NHS Circular:
PCA(M)(2004)4

SCOTTISH EXECUTIVE

Health Department
Human Resources Directorate

St Andrew's House
2 Regent Road
EDINBURGH
EH1 3DG

Dear Colleague

26 January 2004

DRAFT GENERAL MEDICAL SERVICES STATEMENT OF FINANCIAL ENTITLEMENTS FOR 2004/05

Addressees

For action
Chief Executives of Primary Care Trusts
Chief Executives of Island NHS Boards
Chief Executives of NHS Boards
General Medical Practitioners

For information
Chief Executives of NHS Trusts
Director of Practitioner Services Division,
Common Services Agency

Enquiries to:

John Hannah
1ER
St Andrew's House
EDINBURGH
EH1 3DG

Tel: 0131-244 2465
Fax: 0131-244 2461

Summary

1. This Circular introduces the draft General Medical Services Statement of Financial Entitlements (SFE) for 2004/05, a copy of which can be found in the links provided below.

Background

2. The 4 UK Health Departments and the NHS Confederation have negotiated a new General Medical Services contract with the General Practitioners Committee of the British Medical Association, which comes into effect on 1 April 2004.

3. The new contract is designed to benefit General Practitioners, other primary care professionals, the NHS, and most importantly patients. It aims to reward practices offering higher quality care, improve GPs' working lives and ensure patients benefit from a wider range of services in the community.

4. Underpinning this new General Medical Services contract is a Statement of Financial Entitlements for the financial year 2004/05 for Scotland. This replaces the current Statement of Fees and Allowances, which will no longer apply from 1 April 2004.

5. An electronic copy of the draft SFE can be found at the Pay Modernisation Website at:

http://www.show.scot.nhs.uk/sehd/paymodernisation/

or the SHOW Website at:

http://www.show.scot.nhs.uk/sehd/pca/PCA2004(M)04.pdf

6. If you have any comments on the draft SFE, please send them to:

John Hannah
1ER
St Andrew's House
EDINBURGH
EH1 3DG

Alternatively, you can e-mail comments to:

John.hannah@scotland.gsi.gov.uk

The deadline for comments is by 12 February 2004 to enable publication of the final document by 27 February, as highlighted in the schedule attached to PCA(M)(2004)3 issued on 21 January 2004.

Action

7.Primary Care Trusts/NHS Boards are requested to bring this Circular to the attention of GP practices in their area and their Area Medical Committee for the attention of the secretary of the GP sub-committee.

Yours sincerely

MIKE PALMER
Assistant Director (Workforce and Policy)

Draft: 26 January 2004

GMS STATEMENT OF FINANCIAL ENTITLEMENTS FOR 2004/5

TABLE OF CONTENTS

PART 3
DIRECTED ENHANCED SERVICES

PART 4
PAYMENTS FOR SPECIFIC PURPOSES

12. PAYMENTS IN RESPECT OF PROLONGED STUDY LEAVE

Types of study in respect of which prolonged study leave may be taken
The educational allowance payment
Locum cover in respect of doctors on prolonged study leave
Payment arrangements
Conditions attached to the amounts payable

13. SENIORITY PAYMENTS

Eligible posts
Service that is Reckonable Service
Calculation of years of Reckonable Service
Determination of the relevant dates
Calculation of the full annual rate of Seniority Payments
Superannuable Income Fractions
Amounts payable
Conditions attached to payment of Quarterly Seniority Payments

14. GOLDEN HELLO SCHEME

Standard payments under the Golden Hello Scheme
Payments for Practitioners in Areas attracting Additional Payments
Job Sharers
Changes in circumstances
Return of Payments
Payments for non principal doctors new to primary care
Relocation Costs
Recruitment Costs
Rates of Payment

15. NOT ALLOTTED16. NOT ALLOTTED17. DOCTORS' RETAINER SCHEME

Payments in respect of sessions undertaken by members of the Scheme
Payment conditions

18. DISPENSING

Dispensing arrangements
Transitional arrangements
Claims
Payments on account
Examination of prescription forms
Schedule 1 – Discount Scale
Schedule 2 - Feescale
Schedule 3 – Addresses for claims
Schedule 4 – List of Vaccines

PART 5
CERTAIN PREMISES COSTS

PART 6
SUPPLEMENTARY PROVISIONS

ANNEXES

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[1], 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 GMS contract.

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 (parallel Statements will be made for England, Wales and Northern Ireland). They were authorised to be given, and by an instrument in writing, on behalf of Scottish Ministers, by [Mike Palmer], a member of the Senior Civil Service, on [Date] 2004, and shall come into force on 1st April 2004.

1.6 This SFE may be revised during the financial year 2004 to 2005, in accordance with section 17M(3)(e) of the 1978 Act. For the most up-to-date information, contact the Scottish Executive Health Department, Directorate of Human Resources, General Medical Services Branch, Area 1.ER, St Andrews House, Regent Road, EDINBURGH EH1 3DG.

[1] Section 17M was inserted by section 4 of the Primary Medical Services (Scotland) Act 2004.

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 Health Boards must calculate for each contractor the first value of its Initial Global Sum Monthly Payment ("Initial GSMP"). This calculation is to be made by first establishing the contractor's Contractor Registered Population (CRP)–

(a) if the contract takes effect on 1st April 2004 – or is treated as taking effect for payment purposes on 1st April 2004, which will be the case for GMS contracts replacing default contracts – on that date; or

(b) if the contract takes effect (for payment purposes) after 1st April 2004, on the date 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 of £279.6m in 2004/05 [this amount will be adjusted after further consideration of the funding of employer's superannuation contributions] 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. For comparative purposes only, this figure should correspond to the Contractors Weighted Population for the Quarter multiplied by (approximately) £52* [this amount will be adjusted after further consideration of the funding of employer's superannuation contributions]

* This is an approximate value (rounded to the whole pound figure) which may vary in accordance with the quarterly total changes to Contractor Registered Populations in Scotland, to ensure accurate delivery of the total Scotland-wide global sum figure.

2.4 Then, the Health Board will need to add to the total produced by paragraph 2.3 the annual amount of the contractor's Temporary Patients Adjustment. The method of calculating contractors' Temporary Patients Adjustments is set out in Annex C. The

resulting amount is then to be divided by twelve, and the resulting amount from that calculation is the contractor's first Initial GSMP.

Calculation of Adjusted Global Sum Monthly Payments

2.5 If the GMS contract stipulates from the outset 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 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 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

Column 1	*Column 2*
Additional or Out-of-Hours Services	**Percentage of Initial GSMP**
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
Vaccinations 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 Payment

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

(a) at the start of each quarter (when the contractor may have a new Contractor Weighted Population for the Quarter);

(b) if there are to be new Additional or Out-of-Hours Services opt-outs (whether temporary or permanent); or

(c) if the contractor is to start or resume providing specific Additional or Out-of-Hours Services that it has not been providing.

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. 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) 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 the Common Services Agency (CSA), 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 respect of the financial year 2004 to 2005 an Achievement Points Total of at least 100. If it breaches this condition, the Health Board must withhold from the contractor [£7,500] multiplied by its Contractor Population Index (i.e. for the last quarter) in respect of its Payable GSMPs for the financial year 2004 to 2005 (the contractor will, however, receive an Achievement Payment in respect of the points it does score pursuant to paragraph 5.39).

2.17 However, if the contactor's GMS contract either takes effect after 1st April 2004 or is terminated before 31st March 2005, 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 2004 to 2005 for which its GMS contract had effect by 365.

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 a list of Red Book fees and allowances, and is designed to protect income levels in relation to these fees and allowances. A one year aggregate of these fees and allowances is the contractor's Initial Global Sum Equivalent (GSE), is then adjusted to produce first its Adjusted GSE and then its Final GSE.

Calculation of Global Sum Equivalent

3.2 In order to calculate a contractor's GSE, a calculation will first need to be made of its Initial and Adjusted GSE. This is to be 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; and

(b) in accordance with the Scottish Executive Health Department (SEHD) guidance reproduced in Annex D. Paragraphs 1 – 7 cover the calculation of the Initial GSE, and adjustments to take account, for example, of practice mergers and splits are covered in paragraphs 8 – 19.

(c) Details of GSE allocations for previous Inducement Practitioners are at Annex D part 2.

3.3 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 is known as

the contractor's Adjusted GSE. That amount is then subject to three further adjustments–

(a) the amount is 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 is adjusted by the contractor's GSE Superannuation Adjustment. This is an adjustment to take account of the increases to the existing costs of employer's superannuation contributions as a result of the Treasury transfer to SEHD of the money previously paid by Treasury in respect of NHS employer's superannuation contributions (the method of calculating this Adjustment is still the subject of negotiation); then

(c) the sub-paragraph (b) amount is 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).

The resulting amount is the contractor's Final GSE.

Calculation of Correction Factor Monthly Payments

3.4 The contractor's Final GSE is then to be compared to the paragraph 2.3 total in respect of the contractor, taking away from that total both any Historic Opt-Outs Adjustment to which it is entitled and its Global Sum Superannuation Adjustment.

3.5 A contractor is entitled to the Historic Opt-Outs Adjustment if–

(a) since 1st July 2002 the GPs comprising the contractor have not been providing, within GMS services, services which as far as possible are 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 will not be providing those services in the financial year 2004 to 2005.

