or after 29th November 2002; and
  - (bb) under a contract for an indefinite period (but not for a fixed number of sessions) or for a fixed term of more than two years;

unless he only comes within heads (i) to (iii) because of his participation in the GP Retainer Scheme and the claim pursuant to this Section relates to his first post after leaving the GP retainer scheme; and

- (e) subject to the provisions in this Section for making further payments because of new commitments, he has not previously received a standard payment under—
  - (i) this Section;
  - (ii) paragraph 15 of the Red Book; or
  - (iii) the Golden Hello Scheme under a section 17C (formerly Personal Medical Services) contract.

14.3 Paragraph 14.2(d) shall not apply to a GP performer who did not perform general medical services or personal medical services between 24th June 2002 and 24th September 2002 (except as a locum).

***Additional payments under the Golden Hello Scheme.***

14.4 In addition to the standard payment, practitioners taking up an eligible post in a practice within an area attracting additional payments on the first date in post will be eligible to receive a further payment. Criteria for payment shall be the same as for standard payments to doctors taking up an eligible post as set out in paragraph 14.2. The criteria may be reviewed by Scottish Ministers from time to time. Additional payments are available as follows:

14.4.1 A supplementary golden hello of £5,000 will be paid to every GP taking up an eligible post in a remote and rural area. For these purposes, remote and rural is defined as practices with an out of hours rota of 1:3 or worse, or island practices as listed at Annex H. For out of hours cases, this payment will be available only where the Health Board, in consultation with the GP Sub-Committee, confirms that the reason for the heavy out of hours commitment is the practice's location.

14.4.2 A supplementary golden hello averaging £5,000 will be payable to every eligible GP taking up a substantive post in one of the 40% most deprived practices in Scotland. These practices have been defined using information held centrally which shows the level of deprivation payments paid to each practice per 1,000 patients during 2003/04. Payments will be made on a sliding scale with increases at a linear rate between £2,500 and £7,500 with those practices in the most deprived areas receiving the highest payment. Health Boards will hold a list of such practices and will ensure that any new GP applying for a post knows in advance whether the post attracts a supplementary payment of this nature and if it does, the level of such payment.

14.4.3 Where a practice meets both the remote and rural and the deprivation criteria, the GP will be eligible for one supplementary golden hello only, whichever is the more favourable.

#### ***Job Sharers.***

14.5 Each partner in a job-sharing arrangement will be eligible individually for payment under paragraphs 14.2 and 14.4 if he or she satisfies the appropriate conditions.

14.6 The amount of money payable will be dependent on the time commitment of the job-sharer.

#### ***Changes in circumstances.***

##### Extra payments

14.7 These paragraphs are intended to ensure that if a practitioner has a change in circumstances involving an increase in time commitment and/or a move to or increase in time commitment in an area that attracts additional payments within two years of the first appointment she or he will be entitled to make a second claim based on these new circumstances. An increase in commitment and/or move to an area that attracts additional payments under paragraphs 14.8-14.12 may occur within post, by starting a different post or by taking a second post.

14.8 An eligible practitioner who increases his or her commitment (in an eligible position as specified in 14.2) within 6 months of taking up an eligible post, to such a level as would have attracted a higher payment had the position been the first held will receive the standard payment for their new commitment less any payment they have previously been awarded under this paragraph.

14.9 An eligible practitioner who between six months and two years of joining general practice increases his or her commitment (in an eligible position as specified in 14.2) to such a level as would have attracted a higher payment had the position been the first held, will receive half of the difference between the full payment for their current commitment and the payment for their previous commitment as awarded under this paragraph.

14.10 Practitioners whose changes in circumstances involve a move to an area attracting additional payments, at the time of that change, will be eligible for extra additional payments. These payments will be calculated as in paragraphs 14.8-14.10. An increase in commitment will not be necessary to attract payments under this paragraph.

14.11 Where payment under 14.10 is due to a practitioner taking a second post, payments should be based only on the practitioner's percentage commitment in the area attracting additional payments.

14.12 Practitioners who move to another post within the same area which attracted additional payments when she/he took up the first post but has subsequently ceased to attract additional payments and increases his/her commitment (in a eligible post as specified in 14.2) to such a level as would have attracted a higher payment had the position been the first held, will be eligible for extra additional payments. These will be calculated as in paragraphs 14.8-14.9.

14.13 A doctor in receipt of a standard payment does not receive an additional payment where:

- the area in which they practice is subsequently designated as attracting an additional payment;
- she/he moves to a post within the same area which was not included in the list of those areas attracting an additional payment at the time she/he took up the first post but has subsequently been designated as an area attracting additional payments.

#### Return of Payments

14.14 Where, within two years, a practitioner in receipt of payments under paragraph 14.2 or 14.4 and 14.7 – 14.13 stops providing or assisting in the provision of general medical services or performing section 17C (formerly Personal Medical Services) arrangements as:

- a GP principal on the medical list of a Health Board;
- an employee of a principal assisting in the provision of general medical services;
- A section 17C (formerly Personal Medical Services) performer;

she or he will be required to return some or all of the payment received as specified in paragraph 14.15.

14.15 The proportion of the payment returnable will be dependent on the amount of time spent in general practice as shown below:

- |                              |      |
|------------------------------|------|
| i. less than 6 months        | 100% |
| ii. from 6 months to 2 years | 50%  |

14.16 The provisions for the return of payments will not apply where the Health Board is satisfied that the practitioner has ceased to work in this capacity due to:

- i. death;
- ii. enforced early retirement from general practice due to illness or injury;
- iii. exceptional personal circumstances and with the approval of the Health Board;

- iv. maternity (or other extended parenting leave agreed by the Health Board) provided the GP gives an undertaking that (s)he will return to practise and does so within a reasonable period, to be considered case-by-case by the Health Board. (As a minimum absences of up to two years will normally be considered reasonable, but requests for any longer periods should be considered sympathetically by the Health Board);
- v. transfer to a post under GMS or section 17C (formerly Personal Medical Services) arrangements elsewhere in the UK.

14.17 Periods of absence under 14.16 iii and iv shall not be included in the computation of periods of time for the purposes of paragraphs 14.7– 14.15 and 14.18.

14.18 Practitioners in receipt of an additional payment shall be liable to return some or all of the sum received if they move to an area, which at the time of the move does not attract an additional payment, within 2 years of receiving it. The criteria for return of the money will be the same as set out in paragraphs 14.14 – 14.16 and 14.19.

14.19 Practitioners in receipt of an additional payment shall be liable to return the sum received if:

- the area in which she/he practices ceases to attract additional payments;
- she/he moves to another post within the same area which attracted additional payments when she/he took up the first post but has subsequently ceases to attract additional payments.

***Relocation costs.***

14.20 Where a GP (whether newly qualified or not) takes up a substantive post in a remote and rural area (as defined at Paragraph 14.4.1), support for relocation costs is available as follows:

- Subject to the submission of three competitive tenders where practicable;
- GPs are eligible to claim up to the first £2,000 of relocation costs, assessed against the lowest tender.

***Recruitment costs.***

14.21 Subject to submission of appropriate receipts, practices in remote and rural areas as defined at paragraph 14.4.1 above, are eligible to claim up to the first £2,000 of recruitment costs, including, in exceptional circumstances, the cost of locum cover where there were difficulties and delays in finding a replacement partner.

14.22 Applications for payment should be made to Health Boards within 12 months of the date on which the doctor took up the eligible post or from the date on which the new time commitment started.

***Rates of payment.***

14.23 Rates of payment will be at the following rates.

Standard Payment

Full-time or Part-time with a time commitment fraction of at least ½ £5,000

Part-time with a time commitment fraction of less than ½ £3,000

Additional Payment

Remote and Rural Area £5,000\*

40% most deprived practices Between £2,500-  
£7,500\*

\*To be reduced pro-rata depending on time commitment

## **15. Payment of Fees to Doctors Under Section 47 of Part 5 of the Adults with Incapacity (Scotland) Act 2000.**

15.1 Where a general practitioner carries out an assessment and issues a certificate to allow the general practitioner or member of the Primary Health Care Team who has had authority appropriately delegated and who is acting on his behalf or under his instructions to treat the patient, no fee is payable.

*Where an independent health professional seeks confirmation that a certificate of incapacity is in force.*

15.2 Where a medical certificate of incapacity already exists for a patient to permit general practitioners and staff acting on their behalf to treat a patient, an 'independent health professional' (e.g. dentists, opticians and community pharmacists) may be permitted to draw upon this existing medical certificate, providing it covers the intervention proposed to treat the patient in question. Under this arrangement practices are not entitled to charge a fee.

*Where a general practitioner is requested by an independent health professional to carry out an assessment.*

15.3 Where a general practitioner has not issued a certificate of incapacity and one is believed to be required by another independent health professional to treat the patient under the NHS, the practice may receive a fee for the assessment and completion of the certificate for the purposes of the independent health professional. The fee payable is £105.56.

15.4 Where a GP is required to undertake a second assessment and produce an additional certificate for an independent health professional to provide treatment under the NHS, having already issued a certificate which enabled the GP to treat a patient, payment of a fee of £105.56 is payable to the GP.

15.5 Applications for payment should be completed and sent to the local Practitioner Services Division for processing and payment.

15.6 Claims will be the subject of checks by Practitioner Services Division with the independent health professional requesting the assessment and certificate.

## **16. NOT ALLOCATED**

### **17. Doctors' Retainer Scheme**

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

#### ***Payments in respect of sessions undertaken by members of the Scheme.***

17.2 Subject to paragraph 17.2A, where—

- (a) a contractor who is considered as a suitable employer of members of the Doctors' Retainer Scheme by the Director of Postgraduate GP Education employs or engages a member of the Doctors' Retainer Scheme; and
- (b) the service sessions for which the member of the Doctors' Retainer Scheme is employed or engaged by that contractor have been arranged by the local Director of Postgraduate GP Education,

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

#### ***Provisions in respect of leave arrangements.***

17.2A The Health Board must pay to the contractor under its GMS contract any payment payable under paragraph 17.2 in respect of any session which the member of the Doctors' Retainer Scheme is employed or engaged to undertake but which that member does not undertake because they are absent due to leave related to—

- (a) annual holiday up to a maximum number of sessions annually equivalent to 6 weeks' worth of arranged sessions for the member of the Doctors' Retainer Scheme;
- (b) maternity, paternity or adoption, in accordance with the circumstances and for the periods referred to in Section 9 (payments for locums covering maternity, paternity and adoption leave);
- (c) parental leave, in accordance with statutory entitlements (except that the normal statutory qualifying period of one year's service with the contractor does not apply);
- (d) sickness, for a reasonable period as agreed by the contractor and the Health Board;
- (e) an emergency involving a dependant, in accordance with employment law and any guidance issued by The Department for Work and Pensions;

- (f) other pressing personal or family reasons where the contractor and the Health Board agree that the absence of the member of the Doctors' Retainer Scheme is necessary and unavoidable.

***Payment conditions.***

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

- (a) the contractor must inform the Health Board of any change to the member of the Doctors' Retainer Scheme's working arrangements that may affect the contractor's entitlement to a payment under this section;
- (b) the contractor must inform the Health Board of any absence on leave of the member of the Doctors' Retainer Scheme and the reason for such absence;
- (c) in the case of any absence on leave in respect of which there are any matters to be agreed between the contractor and the Health Board in accordance with paragraph 17.2A above, the contractor must make available to the Health Board any information which the Health Board does not have but needs, and which the contractor either has or could be reasonably expected to obtain, in order to form an opinion in respect of any of the matters which are to be agreed between the contractor and the Health Board;
- (d) the contractor must inform the Health Board if the doctor in respect of whom the payment is made ceases to be a member of the Doctors' Retainer Scheme, or if it ceases to be considered a suitable employer of members of the Doctors' Retainer Scheme by the Director of Postgraduate GP Education.

17.4 If a contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any payment otherwise payable under this Section.



## 18. Dispensing

18.1 Payment is made for the supply of drugs and appliances only where they have been supplied by a dispensing practice in accordance with arrangements made under Schedule 5, Part 3 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004. In this and the following paragraphs "appliances" means appliances listed in the Drug Tariff (ie the Statement prepared by Scottish Ministers under regulation 9 of the National Health Service (Pharmaceutical Services)(Scotland) Regulations 2009, as amended).

18.2 Some practices are prescribing practices as well as dispensing practices, i.e. their lists include some patients who can conveniently obtain their medicines etc from chemists, and for whom, accordingly, the practice is not required to dispense medicines but to write prescriptions and hand them to the patient in the ordinary way. This section does not apply to the supply of drugs and appliances to these 'prescribing patients' but only to those 'dispensing patients' for whom the practice has been required by the Health Board to dispense.

18.3 Payments to a dispensing practices for drugs, appliances, etc supplied to patients on the practice dispensing list, temporary residents and patients who are receiving maternity medical services or contraceptive services from the practice (and in respect of whom the Health Board have required the practice to dispense) shall be as follows:

- i. the basic price. For proprietary preparations this is the List Price as defined in the Drug Tariff. For non-proprietary items the basic price is the Tariff price as listed in Parts 7, 7S and 9 of the Drug Tariff or, when not so listed, the price as determined in accordance with paragraph 13 of Part 1 of the Tariff. The price of appliances shall be that listed in the Drug Tariff;

**less**, except where the practice has been exempted under paragraph 18.7, 18.8 or 18.9 below, a discount calculated in accordance with schedule 1 to this paragraph;

- ii. an on-cost allowance of 10.5% of the basic price **before** deduction of any discount under schedule 1;
- iii. a container allowance of 3.8 pence per prescription;
- iv. a dispensing fee as shown in schedule 2 to this paragraph, other than in relation to appliances and oxygen therapy equipment;
- v. an allowance in respect of VAT in accordance with paragraph 18.5;  
and
- vi. if appropriate, exceptional expenses in accordance with paragraph 18.6.

A practice may not claim payment under this paragraph for a vaccine specified in Schedule 4 (a).

18.4 Payments in respect of the supply of oxygen therapy equipment shall be made in accordance with the provisions of part 10, paragraph 6 of the Drug Tariff and shall not be subject to these discount arrangements.

18.5a **For the dispensing period 1 July 2011 onwards** A VAT allowance shall be paid to cover any VAT payable on the purchase of any products listed below for personal administration under a GMS contract:

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

No allowance will however be paid for any item which is centrally supplied as part of a programme such as the Childhood Immunisation Programme or any programme against a Pandemic Influenza Virus.

18.5b Where after making any enquiries as it deems necessary and after consulting the GP subcommittee of the Area Medical Committee, the Board anticipates that the requirement on a practice to dispense will be time limited, for example an application has been made before 30 June 2011 to open a pharmacy to serve the patients currently served by the dispensing practice concerned, the Board may agree to temporarily continue to make payments in accordance with the arrangements set out in SFE 2011-12 at sub paragraph 18.5a.

18.6 Where additional expenses have been incurred in obtaining from a manufacturer or wholesaler supplies of a drug or appliance (other than those items for which prices are given in Parts 2-5, 7, 7S and 9 of the Tariff), which a practice does not frequently require to provide, payment of the amount incurred will be authorised if the practice submits a claim giving full details to the Health Board with the appropriate prescription form and if, in any doubtful cases, the Health Board, after consultation with the GP Subcommittee of the Area Medical Committee, is satisfied that the additional expenses were necessarily incurred and were reasonable.