3.6 The amount of the contractor's Historic Opt-Outs Adjustment is 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 is the amount by which its paragraph 2.3 total is reduced if it is 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 is to include an amount in respect of each service. The value of the amount for each service is the amount

by which the contractor's paragraph 2.3 total is reduced if it is 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 is then aggregated to produce the final amount of the contractor's Historic Opt-Outs Adjustment.

3.7 The Global Sum Superannuation Adjustment is to be calculated as follows (this is still the subject of negotiation).

3.8 A contractor's paragraph 2.3 total, minus any Historic Opt-Outs Adjustment to which it is entitled, minus its Global Sum Superannuation Adjustment, is its Global Sum Comparator (i.e. the Global Sum Comparator = Initial Global Sum – Temporary Patients Adjustment – any Historic Opt-Outs Adjustment – Global Sum Superannuation Adjustment). If the contractor's Final GSE is less than its Global Sum Comparator, a Correction Factor is not payable in respect of that contractor. However, if its Final GSE is greater than its Global Sum Comparator, Correction Factor Monthly Payments ("CFMPs") must be paid by the Health Board to the contractor under its GMS contract. The amount of the CFMPs payable is the difference between the contractor's Final GSE and its Global Sum Comparator, divided by twelve. CFMPs are to fall due on the last day of each month.

3.9 Unless the contractor is subject to a partnership merger or split, the amount of the contractor's CFMPs is to remain unchanged throughout the financial year 2004 to 2005, even if the amount of the contractor's Payable GSMP changes.

Practice mergers or splits

3.10 The MPIG calculation is a one-off calculation, which will remain unchanged. It is only to be made in respect of GMS contracts that take effect, or are treated as taking effect, on 1st April 2004. Except as provided for in paragraphs 3.11 to 3.14, a contractor with a GMS contract which takes effect, or is treated as taking effect, after 1st April 2004 will not be entitled to an MPIG.

3.11 If the new contractor comes into existence as the result of a merger between one or more other contractors, and 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 previous GMS contracts.

3.12 If-

(a) a new contractor comes into existence as the result of the split of a previous contractor;

(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.

3.13 If a new GMS contract is agreed by a contractor which has split from a previously established contractor, but 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.

3.14 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

3.15 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.

3.16 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.

Future years

3.17 In future years, Correction Factor Payments will be uprated by the same percentage as Global Sum Payments.

PART 2

QUALITY AND OUTCOMES FRAMEWORK

4. Quality Preparation Payments

4.1 Quality Preparation Payments are to fund the initial collection of data to establish the contractor's current position, and to assist contractors in preparing for the Quality and Outcomes Framework ("QOF"), which is Annex E to this SFE.

4.2 Individual practitioners will have received a Quality Preparation Payment during the financial year 2003 to 2004 as a Standard Capitation Fee Supplement. For the financial year 2004 to 2005, as capitation fees have been abolished, the way in which Quality Preparation Payments are paid is to change.

Calculation of Quality Preparation Payments

4.3 The Quality Preparation Payment is an annual amount. In order to calculate it, the Health Board must first establish the CRP of the contractor–

(a) if the contract takes effect on 1st April 2004 – or is treated as taking effect for payment purposes on 1st April 2004, which will be the case for GMS contracts replacing default contracts – on that date; or

(b) if the contract takes effect (for payment purposes) after 1st April 2004, on the date the contract takes effect.

4.4 From this number, the contractor's Contractor Population Index is to be calculated (which is the number produced by dividing a contractor's most recently established CRP by [5100]). The contractor's CPI is then multiplied by [£3,250] which, unless the contract takes effect after 1st April 2004, is the amount of the contractor's Quality Preparation Payment.

4.5 If the contract takes effect after 1st April 2004, the amount is to be adjusted by the fraction produced by dividing the number of days during the financial year 2004 to 2005 for which the contract is to have effect by 365.

4.6 Once the amount of a contractor's Quality Preparation Payment has been established, the Health Board must pay it to the contractor under its GMS contract. The payment is to fall due at the same time as the contractor's first Payable GSMP falls due.

Condition attached to quality preparation payments

4.7 Quality Preparation Payments are only payable in respect of GMS contracts that take effect on or before 1st February 2005 if the contractor agrees an Aspiration Points Total with the Health Board for the financial year 2004 to 2005. They are only

payable in respect of GMS contracts agreed after 1st February2005 if the contractor has agreed to participate in the QOF.

5. Aspiration and Achievement Payments

5.1 Participation in the QOF is voluntary, and if a contractor decides not to participate in the QOF, this Section will not apply to it.

5.2 Aspiration Payments are payments 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 2004 to 2005. 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).

5.3 If a contractor is to have an Aspiration Points Total, this is to be agreed between it and the Health Board for when its contract takes effect. However, if the contract is to take effect on or after 2nd February 2005, no Aspiration Points Total is to be agreed for the financial year 2004 to 2005. Contractors which do not have an Aspiration Points Total will nevertheless be entitled to Achievement Payments under the QOF if they participate in the QOF.

5.4 Achievement Payments are payments based on the points total that the contractor achieves under the QOF during the financial year 2004 to 2005 (which 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 when its Aspiration Points Total was agreed.

CALCULATION OF POINTS TOTALS

5.5 The QOF is divided into four principal domains, which are: the clinical domain; the organisational domain; the patient experience domain; and the additional services domain.

Calculation of points in the clinical domain

5.6 The clinical domain contains ten 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.

5.7 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, 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 2 of the QOF.

5.8 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.

5.9 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.

5.10 First, a calculation will have to be made of the percentage the contractor actually scores (D). This 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 2.2 of the QOF. This fraction is then multiplied by 100 for the percentage score. The calculation can be expressed as: $\frac{A}{(B - C)} \times 100 = D.$

5.11 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:

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

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

Calculation of points in the organisational domain

5.13 This domain is itself split into five further sub-domains: records and information about patients; information for patients; education and training; practice management; and medicines management. Section 3 of the QOF contains a number of indicators for each of these sub-domains, which in turn contain standards against which the performance of the contractor will be assessed.

5.14 The standards set relate either to a task to be performed or an outcome to be achieved. The points available in relation to these indicators are only obtainable (and then in full) if the task is in fact accomplished or the outcome achieved. Guidance on what is required to accomplish the task or achieve the outcome is given in Section 3 of the QOF.

Calculation of points in the patient experience domain

5.15 This domain, in Section 4 of the QOF, contains essentially two indicators, both of which relate to patient experience: the first is about the length of patient consultations; the second, split into three levels, is about patient surveys.

5.16 The points available in relation to the first indicator will only be obtainable (and then in full) if the relevant outcomes recorded in that indicator are achieved.

5.17 The points are available in relation to the second indicator will only be obtainable if–

(a) the task set out in the lowest performance level is accomplished, i.e. the contractor has undertaken an approved patient survey; and

(b) in the course of that survey, at least 25 questionnaires per 1000 patients registered with the contractor have been returned by patients.

For each additional level of performance that is reached, the additional points available in relation to that level are obtainable, so a contractor reaching the highest level of performance achieves the points available for all three levels of performance.

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

Calculation of points in the additional services domain

5.19 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 5 of the QOF, which contain standards against which the performance of the contractor will be assessed.

5.20 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. The contraceptive services indicators 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. One of the cervical screening services indicators has a designated achievement threshold, and the method for calculating points in relation to this indicator is the same as the method for calculating points in relation to this type of indicator in the clinical domain. Guidance

on what is required to gain the points set out in this domain is given in Section 5 of the QOF and Annex F.

Calculation of points in relation to the Holistic Care Payment

5.21 Contractors will be entitled to a proportion of 100 points as the basis of a Holistic Care Payment. This is a payment designed to recognise breadth of achievement across the clinical domain.

5.22 In order to calculate the points in respect of this Payment, the contractor's points totals in each of the clinical areas in the clinical domain are to be ranked on the basis of the proportion it scores of the points available in that clinical area, the highest proportion being ranked first. The proportion that is third-to-last is the proportion of 100 points to which it is entitled as the basis of its Holistic Care Payment.

Calculation of points in relation to the Quality Practice Payment

5.23 Contractors will also be entitled to a proportion of 30 points as the basis of a Quality Practice Payment, designed to recognise breadth of achievement across the organisational, patient experience and additional services domains.

5.24 In order to calculate the points in respect of this Payment, the contractor's points totals in each of the sub-domains in the organisational, patient experience and additional services domains are to be ranked on the basis of the proportion it scores of the points available in that sub-domain, the highest proportion being ranked first. For these purposes, the sub-domains–

(a) in the organisational domain are under the headings–

(i) records and information about patients,

(ii) information for patients,

(iii) education and training,

(iv) practice management, and

(v) medicines management;

(b) in the patient experience domain are the length of consultations indicator and the patient survey indicator. For the patient survey indicator, the ranked proportion is to be the proportion of the maximum number of points available in relation to this indicator (i.e. if the highest performance level is achieved); and

(c) in the additional services domain are the four different additional services in that domain.

5.25 The proportion that is ranked third-to-last is the proportion of 30 points to which it is entitled as the basis of its Quality Practice Payment. Additional services which the contractor does not provide must nevertheless be included in the ranking.

Calculation of points in relation to QOF Access Payment

5.26 The Scottish access target is described in Annex J. Achievement in relation to this target from 1 April 2004 to 31 March 2005 will ensure that practices will be entitled to 50 points as the basis of a QOF Access Payment.

CALCULATION OF PAYMENTS

Calculation of Monthly Aspiration Payments

5.27 Aspiration Payments are based on a contractor's Aspiration Points Total. As indicated in paragraph 5.3, if a contractor is to have an Aspiration Points Total for the financial year 2004 to 2005, this is to be agreed between it and the Health Board for when its contract takes effect.

5.28 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 [£75], and then by the contractor's CPI. The resulting amount, which is the annual amount of the contractor's Aspiration Payment, is then to be divided by twelve for the contractor's Monthly Aspiration Payment.

5.29 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 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.

5.30 The amount of a contractor's Monthly Aspiration Payments is thereafter to remain unchanged throughout the financial year 2004 to 2005, 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

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

(a) 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 each of the areas of the Quality and Outcomes Framework (clinical domain, organisational

domain, patient experience domain, additional services domain, holistic care payment, quality practice payment and access payment;

(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) the contractor must make any returns required of it (whether computerised or otherwise) to PSD of the CSA, and do so promptly and fully;

(d) once it is possible for accredited computer systems to generate monthly returns relating to achievement of the standards contained in the indicators in the QOF–

(i) contractors utilising accredited computer systems must make available to the Health Board anonymised, 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, and

(ii) contractors not utilising accredited computer systems must make available to the Health Board similar monthly returns, in such form as the PCT 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);

(e) The contractor must make available to the Health Board, information relating to its achievement in relation to meeting the requirements of the access targets referred to in paragraph 5.26 (relating to the period from April 2004); and

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

5.32 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.

Payment of Achievement Payments

5.33 Achievement Payments are to be based on the Achievement Points Total to which a contractor is entitled at the end of the financial year 2004 to 2005, as calculated in accordance with this Section.

5.34 The date in respect of which the assessment of achievement points is to be made is 31st March 2005, 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 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.

5.35 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.

5.36 On the basis of that return, but subject to any revision of the Achievement Points total that the PCT may reasonably see fit to make–

(a) to correct the accuracy of any points total; or

(b) having regard to any guidance issued by SEHD,

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

5.37 The parts of the Achievement Payment that relate to the clinical domain 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, the Achievement Points total in respect of each disease area is first multiplied by [£75]. It is then multiplied by the Adjusted Practice Disease Factor (which gives each practice a different "pounds per point" figure for each disease area) to produce a cash amount for that disease area for that contractor, and then the cash total in respect of all the disease areas in the domain is to be added together to give the cash total in respect of the domain. A fuller explanation of how the prevalence calculation in respect of this domain is to be made 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.

5.38 As regards all the other Achievement Points gained by the contractor, the total number of them is to be multiplied by [£75].

5.39 The cash totals produced under paragraphs 5.37 and 5.38 are then added together and multiplied by the contractor's CPI at the start of the final quarter of the financial year 2004 to 2005 (or, if its contract has terminated, its CPI immediately before the contract terminated). If the contractor's GMS contract had effect–

(a) throughout the financial year 2004 to 2005, the resulting amount is the provisional total for the contractor's Achievement Payment for the financial year 2004 to 2005;

(b) for only part of the financial year 2004 to 2005, the resulting amount is to be adjusted by the fraction produced by dividing the number of days during the financial year 2004 to 2005 for which the contractor's GMS contract had effect by 365, and the result of that calculation is the provisional total for the contractor's Achievement Payment for the financial year 2004 to 2005.

5.40 From these provisional 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 2004 to 2005. 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 the financial year 2004 to 2005.

5.41 This Achievement Payment is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year 2004 to 2005 but is to fall due–

(a) if the Health Board is considering revising the contractor's Achievement Points Total in accordance with paragraph 5.36, on 30th June 2005; and

(b) in all other cases, on 30th April 2005.

Conditions attached to Achievement Payments

5.42 Achievement Payments, or any part thereof, are only payable if the contractor satisfies the following conditions–

(a) the contractor must make the return required of it under paragraph 5.35;

(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 the CSA, 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.

5.43 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

6. NOT ALLOTTED

7. Quality Information Preparation Scheme

7.1 Health Boards are under a duty to establish, operate and, as appropriate, revise a Quality Information Preparation Scheme (QuIPS) for their area, the underlying purpose of which is to summarise and improve the quality of medical records held by primary medical services contractors in their area.

7.2 A Health Board must, as part of its QuIPS, offer to enter into arrangements with contractors for the purposes of summarising and improving their medical records. Plans setting out those arrangements ("QuIPS plans") are to include–

(a) a project for summarising the medical records held by the contractor, which must include–

(i) a protocol for how the summarising is to be done, to be agreed (if the contractor is a partnership) by all the members of the contractor, and

(ii) the arrangements for the ongoing maintenance of the summarising project; and

(b) provision for fully trained summarisers, who–

(i) must not take medical records away from practice premises,

(ii) must have appropriate access to GP performers when they have queries,

(iii) must sign a confidentiality agreement, and

(iv) must be appropriately supervised.

Quality Information Preparation Scheme Payments

7.3 If, as part of a GMS contract a contractor and a Health Board have agreed a QuIPS plan under which payment is due in respect of the financial year 2004 to 2005, the Health Board must in respect of the financial year 2004 to 2005 pay to the contractor under the GMS contract a QuIPS Payment. The amount of this payment is to be–

(a) not less than [£1,000] multiplied by the contractor's CPI; but

(b) not more than [£5,000] multiplied by the contractor's CPI.

7.4 The precise figure is to depend on the amount of work that needs doing, having regard to the fact that QuIPS payments are not intended to cover the full cost of ensuring that contractors' records are appropriately summarised and edited.

7.5 The payment is to fall due–

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

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

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 require contractors to–

(a) develop and maintain a register (its "Childhood Immunisations Scheme Register") of all children up to five years of age for whom the contractor has a contractual duty to provide Childhood Immunisation and Pre-School Booster Services (who may have been immunised, by the contractor or otherwise, or to whom the contractor has offered or needs to offer childhood immunisations);

(b) develop a strategy for liaising with and informing parents or guardians of young children about the immunisation programme, and providing advice and information on request to parents and guardians of young children about immunisation;

(c) undertake to immunise children registered in its Childhood Immunisations Scheme Register with the relevant immunisations in accordance with the Green Book; and

(d) conduct an annual review of the plan.

Target payments in respect of two-year-olds

8.3 Health Boards must in respect of the financial year 2004 to 2005 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–

(a) as part of its GMS contract the contractor and the Health Board have agreed a Childhood Immunisations Scheme plan; and

(b) on the first day of the quarter to which the payment relates, at least 70%, for the lower payment, or at least 90%, for the higher payment, of the children aged two (i.e. who have celebrated their second birthday but not yet their third) registered with the contractor have completed the immunisation courses recommended by the Green Book for protection against–

(i) (Group 1) diphtheria, tetanus, and poliomyelitis,

(ii) (Group 2) pertussis,

(iii) (Group 3) measles/mumps/rubella, and

(iv) (Group 4) Haemophilus influenzae type B (HiB).

Calculation of Quarterly Two-Year-Olds Immunisation Payment

8.4 Health Boards will first need to determine the number of completed immunisation courses recommended by the Green Book that are required over the four 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, and then the Health Board must make the following calculations–

(a) (0.7 x **A** x 4) = $\mathbf{B^1}$ (the number of completed immunisations needed to meet the 70% target);

(b) (0.9 x **A** x 4) = $\mathbf{B^2}$ (the number of completed immunisations 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 sum of the total number of children aged two whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register and who have completed immunisations in each of the four groups ($\mathbf{C^{S1\text{-}4}}$). 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 is then to be made of whether or not the targets are achieved–

(a) if $\mathbf{C^{S1\text{-}4} = B^1}$, then the 70% target is achieved; and

(b) if $\mathbf{C^{S1\text{-}4} = B^2}$, then the 90% target is achieved.

8.6 Next the Health Board will need to calculate the number of the completed immunisations 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 of the completed immunisation courses in each disease group that were carried out by it, or by another GMS or PMS contractor, within the NHS.

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

$$\begin{array}{lrcl} & \mathbf{C^{S1}} & - & \mathbf{E^{S1}} \\ & \mathbf{C^{S2}} & - & \mathbf{E^{S2}} \\ & \mathbf{C^{S3}} & - & \mathbf{E^{S3}} \\ \mathbf{+} & \mathbf{C^{S4}} & - & \mathbf{E^{S4}} \\ \mathbf{=} & & \mathbf{D} & \end{array}$$

For these purposes–

(a) ($\mathbf{E^{Sx}}$) is the number of completed immunisation carried out other than by a GMS or section 17C (formerly Personal Medical Services) contractor for the NHS in each group (i.e. Group 1 equals $\mathbf{E^{S1}}$); and

(b) in each case the sum of $\mathbf{C^{Sx}}$-$\mathbf{E^{Sx}}$ can never be greater than $\mathbf{C^{Sx}}$ **x [0.7] or [0.9]** (depending on which target achieved). Where it is, it is treated as the result of: $\mathbf{C^{Sx}}$ **x [0.7]** or as the case may be **[0.9]**.