18.7 Where a practice is able to provide evidence and the Health Board, after making such enquiries as it deems necessary and after consulting the GP Subcommittee of the Area Medical Committee, is satisfied that by reason of the remoteness of the practice the practice is unable to obtain any discount on the basic price (see paragraph 18.3) for the purchase of drugs and appliances the Health Board shall approve the exemption of the practice from the application of the discount scale. In such cases the Health Board shall inform Practitioner Services Division of the period during which the exemption should be applied. Payments will then be calculated on the full, and not the discounted, basic price. Such an exemption may be granted for a period of up to one year and may be renewed for further such periods if the practice is able to satisfy the Health Board that he or she continues to be unable to obtain any discount.

18.8 Where

- a. a practice is able to provide evidence; and
- b. the Health Board after making such enquiries as it deems necessary and after consulting the GP Subcommittee of the Area Medical Committee is satisfied;

that by reason of

- i. the remoteness of the practice; or
- ii the small quantities of drugs and appliances the practice needs to buy (normally where the total monthly basic price to be reimbursed is below that which would attract an adjustment for discount );

the practice is only able to obtain drugs and appliances at a price in excess of the basic price (see paragraph 18.3) and on average more than 5% above the basic price then Practitioner Services Division shall approve a special payment. Practitioner Services Division shall determine the appropriate level of the special payment from the scale below:

Where on average the price paid (excluding VAT) is	Special Payment
in excess of 5% and up to 10% over basic price	5% over basic price
in excess of 10% and up to 15% over basic price	10% over basic price
in excess of 15% and up to 20% over basic price	15% over basic price
in excess of 20% over basic price	20% over basic price

Practitioner Services Division shall apply the rate for the special payment and the period during which it should be applied to the basic price payable. The VAT allowance (see paragraph 18.5) shall be calculated on the basic price plus the special payment. The oncost allowance shall be calculated on the basic price. No discount shall be applied. Such payments may be granted for a period of up to one year and may be renewed for further such periods at the same or a different rate if the practice is able to satisfy the Health Board that it continues to meet the above conditions.

***Transitional Arrangements.***

18.9 Where a practitioner succeeds to the practice of a dispensing practitioner who at the time of his or her withdrawal from the performer list or medical list was exempted from application of the discount scale under paragraph 18.7 or was in receipt of the special payment provided under paragraph 18.8 and the successor has made application to Practitioner Services Division for such exemption or special payment, Practitioner Services

Division shall treat the practitioner as qualifying for the exemption or special payment as appropriate for a period of 3 months from the date of his or her admission to the performers list or until his or her application is determined, whichever is the earlier.

***Claims.***

18.10 Payments are based on the monthly surrender and pricing of the prescriptions issued. Prescriptions for proprietary preparations (including prescriptions for non-proprietary preparations available only in proprietary form) should be endorsed with the size of the pack used in dispensing. All the prescriptions should then be noted, counted and sent under cover of Form GP34A to the appropriate Prescription Pricing Bureau (see schedule 3) within the first week of the month following that in which the prescriptions were dispensed.

18.11 Dispensing practices must submit all prescriptions for pricing in one batch under cover of one claim form relating to the practice in order that the appropriate rate of discount under schedule 1 may be applied. Practices may if they wish sub-divide the partnership batch into bundles relating to the individual practitioners and attach separate claims to each for the purpose of calculating the dispensing fees provided that all such bundles are sent to Practitioner Services Division together in one batch for the partnership.

***Payments On Account.***

18.12 Monthly payments on account will be made by Practitioner Services Division based on about 80% of the sum due. The estimated sum due will be based on the number of prescriptions submitted for pricing and the average payments per prescription for the previous authorisation. In the case of a practice who has not previously dispensed in a practice and for whom no such authorisation is available, the estimated sum due will normally be based on the last authorisation for the practice, as appropriate. For prescriptions dispensed in February and submitted in March the practice should receive at the beginning of April about 80% of the estimated sum due for February plus the balance of the sum due for prescriptions dispensed in January. Where, because the average cost of prescriptions varies significantly from month to month, it appears to Practitioner Services Division that payment of the amount notified would be likely to result in an overpayment, Practitioner Services Division will pay a lesser amount on account.

***Examination Of Prescription Forms.***

18.13 Priced prescription forms will not normally be returned to a practice. However any practice which has supplied drugs and appliances and which wishes to examine their prescription forms after they have been priced should inform Practitioner Services Division so that they may make the necessary arrangements. It would normally be from 2 to 6 months after pricing before the forms are available for inspection at Practitioner Services Division premises.

***Accounting.***

18.14 In order to ensure that the annual surveys of practitioners' practice expenses carried out by HM Revenue and Customs are as accurate as possible, practitioners should ensure that their actual expenditure on drugs and appliances are shown 'gross' in their accounts. Payments under this paragraph should be brought to account 'gross' as 'income'.

***Payments for the provision of flu vaccines.***

18.15 The provisions set out in paragraphs 18.1 to 18.5 do not cover remuneration and reimbursement arrangements for dispensing and non dispensing practices in respect of the provision of influenza vaccine. Specific arrangements in relation to the reimbursement costs and fees for provision of vaccines for the 2013-14 influenza season are detailed in NHS Circular PCA(M/P)(2013)1 issued on 31 January 2013.

**PARAGRAPH 18/SCHEDULE 1: DISCOUNT SCALE**

Total Basic Price of all Prescriptions submitted for Pricing by Practitioner/ Practice in Month £	Rate of Discount to be applied to Basic Practice %	Total Basic Price of all Prescriptions submitted for Pricing by Practitioner/ Practice in Month £	Rate of Discount to be applied to Basic Practice %
1 - 1000	0.00	6501 - 6625	5.20
1001 - 1125	0.08	6626 - 6750	5.29
1126 - 1250	0.15	6751 - 6875	5.37
1251 - 1375	0.21	6876 - 7000	5.45
1376 - 1500	0.26	7001 - 7125	5.54
1501 - 1625	0.32	7126 - 7250	5.61
1626 - 1750	0.37	7251 - 7375	5.69
1751 - 1875	0.42	7376 - 7500	5.76
1876 - 2000	0.48	7501 - 7625	5.83
2001 - 2125	0.54	7626 - 7750	5.90
2126 - 2250	0.61	7751 - 7875	5.96
2251 - 2375	0.68	7876 - 8000	6.03
2376 - 2500	0.77	8001 - 8125	6.09
2501 - 2625	0.88	8126 - 8250	6.15
2626 - 2750	0.99	8251 - 8375	6.21
2751 - 2875	1.12	8376 - 8500	6.27
2876 - 3000	1.25	8501 - 8625	6.32
3001 - 3125	1.42	8626 - 8750	6.38
3126 - 3250	1.59	8751 - 8875	6.43
3251 - 3375	1.76	8876 - 9000	6.48
3376 - 3500	1.93	9001 - 9125	6.53
3501 - 3625	2.09	9126 - 9250	6.58
3626 - 3750	2.24	9251 - 9375	6.62
3751 - 3875	2.38	9376 - 9500	6.67

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3876 - 4000	2.53	9501 - 9625	6.72
4001 - 4125	2.69	9626 - 9750	6.76
4126 - 4250	2.85	9751 - 9875	6.80
4251 - 4375	3.01	9876 - 10000	6.84
4376 - 4500	3.15	10001 - 10125	6.88
4501 - 4625	3.29	10126 - 10250	6.92
4626 - 4750	3.42	10251 - 10375	6.96
4751 - 4875	3.54	10376 - 10500	7.00
4876 - 5000	3.68	10501 - 10625	7.04
5001 - 5125	3.81	10626 - 10750	7.07
5126 - 5250	3.86	10751 - 10875	7.11
5251 - 5375	4.09	10876 - 11000	7.14
5376 - 5500	4.23	11001 - 11125	7.18
5501 - 5625	4.35	11126 - 11250	7.21
5626 - 5750	4.47	11251 - 11375	7.24
5751 - 5875	4.59	11376 - 11500	7.27
5876 - 6000	4.70	11501 - 11625	7.31
6001 - 6125	4.81	11626 - 11750	7.34
6126 - 6250	4.91	11751 - 11875	7.37
6251 - 6375	5.01	11876 - 12000	7.39
6376 - 6500	5.11	12000+ -	7.42

NB: Where a practitioner is in partnership the rate of discount to be applied is that which relates to the total Basic Price of all prescriptions submitted for pricing by all the partners.

## PARAGRAPH 18/SCHEDULE 2: FEE SCALE

Dispensing Fees (see paragraph 18.3) - marginal fee scale for application to prescriptions submitted for pricing by practitioner/practice per month.

Prescriptions in Bands	Payment per* Prescription from 1.4.2002
1-100	154.7
101-200	153.7
201-300	150.2
301-450	147.2
451-600	142.7
601-650	122.2
651-700	119.2
701-750	115.2
751-800	113.7
801-850	108.2
851-900	103.2
901-950	100.2
951-1000	94.7
1001-1050	92.7
1051-1100	88.2
1101-1150	83.7
1151-1200	81.7
1201-1250	76.7
1251-1300	74.7
1301-1350	70.2
1351-1400	64.2
1401-1450	62.2



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1451-1500	57.2
1501-1750	84.7
1751-2000	94.7
2001-2250	92.7
2251-2500	90.2
2501-2750	88.7
2751-3000	86.2
3001-3250	85.7
3251-3500	84.7
3501-3750	83.2
3751-4000	82.7
4001-4250	81.7
4251-4500	79.7
4501-4750	78.7
4751-5000	77.7
5001-5250	77.2
5251-5500	75.7
5501-5750	74.7
5751-6000	73.7
6001-6250	72.7
6251-6500	71.7
6501-6750	70.7

\* Payment will be reduced by 1p per prescription for each additional 250 prescriptions per month in excess of 6,750.

**PARAGRAPH 18/SCHEDULE 3: ADDRESS FOR CLAIMS**

**ADDRESSES TO WHICH DISPENSING PRACTICES SHOULD SUBMIT THEIR  
CLAIMS**

Practitioner Services Division (Pharmacy)

3 Bain Square

Livingston

EH54 7DQ

## **PARAGRAPH 18/ SCHEDULE 4: LIST OF VACCINES**

Subject to the provisions of (b) below, no payments are payable under Section 18 in respect of the products listed in paragraph (a) below, which are centrally supplied as part of the Childhood Immunisation Programme-

- (a) MMR (Measles, Mumps and Rubella); BCG (Bacillus Calmette-Guerin); Tuberculin Purified Protein Derivative; Meningococcal C conjugate vaccine and Rotavirus (for children under 5 and persons entering the first year of higher education);

DTaP/IPV/HiB (Diphtheria/Tetanus/Pertussis/Inactivated Polio/Haemophilus influenzae type B); dTaP/IPV (low dose Diphtheria/Tetanus/Pertussis/Inactivated Polio); DTaP/IPV (Diphtheria/Tetanus/Pertussis/Inactivated Polio); and Td/IPV (Diphtheria/Tetanus/ Inactivated Polio); HiB/MenC (Haemophilus influenzae type B/meningitis C) and PCV(pneumococcal);

- (b) payments are payable under this Section in respect of Td/IPV (Diphtheria/Tetanus/ Inactivated Polio) where that product is used for the treatment of adults or supplied to patients who require such products prior to travelling outside the United Kingdom and in either case where the Td/IPV product has been purchased by the contractor directly from the manufacturer.

## **PART 5**

### **PREMISES AND IT EXPENSES**

#### **19. Premises**

19.1 There are other premises costs payable under GMS contracts which are dealt with in the Primary Medical Services (Premises Development Grants, Improvement Grants and Premises Costs) Directions 2004. These include payments in respect of new premises development and improvement projects, and payments in respect of recurring premises costs such as mortgage repayments, rent payments and notional rent payments.

#### **20. IT Expenses**

20.1 NHS Boards, rather than contractors, are responsible for the purchase, maintenance, future upgrades and running costs of integrated IM &T systems for providers of services under GMS contracts, as well as for telecommunications links within the NHS and it is for them to determine the way in which this responsibility is exercised in accordance with any extant national guidance, further advice on which is provided in 'Delivering Investment in General Practice - Implementing the New GMS Contract in Scotland'.

## PART 6

### SUPPLEMENTARY PROVISIONS

#### 21. Administrative Provisions

##### *Overpayments and withheld amounts.*

21.1 Without prejudice to the specific provisions elsewhere in this SFE or in the 2004/5 SFE relating to overpayments of particular payments, and without prejudice to paragraph 21.1 of the 2004/5 SFE, if a Health Board makes a payment to a contractor under its GMS contract pursuant to this SFE or the 2004/5 SFE and—

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

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

21.2 Where a Health Board is entitled pursuant to this SFE to withhold all or part of a payment because of a breach of a payment condition, and the Health Board does so or recovers the money by deducting an equivalent amount from another payment in accordance with paragraph 21.1, it may, where it sees fit to do so, reimburse the contractor the amount withheld or recovered, if the breach is cured.

##### *Underpayments and late payments.*

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

- (a) this is with the consent of the contractor; or
- (b) the amount of, or entitlement to, the payment, or any part thereof, is in dispute,

once it falls due, it must be paid promptly (see regulation 22 of the 2004 Regulations).

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

- (a) pay to the contractor, promptly, an amount representing the amount that the Health Board accepts that the contractor is at least entitled to; and
- (b) thereafter pay any shortfall promptly, once the dispute is finally resolved.

21.5 However, if a contractor has—

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

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

***Payments on account.***

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

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

and if that payment results in an overpayment in respect of the payment, paragraph 21.1 applies.

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

- (a) the Average Adjusted Superannuable Income for that financial year has been established; and
- (b) the GP provider's pensionable earnings from all sources for that financial year, excluding—

- (i) pensionable earnings which do not appear on his certificate submitted to the Health Board in accordance with paragraph 22.10, and
  - (ii) any amount in respect of Seniority Payments,
- have been established.

If a Health Board cannot reach agreement with a contractor on a payment on account in respect of a Quarterly Seniority Payment pursuant to paragraph 21.6, it must nevertheless pay to the contractor on account a reasonable approximation of the Quarterly Seniority Payment, on or before the unrevised due date for payment of that payment (i.e. before it is revised in accordance with paragraph 21.5). If that payment results in an overpayment in respect of the Quarterly Seniority Payment, paragraph 21.1 applies.

**Payments to or in respect of suspended doctors whose suspension ceases.**

21.8 If the suspension of a GP from a medical practitioners list ceases, and—

- (a) that GP enters into a GMS contract that takes effect for payment purposes on 1st April 2004, any payments that the GP received under a determination made under regulation 15(1) of the Performers List Regulations may be set off, equitably, against the payments that he is entitled to receive under his GMS contract pursuant to this SFE; or
- (b) a contractor is entitled to any payments in respect of that GP pursuant to this SFE or the 2004/5 SFE and a payment was made to the GP pursuant to a determination made under regulation 15(1) of the Performers List Regulations but the GP was not entitled to receive all or any part thereof, the amount to which the GP was not entitled may be set off, equitably, against any payment in respect of him pursuant to this SFE.

***Effect on periodic payments of termination of a GMS contract.***

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

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

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

***Time limitation for claiming payments.***

21.10 Payments under this SFE are only payable if claimed within 6 years of the date on which they could first have fallen due (albeit that the due date has changed pursuant to paragraph 21.5).

***Dispute resolution procedures.***

21.11 Any dispute arising out of or in connection with this SFE between a Health Board and a contractor (except one to which paragraph 19.4(a) applies) is to be resolved as a dispute arising out of or in connection with the contractor's GMS contract, i.e. in accordance with the NHS dispute resolution procedures or by the courts (see Part 7 of Schedule 5 to the 2004 Regulations).