8.8 In the financial year 2004 to 2005, 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 59.25. The maximum amounts payable to the contractor (**F**) are therefore to be calculated as follows–

(a) where the 70% target is achieved: ($\mathbf{F^1}$) = $\frac{\mathbf{A}}{59.25}$ x £685.25

(b) where the 90% target is achieved: ($\mathbf{F^2}$) = $\frac{\mathbf{A}}{59.25}$ x £2,055.75

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

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

8.10 The amount payable as a Quarterly TYOIP is to fall due on the last day of the first month of the quarter to which it relates. However, if the contractor delays providing the information the Health Board needs to calculate its Quarterly TYOIP beyond the middle of the quarter, the amount is to fall due at the end of the quarter after the quarter during which the contractor provides the necessary information. No Quarterly TYOIP is payable if the contractor provides the necessary information more than four months after the date to which the information relates.

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,

(ii) how many of those two-year-olds have completed each of the immunisation courses recommended by the Green Book for protection against the disease groups referred to in paragraph 8.3(c), and

(iii) of those completed immunisation courses, how many were carried out by a GMS or section 17C (formerly Personal Medical Services) contractor within the NHS; 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 in respect of the financial year 2004 to 2005 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) on the first day of the quarter to which the payment relates, at least 70%, for the lower payment, or at least 90%, for the higher payment, of the children aged five (i.e. who have celebrated their fifth birthday but not yet their sixth) registered with the contractor have received the reinforcing doses recommended by the Green Book for protection against diphtheria, tetanus and poliomyelitis.

Calculation of Quarterly Five-Year-Olds Immunisation Payment

8.14 Health Boards will need to determine the number of completed immunisation courses recommended by the Green Book 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, and then the Health Board must make the following calculations–

(a) (0.7 x **A**) = $\mathbf{B^1}$ (the number of completed booster courses needed to meet the 70% target; and

(b) (0.9 x **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 sum of the total number of children aged five whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register and who 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 $\mathbf{C = B^1}$**,** then the 70% target is achieved; and

(b) if $\mathbf{C = B^2}$**,** then the 90% target is achieved.

8.16 Next the Health Board will need to calculate the number of the completed booster courses 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 of the completed booster courses were carried out by it, or by another GMS or section 17C (formerly Personal Medical Services) contractor, within the NHS.

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

8.18 In the financial year 2004 to 2005, 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 61.45. The maximum amounts payable to the contractor (**E**) are therefore to be calculated as follows–

(a) where the 70% target is achieved: $\mathbf{E^1} = \frac{\mathbf{A}}{61.45} \times £212.25$

(b) where the 90% target is achieved: $\mathbf{E^2} = \frac{\mathbf{A}}{61.45} \times £636.75$

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

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

8.20 The amount payable as a Quarterly FYOIP is to fall due on the last day of the first month of the quarter to which it relates. However, if the contractor delays providing the information the Health Board needs to calculate its Quarterly FYOIP beyond the middle of the quarter, the amount is to fall due at the end of the quarter after the quarter during which the contractor provides the necessary information. No Quarterly FYOIP is payable if the contractor provides the necessary information more than four months after the date to which the information relates.

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,

(ii) how many of those five-year-olds have received the complete course of reinforcing doses recommended by the Green Book for protection against diphtheria, tetanus and poliomyelitis, and

(iii) of those completed courses, how many were carried out by a GMS or section 17C (formerly Personal Medical Services) contractor within the NHS; 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.

PART 4

PAYMENTS FOR SPECIFIC PURPOSES

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 has been employed for at least three months by the contractor and 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 reimburse the contractor under its GMS contract for the actual cost of engaging that locum.

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 [£948.33] 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 14 days 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, and the performer on leave must have been employed for at least three months by the contractor;

(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 reimburse the contractor under its GMS contract with the amount determined in accordance with this Section as a contribution towards the cost of the locum engaged.

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.

(c) 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–

Absences lasting or expected to last	*Full-time GP*	*Three-quarter- time GP*	*Half-time GP*
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

(d) 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 [£948.33] per week.

10.6 However, in any twelve month period, the maximum periods in respect of which payments under this Section are payable in relation to a particular GP performer are–

(a) 6 months for the full amount of the sum that the Health Board has determined is payable; and

(b) a further 6 months for half the full amount of the sum the Health Board initially determined was payable.

Payment arrangements

10.7 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

10.8 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.

10.9 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 performers' list either–

(a) on or after 1st April 2004; or

(b) by virtue of being suspended from a medical list or a supplementary list,

will need to be financially supported. Financial support from Health Boards will be covered by a separate determination (and this Section is likely to be revised as a result of that determination).

Eligible cases

11.3 In any case where a contractor–

(a) is paying a suspended GP performer the full amount of the income to which he was entitled before the suspension (i.e. his normal drawings from the partnership account or his normal salary);

(b) actually and necessarily engages a locum (or more than one such person) to cover for the absence of the suspended GP performer; and

(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 reimburse the contractor under its GMS contract for the actual cost of engaging that locum.

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 [£948.33] 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 14 days 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 the full amount of the income to which he was entitled before the

suspension (i.e. his normal drawings from the partnership account or his normal salary); 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 for the financial year 2004 to 2005.

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 [£129.50] per week, 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 reimburse the contractor under its GMS contract with the amount determined in accordance with this Section as a contribution towards the cost of the locum engaged.

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 [£948.33] 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 within the NHS or service as a doctor in the health care system of another EEA Member State;

(b) 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,

(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;

(c) 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.

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;

(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(b), 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(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.

13.9 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) if the practitioner'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), 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), 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 in 2004-05
0	**0**
1	**0**
2	**0**
3	**0**
4	**0**
5	**0**
6	**0**
7	**600**
8	**630**
9	**662**
10	**695**
11	**729**
12	**766**
13	**804**
14	**844**
15	**886**
16	**3,185**
17	**3,344**
18	**3,511**
19	**3,687**
20	**3,871**
21	**4,065**
22	**6,785**
23	**6,989**
24	**7,198**
25	**7,414**
26	**7,637**
27	**7,866**
28	**8,225**
29	**8,447**
30	**8,675**
31	**8,909**

32	**9,150**
33	**9,397**
34	**9,651**
35	**9,911**
36	**10,179**
37	**10,454**
38	**10,736**
39	**11,026**
40	**11,324**
41	**11,629**
42	**11,943**
43	**12,266**
44	**12,597**
45	**12,937**
46	**13,286**
47	**13,645**

13.13 If, for any GP provider, the full annual rate payable in respect of him, as calculated above, is less than the total amount he was entitled to receive on 31st March 2004 as the full annual rate of–

(a) his Seniority Payment under the Red Book; plus

(b) his Retention Incentive Scheme payment under the Red Book,

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

Superannuable Income Fractions

13.14 In all cases, the full annual rate of a Seniority Payment for a GP provider only payable 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) his NHS profits from all sources for the financial year 2004 to 2005, excluding–

(i) superannuable income which does not appear on his certificate submitted to the Health Board in accordance with paragraph 22.10 (i.e. NHS income already superannuated elsewhere), and

(ii) any amount in respect of Seniority Payments; by

(b) the Average Adjusted Superannuable Income.

13.16 The Average Adjusted Superannuable Income is to be calculated as follows (this is still the subject of negotiation)–

(a) all the NHS profits 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 to be agreed) 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 2004 to 2005 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 in respect of him. If he has a Superannuable Income Fraction of less than one third, no Seniority Payment is payable 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, 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, 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 21.8).

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 (a) 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(c), 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 2004, 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,

(ii) and 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 (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,

(iii) the Golden Hello Scheme under a section 17C (formerly Personal Medical Services) contract, or

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 Primary Care Trust/NHS 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 dependant 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 Payment

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 PCT/NHS 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

Payments for non principal Doctors new to Primary Care

14.20 A practitioner employing a doctor on a fixed term contract of more than two years will be eligible for payments under this scheme provided the doctor being employed satisfies the eligibility criteria set out in paragraphs 14.2. Payments will follow paragraphs 14.2 – 14.4.

14.21 The amount of money payable will be dependent on the commitment of the qualifying doctor, as agreed with the local Health Board and based on the normal contracted hours within the local area of the doctor being employed. Doctors with a time commitment fraction of less than one-fifth will not be eligible for payment.

14.22 Doctors may attract extra payments if their circumstances change within two years of taking a first post. Paragraphs 14.7 -14.13 will apply.

14.23 Where a doctor becomes eligible for extra payments due to taking a second post payments should be paid to the employing practitioner with whom the doctor has the largest percentage time commitment or in such other way as agreed by the doctor, practices and Health Board.

14.24 General practices should ensure that the full amount of the payment (less any deductions for tax, National Insurance or superannuation) is paid to the qualifying practitioner.

14.25 Some or all of the payments made under paragraph 14.20 – 14.23 may be liable to be returned if within two years the doctor ceases to be employed within primary care or moves to a post in a Health Board not at the time of the move attracting an

additional payment. Paragraphs 14.14 – 14.19 shall be used to determine the sum to be returned.

Relocation Costs

14.26 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

14.27 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.

14.28 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

14.29 Rates of payment will be at the following rates.

Standard Payment	
Full-time or Part-time with a time commitment fraction of at least 1/2	£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. NOT ALLOTTED

16. NOT ALLOTTED

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. If the doctor is a suspended doctor, the payment arrangements in respect of him will be covered by a separate determination (but this Section may be revised as a result of that determination).

Payments in respect of sessions undertaken by members of the Scheme

17.2 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 [£57.33] 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.

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; and

(b) 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 1995.

18.2 Some practices are prescribing practices as well as dispensing practices, ie 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 and 9 of the Drug Tariff or, when not so listed, the price as determined in accordance with paragraph 11 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.

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.

18.5 Unless a dispensing practice is registered with Customs and Excise for Value Added Tax (VAT) purposes (normally when a registered pharmacist is employed for dispensing), a VAT allowance shall be paid to cover the VAT payable on the practice purchases of drugs and appliances and containers. The allowance shall be calculated as a percentage both of the basic price less any discount applicable under schedule 1 and of the container allowance equivalent to the rate of VAT in force on the first day of the quarter in which the items are dispensed.

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 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 Commit 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 the Inland Revenue 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'.

PARAGRAPH 18/SCHEDULE 1

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
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

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
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

ADDRESSES TO WHICH DISPENSING PRACTICES SHOULD SUBMIT THEIR CLAIMS

Practitioner Services Division (Pharmacy)

Room B070

Trinity Park House

South Trinity Road

EDINBURGH

EH5 3SG

(Please note that any changes to this address will be notified separately).

PARAGRAPH 18/ SCHEDULE 4

LIST OF VACCINES EXCLUDED FROM REIMBURSEMENT UNDER PARAGRAPH 17

Hib	haemophilus influenzae type b
MMR	measles, mumps and rubella
MR	measles and rubella
Rubella	
BCG	Bacillus Calmette-Guerin
Diphtheria Vaccine Absorbed (Child)	
Low dose diphtheria vaccine for adults (absorbed)[1]	
D/T	diphtheria/tetanus
D/T/P	diphtheria/tetanus/pertussis
D/T/P-Hib	diphtheria/tetanus/pertussis and haemophilus influenzae type b combined product for administration as one injection
Td	ampoule presentation[2] (Tetanus combined with Diphtheria Vaccine for adults)
Pertussis	
Polio	oral
Polio	inactivated
Tuberculin Purified	- Protein Derivative
Group C	Meningococcal vaccine (Men C)

[1]Absorbed Diphtheria vaccine for adults (low dose) became a centrally supplied item from 1 August 1995 and only supplies made before this date can be reimbursed under the provisions of paragraph 18.3.

[2]Td in syringe presentation is not centrally supplied, and purchase therefore can be reimbursed under the provisions of paragraph 18.3. However, when Td is

administered to children in the ampoule presentation, reimbursement under paragraph 18.3 is not available as this presentation is supplied free of charge.

PART 5

CERTAIN PREMISES AND I.T. COSTS

There are other premises costs payable under GMS contracts which are dealt with in the Primary Medical Services (Premises Development Grants, Improvement Grants and 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.

19. Existing premises development and improvement commitments

Existing commitments

19.1 Where Health Boards have already committed themselves, prior to 1st April 2004, to provide financial assistance in the financial year 2004 to 2005–

(a) towards the building of new premises to be used for providing medical services;

(b) towards the purchase of premises to be used for providing medical services;

(c) towards the development of premises which are used or are to be used for providing medical services; or

(d) in the form of premises improvement grants,

in accordance with the arrangements for funding capital investment in premises set out in the Red Book, then subject to the provisions of this Section, those commitments are to be met.

19.2 As regards any such capital investment project, a Health Board must pay to a contractor under its GMS contract any amount that the Health Board agreed before 1st April 2004 to pay to the contractor (or to the practice for which the contractor is now responsible) during the financial year 2004 to 2005, subject to the following conditions–

(a) the contractor must comply with any conditions to which the agreement to make the payment was subject. For these purposes, it shall be deemed that the specifications for the project which are set out in the project proposal, and any standards to be met during

construction or development work which are set out in the project proposal, are all conditions of the agreement to make the payment; and

(b) the project must not change significantly (in the Health Board's view) from the version of the project in respect of which the Health Board agreed to make the payments.

19.3 If any of these conditions are breached, the Health Board may in appropriate circumstances withhold payment of any or any part of any payment that is otherwise payable under paragraph 19.2. If the breach arises because the project has changed significantly, and additional costs will be incurred as a consequence, any claim for PCT funding in respect of those additional costs is to be determined in accordance with the arrangements for funding new capital investment set out in the Primary Medical Services (Premises Development Grants, Improvement Grants and Costs) Directions 2004.

19.4 If it was agreed before 1st April 2004 that the amount of payments payable in respect of the project plan would be reviewed in the financial year 2004 to 2005, the payments payable under this Section are subject to the outcome of that review and any revised amount agreed in accordance with that review becomes the amount payable under this Section. If a dispute as to the amounts payable arises as a result of that review, resolution of that dispute shall be resolved in accordance with–

(a) any dispute resolution procedure (for resolution of disputes between the Health Board and the contractor) agreed in respect of the project plan; or

(b) if no such procedure was agreed, the NHS dispute resolution procedures – or by the courts (see Part 7 of The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004.

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

21.1 Without prejudice to the specific provisions elsewhere in this SFE relating to overpayments of particular payments, if a Health Board makes a payment to a contractor under its GMS contract pursuant to this SFE and–

(a) the contractor was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment or because the payment was calculated incorrectly;

(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.

Underpayments and late payments

21.2 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 [32] of the 2004 Regulations).

21.3 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.

21.4 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.

21.5 Furthermore, for the first quarter to which this SFE relates, if a Health Board is unable to calculate any payment payable pursuant to this SFE that falls due before the end of that quarter 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 that quarter.

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 However, during the first quarter to which this SFE relates, if–

(a) a Health Board is unable to calculate a payment payable pursuant to this SFE that is due to fall due before the end of that quarter 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 calculate the payment, having been undertaken); and

(b) it cannot reach agreement with the contractor on a payment on account in respect of the payment pursuant to paragraph 21.6,

it must nevertheless pay to the contractor on account a reasonable approximation of the amount of the 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 payment, paragraph 21.1 applies.

21.8 Health Boards will not be able to calculate the correct amount of GP providers' Seniority Payments during the financial year 2004 to 2005 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 the financial year 2004 to 2005 has been established; and

(b) the GP provider's own NHS superannuable profits from all sources for the financial year 2004 to 2005, excluding–

(i) superannuable income which does 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 21.4). If that payment results in an overpayment in respect of the Quarterly Seniority Payment, paragraph 21.1 applies.

Default contracts

21.9 If–

(a) a contractor's GMS contract was agreed after 1st April 2004 but the contract takes effect for payment purposes on 1st April 2004; and

(b) that contractor has received payments under a default contract that are in place of payments pursuant to this SFE,

the payments that the contractor has received under the default contract in place of payments pursuant to this SFE must be set off, equitably, against the payments that the contractor is entitled to receive under its GMS contract pursuant to this SFE.

21.10 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 are instead to fall due at the end of that quarter, unless–

(a) the GMS contract is agreed between 1st June 2004 and 1st September 2004, in which case they are instead to fall due at the end of the second quarter, 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 and 1st December 2004, in which case they are instead to fall due at the end of the third quarter, as are all the payments that are or were due to fall due pursuant to this SFE in that quarter or in the second quarter;

(c) the GMS contract is agreed between 1st December 2004 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.

Effect on periodic payments of termination of a GMS contract

21.11 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

21.12 Payments under this SFE are only payable if claimed within 12 months of the date on which they would have fallen due, if a claim for the payment had been submitted in advance of the first date on which the payment could have fallen due (albeit that the due date has changed pursuant to paragraph 21.4 or 21.5).

Dispute resolution procedures

21.13 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 the 2004 Regulations).

21.14 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

21.15 Part 4 sets out a number of circumstances in which Health Boards are obliged to pay a maximum amount of [£948.33] 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 [£948.33] maximum directed amount is payable.

21.16 As a supplementary measure, Health Boards are directed to adopt 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; and

(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 that the maximum amount payable (for example to take account of less than full-time working).

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

21.17 The starting point for the determination of a contractor's Contractor Registered Population is the number of patients recorded by PSD of the CSA 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.

21.18 However, in respect of any quarter, this number may be adjusted as follows (this is still the subject of negotiation)–

(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 the CSA 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) is not to be treated as part of any other contractor's Contractor Registered Population at the start of that quarter (and the Health Board must notify any other Health Board that will need to adjust another contractor's Contractor Registered Population accordingly);

(b) if, included in the number of patients recorded by PSD of the CSA 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 the CSA 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.

21.19 If a contractor wishes its Contractor Registered Population to be adjusted in accordance with paragraph 2.18, 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.

22. Superannuation contributions

Health Board's responsibility in respect of paying GPs' employer's and employee's superannuation contributions

22.1 Under the NHS Pension Scheme Regulations, contractors are responsible for paying employer's superannuation contributions of practice staff who are members of the NHS Pension Scheme, and collecting and forwarding to the NHS Pensions Agency both employer's and employee's superannuation contributions in respect of their practice staff.

22.2 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 Health Boards, which act as their employer for superannuation purposes.

22.3 Health Boards are also responsible for paying the employer's superannuation contributions of a contractor's members of the NHS Pension Scheme who are–

(a) GP performers who are not GP Registrars,

(b) non-practising GP partners and non-GP partners, if the contractor is a partnership,

(c) non-practising GP shareholders and non-GP shareholders, if the contractor is a company limited by shares,

in respect of their NHS superannuable profits from all sources – unless superannuated for the purposes of the NHS Pension Scheme elsewhere – whether or not these earnings are derived from payments under this SFE. In this Section, the three categories of people set out in sub-paragraphs (a) to (c) are referred as "partner/GPs".