21.12 The procedures require the contractor and the Health Board to make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute between themselves before referring it for determination. Either the contractor or the Health Board may, if it wishes to do so, invite the GP sub-committee of the area medical committee to participate in these discussions.

***Protocol in respect of locum cover payments.***

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

21.14 As a supplementary measure, Health Boards are directed to adopt and keep-up-to-date a protocol, which they must take all reasonable steps to agree with any relevant GP sub-committee of the area medical committee, setting out in reasonable detail–

- (a) how they are likely to exercise their discretionary powers to make payments (including top-up payments) in respect of locum cover, having regard to the budgetary targets they have set for themselves, where they are not obliged to make such payments;
- (b) where they are obliged to make payments in respect of locum cover pursuant to Part 4, the circumstances in which they are likely to make payments in respect of locum cover of less than the maximum amount payable (for example where the locum cover is in respect of a part-time GP performer who normally works three days per week);
- (c) how they are likely to exercise their discretionary powers to make payments in respect of cover for absent GP performers which is provided by nurses or other health care professionals;



- (d) how they are likely to exercise their discretionary powers to make payments to a partner or shareholder in a contractor, or an employee of a contractor, who is providing locum cover for an absent GP performer who is also a partner or shareholder in, or an employee of, the contractor;
- (e) how they are likely to exercise their discretionary powers to make payments in respect of a GP performer who is on long term sickness leave, where locum cover payments are no longer payable in respect of him under Section 10. In determining the amounts that may be appropriate in these circumstances, the expectation of the Scottish Government, Health and Social Care Integration Directorate that they would not exceed the half rate payable in the second period of 26 weeks under paragraph 10.6(b), or the amount that would be payable under the NHS Superannuation Scheme (Scotland) Regulations if the performer retired on grounds of permanent incapacity, whichever is the lower; and
- (f) where they are not obliged to make payments in respect of locum cover pursuant to Part 4, how they are likely to exercise their discretionary powers to make payments in respect of a sole practitioner who is absent for the purposes of attending an accredited postgraduate educational course, in circumstances where, because of the nature of the locality in which the contractor's premises are situated, locum cover arrangements (i.e. arrangements other than cover provided by a neighbouring practice) are essential to meet the needs of patients in that locality for primary medical services.

Where a Health Board departs from that protocol in any individual case and refuses an application for funding in respect of locum cover, this must be duly justified to the unsuccessful applicant.

***Adjustment of Contractor Registered Populations.***

21.15 The starting point for the determination of a contractor's Contractor Registered Population is the number of patients recorded by PSD of NHS National Services Scotland as being registered with the contractor, initially when its GMS contract takes effect and thereafter at the start of each quarter, when a new number must be established.

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

- (a) if a contractor satisfies a Health Board that a patient who registered with it before the start of a quarter was not included in the number of patients recorded by PSD of NHS National Services Scotland as being registered with it at the start of that quarter, and the Health Board received notification of the new registration within 48 hours of the start of that quarter, that patient—
  - (i) is to be treated as part of that contractor's Contractor Registered Population at the start of that quarter; and
  - (ii) if he was registered with another of the Health Board's contractors at the start of that quarter, is not to be counted as part of that other contractor's Contractor Registered Population for that quarter;

- (b) if, included in the number of patients recorded by PSD of NHS National Services Scotland as being registered with a contractor at the start of a quarter, there are patients who—
  - (i) transferred to another contractor in the quarter before the previous quarter (or earlier); but
  - (ii) notification of that fact was not received by the Health Board until after the second day of the previous quarter;

those patients are not to be treated as part of the contractor's Contractor Registered Population at the start of that quarter;

- (c) if a patient is not recorded by PSD of NHS National Services Scotland as being registered with a contractor at the start of a quarter, but that patient—
  - (i) had been removed from a contractor's patient list in error; and
  - (ii) was reinstated in the quarter before the previous quarter (or earlier);

that patient is to be treated as part of the contractor's Contractor Registered Population at the start of that quarter.

21.17 If a contractor wishes its Contractor Registered Population to be adjusted in accordance with paragraph 21.16, it must—

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

and the Health Board must seek to resolve the matter as soon as is practicable. If there is a dispute in connection with the adjustment, paragraphs 21.11 and 21.12 apply.

***Default contracts and payments to persons not able to enter into default contracts.***

21.18 If a contractor's GMS contract was agreed after 1st April 2005 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 21.6, it shall be treated as a payment on account pursuant to paragraph 21.6 (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.

21.19 In these circumstances, the payments that a contractor is entitled to receive under its GMS contract pursuant to this SFE that are or were due to fall due before the end of the first quarter of the financial year 2005 to 2006 are instead to fall due at the end of that quarter, unless—

- (a) the GMS contract is agreed between 1st June 2005 and 1st September 2005, in which case they are instead to fall due at the end of the second quarter of the financial year 2005 to 2006, as are all the payments that are or were due to fall due pursuant to this SFE in the second quarter;
- (b) the GMS contract is agreed between 1st September 2005 and 1st December 2005, in which case they are instead to fall due at the end of the third quarter of the financial year 2005 to 2006, as are all the payments that are or were due to fall due pursuant to this SFE in that third quarter or in the second quarter of that financial year; or
- (c) the GMS contract is agreed between 1st December 2005 and the end of the financial year, in which case they are to fall due at the end of the financial year, as are all the other payments that are or were due to fall due pursuant to this SFE before the end of the financial year.

## 22. Superannuation contributions

### *Health Boards' responsibilities in respect of contractors' employer's and employee's superannuation contributions.*

22.1 Employer's superannuation contributions in respect of GP Registrars – who are subject to separate funding arrangements from those in respect of other GP performers – are the responsibility of NHS Boards, which act as their employer for superannuation purposes.

22.2 Under the NHS Superannuation Scheme (Scotland) Regulations, contractors continue to be responsible for paying employer's superannuation contributions of practice staff who are members of the NHS Superannuation Scheme (Scotland), and for collecting and forwarding to the Scottish Public Pensions Agency both employers and employee's superannuation contributions in respect of their practice staff. With effect from 1st April 2004, contractors also have become responsible for paying to the Scottish Public Pensions Agency both the employer's and employee's superannuation contributions for–

- (a) non-GP providers;
- (b) GP performers who are not GP Registrars; and
- (c) Assistant Practitioners;

who are members of the NHS Superannuation Scheme (Scotland). The detail of all these arrangements is set out in the NHS Superannuation Scheme (Scotland) Regulations.

22.3 In this Section non-GP providers and GP performers who are not GP Registrars are together referred to as "Pension Scheme Contributors".

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

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

22.5 Accordingly, the costs of paying the employer's and employee's superannuation contributions of a contractor's Pension Scheme Contributors under the NHS Superannuation Scheme (Scotland) in respect of their NHS pensionable profits from all sources – unless superannuated for the purposes of the NHS Superannuation Scheme (Scotland) elsewhere, for example, under a contract of employment with a NHS Board – are all to be deducted by PSD from the monies paid to the contractor, pursuant to this SFE.

***Monthly deductions in respect of superannuation contributions.***

22.6 The deductions are to be made in two stages. First, PSD must, as part of the calculation of the net amount of a contractor's monthly payments under this SFE, deduct an amount that represents a reasonable approximation of a monthly proportion of–

- (a) the contractor's liability for the financial year in respect of the employer's superannuation costs under the NHS Superannuation Scheme (Scotland) relating to any of the contractor's Pension Scheme Contributors (i.e. a reasonable approximation in respect of their total NHS Superannuation Scheme (Scotland) NHS pensionable profits which are not superannuated elsewhere) who are members of the NHS Superannuation Scheme (Scotland);
- (b) those Pension Scheme Contributors' related employee's superannuation contributions (including added years contributions); and
- (c) any payable Money Purchase Additional Voluntary Contributions in respect of those Pension Scheme Contributors.

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

22.7 Superannuation contributions in respect of payments for specific purposes which are paid after the start of the financial year will, for practical reasons, need to be handled slightly differently. The relevant NHS Board and the contractor may agree that the payment is to be made net of any superannuation contributions that the Health Board is responsible for collecting on behalf of the Scottish Public Pensions Agency or an Additional Voluntary Contributions Provider. In the absence of such an agreement, the default position is that the contribution will be calculated as part of the finalisation of the pension contributions for the financial year and the contributions will actually be deducted from payments made to the practice in the following financial year.

22.8 An amount equal to the monthly amount that PSD (or the NHS Board where pensioned separately) deducts must be remitted to the Scottish Public Pensions Agency and any relevant Money Purchase Additional Voluntary Contributions Providers no later than –

- (a) the 19th day of the month after the month in respect of which the amount was deducted; or
- (b) in the case of Money Purchase Additional Voluntary Contributions, 7 days after an amount in respect of them is deducted pursuant to paragraph 22.6 (c).

***End-year adjustments.***

22.9 After the end of any financial year, including after the end of the financial year 2004 to 2005, the final amount of each Pension Scheme Contributor's superannuable income in respect of the financial year will need to be determined. For these purposes, the superannuable income of a Pension Scheme Contributor is his total NHS pensionable profits, as determined in accordance with the NHS Superannuation Scheme (Scotland) Regulations.

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

- (a) an accurately completed certificate, the General Medical Practitioner's Annual Certificate of Pensionable Profits, in the standard format provided nationally; and
- (b) no later than one month from the date on which the GP was required to submit the HM Revenue and Customs return on which the certificate must be based.

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

22.12 Once a contractor's Pension Scheme Contributors' superannuable earnings in respect of a financial year have been agreed, PSD must–

- (a) if its deductions (whether pursuant to this SFE or the 2004/05 SFE) from the contractor's payments under the SFE for the relevant financial year relating to the superannuation contributions in respect of those earnings–
  - (i) did not cover the cost of all the employer's and employee's superannuation contributions that are payable by the contractor or the Pension Scheme Contributors in respect of those earnings–
    - (aa) deduct the amount outstanding from any payment payable to the contractor under its GMS contract pursuant to this SFE (and for all purposes the amount that is payable in respect of that payment is to be reduced accordingly); or

- (bb) obtain payment (where no such deduction can be made) from the contractor of the amount outstanding, and it is a condition of the payments made pursuant to this SFE that a contractor that is an employing authority of a Pension Scheme Contributor must pay to the Contributor's relevant NHS Board the amount outstanding; or
- (ii) were in excess of the amount payable by the contractor and the Pension Scheme Contributor to the Scottish Public Pensions Agency in respect of those earnings, repay the excess amount to the contractor promptly; and
- (b) forward any outstanding employer's and employee's superannuation contributions due in respect of those earnings to the Scottish Public Pensions Agency (having regard to the payments it has already made on account in respect of those Pension Scheme Contributors for that financial year).

***Locums.***

22.13 There are different arrangements for superannuation contributions of locums, and these are not covered by this SFE.

## **ANNEX A**

### **GLOSSARY**

#### **PART 1**

##### **ACRONYMS**

The following acronyms are used in this document:

CFMP – Correction Factor Monthly Payment  
CPI – Contractor Population Index  
CRP – Contractor Registered Population  
CWP – Contractor Weighted Population  
FYOIP – Five-Year-Olds Immunisation Payment  
GMS – General Medical Services  
GSE – Global Sum Equivalent  
GSMP – Global Sum Monthly Payment  
LMC – Local Medical Committee  
MPIG – Minimum Practice Income Guarantee  
NHS – National Health Service  
QOF – Quality and Outcomes Framework  
TYOIP – Two-Year-Olds Immunisation Payment

#### **PART 2**

##### **DEFINITIONS**

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

The following words and expressions used in this SFE have, unless the context otherwise requires, the meanings ascribed below.

“The 1978 Act” means the National Health Service (Scotland) Act 1978. This Act was significantly amended (for the purposes of this SFE) by the Primary Medical Services (Scotland) Act 2003

“The 2004 Regulations” means the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004.

“The 2004/5 SFE” means the Statement of Financial Entitlements under section 17M of the 1978 Act in respect of the financial year 2004 to 2005.

“Achievement Payment” is to be construed in accordance with Section 6.

“Aspiration Payment” is to be construed in accordance with Section 5.



“Aspiration Points Total” is to be construed in accordance with paragraph 4.2(b) and 5.11.

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

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

“Adjusted Global Sum Equivalent” is to be construed in accordance with paragraphs 3.2 and 3.3.

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

“Adjusted Practice Disease Factor” is to be construed in accordance with paragraph 6.5(a) and Annex F.

“Childhood Immunisations and Pre-school Boosters” is to be construed as a reference to the Childhood Vaccines and Immunisations additional service referred to in the 2004 Regulations.

“Contractor” means a person entering into, or who has entered into, a GMS contract with a Health Board.

“Contractor Population Index” is to be construed in accordance with paragraph 2.18.

“Contractor Registered Population”, in relation to a contractor, means – subject to any adjustment made in accordance with paragraph 21.16 – the number of patients recorded by PSD of NHS National Services Scotland as being registered with the contractor, initially when its GMS contract takes effect and thereafter at the start of each quarter, when a new number must be established.

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

“Correction Factor Monthly Payment” is to be construed in accordance with paragraph 3.9.

“Default contract” means a contract entered into under section 7(1) of the Primary Medical Services (Scotland) Act 2004.

“DES Directions” means the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2012.

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

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

“Employing authority” has the same meaning as in the NHS Superannuation Scheme (Scotland) Regulations.

“Final Global Sum Equivalent” is to be construed in accordance with paragraph 3.4.

“Full-time” means, in relation to a performer of primary medical services with a contract of employment, a contractual obligation to work for at least 37½ hours per normal working week. In relation to a performer without a contract of employment (which is only relevant in the context of Golden Hello payments), it means an equivalent working commitment of at least 37½ hours per normal working week. The hours total may be made up surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services.

“General Practitioner” means—

- (a) a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council.
- (b) until the coming into force of the said article 10, a medical practitioner who is either—
  - (i) until the coming into force of paragraph 22 of Schedule 8 to the 2003 Order, suitably experienced within the meaning of section 31(2) of the National Health Service Act 1977, section 21 (2) of the National Health Service (Scotland) Act 1978 or Article 8(2) of the Health and Personal Social Services (Northern Ireland) Order 1978; or
  - (ii) upon the coming into force of paragraph 22 of Schedule 8 to the 2003 Order, an eligible general practitioner pursuant to that paragraph other than by virtue of an acquired right under paragraph 1(d) of Schedule 6 to the 2003 Order.

“Global Sum Equivalent” is to be construed in accordance with paragraph 3.2.

“GMS contract” means a general medical services contract under section 17J of the 1978 Act.

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

“GP performer” means a general practitioner—

- (a) whose name is included in a medical performers' list of a Health Board; and
- (b) who performs medical services under a GMS contract, and who is–
  - (i) himself a GMS contractor (i.e. a sole practitioner); or
  - (ii) an employee of, a partner in or a shareholder in the contractor.

“GP provider” means a GP who is–

- (a) himself a GMS contractor (i.e. a sole practitioner);
- (b) a partner in a partnership that is a GMS contractor; or
- (b) a shareholder in a company limited by shares that is a GMS contractor.

“GP registrar” has the same meaning as in Regulation 2 of the National Health Service (Primary Medical Services Performers Lists)(Scotland) Regulations 2004.

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

“Historic Opt-Outs Adjustment” is to be construed in accordance with paragraphs 3.6 and 3.7.

“Initial Global Sum Equivalent” is to be construed in accordance with paragraphs 3.2 and 3.3.

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

“Medical Performers List” is to be construed in accordance with regulation 4(1) of the Performers List Regulations.

“Minimum Practice Income Guarantee” is to be construed in accordance with paragraph 3.1.

“Money Purchase Additional Voluntary Contributions Provider” is an “authorised provider” as defined in section 10(6) of the Superannuation Act 1972.

“Money Purchase Additional Voluntary Contributions” means voluntary contributions made by a member of an occupational pension scheme over and above his or her normal contributions.

“Monthly Aspiration Payment” is to be construed in accordance with paragraphs 5.7 and 5.12.

“NHS Pension Scheme Regulations” means the National Health Service Superannuation Scheme (Scotland) Regulations 1995, as amended.

“Non-GP provider” has the same meaning as in the NHS Superannuation Scheme (Scotland) Regulations.

Organisational Core Standard means the previous Organisational Indicators transferred from the QOF for 2013/14 covering infrastructure areas within a GP practice around records, management and education.

“Part-time” means, in relation to a performer of primary medical services with a contract of employment, a contractual obligation to work for less than 37½ hours per normal working week. In relation to a performer without a contract of employment (which is only relevant in the context of Golden Hello payments), it means an equivalent working commitment which is less than 37½ hours per normal working week. The hours total may be made up surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services.

“Payable Global Sum Monthly Payment” is to be construed in accordance with paragraphs 2.6 and 2.11.

“Pension Scheme Contributor” shall be construed in accordance with paragraph 22.3.

“Performers List Regulations” means the National Health Service (Primary Medical Services Performers List) (Scotland) Regulations 2004.

“PMS contract” means section 17C arrangements.

“PMS contractor”, except where the context otherwise indicates means a section 17C provider.

“Provisional Achievement Payment” is to be construed in accordance with paragraphs 5.4 and 5.5.

“Quality and Outcomes Framework” is the framework reproduced at Annex E.

“Quality and Outcomes Framework Uprating Index” is to be construed in accordance with paragraph 5.6.

“Quarter” means a quarter of the financial year.

“Reckonable Service” is to be construed in accordance with paragraph 13.3.

“Red Book” means the Statement of Fees and Allowances under regulations 35 and 36 of the National Health Service (General Medical Services) (Scotland) Regulations 1995, as it had effect on 31st March 2004. However, for the purposes of paragraph 13.3(e)(ii)(aa) and 13.13(a), it means the Statement of Fees and Allowances under regulations 35 and 36 of the National Health Service (General Medical Services) (Scotland) Regulations 1995, as it had effect on 31st March 2003.

“Sole practitioner” means a GP performer who is himself a contractor.

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

“Target Population Factor is to be construed in accordance with paragraphs F3 and F4.

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

“Time Commitment Fraction” is the fraction produced by dividing a performer of primary medical services’ actual working commitment by 37½ hours. The hours total may be made up of surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services.

“Unadjusted Achievement Payment” is to be construed in accordance with paragraph 5.4.

“Uprating Percentage” is to be construed in accordance with paragraph 3.12.

## ANNEX B

### THE SCOTTISH ALLOCATION FORMULA (SAF) FOR GENERAL MEDICAL SERVICES

#### Introduction.

B.1. The following note is an explanation of the **Scottish Allocation Formula (SAF)** for General Medical Services (GMS) which forms part of the contract.

B.2. The SAF is a formula that allocates resources to GP practices on the basis of the relative needs and workload of their patients, taking into consideration the relative costs of service delivery. The SAF is responsible for the allocation of a **global sum** to each practice. The global sum accounts (on average) for **50-55 per cent** of a practices' current fees and allowances in Scotland. The remainder of the resources available to GMS flows through NHS boards (including premises, IT and seniority), the Quality and Outcomes Framework (QOF), enhanced services, and the Minimum Practice Income Guarantee (MPIG).

#### The Scottish Allocation Formula.

B.3. The Scottish Allocation Formula (SAF) determines how the global sum in Scotland is distributed between GP practices; **it does not inform the total size of the Scottish budget for the global sum**. The SAF is a population-based formula at GP practice level with a series of '**weightings**' to reflect the relative needs of GMS patients and the additional costs of providing an adequate service in remote and rural areas of Scotland. The components of the SAF are:

- The **GP practice population** (total practice list size).

Adjusted for 'weightings' to reflect:

- The **age and sex structure** of the practice population (demography).
- The **additional need** of the practice population (morbidity and deprivation).
- The **rurality and remoteness** of the practice population.

There are other weights - set at a UK level - to take account of the larger workload in regard to care home patients and new registrations. A further adjustment allows for differences in staff costs between health board areas.

#### GP Practice Population.

B.4. The SAF uses the **registered list** of each practice as the basis for the GP practice population.

#### Demography.

B.5. The relative need for GMS will to a significant extent depend on the **age and sex structure** of the GP practice population. The population groups that are relatively intensive users of GP services are children, young women and older patients. The SAF includes a

series of age and sex ‘weightings’ to allocate a greater share of resources to practices with greater proportions of high-user patient groups than the Scottish average. The ‘weightings’ which will be applied from 1 April 2013 to 31 March 2014 are summarised in the following table:

	0-4	5-14	15-24	25-44	45-64	65-74	75-84	85+
Male	2.60	1.00	1.10	1.38	2.03	2.99	4.42	6.19
Female	2.44	1.15	2.54	2.75	2.81	3.56	4.78	6.14

Note that these SAF age-sex ‘weightings’ are based on 2011/12 year data from the **Practice Team Information (PTI)** practices<sup>8</sup> and are expressed relative to a male patient aged 5-14.

### Additional Need.

B.6. The relative need for GMS will also depend on the **socio-economic status** of the GP practice population. People from deprived backgrounds typically have poorer health outcomes, higher morbidity and greater health needs. The SAF includes an **index of deprivation and mortality** to ‘weight’ the GP practice population on the basis of the following indicators:

- The unemployment rate.
- The proportion of elderly people claiming income support.
- The standardised mortality rate amongst people under the age of 65.
- Households with two or more indicators of deprivation.

A GP practice population with a higher proportion of high user patient groups - as defined by the above set of indicators - will receive a greater additional need ‘weighting’ under the SAF. The exact nature of the formula that ‘weights’ a practice list for deprivation and mortality is:

$$\text{Practice List} * [(0.94 * (109.04 + 3.09 * \text{Index}) + (0.06 * (82.46 + 4.89 * \text{Index}))]$$

Where, *Index* denotes the index of deprivation and mortality. Note that this adjustment is also split between 94 per cent surgery contacts and 6 per cent home contacts.

### Remote and Rural Areas.

B.7. The costs of providing GMS in **remote and rural locations** are generally greater (per patient) than in urban population centres. The SAF therefore attempts to reflect this by ‘weighting’ practices for their remoteness and rurality. The three indicators that are used to reflect remoteness and rurality in the SAF are:

- The population density (hectares per resident) of the GP practice population.
- The population sparsity (the percentage of the population living in settlements of less than 500 residents) of the GP practice population.
- The percentage of patients in the GP practice population attracting road mileage payments.

The exact nature of the formula that ‘weights’ a practice list for remoteness and rurality is:

<sup>8</sup> Approximately 45 practices in Scotland provide monthly consultation returns to the PTI database.

$$\text{Practice List} * [54.54 + 1.88 * \text{Population Density} + 0.14 * \text{Population Scarcity} + 0.11 * \text{Road Mileage Payments}]$$

This adjustment recognises the extra costs incurred in providing GMS services in remote and rural areas.

### The Weighted Practice Population.

B.8. The ‘**weighted**’ practice population or list is the registered GP practice population adjusted to reflect the Scottish ‘weights’ for age-sex, additional need and remoteness and rurality. The following *illustrative* example shows how the adjustments for age-sex, additional need and remoteness and rurality impact on the GP practices’ final allocation.

B.9. Suppose we have two practices A and B:

- Practice A is a small practice with 2,000 registered patients.
- Practice B is larger with 8,000 registered patients.

Practice A is in a poorer rural area, which is serving an ageing population. Practice B is located in an affluent urban area, serving a relatively young population. If a budget of £10,000 was divided between practices A and B on the basis of their registered lists, then practice A would receive £2,000 and practice B £8,000.

B.10. However, the basis for the allocation is **not** the registered but the ‘weighted’ lists of the two practices, A and B. Possible adjustments for practices A and B are shown in the following table:

Table - Illustrated Example

	Practice A	Practice B	Total
<b>Registered List</b>	<b>2,000</b>	<b>8,000</b>	<b>10,000</b>
Age-Sex Adjustment	1.10	0.98	-
Deprivation Adjustment	1.15	0.95	-
Remote/Rural Adjustment	1.15	0.95	-
<b>Weighted List</b>	<b>2,910</b>	<b>7,090</b>	<b>10,000</b>

The ‘weighted’ list for practice A is equal to  $(2,000 \times 1.10 \times 1.15 \times 1.15 = 2,910$  ‘weighted’ patients) and for practice B the relevant calculation is  $(8,000 \times 0.98 \times 0.95 \times 0.95 = 7,090$  ‘weighted’ patients). Practice A with 2,910 ‘weighted’ patients receives an increase in its allocation of £910. Practice B’s final allocation falls to £7,090.

B.11. The effect on the allocations for practices A and B is that £910 has been redistributed from practice B to practice A compared with what they would have received on the basis of their registered lists. **Therefore, it is on the basis of the ‘weighted’ list that a practice’s indicative allocation for its share of the Scotland-wide global sum has been calculated.**



### **Minimum Practice Income Guarantee (MPIG).**

B.12. The minimum practice income guarantee (MPIG) applies to all Scottish GP practices that qualify for this funding supplement. The method of calculation of MPIG in Scotland is identical to the rest of the UK, the only difference is that Scottish practices' indicative allocations are based on the Scottish Allocation Formula. Any practice in Scotland with an indicative allocation, which is less than their equivalent **global sum** fees and allowances receives a correction factor/ MPIG.

### **Summary.**

B.13. In summary the main points are that:

- The Scottish Allocation Formula (SAF) is a **population-based formula** that allocates resources according to **relative patient need** for GMS. The SAF allocates a **global sum** for each practice in Scotland.
- The SAF uses **registered** practice population data, **'weighted'** for variations in **demography, deprivation and remoteness and rurality** between GP practice populations. The 'weighted' list is used to calculate the share of global sum resources that are allocated to the GP practice.

## ANNEX C

### TEMPORARY PATIENTS ADJUSTMENT

C.1 The need for this arises because of GPs' obligations to provide emergency treatment to people who are not registered with their practice and to provide treatment to temporary residents. Previously, this treatment was paid for by the temporary residents fees, emergency treatment fees and immediately necessary treatment fees under the Red Book, but these fees have been discontinued. The Temporary Patients Adjustment will be calculated as follows.

C.2 All contractors are to receive a payment for unregistered patients as an element in their global sum allocation. The amount each contractor receives in respect of such patients is generally to be based on the average amount that, historically, the contractor's practice has claimed in respect of treating such patients each year under the Red Book prior to 1st April 2003.

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

C.4 However, there may be exceptional cases where a calculation pursuant to paragraph C.3 produces an amount that is clearly inappropriate as the basis for a payment in the financial year 2004 to 2005. This may occur, for example, where the practice has faced a significant increase or decrease in the numbers of unregistered patients requiring treatment from it. In these cases, the Health Board is instead to determine for the contractor, as the basis for its Temporary Patients Adjustment, a reasonable annual amount which is an appropriate rate for the area where the practice is located.

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

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

C.7 Once a Temporary Patients Adjustment has been determined, it remains unchanged.

## **ANNEX D -**

### **ORGANISATIONAL CORE STANDARD PAYMENT**

D.1 Following the transfer of certain Organisational Services from the QOF to the global sum. The Organisational Core Standard Payment will be calculated as follows.

D.2 All contractors are to receive a payment for organisational core standard as an element in their global sum allocation. The amount each contractor receives in respect of such standards is to be the annual average amount that, historically, the contractor's practice has received in respect of the equivalent Organisational Indicators under the QOF for the three years prior to 1 April 2012.

D.3 However, there may be exceptional cases where a calculation pursuant to paragraph D.2 produces an amount that is clearly inappropriate as the basis for a payment in the financial year 2013 to 2014. This may occur, for example, where the practice has faced a significant increase or decrease in the numbers of QOF points in the historical period. In these cases, the Health Board should determine in conjunction with the practice a reasonable annual amount for the contractor, as the basis for its Organisational Core Standard payment.

D.4 The amount calculated in accordance with paragraphs D.2 to D.3 is the annual amount of the contractor's Organisational Core Standard Payment, which is the amount to be included in its Initial GSMP calculation.

D.6 Once an Organisational Core Standard Payment has been determined, it remains unchanged, but will be subject to any future uplift applied to the Global Sum.

## ANNEX E

### QUALITY AND OUTCOMES FRAMEWORK

## Section 2: Summary of all indicators.

### Section 2.1: Clinical domain.

Section 2.1. applies to all GMS contractors participating in QOF.

#### Atrial fibrillation (AF).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation.	5	
<b>Ongoing management.</b>		
AF002. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS score is greater than 1). <i>NICE 2011 menu ID: NM24</i>	10	40–90%
AF003(S). In those patients with atrial fibrillation in whom there is a record of a CHADS score of 1 (latest in the preceding 12 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy. <i>NICE 2011 menu ID: NM45</i>	6	50–90%
AF004. In those patients with atrial fibrillation whose latest record of a CHADS score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy. <i>NICE 2011 menu ID: NM46</i>	6	40–70%

## Secondary prevention of coronary heart disease (CHD).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease.	4	
<b>Ongoing management.</b>		
CHD002(S). The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.	17	50–85%
CHD003(S). The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5mmol/l or less.	17	50–80%
CHD004(S). The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March.	7	50–90%
CHD005(S). The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.	7	50–90%
CHD006(S). The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin. <i>NICE 2010 menu ID: NM07</i>	10	45–80%

## Heart failure (HF).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
HF001. The contractor establishes and maintains a register of patients with heart failure.	4	
<b>Initial diagnosis.</b>		
HF002. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register.	6	50–90%
<b>Ongoing management.</b>		
HF003(S). In those patients with a current diagnosis of heart	10	50–85%

failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB.		
HF004(S). In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure.	9	50–75%

## Disease registers.

There are two disease registers used for the HF indicators for the purposes of calculating APDF:

1. a register of patients with HF is used to calculate APDF for HF001, HF002 and HF003(S)
2. a register of patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003(S) and HF004(S).