22.4 The cost of paying partner/GPs' employer's and employee's superannuation contributions relating to the income of partner/GPs 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 medical services to the NHS, whether or not under its GMS contract, will have included provision for all the payable superannuation contributions in respect of its partner/GPs in the contract price; and

(b) the payments from the Health Board to the contractor in respect of services under the GMS contract, together with the contract price of

any other contract to provide medical services to the NHS that the contractor has entered into, also cover the cost of any additional voluntary contributions that the Health Board is obliged, as its partner/GPs' employer for superannuation purposes, to make to the NHS Pensions Agency or an Additional Voluntary Contributions Provider on the partner/GPs' behalf.

22.5 Accordingly, the costs of paying the employer's and employee's superannuation contributions of a contractor's partner/GPs under the NHS Pensions Scheme in respect of their NHS superannuable profits from all sources – unless superannuated for the purposes of the NHS Pension Scheme elsewhere – are all to be deducted by the Health Board from the money the Health Board pays 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, Health Boards must, as part of the calculation of the net amount (as opposed to the gross amount) of a contractor's Payable GSMPs, deduct an amount that represents a reasonable approximation of a monthly proportion of–

(a) the Health Board's liability for the financial year 2004 to 2005 in respect of the employer's superannuation costs under the NHS Pension Scheme relating to any of the contractor's partner/GPs who are members of the Scheme;

(b) those partner/GPs' related employee's superannuation contributions; and

(c) any payable additional voluntary contributions in respect of those partner/GPs.

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

22.7 An amount equal to the monthly amount that the Health Board deducts must be remitted to NHS Pensions Agency and any relevant Additional Voluntary Contributions Providers no later than the 19th day of the month after the month in respect of which the amount was deducted.

End-year adjustments

22.8 Then, after the end of the financial year, the final amount of each partner/GP's superannuable income in respect of the financial year will need to be determined.

22.9 For these purposes, the superannuable income of–

(a) a salaried GP who is an employee of the contractor, or of a partner/GP who is a shareholder in a contractor that is a company limited by shares, will be–

(i) his earnings – less expenses, bonuses or overtime – from his contract of employment with the contractor, and

(ii) his income from any Golden Hello Payment, or Seniority Payment paid in respect of him to the contactor pursuant to Part 4; or

(b) any other partner/GP will be–

(i) in the case of a sole practitioner, his NHS profits from all sources, and

(ii) in the case of a partner in a partnership, his share of the partnership's NHS profits, together with his income from any Golden Hello Payment or Seniority Payment paid in respect of him to the contractor pursuant to Part 4.

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 partner/GPs are members of the NHS Pension Scheme – that the contractor ensures that its partner/GPs prepare, sign and forward to the Health Board within what, in all the circumstances, is a reasonable time an accurate certificate, in the standard format provided nationally, which provides the following information–

(a) the contractor's NHS superannuable profits in respect of the financial year 2004 to 2005 (i.e. for the tax year, which may be different from the contractor's own accounting year);

(b) in the case of–

(i) a partner in a partnership, his own share of those profits, or

(ii) a shareholder in a company limited by shares, his earnings – less expenses, bonuses or overtime – from his contract of employment with the contractor; and

(c) his NHS profits from all other sources, if these are not superannuated (for the purposes of the NHS Pension Scheme) elsewhere.

22.11 Seniority Payments have to be separately identifiable in the certificate for the purposes of the calculation of Average Adjusted Superannuable Income, which is necessary for the determination of the amount of GP providers' Seniority Payments. Seniority Payment figures in the certificates forwarded to Health Boards will necessarily be provisional (unless they are submitted too late for the information they

contain to be included in the Average Adjusted Superannuation Income calculation), but the forwarding of certificates must not be delayed simply because of this.

22.12 Once a contractor's partner/GPs' superannuable earnings in respect of the financial year 2004 to 2005 have been agreed, the PCT must–

(a) pay any outstanding NHS Pension Scheme employer's and employee's superannuation contributions due in respect of those earnings to the NHS Pensions Agency or any relevant Additional Voluntary Contributions Provider (having regard to the payments it has already made on account in respect of those partner/GPs for the financial year 2004 to 2005); and

(b) if its deductions from the contractor's Payable GSMPs during the financial year 2004 to 2005 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 Health Board or the partner/GPs 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 the contractor must pay to the Health Board the amount outstanding, or

(ii) were in excess of the amount payable by the Health Board and the partner/GP to the NHS Pensions Agency or an relevant Additional Voluntary Contributions Provider in respect of those earnings, repay the excess amount to the contractor promptly.

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

ACRONYMNS

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
PPA – Prescription Pricing Authority
QOF – Quality and Outcomes Framework
QuIPS – Quality Information Preparation Scheme
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 2003 Order" means the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003.

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

"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.

"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.

"Contractor" means a person entering into, or who has entered into, a GMS contract with a PCT.

"Contractor Population Index" is the number produced by dividing a contractor's most recently established CRP by [5100].

"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 the CSA 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 3.7.

"Default contract" means a contract under section 7(1) of the Primary Medical Services (Scotland) Act 2004.

"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.

"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) on the coming into force of article 10 of the 2003 Order, a medical practitioner whose name is included in the General Practitioner Register otherwise than by virtue of paragraph 1(d) of Schedule 6 to that Order; and

(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 1977 Act, section 21 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.

"GP performer" means a general practitioner–

(a) whose name is included in a 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.

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

"Global Sum Equivalent" is to be construed in accordance with paragraph 3.1.

"Green Book" means 'Immunisation Against Infectious Diseases', published by HMSO, as updated on http://www.doh.gov.uk/greenbook.

"Historic Opt-Outs Adjustment" is to be construed in accordance with paragraphs 3.5 and 3.6.

"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.

"Minimum Practice Income Guarantee" is to be construed in accordance with paragraph 3.1

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

"Non-GP partner" means a partner in a contractor that is a partnership who is not a GP.

"Non-GP shareholder" means a shareholder in a contractor that is a company limited by shares who is not a GP.

"Non-practising GP partner" partner means a partner in a contractor that is a partnership who is a GP but who does not perform medical services under the contractor's GMS contract.

"Non-practising GP shareholder" means a shareholder in a contractor that is a company limited by shares who is a GP but who does not perform medical services under the contractor's GMS contract.

"Partner/GPs" means–

(a) GP performers who are not GP Registrars,

(b) non-practising GP partners and non-GP partners in a contractor that is a partnership, if they are members of the NHS Pension Scheme;

(c) non-practising GP shareholders and non-GP shareholders in a contractor that is a company limited by shares, if they are members of the NHS Pensions Scheme.

"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.

"Quality and Outcomes Framework" is the guidance reproduced at Annex E (published separately).

"Quarter" means a quarter of the financial year.

"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.

"Sole practitioner" means a GP performer who is himself a contractor.

"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 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.

"Unregistered Patients Adjustment" is to be construed in accordance with paragraph 2.4 and Annex C.

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) as part of the new contract. Under the terms of the new contract, the SAF will replace the current 'Red Book of Fees and Allowances' as an important element of determining remuneration for GMS in Scotland.

B.2. The SAF is a resource allocation formula that will allocate resources to GP practices on the basis of the relative needs and workload of their patients. The SAF will be responsible for the allocation of a **global sum** to each practice. The global sum will account (on average) for **50-55 per cent** of a practices' current fees and allowances in Scotland. The remainder of the resources available to GMS will flow through NHS boards (including premises, IT and seniority), the quality-outcomes framework and enhanced services.

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 reflect nursing and residential home patients, new registrations and staff costs. These 'weightings' are identical across the UK, including Scotland.

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. These 'weightings' are summarised in the following table:

	0-4	5-14	15-24	25-44	45-64	65-74	75-84	85+
Male	2.81	1.00	1.14	1.33	1.93	3.06	4.32	4.59
Female	2.44	1.12	2.53	2.70	2.93	3.52	4.98	4.83

Note that the SAF age-sex 'weightings' are based on 2002 year data from the **Continuous Morbidity Recording (CMR)** practices[2] 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:

$$\text{Practice List} * [(0.87\ (109.04 + 3.09 * \text{Index}) + (0.13\ (82.46 + 4.89 * \text{Index}))]$$

Where, *Index* denotes the index of deprivation and mortality. Note that this adjustment is also split between 87 per cent surgery contacts and 13 per cent home contacts.

Remote and Rural Areas

[2] Approximately 70 practices in Scotland provide monthly consultation returns to the CMR database.

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:

Practice List * [54.54 + 1.88 * Population Density + 0.14 * Population Scarcity +
0.11 * 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**
Registered List	**2,000**	**8,000**	**10,000**
Age-Sex Adjustment	1.10	0.98	-
Deprivation Adjustment	1.15	0.95	-
Remote/Rural Adjustment	1.15	0.95	-
Weighted List	**2,910**	**7,090**	**10,000**

The 'weighted' list for practice A is equal to (2,000 x 1.10 x 1.15 x 1.15 = 2,910 'weighted' patients) and for practice B the relevant calculation is (8,000 x 0.98 x 0.95 x 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) will apply 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 would receive a MPIG.

Summary

B.13. In summary the main points are:

- The Scottish Allocation Formula (SAF) is a **population-based formula** that allocates resources according to **relative patient need** for GMS. The SAF will allocate a **global sum** for each practice in Scotland. There is **no** direct read across between the indicative global sum and current fees and allowances.
- 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 2004.

C.3 In a case where that practice has been providing general medical services for five years or more, prior to 1st April 2003, the annual amount which is to be the basis of its Temporary Patients Adjustment is to be calculated as the average annual amount claimed in respect of treating unregistered patients over the most recent five years (i.e. the aggregate of the five yearly totals divided by five). For the purposes of the calculation, the amounts claimed are to be uprated by the following amounts–

- claims in respect of the financial year 1998/1999: [V]%
- claims in respect of the financial year 1999/2000: [W]%
- claims in respect of the financial year 2000/1: [X]%
- claims in respect of the financial year 2001/2: [Y]%
- claims in respect of the financial year 2002/3: [Z]%

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 If a contractor does not have five years' worth of data, the Health Board is instead to determine for the contractor, as the basis for its Temporary Patients Adjustment, a reasonable annual amount (having taken into account whatever historic data the contractor does have in respect of temporary residents fees, emergency treatment fees and immediately necessary treatment fees) which is an appropriate rate for the area where the practice is located.

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 for the financial year 2004 to 2005.

ANNEX D

MPIG GUIDANCE

Calculation of GSE

D.1 The calculation of GSE is based on expenditure for the last three quarters of 2002-03 plus the first quarter of 2003-04. This will be subject to an uplift to 2004-05 prices by national uplifts in accordance with paragraph 3.3.

D.2 The GSE will also be adjusted to take account of changes in list size. The Initial GSE for the baseline period (July 2002 – June 2003) will be divided by the average CRP for the period, and then multiplied by the CRP on 1st April 2004. This is to take account of growing or shrinking practices.

D.3 The GSE covers the following expenditure[3]–

(i) Basic practice allowance
(ii) Night consultation fees
(iii) Night annual payments
(iv) Capitation fees
(v) Health promotion annual payments (excluding chronic disease management)
(vi) Contraceptive services fees (excluding intrauterine device fees)
(vii) Maternity medical services fees (excluding intra partum care)
(viii) Deprivation payments
(ix) New registration fees
(x) Minor surgery fees (part)
(xi) Child health surveillance fees
(xii) Vaccinations and immunisations item-of-service fees (excluding influenza, and childhood immunisation and pre-school booster target payments)
(xiii) Arrest of dental haemorrhage fees
(xiv) Rural practice payments
(xv) Postgraduate education allowance
(xvi) Telephone advice fees
(xvii) Cervical cytology target payments (part)
(xviii) Anaesthetic administration fees

(xix) Practice staff reimbursements (including employer's NI)
(xx) GP superannuation payments (i.e. paid by employer PCTs in the baseline period)
(xxi) Chapter 10.5 Payments

[3] Health Boards should note that, contrary to what was originally intended, temporary residents fees, emergency treatment fees and immediately necessary treatment fees do not feature in the list. They should also note the special treatment of maternity medical services fees, minor surgery fees and cervical cytology target payments in the text below and in the appendix.

D.4 **Appendix A** maps the constituents of the GSE to the relevant lines in the PFR1 financial return and the FIMS(FHS)4 return.

D.5 GSE payments for these periods should be available from PSD of the CSA.

D.6 Cash payments for the first quarter of 2003-04 should be at 2002-03 prices. This is because the 2003-04 pay deal, including the general uplift to fees and allowances, did not become effective until October and the backdated arrears are being recorded as a separate lump sum.

D.7 Health Boards should note the following about certain constituents of the GSE:

(a) *maternity medical services fees (excluding intra partum care)*
the GSE excludes expenditure on intra partum care. This expenditure is not separately identified in the accounts. Identification of these payments is to be agreed by the Health Board and the contractor, as the level of expenditure will differ between practices;

(b) *minor surgery fees (part)*
this should be based on one-third of the contractor's minor surgery fees income on the basis that one-third of expenditure on minor surgery is included in the GSE; and

© *cervical cytology target payments (part)*
this should be based on one-half of the contractor's cervical cytology lower and higher target payments on the basis that one-half of expenditure on cervical cytology is included in the GSE.

Treatment of unusual practices

D.8 The configuration of practices is not static. This means that there will be cases where expenditure data will not be readily available for the practices as currently configured. In such cases Health Boards will need to map GSE payments according to the guidance below.

GP vacancies during the baseline period

D.9 Calculation of the GSE will take account of GP vacancies during the baseline period. There are two separate criteria for assessing whether a vacancy adjustment should be made. These are–

(a) where the practice has a Health Board-approved vacancy overlapping the baseline period at any time; or

(b) where the practice loses one or more principals during the baseline period at any time, and where approval for replacement has been agreed.

D.10 In such cases the adjustment will be made on a per day, per vacancy basis for each day during the baseline period. Health Boards should count vacancies from the day they occur and not from the day they were approved.

D.11 Where the vacancy is full-time the full-time rate will apply. As per the current Statement of Fees and Allowances (SFA) rules, where it is three-quarter-time, 83.5% of the full rate should apply, where it is half-time, 62.5% should apply, and where it is one-quarter-time, 41.5% should apply. The absence of a job-sharer should be calculated *pro rata* to that absent job-sharer's availability.

D.12 The full-time vacancy cost factor is [£19,931].

Staff vacancies during the baseline period

D.13 Health Boards may add in an adjustment in respect of staff vacancies, or new staff posts, where appropriate.

Practices that merged during the period covered by the data collection (between 1 July 2002 and 30 June 2003)

D.14 Some practices may have merged during the baseline period. In these circumstances, the GSE should be the sum of the constituent practices' GSE income in the part of the year before they merged, plus the new practice's GSE income for the rest of the year. For example–

Practices A and B merge to form Practice C on 1 April 2003

GSE for Practice A (up to end March)	=	£200k
GSE for Practice B (up to end March)	=	£150k
GSE for Practice C (April to end June)	=	£120k
Full year GSE for Practice C	=	£470k

Practices that split during the period covered by the data collection (between 1 July 2002 and 30 June 2003)

D.15 Some practices in existence during the first quarter of 2003-04 will have previously been part of another practice. For the part of the year where data are available for the new practices this should be used.

D.16 For the part of the year before the practice split, the GSE for the new practices will have to be based on the GSE of the old practice. GSE income for the new practices will be calculated pro rata to the practice list size at the time of the split. For example–

Practice X splits into Practice Y and Practice Z on 31 March 2003

Practice X GSE (1 July 2002 to 31 March 2003)	=	£400k
Practice X list size	=	2,500
Practice Y list size	=	1,000

Practice Y GSE (1 April to 30 June 2003)	=	£50k
Practice Y GSE (1 July 2002 to 31 March 2002)	=	£160k
Practice Y full year GSE	=	£210k
Practice Z list size	=	1,500
Practice Z GSE (1 April to 30 June 2003)	=	£65k
Practice Z GSE (1 July 2002 to 31 March 2002)	=	£240k
Practice Z full year GSE	=	£305k

Practices that formed during the period covered by the data collection (between 1 July 2002 and 30 June 2003)

D.17 If a practice formed during the baseline period, the GSE should be calculated on any part-year data that are available and then grossed up to the full-year figure.

Practices that merge after the period covered by the data collection (quarter 1 2003-04) but before 1 April 2004

D.18 Some practices that existed up to the first quarter of 2003-04 will have subsequently merged with others during 2003-04. In these circumstances, the GSE for the new practice should be the sum of the GSEs for the constituent practices before the merger.

Practices that split after the period covered by the data collection (quarter 1 2003-04) but before 1 April 2004

D.19 Some practices that existed up to first quarter 2003-04 will have subsequently split and formed different practices during 2003-04. In these circumstances, the GSE for the new practices will be based on the old practice's GSE shared pro-rata on a list size basis.

New practices in 2003-04

D.20 Practices forming in 2003-04 will be eligible for an MPIG. It will be based on the funding for the GSE items for the months in which they have been in existence, increased *pro rata* to a full year.