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

## Hypertension (HYP).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
HYP001. The contractor establishes and maintains a register of patients with established hypertension.	6	
<b>Ongoing management.</b>		
HYP002(S). The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less.	55	45–80%

## Peripheral arterial disease (PAD).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease. <i>NICE 2011 menu ID: NM32</i>	2	
<b>Ongoing management.</b>		
PAD002. The percentage of patients with peripheral arterial	2	40–90%

disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less. <i>NICE 2011 menu ID: NM34</i>		
PAD003. The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 12 months) is 5mmol/l or less. <i>NICE 2011 menu ID: NM35</i>	3	40–90%
PAD004. The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken. <i>NICE 2011 menu ID: NM33</i>	2	40–90%

### Stroke and transient ischaemic attack (STIA).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA.	2	
<b>Initial diagnosis.</b>		
STIA002(S). The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2008) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or TIA.	2	50–90%
<b>Ongoing management.</b>		
STIA003(S). The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.	5	50–85%
STIA004. The percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 12 months.	2	50–90%
STIA005. The percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 12 months) is 5mmol/l or less. <i>NICE 2012 menu ID: NM60</i>	5	40–65%
STIA006(S). The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March.	2	50–90%
STIA007(S). The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken.	4	50–90%

## Diabetes mellitus (DM).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
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. <i>NICE 2011 menu ID: NM41</i>	6	
<b>Ongoing management.</b>		
DM002(S). The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less. <i>NICE 2010 menu ID: NM01</i>	8	45–71%
DM003(S). The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less. <i>NICE 2010 menu ID: NM02</i>	10	40–65%
DM004. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	6	40–75%
DM005. The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months. <i>NICE 2012 menu ID: NM59</i>	3	50–90%
DM006(S). The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs).	3	50–90%
DM007(S). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months. <i>NICE 2010 menu ID: NM14</i>	17	40–50%
DM008(S). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months.	8	45–70%
DM009(S). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.	10	50–90%
DM010(S). The percentage of patients with diabetes, on the register, who have had influenza immunisation in the	3	50–90%



preceding 1 September to 31 March.		
DM011. The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months.	5	50–90%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months. <i>NICE 2010 menu ID: NM13</i>	4	50–90%
DM013. The percentage of patients with diabetes, on the register, who have a record of a dietary review by a suitably competent professional in the preceding 12 months. <i>NICE 2011 menu ID: NM28</i>	3	40–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register. <i>NICE 2011 menu ID: NM27</i>	11	40–90%
DM015. The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 12 months. <i>NICE 2012 menu ID: NM51</i>	4	40–90%
DM016. The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months. <i>NICE 2012 menu ID: NM52</i>	6	40–90%

## Hypothyroidism (THY).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
THY001. The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine.	1	
<b>Ongoing management .</b>		
THY002. The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 12 months.	6	50–90%

## Asthma (AST).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
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.	4	
<b>Initial diagnosis.</b>		
AST002. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis.	15	45–80%
<b>Ongoing management.</b>		
AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. <i>NICE 2011 menu ID: NM23</i>	20	45–70%
AST004. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months.	6	45–80%

## Chronic obstructive pulmonary disease (COPD).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
COPD001. The contractor establishes and maintains a register of patients with COPD.	3	
<b>Initial diagnosis.</b>		
COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register.	5	45–80%
<b>Ongoing management.</b>		
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 12 months.	9	50–90%
COPD004(S). The percentage of patients with COPD with a record of FEV <sub>1</sub> in the preceding 12 months.	7	50–85%
COPD005. The percentage of patients with COPD and Medical Research Council dyspnoea grade $\geq 3$ at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months. <i>NICE 2012 menu ID: NM63</i>	5	40-90%
COPD006(S) The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March.	6	50-90%

## Dementia (DEM).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia.	5	
<b>Ongoing management.</b>		
DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months.	15	35–70%

DEM003. The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register. <i>NICE 2010 menu ID: NM09</i>	6	45–80%
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## Depression (DEP).

Indicator	Points	Achievement thresholds
<b>Initial diagnosis.</b>		
DEP001. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a bio-psychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded. <i>NICE 2012 menu ID: NM49</i>	21	50–90%
<b>Initial management.</b>		
DEP002. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis. <i>NICE 2012 menu ID: NM50</i>	10	45–80%

## Disease register.

There is no register indicator for the depression indicators. The disease register for the indicators in the depression area for the purpose of calculating the APDF is defined as all patients aged 18 or over, with a new diagnosis of depression in the preceding 1 April to 31 March, who have an unresolved record of depression in their patient record.

## Mental health (MH).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy.	4	
<b>Ongoing management.</b>		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a	6	40–90%

comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate.		
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months. <i>NICE 2010 menu ID: NM17</i>	4	50–90%
MH004. The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months. <i>NICE 2010 menu ID: NM18</i>	5	45–80%
MH005. The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months. <i>NICE 2011 menu ID: NM42</i>	5	45–80%
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months. <i>NICE 2010 menu ID: NM16</i>	4	50–90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months. <i>NICE 2010 menu ID: NM15</i>	4	50–90%
MH008(S). The percentage of women aged 20 or over and who have not attained the age of 60 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years. <i>NICE 2010 menu ID: NM20</i>	5	45–80%
MH009. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months. <i>NICE 2010 menu ID: NM21</i>	1	50–90%
MH010. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months. <i>NICE 2010 menu ID: NM22</i>	2	50–90%

## **Disease register.**

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

### **Remission from serious mental illness.**

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

- no record of antipsychotic medication;
- no mental health in-patient episodes; and
- no secondary or community care mental health follow-up for at least five years.

Where a patient is recorded as being 'in remission' they remain on the MH001 register (in case their condition relapses at a later date) but they are excluded from the denominator for mental health indicators MH002 - MH008(S).

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

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

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

## Cancer (CAN).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'.	5	
<b>Ongoing management.</b>		
CAN002. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 3 months of the contractor receiving confirmation of the diagnosis. <i>NICE 2012 menu ID: NM62</i>	6	50–90%

## Chronic kidney disease (CKD).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
CKD001. The contractor establishes and maintains a register of patients aged 18 or over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD).	6	
<b>Ongoing management.</b>		
CKD002(S). The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less.	11	45–70%
CKD003. The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with an ACE-I or ARB.	9	45–80%
CKD004. The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 12 months.	6	45–80%

## Epilepsy (EP).

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

<b>Ongoing management.</b>		
EP002. The percentage of patients aged 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months.	6	45–70%
EP003. The percentage of women aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 12 months. <i>NICE 2010 menu ID: NM03</i>	3	50–90%

### Learning disability (LD).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
LD001. The contractor establishes and maintains a register of patients aged 18 or over with learning disabilities.	4	
<b>Ongoing management.</b>		
LD002. The percentage of patients on the learning disability register with Down’s Syndrome aged 18 or over who have a record of blood TSH in the preceding 12 months (excluding those who are on the thyroid disease register). <i>NICE 2010 menu ID: NM04</i>	3	45–70%

### Osteoporosis: secondary prevention of fragility fractures.

Indicator	Points	Achievement thresholds
<b>Records.</b>		
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. <i>NICE 2011 menu ID: NM29</i>	3	
<b>Ongoing management.</b>		
OST002. The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate	3	30–60%



bone-sparing agent. <i>NICE 2011 menu ID: NM30</i>		
OST003. The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent. <i>NICE 2011 menu ID: NM31</i>	3	30–60%

## Disease register.

Although the register indicator OST001 defines two separate registers, the disease register for the purposes of calculating the APDF is defined as the sum of the number of patients on both registers.

## Rheumatoid arthritis (RA).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis. <i>NICE 2012 menu ID: NM55</i>	1	
<b>Ongoing management.</b>		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months. <i>NICE 2012 menu ID: NM58</i>	5	40–90%
RA003. The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months. <i>NICE 2012 menu ID: NM56</i>	7	40–90%
RA004. The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 24 months. <i>NICE 2012 menu ID: NM57</i>	5	40–90%

## Palliative care (PC).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age.	3	
<b>Ongoing management.</b>		
PC002. The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.	3	

## Disease register.

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

## Cardiovascular disease – primary prevention (CVD-PP).

Indicator	Points	Achievement thresholds
<b>Ongoing management.</b>		
CVD-PP001. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS Board) of $\geq 20\%$ in the preceding 12 months: the percentage who are currently treated with statins. <i>NICE 2011 menu ID: NM26</i>	10	40–90%
CVD-PP002(S). The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.	5	40–75%
CVD-PP003(S). The patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who require lifestyle advice on increasing physical activity, as identified in CVD-PP002(S), in the preceding 12 months are given that advice utilising the Scottish Physical Activity Screening Questions (Scot-PASQ).	5	

## Disease register.

The disease register for the purposes of calculating the APDF for the indicators in the CVD-PP area is defined as follows: patients diagnosed with a first episode of hypertension on or after 1 April 2009, excluding patients with the following conditions:

- CHD or angina;
- stroke or TIA;
- peripheral vascular disease;
- familial hypercholesterolemia;
- diabetes;
- CKD (US National Kidney Foundation: Stage 3 to 5 CKD).

## Obesity (OB).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
OB001. The contractor establishes and maintains a register of patients aged 16 or over with a BMI $\geq 30$ in the preceding 12 months.	8	

## Smoking (SMOK).

Indicator	Points	Achievement thresholds
<b>Records.</b>		
SMOK001. The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months.	11	50–90%
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months. <i>NICE 2011 menu ID: NM38</i>	25	50–90%
<b>Ongoing management.</b>		
SMOK003. The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.	2	

<p>SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months. <i>NICE 2011 menu ID: NM40</i></p>	<p>12</p>	<p>40–90%</p>
<p>SMOK005(S). The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months. <i>NICE 2011 menu ID: NM39</i></p>	<p>25</p>	<p>50–90%</p>

### **Disease register.**

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

There is no APDF calculation for SMOK001, SMOK003 and SMOK004.

## Section 2.2 Additional Services domain.

Section 2.2 applies to contractors who provide additional services under the terms of the GMS contract and participate in QOF.

### Cervical screening (CS).

Indicator	Points	Achievement thresholds
CS001(S). The contractor has a protocol that is in line with national guidance agreed with the NHS Scotland for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates.	7	
CS002(S). The percentage of women aged 20 or over and who have not attained the age of 60 whose notes record that a cervical screening test has been performed in the preceding 5 years.	11	45–80%
CS003. The contractor ensures there is a system for informing all women of the results of cervical screening tests.	2	
CS004. The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every 2 years.	2	

### Child health surveillance (CHS).

Indicator	Points	Achievement thresholds
CHS001(S). Child development checks are offered at intervals that are consistent with national guidelines and policy agreed with the NHS Board.	6	

### Maternity services (MAT).

Indicator	Points	Achievement thresholds
MAT001(S). Antenatal care and screening are offered according to current local guidelines agreed with the NHS Board.	6	

## Contraception (CON).

Indicator	Points	Achievement thresholds
CON001. The contractor establishes and maintains a register of women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS.	4	
CON002. The percentage of women, on the register, prescribed an oral or patch contraceptive method in the preceding 12 months who have also received information from the contractor about long acting reversible methods of contraception in the preceding 12 months.	3	50–90%
CON003. The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception at the time of or within 1 month of the prescription.	3	50–90%

## Section 2.3. Quality and Productivity (QP) domain.

Section 2.3. applies to all GMS contractors participating in QOF.

Indicator	Points
QP001(S). The contractor meets internally to review data on secondary care outpatient referrals, for patients on the contractor's registered list, provided by the NHS Board.	5
QP002(S). The contractor participates in an external peer review with either a group of local practices, or practices from within the Board area, to compare its secondary care outpatient referral data with that of the other contractors. The contractor proposes areas for internal practice improvement and service design improvements for the NHS Board.	5
QP003(S). The contractor engages with the development of and follows 3 care pathways, agreed with the NHS Board for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate outpatient referrals.	11
QP004(S). The contractor meets internally to review data on emergency admissions, for patients on the contractor's registered list, provided by the NHS Board and the learning from at least 25 per cent of the Anticipatory Care Plans (ACPs) completed for QP007(S).	7
QP005(S). The contractor participates in an external peer review with either a group of local practices, or practices from within the board area, to compare its data on emergency admissions and to share the learning from at least 25 per cent of the Anticipatory Care Plans (ACPs) completed for QP007(S) and proposes areas for internal practice improvement or service design improvements for the NHS Board.	17
QP006(S) . The contractor produces a list of 5 per cent of patients in the practice, who are predicted to be at significant risk of emergency admission or unscheduled care. This list can be produced using a risk profiling tool accessible to practices e.g. SPARRA, or where this is not available/ required (by local agreement), alternative arrangements can be agreed between the NHS Board and LMC.	5
QP007(S) The contractor identifies a minimum of 15 per cent (in 2014/15, 30 per cent) of those patients from the list produced in indicator QP006(S) who would most benefit from, and creates, an Anticipatory Care Plan (the ACP must include a poly-pharmacy review), be shared with the local out of hours service and has an appropriate review date. The frequency of each patient's review should be determined in the light of their clinical and care needs. The contractor will be responsible for ensuring that an appropriate system is in place for monitoring and reviewing the patients identified in this cohort.	30
QP008(S) . The contractor holds at least 4 meetings during the year to review the needs of the relevant patients in the practice ACP cohort, to agree any required changes in the patient management and to share	10

learning/ identify learning needs. These meetings should be open to multi-disciplinary professionals who support the practice's patients.	
QP009(S) . The contractor produces and submits a report to the Board before 15 March 2014 on internal practice and wider Board system changes that may benefit patients with Anticipatory Care Plans (ACPs). The report should include Significant Events Reviews (SERs) on 1/1000, to a maximum of 3 patients per practice, of patients with ACPs from the cohort in QP007(S), who were admitted during the QOF year, after their ACP had been created. If less than the required number of patients with ACPs were admitted during the QOF year then the practice should write SERs of the care of an equivalent number of these patients who remained in the community.	10

### **Composition of external review groups.**

For indicators QP002(S) and QP005(S) , the local NHS Board and LMC will agree, on behalf of the contractor, a suitable group of practices, with which it will carry out the external review. The group should comprise a minimum of six practices unless the NHS Board and LMC agree otherwise.



## Section 2.4: Patient experience (PE), Quality improvement (QI), Medicines management (MM) and Public health domain.

Section 2.4. applies to all GMS contractors participating in QOF.

### Patient experience (PE).

Indicator	Points
<p>PE001 (Length of consultations)</p> <p>The contractor ensures that the length of routine booked appointments with doctors in the surgery is not less than 10 minutes. If the contractor routinely admits extra patients during booked surgeries, then the average booked consultation length should allow for the average number of extra patients seen in a surgery session such that the length of booked appointments is not less than 10 minutes. If the extra patients are seen at the end of surgery, then it is not necessary to make this adjustment.</p> <p>For contractors with only an open surgery system, the average face-to-face time spent by the GP with the patient is not less than 8 minutes.</p> <p>Contractors that routinely operate a mixed economy of booked and open surgeries should ensure that the length of booked appointments is not less than 10 minutes and the length of open surgery appointments is not less than 8 minutes.</p>	33

### Quality improvement (QI).

Indicator	Points
<p>QI001(S). The practice conducts two case note reviews, using a validated tool, to detect patient safety incidents, meets to discuss the results, and shares a reflective report on actions and themes that arise from this with the NHS Board.</p>	6
<p>QI002(S). The practice conducts a safety climate survey with all staff, clinical and non-clinical, using a validated tool, meets to discuss the results, and shares a reflective report on actions that arise from this with the NHS Board.</p>	5

### Medicines Management (MM).

Indicator	Points
<p>MM001(S). The practice meets with the NHS Board prescribing adviser at least annually and agrees 3 actions related to prescribing.</p>	4
<p>MM002(S). The practices meets with the NHS Board prescribing adviser, has agreed 3 actions related to prescribing and subsequently provided evidence of change.</p> <p>The practice should also undertake an audit of an area of prescribing that is a clinical issue that has been agreed with the NHS prescribing adviser.</p>	9

MM003(S). A medication review is recorded in the notes in the preceding 12 months for all patients being prescribed 4 or more repeat medicines. Standard 80 per cent.	10

## Public health (PH).

### Blood pressure (BP).

Indicator	Points	Achievement thresholds
BP001. The percentage of patients aged 40 or over who have a record of blood pressure in the preceding 5 years. <i>NICE 2012 menu ID: NM61</i>	15	40–80%

**We have retained SMOK003, previous Education 1, within the Smoking Cessation section in the Clinical Domain.**

## Section 3: Organisational Core Standard

### QOF Organisational Indicators (OI)

3.1 A number of changes have been agreed to the QOF organisational indicators in Scotland for 2013-14. In summary, indicators worth 37 points will be retired, indicators worth 17 points transferred to the public health domain and indicators worth 77 points will become core activity for which core funding will apply as set out below.

3.2 As the purpose is to transfer the work and associated funding into core funding, the transfer will reflect the historical achievement and relative unweighted practice list size, without deductions for opt-out or reduction in correction factor. The payments to the GP Practices will be based not on the Scottish Allocation Formula but on the three year average achievement for each practice as described in annexe D. The overall achievement by all GP practices in 2011/12 was 75.5/ 77 points.

3.3 It is not proposed to continue with QOF-style reporting, controls and checks. The creation of organisational standards across Records, Education and Management, for monitoring via post-payment verification methods, is the preferred way to conduct this monitoring without introducing an overly bureaucratic process.

3.4 Although in formal terms practices will be advised that they are expected to continue to undertake the activity against the indicators covered by the 77 points the monitoring will concentrate on the small number of practices selected for post-payment verification and on selected indicators around which assurance was especially important (see below). Currently this process affects 3% of practices in a Board area.

3.5 The following domains and indicators would be included in the post-payment verification process. For the purposes of this we have taken the QOF value as the starting point and have rounded the value of each activity area to an appropriate percentage. As an indication of value, each 0.125% is approximately £516 per average sized practice of 5,500 patients:

#### Records Standard OI001

- (a) The practice has an effective system for maintaining safe clinical records for patients, including communication with OOH services and a minimum clinical summary level of 80% which is calculated at year end.

Proposed subsections/Global sum %:

- information sharing with OOH (0.125%);
- drug indication and allergies (0.375%);
- clinical summaries (0.5%).
  
- **Equivalent to £4.2m.**
- **Equivalent to 1% of Global Sum.**

### **Education Standard OI002**

- (a) The practice has an effective system for Continuous Professional Development for nurses, annual appraisal for nurses and non-clinical staff and completes a minimum of 3 SEAs annually.

Proposed subsections/Global sum %:

- Life support training (0.25%);
  - Complaints and SEA (0.25%);
  - CPD for nurses, appraisal for nurses and practice staff (0.25%).
- 
- **Equivalent to £3.15m.**
  - **Equivalent to 0.75% of Global Sum.**

### **Management Standard OI003**

- (a) The practice has an effective system for handling repeat medicine requests within 48 hours (2 working days) and staff employment policies.

Proposed subsections/Global sum %:

- Written procedures and employment policies accessible by staff (0.25%);
  - Repeat prescription availability timescales of 48 hours (0.25%).
- 
- **Equivalent to £2.1m.**
  - **Equivalent to 0.5% of Global Sum.**

- (b) The funding associated with these indicators will be transferred on an on-going basis to the Global Sum, although it will be possible to identify separately that % for PV purposes.

- (c) Transferring these organisational indicators to core activity recognises that they are now part of expected core activity, for which on-going funding will be provided without the need for cumbersome monitoring.

3.6 The creation of Records, Education and Management standards, built from QOF components, with an indicative proportion of global sum associated with them, allows this process to be carried out in an appropriate, light touch manner, via post-payment verification.

### **Recording and verification OI001, OI002 and OI003.**

3.7 Should, as part of a PV visit, evidence be found that a practice has not fulfilled the requirements of a given standard, with no acceptable explanation, then a retrospective recovery will be undertaken based on the designated % of the Global Sum allocated to that sub section of the standard, as shown above. There will be an appropriate appeals mechanism. Previous performance will influence future PV activity.

3.8 PSD PV team will jointly review the wording of the 3 standards with SGPC to ascertain how this could be verified as part of a practice post payment verification visit.

## 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 20 to 60 years;
- Child health surveillance: children of both sexes under the age of 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 under the age of 5 years.

F.3 For 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 number of patients registered with all contractors in Scotland in the relevant target population at the start of the final quarter (**C**) is to be divided by the total number of patients registered in Scotland (according to PSD of NHS National Services Scotland) 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 For the purposes of paragraph F.3, the "relevant date" is the date in respect of which the value of the contractor's CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the financial year to which the Achievement Payment relates, but see paragraph 6.7.

F.5 The Target Population Factor for the additional service is to be multiplied by £133.47 to produce the cash total in respect of the additional service (**F**).

F.6 This calculation could be expressed as—

$$\frac{(A \div B)}{(C \div D)} \times £133.47 \times E = F$$

F.7 If the contractor has not been under an obligation to provide an additional service for any period during the financial year to which the Achievement Payment relates, the adjusted total for that particular additional service is to be further adjusted by the fraction produced by dividing—

- (a) the number of days in the financial year during which its GMS 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.8 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.

## ANNEX G

### ADJUSTED PRACTICE DISEASE FACTOR CALCULATIONS

G.1 The calculation involves three steps:

- the calculation of the practice's Raw Practice Disease Prevalence's. There will be a Raw Practice Disease Prevalence in respect of each disease area (other than the area relating to palliative care) for which the contractor is seeking to obtain Achievement Points;
- making an adjustment to give an Adjusted Practice Disease Factor (APDF);
- applying the factor to the pounds per point figure for each disease area (other than the area relating to palliative care).

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 at 31st March in the financial year to which the Achievement Payment relates by the contractor's CRP for the relevant date. For these purposes, the "relevant date" is the date in respect of which the value of the contractor's CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the financial year to which the Achievement Payment relates, but see paragraph 6.7.

G.4 Subject to the provisions at G4A and G4B relating to calculations in respect of Achievement Payments relating to financial years prior to 2010/2011, the Adjusted Practice Disease Factor is calculated by:

- (a) calculating the national range of Raw Practice Disease Prevalence in Scotland (Health Boards are to use the national range established annually through the QOF Calculator System) 2010/2011;
- (b) re-basing the contractor figures around the new national Scottish 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 in the period commencing on 1 April 2013 and ending on 31 March 2014 the average contractor (i.e. one with an APDF of 1.0) receives £133.47<sup>9</sup> per point, after adjustment;
- (c) thus, adjusting via the factor the contractor's average pounds per point for each disease, rather than the contractor's points score. For example, a contractor with an APDF of 1.2 for CHD in the period commencing 1 April 2013 and ending on 31 March 2014 will receive £160.16 per point scored on the CHD indicators.

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<sup>9</sup>The amount specified in paragraph G.4 (b) in respect of the financial year 1 April 2021 to 31 March 2013 was £133.47.

G.5 As a result of this calculation, each contractor will have a different ‘pounds per point’ figure for each disease area (other than the area relating to palliative care), 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 (other than the area relating to palliative care).

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

G.6B If the contractor’s GMS contract terminates before 1<sup>st</sup> January in the financial year to which the Achievement Payment relates the Adjusted Practice Disease Factor to be used in calculating the contractor’s Achievement Payment should be the Adjusted Practice Disease Factor calculated for the previous financial year.

G.6C 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.

G7 If, after 31<sup>st</sup> March 2010, the contractor’s GMS contract terminates on or after 1<sup>st</sup> January, but before 31<sup>st</sup> March, 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 for that year should be the Adjusted Practice Disease Factor calculated in accordance with paragraphs G1 to G4.



## ANNEX H

### LIST OF PRACTICES FOR WHICH ADDITIONAL PAYMENTS ARE PAYABLE UNDER THE GOLDEN HELLO SCHEME

#### GP PRACTICES LOCATED ON ISLANDS IN SCOTLAND.

Location	Health Board	Practice code	Address			Post code
MAIN	ORKNEY	38008	SCAPA MEDICAL GROUP	NEW SCAPA ROAD	KIRKWALL	KW151BZ
MAIN	ORKNEY	38012	SKERRYVORE PRACTICE	NEW SCAPA ROAD	KIRKWALL	KW151BZ
MAIN	ORKNEY	38027	JOHN STREET	STROMNESS	ORKNEY	KW163AD
MAIN	ORKNEY	38031	DOUNBY	ORKNEY		KW172HT
MAIN	ORKNEY	38046	GREYSTONES	EVIE	ORKNEY	KW172PQ
MAIN	ORKNEY	38051	DAISY VILLA	ST MARGARET'S HOPE	ORKNEY	KW172SN
BRANCH	ORKNEY	38051	HALL	BURRAY	ORKNEY	KW172SS
MAIN	ORKNEY	38065	HEATHERLEA	EDAY	ORKNEY	KW172AB
MAIN	ORKNEY	38070	NEW MANSE	NORTH RONALDSAY	ORKNEY	KW172BE
MAIN	ORKNEY	38084	BRINIAN HOUSE	ROUSAY	ORKNEY	KW172PU
BRANCH	ORKNEY	38084	EGILSAY	ORKNEY		KW172QD
MAIN	ORKNEY	38099	GERAMOUNT HOUSE	STRONSAY	ORKNEY	KW172AE
MAIN	ORKNEY	38101	FLEBISTER HOUSE	SANDAY	ORKNEY	KW172BW
MAIN	ORKNEY	38116	ELWICKBANK	SHAPINSAY	ORKNEY	KW172EA
MAIN	ORKNEY	38121	HOY AND WALLS HEALTH CENTRE	LONGHOPE	ORKNEY	KW163PA
MAIN	ORKNEY	38135	SPRINGBANK	FLOTTA	ORKNEY	KW163NP
MAIN	ORKNEY	38140	TRENABIE HOUSE	WESTRAY	ORKNEY	KW172DL
BRANCH	ORKNEY	38140	PAPA WESTRAY	ORKNEY		KW172BU
MAIN	SHETLAND	39015	YELL HEALTH CENTRE	REAFIRTH	MID YELL	ZE2 9BX
BRANCH	SHETLAND	39015	CULLIVOE	YELL	SHETLAND	ZE2 9BT
BRANCH	SHETLAND	39015	BURRAVOE	YELL	SHETLAND	ZE2 9AY
BRANCH	SHETLAND	39015	NURSES HOUSE	HUBIE	FETLAR	ZE2 9DJ
MAIN	SHETLAND	39020	WHALSAY HEALTH CENTRE	SYMBISTER	WHALSAY	ZE2 9PS
BRANCH	SHETLAND	39020	NURSES HOUSE	SKERRIES	SHETLAND	ZE2 9AS
MAIN	SHETLAND	39034	HILLSWICK HEALTH CENTRE	WEST AYRE	HILLSWICK	ZE2 9RW
MAIN	SHETLAND	39049	BRAE HEALTH CENTRE	BRAE	SHETLAND	ZE2 9QJ
MAIN	SHETLAND	39053	WALLS HEALTH CENTRE	WALLS	SHETLAND	ZE2 9PS
BRANCH	SHETLAND	39053	SANDNESS	WALLS	SHETLAND	ZE2 9PL
BRANCH	SHETLAND	39053	SCHOOLHOUSE	PAPASTOUR	WALLS	ZE2 9PW
BRANCH	SHETLAND	39053	NURSES HOUSE	FOULA	SHETLAND	ZE2 9PN
MAIN	SHETLAND	39068	BIXTER HEALTH CENTRE	BIXTER	SHETLAND	ZE2 9NA
BRANCH	SHETLAND	39068	AITH	BIXTER	SHETLAND	ZE2 9NB
BRANCH	SHETLAND	39068	SKELD	BIXTER	SHETLAND	ZE2 9NL
MAIN	SHETLAND	39072	GORD	LEVENWICK	SHETLAND	ZE2 9HX
BRANCH	SHETLAND	39072	NURSE'S HOUSE	FAIR ISLE	SHETLAND	ZE2 9JU
MAIN	SHETLAND	39087	SCALLOWAY	SHETLAND		ZE1 0UX

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BRANCH	SHETLAND	39087	WEISDALE	SHETLAND		ZE2 9LQ
BRANCH	SHETLAND	39087	HAMNOVOE	BURRA	SHETLAND	ZE2 9JY
BRANCH	SHETLAND	39087	WHITENESS	SHETLAND		ZE2 9LY
BRANCH	SHETLAND	39087	BRIDGE END LERWICK HEALTH CENTRE	BURRA	SHETLAND	ZE2 9LE
MAIN	SHETLAND	39091	SANDWICK	SOUTH ROAD	LERWICK	ZE1 0RZ
BRANCH	SHETLAND	39091	CUNNINGSBURGH	SHETLAND		ZE2 9HW
BRANCH	SHETLAND	39091		SHETLAND		ZE2 9HB
MAIN	SHETLAND	39104	BLOCK 1	MONTFIELD LANE	LERWICK	ZE1 0LF
MAIN	SHETLAND	39161	UNST HEALTH CENTRE	BALTASOUND	UNST	ZE2 9DY
BRANCH	SHETLAND	39161	SAXAVORD	UNST	SHETLAND	ZE2 9EF
BRANCH	SHETLAND	39161	UYEASOUND BROADFORD MEDICAL CENTRE	UNST	SHETLAND	ZE2 9DL
MAIN	HIGHLAND	55516		HIGH ROAD	BROADFORD SKYE AND LOCHALSH	IV499AA
MAIN	HIGHLAND	55521	TRIE DUNVEGAN HEALTH CENTRE	CARBOST		IV478ST
MAIN	HIGHLAND	55535	SLEAT MEDICAL PRACTICE	DUNVEGAN	ISLE OF SKYE	IV558GU
MAIN	HIGHLAND	55540		FERRINDONALD	SLEAT	IV448RF
MAIN	HIGHLAND	55569	CHURCH ROAD PORTREE MEDICAL CENTRE	KYLE OF LOCHALSH		IV408DD
MAIN	HIGHLAND	55573		PORTREE	ISLE OF SKYE	IV519BZ
MAIN	HIGHLAND	55677	GRIANAN BRODICK HEALTH CENTRE	ISLE OF EIGG	LOCHABER	PH424RL
MAIN	ARRAN AYRSHIRE & ARRAN	80645		BRODICK	ARRAN	KA278AJ
MAIN	ARRAN AYRSHIRE & ARRAN	80650	LAMLASH	ARRAN		KA278NS
BRANCH	ARRAN AYRSHIRE & ARRAN	80650	BRODICK CLINIC	INVERCLOY	BRODICK	KA278AJ
BRANCH	ARRAN AYRSHIRE & ARRAN	80650	VILLAGE HALL	KILMORY	ARRAN	KA278PX
BRANCH	ARRAN AYRSHIRE & ARRAN	80650	WHITING BAY CLINIC	ARNHALL LODGE	WHITINGBAY	KA278PX
MAIN	ARRAN AYRSHIRE & ARRAN	80664	SHISKINE CLINIC	INGLEWOOD	SHISKINE	KA278EW
BRANCH	ARRAN AYRSHIRE & ARRAN	80664	VILLAGE HALL	KILMORY	ARRAN	KA278PX
BRANCH	ARRAN AYRSHIRE & ARRAN	80664	NEWTON ROAD	LOCHRANZA	ARRAN	KA278HQ
BRANCH	ARRAN AYRSHIRE & ARRAN	80664	COMMUNITY CENTRE	PIRNMILL	ARRAN	KA278JU
MAIN	ARRAN	80679	10 KELBURN STREET	MILLPORT ISLE OF LISMORE		KA280DT
BRANCH	NHS Highland	84006	PUBLIC HALL	ISLE OF COLL ISLE OF COLONSAY	ARGYLL	PA345UG
MAIN	NHS Highland	84097	ARINAGOUR			PA786SY
MAIN	NHS Highland	84129	BENORAN			PA617YW
MAIN	NHS Highland	84331	WINDSOR	MAIN STREET	BOWMORE	PA437JH
MAIN	NHS Highland	84345	GEIRHILDA THE RHINNS MEDICAL CENTRE	BACK ROAD PORT CHARLOTTE	PORT ELLEN	PA427DL
MAIN	NHS Highland	84350	GLENCAIRN GP SURGERY	CRAIGHOUSE	ISLE OF ISLAY	PA487UD
MAIN	NHS Highland	84383			ISLE OF JURA	PA607XG
BRANCH	NHS Highland	84472	ARDMINISH	ISLE OF GIGHA		PA417AB
MAIN	NHS Highland	84504	SALEN SURGERY	PIER ROAD	SALEN AROS	PA726JL
MAIN	NHS Highland	84519	ROCKFIELD ROAD	TOBERMORY	ISLE OF MULL	PA756PN
MAIN	NHS Highland	84523	BUNESSAN	ISLE OF MULL		PA676DG
BRANCH	NHS Highland	84523	ISLE OF IONA			PA766SJ
MAIN		84646	ROTHESAY HEALTH	HIGH STREET	ROTHESAY	PA209JL

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	NHS Highland		CENTRE			
MAIN	NHS Highland	84805	BAUGH HOUSE GP SURGERY	SCARINISH	ISLE OF TIREE	PA776UN
MAIN	WESTERN ISLES	90007	GEARRA MOR SURGERY	BORVE	ISLE OF LEWIS	HS2 0RX
BRANCH	WESTERN ISLES	90007	HABOST CLINIC	NESS	ISLE OF LEWIS	HS2 0TG
BRANCH	WESTERN ISLES	90007	SHAWBOSTSECONDARY SCHOOL	SHAWBOST	ISLE OF LEWIS	HS2 9BQ
MAIN	WESTERN ISLES	90026	CARLOWAY	ISLE OF LEWIS		HS2 9AG
BRANCH	WESTERN ISLES	90026	DISTRICT NURSE'S COTTAGE	BREASCLETE	ISLE OF LEWIS	HS2 9EF
MAIN	WESTERN ISLES	90031	STORNOWAY HEALTH CENTRE	SPRINGFIELD ROAD	STORNOWAY	HS1 2PS
BRANCH	WESTERN ISLES	90031	CEILIDH HOUSE	NORTH TOLSTA	ISLE OF LEWIS	HS2 0NG
MAIN	WESTERN ISLES	90045	STORNOWAY HEALTH CENTRE	SPRINGFIELD ROAD	STORNOWAY	HS1 2PS
BRANCH	WESTERN ISLES	90045	CEILIDH HOUSE	NORTH TOLSTA	ISLE OF LEWIS	HS2 0NG
MAIN	WESTERN ISLES	90050	ARCHWAY MEDICAL PRACTICE	16 FRANCIS STREET	STORNOWAY	HS1 2XB
MAIN	WESTERN ISLES	90064	MIAVAIG	VIG	ISLE OF LEWIS	HS2 9HW
BRANCH	WESTERN ISLES	90064	THE NURSE'S COTTAGE	BREASCLETE	ISLE OF LEWIS	HS2 9LT
MAIN	WESTERN ISLES	90079	GLEANN MOR	LOCHS	ISLE OF LEWIS	HS2 9JP
BRANCH	WESTERN ISLES	90079	BREASCLETEPRIMARY SCHOOL	BREASCLETE	ISLE OF LEWIS	HS2 9ED
BRANCH	WESTERN ISLES	90079	BALALLANPRIMARY SCHOOL	BALALLAN	ISLE OF LEWIS	HS2 9PN
MAIN	WESTERN ISLES	90083	BLAR MHOR	GRAVIR	ISLE OF LEWIS	HS2 9QX
MAIN	WESTERN ISLES	90098	DOCTOR'S HOUSE	TARBERT	HARRIS	HS3 3BG
BRANCH	WESTERN ISLES	90098	THE CLINIC	SCALPAY		HS4 3XU
MAIN	WESTERN ISLES	90101	FERRY ROAD	LEVERBURGH		HS5 3UA
BRANCH	WESTERN ISLES	90101	LOCH HOUSE SURGERY	GEOCRAB	HARRIS	HS3 3HB
MAIN	WESTERN ISLES	90115	LOCHMADDY	NORTH UIST		HS6 5AE
BRANCH	WESTERN ISLES	90115	**ALL MAIL TO BE SENT TO THE MAIN PRACTI	**AT THE SURGERY, LOCHMADDY HS6 5AE**	**AND NOT TO BAYHEAD, TIGH CEILIALA**	
BRANCH	WESTERN ISLES	90115	**ALL MAIL TO BE SENT TO THE MAIN PRACTI	**AT THE SURGERY, LOCHMADDY HS6 5AE**	**AND NOT TO BERNARAY NURSES COTTAGE**	
BRANCH	WESTERN ISLES	90115	**ALL MAIL TO BE SENT TO THE MAIN PRACTI	**AT THE SURGERY, LOCHMADDY HS6 5AE**	**AND NOT TO TRIANAI, CARINISH**	
MAIN	WESTERN ISLES	90120	SORELLE LODGE SURGERY	GRIMINISH	BENBECULA	HS7 5QA
BRANCH	WESTERN ISLES	90120	DALIBURGHHOSPITAL	DALIBURGH	SOUTH UIST	HS8 5SS
BRANCH	WESTERN ISLES	90120	BENBECULA COMMUNITY CLINIC	BALIVANICH	BENBECULA	HS7 5LA
MAIN	WESTERN ISLES	90134	SOUTH UIST MEDICAL PRACTICE	DALIBURGH	LOCHBOISDALE	HS8 5SS
BRANCH	WESTERN ISLES	90134	ERISKAY	SOUTH VIST	SOUTH UIST	HS8 5JU
BRANCH	WESTERN ISLES	90134	COMMUNITY CENTRE	STONEYBRIDGE	SOUTH UIST	HS8 5SD
MAIN	WESTERN ISLES	90149	CLACH MHILE SURGERY	CASTLEBAY	ISLE OF BARRA	HS9 5XD
BRANCH	WESTERN ISLES	90149	CHURCH HALL	NORTHBAY	BARRA	HS9 5YQ

## ANNEX I

### SCOTTISH IMMUNISATION PROGRAMME – General Practice Elements

Changes were introduced to the routine childhood immunisation programme with effect from 1 June 2013. Details of those changes, which relate to the introduction rotavirus into the routine childhood immunisation programme, changes to the schedule for the Meningitis C (Men C) vaccinations, were set out in a letter dated 7 May 2013 from the Chief Medical Officer, the Chief Nursing Officer and the Chief Pharmaceutical Officer; SGH&SCID/CMO(2013) 6.

#### Annex 1

#### The Routine Childhood Immunisation Programme.

##### 1. Background to the changes.

The background for the changes to the routine childhood immunisation programme is detailed in our letter dated 8 February 2006 (available at: [http://www.show.scot.nhs.uk/sehd/cmo/CMO\(2006\)03.pdf](http://www.show.scot.nhs.uk/sehd/cmo/CMO(2006)03.pdf)). Further information will be available in the factsheets and new green book chapters, on the NHS Health Scotland website [www.healthscotland.com/immunisation](http://www.healthscotland.com/immunisation) and on the JCVI website [www.advisorybodies.doh.gov.uk/JCVI/](http://www.advisorybodies.doh.gov.uk/JCVI/).

##### 2. Timing.

The routine programme will change on 1 June 2013. All children starting their immunisation from that date should be offered the new immunisation schedule. The Hib/MenC booster should also be introduced for children aged 12 months of age from that date.

##### 3. Routine Childhood Immunisation Schedule.

All children starting the immunisation programme at 2 months of age will follow the schedule below (see Table 1):

**Table 1**

When to immunise	What is given	Vaccine and how it is given
Two months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/HiB)	One injection (Pediaceal)
	Pneumococcal (PCV)	One injection (Prevenar)
	Rota virus	Rotarix
Three months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/HiB)	One injection (Pediaceal)
	Meningitis C (MenC)	One injection (Menjugate, Neisvac C)

	Rota virus	Rotarix
Four months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/HiB)	One injection (Pediaceal)
	Pneumococcal (PCV)	One injection (Prevenar 13)
12 - 13 months	<i>Haemophilus influenzae</i> type b,- Meningitis CMeningitis C (HiB/ MenC)	One injection (Mentorix)
	Measles, mumps and rubella (MMR)	One injection (Priorix or MMR VaxPro)
	Pneumococcal (PCV)	One injection (Prevenar 13)
Three years four months to five years old	Diphtheria, tetanus, pertussis and polio (dTaP/IPV or DTaP/IPV)	One injection (Infanrix-IPV or Repevax)
	Measles, mumps and rubella (MMR)	One injection (Priorix or MMR II)
Thirteen to 18 years old	Tetanus, diphtheria and polio (Td/IPV)	One injection (Revaxis)
	Meningitis C (Men C)	One injection (Menjugate, Neisvac C or Meningitec)
	HPV (girls only)	Gardasil

It is important that all those involved in immunisations are familiar with the childhood immunisation schedule (described in Table 1). Changes are:

- Rota virus – one dose at 2 and 3 months;
- One dose of live attenuated influenza nasal vaccine (Fluenz) to all 2 and 3 year olds.
- Children under nine years of age in a clinical at risk group who are receiving influenza vaccine for the first time (under 9 years of age) should receive two doses with second dose at least four weeks after the first;
- Omit the MenC vaccine booster at 4 months of age;

Introducing these changes means that:

- infants will be offered different combinations of vaccines at the 2, 3 and 4 month visits;
- Oral rota virus vaccine will be offered to infants at 2 and 3 months of age;
- One less vaccine injection at 4 month visit (MenC);

- One dose influenza vaccine to all 2 and 3 year olds, with two doses of nasal to children at risk (under 9 years of age) who are receiving influenza vaccine for the first time.;

#### **4. Children aged over 2 months of age at the start of the programme.**

There will be a small number of children who will be part-way through their primary vaccination schedule when the changes are introduced. It is important to ensure that these children receive three doses of DTaP/IPV/HiB (PediaceL), and at least two doses of MenC (with one dose being given at the 4 month and the other at 12 months visit).

All children, irrespective of their primary vaccination history, should receive a booster dose of Hib/MenC vaccine at their routine 12 months of age visit in order to ensure long-term protection.

#### **5. Children at an increased risk of pneumococcal infection.**

Some groups of children are at increased risk from pneumococcal infection (see Table 2).

All at-risk children will routinely be offered PCV vaccine, according to the schedule for the routine immunisation programme (i.e. at 2, 4 and 13 months of age).

In addition, all at-risk children should be offered a single dose of pneumococcal polysaccharide vaccine (PPV) when they are two years of age or over.

##### At-risk children presenting late for immunisation.

At-risk children who present late for vaccination should be offered 2 doses of PCV<sup>10</sup> before the age of 12 months and a further dose at 13 months of age. All at-risk children should also be offered a single dose of PPV when they are two years of age or older and at least 2 months after the final dose of PCV.

At-risk children aged over 12 months and under 5 years of age should be offered a single dose of PCV. Please note that children in this age group who have asplenia or splenic dysfunction, or who are immunocompromised, require a second dose of PCV because this group may have a sub-optimal immunological response to the first dose of vaccine. This should be given 2 months after the first dose. They should also be offered a single dose of PPV (if not previously given) when they are two years of age or older (and at least 2 months after the final dose of PCV).

At-risk children presenting for first pneumococcal immunisation aged 5 years and over should be offered a single dose of PPV.

**6. Children under five years of age who have previously had invasive pneumococcal disease.**

All children under 5 years of age, who have had invasive pneumococcal disease (IPD), for example pneumococcal meningitis or pneumococcal bacteraemia, should be offered a dose of PCV irrespective of previous vaccination history. Children under 13 months who are unvaccinated or partially vaccinated should complete the immunisation schedule.

These children should be investigated for immunological risk factors to seek a possible treatable condition predisposing them to infection. If they are found to fall into one of the risk groups in table 2, they should receive pneumococcal polysaccharide vaccine after the age of two years (and at least 2 months after the final dose of PCV).

All new cases of IPD in children eligible for routine or catch-up PCV will be followed up by the local NHS Board public health department in liaison with Health Protection Scotland. Those cases of IPD, who have been previously immunised with PCV, will be offered antibody testing against each of the 7 vaccine serotypes and advice on clinical and immunological investigation. A blood sample should be taken four weeks after infection to assess antibody response to disease and measure immunoglobulin levels. At this time, a booster dose of pneumococcal vaccine (irrespective of vaccination status of child) should be given. A second blood sample should be taken four weeks after vaccination to measure response to the booster dose.

**7. Vaccination of children with unknown or incomplete status.**

Where a child born in the UK presents with an inadequate or incomplete immunisation record, every effort should be made to clarify what vaccines they have had. A child who has not completed the routine programme for all vaccines should complete the course, including for pneumococcal vaccination. Children under 12 months of age require two doses of PCV, two months apart, followed by a dose at 13 months. Children aged between 12 and 24 months should be offered a single dose of PCV. Children aged over 24 months do not require vaccination.

Children coming to the UK may not have been offered pneumococcal vaccination previously. Where there is not reliable history of previous immunisation it should be assumed they are unimmunised and the UK recommendation should be followed.

**8. Pharmacy issues.**

The following new vaccines will be offered as part of the routine programme. Full details on the products are available in the Summary of Product Characteristics (SPC).

***Pneumococcal Conjugate Vaccine (PCV).***

PCV, brand name Prevenar™ is manufactured by Pfizer.

***HiB/ Men C Vaccine.***

HiB/ Men C, brand name Menitorix™ is manufactured by GlaxoSmithKline.

***Rotarix (Rotarix) Vaccine .***

*Vaccine brand name and manufacturer - Rotarix® – manufactured by GlaxoSmithKline.*

Rotavirus vaccine can be given at the same time as the other vaccines administered as part of the routine childhood immunisation programme (including BCG) and so should ideally be given at the scheduled 2 month and 3 month vaccination visits (see above).

***Live attenuated influenza vaccine (Fluenz®).***

*Vaccine brand name and manufacturer - Fluenz® – Marketed by Astra Zeneca.*

*Fluenz vaccine is for nasal administration. **It must not be injected.***

The requirement for Patient Group Directions (PGD) is described in HDL (2001)7, available from [http://www.show.scot.nhs.uk/sehd/mels/HDL2001\\_07.htm](http://www.show.scot.nhs.uk/sehd/mels/HDL2001_07.htm) .

For those practices that choose to use PGDs, national specimen PGDs for Rotarix, MenC and Fluenz are being developed and will be available on Health Protection Scotland website <http://www.hps.scot.nhs.uk/>, NHS Boards may choose to use these drafts as the basis of their local PGDs and tailor them to reflect local needs.

**9. Funding and Service Arrangements.**

Scottish Government has reached agreement with the Scottish General Practitioners Committee of the BMA in Scotland.

GPs will be remunerated £15.02 per child for the delivery of the pneumococcal vaccinations and the additional vaccination visit at 12 months to deliver the combined Hib and Men C vaccine. The Statement of Financial Entitlements will be amended and back dated to 1 April 2013.



**TABLE 2 Pneumococcal Clinical Risk Groups for Children.**

Note: All children, including those in clinical risk groups, should be offered PCV according to the new routine immunisation schedule. Children in the clinical risk groups listed below, aged 2 months to under 5 years of age should receive 7-valent pneumococcal conjugate vaccine (PCV), according to Annex 1, paragraph 5. This should be followed by a single dose of 23-valent pneumococcal polysaccharide vaccine when they are 2 years of age or over (and at least two months after the last dose of PCV). Children over 5 years of age should receive a single dose of pneumococcal polysaccharide vaccine.

**Annex 2**

**New Vaccines in the GP Childhood Immunisation Programme.**

**Rotavirus.**

<b>Clinical risk group</b>	<b>Examples (decision based on clinical judgement)</b>
<b>Asplenia or dysfunction of the spleen</b>	This includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
<b>Chronic respiratory disease</b>	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neuromuscular disease (e.g. cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless so severe as to require continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below) is needed.
<b>Chronic heart disease</b>	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
<b>Chronic kidney disease</b>	This includes nephrotic syndrome, chronic kidney disease at stages 4 and 5 and those on kidney dialysis or with kidney transplantation.
<b>Chronic liver disease</b>	This includes cirrhosis, biliary atresia, chronic hepatitis
<b>Diabetes</b>	This includes diabetes mellitus requiring insulin or oral hypoglycaemic drugs. This does not include diabetes that is diet controlled.
<b>Immunosuppression</b>	Due to disease or treatment, including asplenia or splenic dysfunction and HIV infection at all stages. Patients undergoing chemotherapy leading to immunosuppression. Individuals on or likely to be on systemic steroids for more than a month at a dose equivalent to prednisolone 20mg or more per day (any age), or for children under 20kg, a dose of $\geq 1\text{mg/kg/day}$ . <i>Some immunocompromised patients may have a suboptimal immunological response to the vaccine.</i>
<b>Individuals with cochlear implants</b>	<i>It is important that immunisation does not delay the cochlear implantation.</i> Where possible, pneumococcal vaccination should be completed at least 2 weeks prior to surgery to allow a protective immune response to develop. In some cases it will not be possible to complete the course prior to surgery. In this instance, the course should be started at any time prior to or following surgery and completed according to the immunisation schedule.
<b>Individuals with cerebrospinal fluid leaks</b>	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery.

Rotavirus vaccination is an addition to the existing (pre 2013-14) childhood immunisation schedule from 1 June 2013, as a one year agreement only. A fee of £7.67 in 2013/14 per dose for this course of two immunisations will be paid, with the payment for one dose being set against the dropped 3<sup>rd</sup> (4 month) childhood dose for Meningitis C.

Therefore **payment of £7.67 for a completed Rotavirus course** will be made at the year-end or in the month following completion of the second dose. In the event that the child does not attend for the second dose, it has been agreed that GPs can claim £3.84 towards the cost of giving the first dose, with a claim being made 6 months after the first dose or at the year end. Rotavirus will form part of the existing DES for childhood immunisations. Rotavirus vaccination rates will not impact upon Childhood Immunisation target payments.

### **Meningitis C – Changes.**

The 3<sup>rd</sup> childhood dose of Meningitis C (given at 4 months) will be removed from the existing programme (pre 2013-14) from June 2013, and this will be re-added as a single dose course as part of the existing teenage booster programme.

### **Childhood Influenza Programme.**

The childhood influenza programme is intended to ultimately cover children from the age of 2 years to 17 years. This programme is being rolled out in a phased fashion from 2013/14 and it is intended that **all 2 and 3 year old children are immunised in 2013/14**, with vaccinations for all pre-school children likely to follow in 2014/15.

**A fee of £7.67** (1 year agreement) per dose (**£15.34 per course** if two doses are advised for at risk children under 9 years who are receiving influenza vaccine for the first time) is claimable for this additional work. GP Practices will receive payment per immunisation (dose) given. Payment for each immunisation will be made at the end of the year or as part of the interim payment if two doses are required.

This will be an extension to the Flu programme for these children, which will require an extension to the existing Flu DES.

### **Data.**

For all the above new programmes GP practices will be expected to provide any appropriate information required by Health Boards, Practitioner Services and Health Protection Scotland (on behalf of Scottish Government) for the purposes of public health monitoring and payment verification.

## ANNEX J

### VACCINES AND IMMUNISATIONS

#### Introduction.

J.1. This Annex sets out types of vaccines and immunisations and the circumstances in which Contractors are to offer and give such vaccines and immunisations.

#### PART 1

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

J.2. Contractors are to offer immunisations in respect of the diseases listed in column 1 of Table 1 (whether or not there is any localised outbreak of the diseases mentioned in Part 3) to persons who do not intend to travel abroad and provide such immunisations in the circumstances set out in column 2 of that Table.

J.3. Contractors who offer and provide immunisations referred to in Table 1 as part of the Additional Services must have regard to the guidance and information on vaccines and immunisations procedures set out in 'Immunisation against infectious diseases – The Green Book'<sup>11</sup> which is published by the UK Government's Department of Health.

**Table 1**

<i>VACCINES AND IMMUNISATION IN RESPECT OF DISEASES</i>	<i>CIRCUMSTANCES IN WHICH VACCINES OR IMMUNISATION IS TO BE OFFERED AND GIVEN</i>
1 Anthrax	Four doses of the vaccine (plus an annual reinforcing dose) are to be offered to persons who are exposed to an identifiable risk of contracting anthrax. Those who are exposed to an identifiable risk will mainly be those persons who come into contact with imported animal products that could be contaminated with anthrax.
2. Diphtheria, Tetanus and Polio (DTaP/IPV/Hib; DTaP/IPV; dTaP/IPV; Td/IPV)	(a) Children under the age of 6 years are to be offered immunisation in accordance with the Childhood Immunisations Scheme (as referred to in Section 8). (b) Persons who are aged 6 years or over who

<sup>11</sup> The Green Book and updates are published on the website of the UK Government's Department of Health (<http://www.dh.gov.uk>).

have not had the full course of immunisation or whose immunisation history is unknown are to be offered, either-

(i) a primary course of three doses plus two reinforcing doses at suitable time intervals; or  
(ii) as many doses as required to ensure that a full five dose schedule has been administered, whichever is clinically appropriate.

### 3. Hepatitis A

(a) A course of immunisation is to be offered to persons who are resident-

(i) in residential care; or

(ii) in an educational establishment, who risk exposure to infection and for whom immunisation is recommended by the local Director of Public Health.

(b) The number of doses of vaccine (either two or three) required will be dependent upon the chosen vaccine and should be sufficient to provide satisfactory long-term protection against the disease.

### 4. Measles, Mumps and Rubella (MMR)

(a) Children under the age of 6 years are to be offered immunisation in accordance with the Childhood Immunisations Scheme (as referred to in Section 8).

(b) Children are to be offered a second dose of MMR vaccine as a follow up to the dose given under the Childhood Immunisations Scheme prior to their sixth birthday.

(c) Persons who have attained the age of 6 years but not the age of 16 years who have not received two doses of the MMR vaccine or whose immunisation history is incomplete or unknown are to be offered one or two doses (whichever is clinically appropriate), to ensure that the complete two-dose schedule necessary to offer satisfactory protection against measles, mumps and rubella has been administered.

(d) Women who may become, but are not, pregnant and are sero-negative are to be offered, one or two doses (whichever is clinically appropriate) to ensure that the complete two- necessary to offer satisfactory protection against measles, mumps and rubella has been administered.

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	<p>(e) Male staff working in ante-natal clinics who are sero-negative are to be offered one or two doses (whichever is clinically appropriate) to ensure that the complete two-dose schedule necessary to offer satisfactory protection against measles, mumps and rubella has been administered.</p>
5. Meningococcal Group C	<p>(a) Children under the age of 6 years are to be offered immunisation in accordance with the Childhood Immunisations Scheme (as referred to in Section 8) and offered the pneumococcal and Hib/MenC booster vaccine in accordance with Section 8A.</p> <p>(b) Persons who have attained the age of 6 years but not the age of 25 years who have not previously been immunised with conjugate meningococcal C vaccine, or whose immunisation history is incomplete or unknown, are to be offered one dose of conjugate meningococcal C vaccine.</p>
6. Paratyphoid <sup>12</sup>	<p>No vaccine currently exists for the immunisation of paratyphoid.</p>
7. Rabies (pre-exposure)	<p>(a) Three doses of the Rabies vaccine are to be offered to the following persons-</p> <ul style="list-style-type: none"><li>(i) laboratory workers handling rabies virus;</li><li>(ii) bat-handlers;</li><li>(iii) persons who regularly handle imported animals, for example, those—<ul style="list-style-type: none"><li>(aa) at animal quarantine stations;</li><li>(bb) at zoos;</li><li>(cc) at animal research centres and acclimatisation centres;</li><li>(dd) at ports where contact with imported animals occurs and this may include certain HM Revenue and Custom offices;</li><li>(ee) persons carrying agents of imported animals; and</li></ul></li></ul>

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<sup>12</sup> No vaccine is currently available for paratyphoid. Should a vaccine subsequently become available a review of this Table would be considered and any agreed amendments specified.

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	<p>(ff) who are veterinary or technical staff in animal health;</p> <p>(iv) animal control and wildlife workers who regularly travel in rabies enzootic areas; and</p> <p>(v) health workers who are at risk of direct exposure to body fluids or tissue from a patient with confirmed or probable rabies.</p> <p>(b) Reinforcing doses are to be provided at recommended intervals to those at continuing risk<sup>14</sup>.</p>
8. Smallpox <sup>13</sup>	<p>The smallpox vaccine exists but is not available to Contractors.</p>
9. Typhoid	<p>(a) A course of typhoid vaccine is to be offered to the following persons-</p> <p>(i) hospital doctors, nurses and other staff likely to come into contact with cases of typhoid; and</p> <p>(ii) laboratory staff likely to handle material contaminated with typhoid organisms.</p> <p>(b) The number of doses (including reinforcing doses) required will be dependent on the chosen vaccine and is to be offered so as to provide satisfactory protection against the disease.</p>

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## PART 2

### VACCINES AND IMMUNISATIONS REQUIRED FOR THE PURPOSES OF FOREIGN TRAVEL

J.4. Immunisation in respect of the diseases listed in column 1 of Table 2 must only be offered in the case of a person who intends to travel abroad, and if the offer is accepted, given in the circumstances set out in column 2 of that Table.

J.5. Contractors who offer and provide immunisations referred to in Table 2 as part of the Additional Services must have regard to-

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

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<sup>13</sup> Routine vaccination is not appropriate and no vaccine is available for use in general practice. Should it become appropriate to vaccinate, a review of the Table would be considered and any agreed amendments specified.

<sup>14</sup> See “Immunisation against infectious diseases – The Green Book”.

(b) the information on travel medicine and travel health issues provided and published through TRAVAX Scotland <sup>15</sup>.

**Table 2**

<i>VACCINES AND IMMUNISATION IN RESPECT OF DISEASES</i>	<i>CIRCUMSTANCES IN WHICH VACCINES OR IMMUNISATION IS TO BE OFFERED AND GIVEN</i>
1. Cholera	<p>(a) A course of immunisation is to be offered to persons travelling-</p> <p>(i) to an area where they may risk exposure to infections as a consequence of being in that area; or</p> <p>(ii) to a country where it is a condition of entry to that country that persons have been immunised.</p> <p>(b) The appropriate course of immunisation is dependent on age and will consist of an initial course and a subsequent reinforcing course of immunisation. If more than two years have elapsed since the last course of immunisation, a new course of immunisation should be commenced.</p>
2. Hepatitis A	<p>(a) A course of immunisation is to be offered to persons travelling to areas where the degree of exposure to infections is believed to be high<sup>16</sup>. Persons who may be at a higher risk of infection include those who-</p> <p>(i) intend to reside in an area for at least three months and may be exposed to Hepatitis A during that period; or</p> <p>(ii) if exposed to Hepatitis A, may be less resistant to infection because of a pre-existing disease or condition or who are at risk of developing medical complications from exposure.</p> <p>(b) The number of doses (either two or three) of the vaccine required will be dependent upon the chosen vaccine and should be sufficient to provide satisfactory long-term protection against the disease.</p>

<sup>15</sup> TRAVAX Scotland ([www.travax.nhs.uk](http://www.travax.nhs.uk)) is maintained and continually updated by the Travel Health Team of Health Protection Scotland. It is provided as an NHS resource for health care professionals who advise patients about avoiding illness and staying healthy when travelling abroad.

<sup>16</sup> See up to date details of travel information on [www.travax.nhs.uk](http://www.travax.nhs.uk).



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3. Paratyphoid <sup>17</sup>	No vaccine currently exists for immunisation of paratyphoid.
4. Poliomyelitis	<p>(a) A course of immunisation (using an age appropriate combined vaccine) is to be offered to persons travelling-</p> <p>(i) to an area where they may risk exposure to infection as a consequence of being in that area; or</p> <p>(ii) to a country where it is a condition of entry to that country that persons have been immunised.</p> <p>(b) Children under the age of 6 years are to be offered immunisation in accordance with the Childhood Immunisations Scheme (as referred to in Section 8).</p> <p>(c) Persons aged 6 years and over who have not had the full course of immunisation or whose immunisation history is incomplete or unknown are to be offered, either-</p> <p>(i) a primary course of three doses plus two reinforcing doses at suitable time intervals; or</p> <p>(ii) as many doses as required to ensure that a full five dose schedule has been administered, whichever is clinically appropriate.</p>
5. Smallpox <sup>18</sup>	The smallpox vaccine exists but is not available to Contractors.
6. Typhoid	<p>(a) A course of typhoid vaccine is to be offered to persons travelling-</p> <p>(i) to an area where they may risk exposure to infection as a consequence of being in that area; or</p> <p>(ii) to a country where it is a condition of entry to that country that persons have been immunised.</p> <p>(b) The number of doses (including reinforcing doses) required will be dependent on the chosen vaccine and is to be offered so as to provide satisfactory protection against the disease.</p>

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<sup>17</sup> No vaccine is currently available for paratyphoid. Should a vaccine subsequently become available a review of this Table would be considered and any agreed amendments specified.

<sup>18</sup> Routine vaccination is not appropriate and no vaccine is available for use in general practice. Should it become appropriate to vaccinate, a review of the Table would be considered and any agreed amendments specified.

## PART 3

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

J.6. In the event of a localised outbreak of any of the diseases listed in paragraph J.7, the Health Board must consider its response to that localised outbreak and contractors must offer and provide immunisations in accordance with any directions given by the local Director of Public Health as part of the Health Board's response to the outbreak, and those directions may make recommendations as to additional categories of persons who should be offered immunisation.

J.7 The diseases referred to in paragraph J.6 are-

- (a) Anthrax;
- (b) Diphtheria
- (c) Meningococcal Group C;
- (d) Poliomyelitis;
- (e) Rabies;
- (f) Tetanus; and
- (g) Typhoid.

J.8. Contractors who offer and provide immunisations in respect of the diseases mentioned in paragraph J.7 as part of the Additional Services must have regard to the guidance and information on vaccines and immunisations procedures set out in "Immunisation against infectious diseases – The Green Book<sup>19</sup>" which is published by the UK Government's Department of Health.

J.9. Contractors who offer immunisation in the circumstances set out in paragraph J.6, are not required, by virtue of this Annex, to carry out a contact tracing or trace back exercise.

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<sup>19</sup> This publication and updates are published on the website of the UK Government's Department of Health (<http://www.dh.gov.uk>).