Appendix A to Annex D: Constituents of the global sum equivalent mapped to financial returns

GSE constituent	Description in financial returns		
Basic practice allowance	Basic practice allowance		
Night consultation fees	Night consultation fee		
Night annual payment	OOH Allowance		
Capitation fees	Capitation fees under 65		
	Capitation fees 65-74		
	Capitation fees over 75		
Health promotion annual payment (excluding chronic disease management)	Sessional fees for health promotion		
Contraceptive services fees (excluding intrauterine device fees)	Contraceptive service – ordinary		
Maternity medical services fees (excluding intra partum care) [1]	Maternity medical services		
Deprivation payments	–UPA 50+		
	–UPA 40-50		
	–UPA 30-40		
	–UPA20-30		
New registration fees	Registration fees		
Minor surgery fees (part) [2]	Minor surgery sessional payments		
Child health surveillance fees	Child health surveillance fees		
Vaccinations and immunisations item-of-service fees (excluding influenza, and childhood immunisations and pre-school booster target payments)	MMR2		
	Vaccination/immunisation		
	Immunisation against group C meningococcal disea–e - 2,3,4 month routine vaccines		
	Immunisation against group C meningococcal disea–e - 5 under 11 months catch up		
	Immunisation against group C meningococcal disea–e - 12 months – under 5 years		
	Immunisation against group C meningococcal disea–e - university students		
	Immunisation against group C meningococcal disea–e - persons aged 15-17 not in full time education		
Arrest of dental haemorrhage fees	Arrest of dental haemorrhage		
Scottish Rural Practices Fund (SRPF)	Rural practice payments		
	Rural practice allowan–e - non units		
Post graduate education allowance	PGEA - full		
	PGEA - level 4		

GSE constituent	Description in financial returns		
	PGEA - level 3		
	PGEA - level 2		
	PGEA - level 1		
Telephone advice fees	Telephone advice for temporary residents and emergency treatment compensation payments		
Cervical cytology target payments (part)[3]	Cervical cytology target paymen–s - higher		
	Cervical cytology target paymen–s - lower		
Anaesthetic administration fees	Service as an anaesthetist		
Inducement payments	Inducement payments		
Practice staff reimbursements	Practice staff		
	Salaried doctors under para 52 of SFA		
	Payments made in respect of replacement doctors (SFA 52.41 salaried doctors)		
GP superannuation	Superannuation contributions (employers share)		
Chapter 10.5 payments	Chapter 10.5 payments		

[1] The GSE excludes expenditure on *intra partum* care. This expenditure is not separately identified in the accounts. Identification of these payments is to be agreed by the Health Board and the contractor, as the level of expenditure will differ between practices.

[2] The GSE should include one-third of the contractor's minor surgery payments on the basis that only one-third of expenditure on minor surgery is covered by the GSE.

[3] The GSE should include one-half of the contractor's cervical cytology lower and higher target payments on the basis that only one-half of expenditure on cervical cytology is covered by GSE.

ANNEX D PART 2

CALCULATION OF GSE FOR INDUCEMENT PRACTITIONERS

Calculation method

D.21 For the sake of clarity, where the mechanism proposed here refers to any existing allowance by name this means only that the monetary value of that allowance should be taken into account when calculating the Global Sum Equivalent, not that the existing allowance will remain under the new GMS contract.

D.22 The GSE for all Inducement Practices should be calculated by:

Adding the following two items:

- The total value of the global sum equivalent fees and allowances payments made to the practice in relation to the baseline year. This is the same set of fees and allowances that apply to all GMS practices as itemised in paragraph D.3 (i)-(xxi) above.
- The value of Inducement Payments made to the practice in relation to the baseline year.

From this figure then subtract the following item:

- The value of locum fees and expenses as claimed by the practice in relation to the baseline year.

For Dispensing Inducement Practitioners, then add back the following item:

- The value of Dispensing Profit in relation to the baseline year as calculated by Practitioner Services Division (PSD) using the values of Dispensing Income and Dispensing Expenses as retained by PSD (Income minus Expenses) in relation to the baseline year (see paragraphs D.28 and D.29 below).

Accountancy fees

D.23 Accountants' fees in relation to the baseline year should be separated out to identify the proportion directly related to the management of the Inducement Scheme. This value will be subtracted from the Global Sum Equivalent total at 1 April 2005. Inclusion in 2004/05 payments is to enable winding up of the inducement scheme in a timely manner and Inducement Practitioners should be diligent in submitting all outstanding financial returns within this timeframe. In those cases where there is unavoidable delay, this period may be extended until no later than 1 April 2006, by agreement with the NHS Board.

The baseline year

D.24 The calculation of GSE is based on expenditure for the year which relates to each individual practice's most recent full year accounts as approved by the SMPC at December 2003. This will be subject to an uplift to 2004-05 prices.

Additional guidance

D.25 In addition to the general guidance set out in paragraphs D.9 – D.20 above, the following guidance will also apply to previous Inducement Practices.

Reviews

D.26 These practices will be subject to the same general UK-wide review of the allocation formula and MPIG arrangements as all GMS practices.

D.27 In addition, in line with the general principle of moving practices towards mainstream arrangements, as current Inducement Practitioners (IPs) retire or leave the practice, arrangements for the provision of Primary Medical Services in the area will be reviewed by the NHS/Island Board and discussed with the remaining partners.

Dispensing doctors

D.28 Arrangements for dispensing doctors have not yet been considered under the terms of the new GMS contract as payment is not part of GMS expenditure. Currently Dispensing IPs' profits are coupled with their Inducement Payment, such that as dispensing profits increase, inducement payments decrease and vice versa. Under the new contract, Dispensing IPs will be able to dispense, as required, for their patients and be paid under the existing system for dispensing doctors with no detriment to the payments they are entitled to under new GMS. This will uncouple dispensing profit from GMS income. Therefore it is appropriate to separate out dispensing profit from GMS income for Dispensing IPs at the stage when Global Sum Equivalent is being calculated and add this figure to the GSE for Dispensing IPs. This should enable these practices to continue dispensing whilst not in any way destabilising their GMS income.

D.29 PSD retain information on Dispensing Income and Expenses in relation to Dispensing IPs. Income minus Expenses provides a figure for profit/loss which contributes to the calculation of Inducement Payments. For the purposes of calculating the GSE for Dispensing IPs, PSD will adjust the GSE figure by the addition of the profit/loss value to the GSE.

Entitlement to holiday and study leave cover

D.30 Currently each eligible GP, as defined in existing arrangements, can claim for reasonable fees and expenses, as per existing arrangements, in obtaining locum cover for periods of up to 42 days a year, plus 2 days for handover purposes, in respect of holidays and for up to 14 days per annum in respect of attendance at postgraduate

courses. The entitlement to this level of cover for holiday and study leave will continue under the new contract arrangements and the existing eligibility criteria in relation to this entitlement will remain unchanged.

D.31 The funding to provide this cover will be in NHS Board administered funds. In order to provide a useful degree of flexibility in this matter, NHS Boards and practices can make local agreements on suitable arrangements for the provision of this cover. This could be achieved by the practice receiving full reimbursement for the actual cost of engaging a locum to provide this cover, or by the NHS Board commissioning and paying for the appropriate holiday and study leave as required. Further guidance will be issued in relation to the arrangements for provision of this cover.

D.32 For the sake of clarity, all other entitlement to locum cover will apply in exactly the same way as for all GPs as set out in Part 4 of this Statement of Financial Entitlements.

Superannuation

D.33 The determination of superannuable income for all GPs under the new contract is still subject to negotiation at UK-level. Any final determination on superannuable income for current IPs under the new contract should take into account the outcome of these negotiations.

ANNEX E

QUALITY AND OUTCOMES FRAMEWORK

(PUBLISHED SEPARATELY)

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. The Child Health Surveillance and Maternity Medical Services indicators require particular services to be offered to particular target populations, and assessment of achievement in relation to the Cervical Screening Services indicators is also limited to achievement in relation to a particular target population. The relevant target populations are–

- Cervical screening services: females aged 21 to 60 years
- Child health surveillance: children of both sexes aged 0 to 5 years
- Maternity medical services: females aged under 55 years
- Contraceptive services females aged under 55 years

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

F.3 Once a points total has been determined in respect of each additional service, that total is then to be multiplied by [£75] to produce the initial total in respect of the additional service (**X**).

F.4 For each of the additional services mentioned in paragraph F.1, this amount is then to be adjusted by an index produced by the following calculation–

(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 the CSA) 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 index for the additional service in question. This is then to be multiplied by the cash total produced to produce the adjusted cash total in respect of the additional service (**Y**).

F.5 This calculation could be expressed as–

$$\frac{(A \div B)}{(C \div D)} \times X = Y$$

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

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

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

F.7 The resulting cash amounts, in respect of each additional service (adjusted, as appropriate, in accordance with paragraphs F.4 and F.6) 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:

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

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

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

G.2 These steps are explained below.

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

G.4 The adjusted practice disease factor is calculated by:

(a) calculating the national range of Raw Practice Disease Prevalences in Scotland and applying a 5% cut-off at the bottom of the range. Practices below this will be treated as having the same prevalence as the cut-off point;

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

(c) after the transformation, rebasing the practice 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 the average practice (i.e. one with an APDF of 1.0) receives [£75] per point, after adjustment;

(e) thus, adjusting via the factor the practice's average pounds per point for each disease, rather than the practice's points score. For example, a practice with an APDF of 1.2 for CHD will receive [£90] per point scored on the CHD indicators.

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

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

ANNEX H

LIST OF PRACTICES FOR WHICH ADDITIONAL PAYMENTS ARE PAYABLE UNDER THE GOLDEN HELLO SCHEME

(This is the 03/04 list, which is due to be updated for 04/05)

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	BAYVIEW	LONGHOPE	ORKNEY	KW163PQ
BRANCH	ORKNEY	38121	ORGIL FARM	HOY	ORKNEY	KW163NJ
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
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	BURRA	SHETLAND	ZE2 9LE
MAIN	SHETLAND	39091	LERWICK HEALTH CENTRE	SOUTH ROAD	LERWICK	ZE1 0RZ
BRANCH	SHETLAND	39091	SANDWICK	SHETLAND		ZE2 9HW
BRANCH	SHETLAND	39091	CUNNINGSBURGH	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	UNST	SHETLAND	ZE2 9DL
MAIN	HIGHLAND	55516	BROADFORD MEDICAL CENTRE	HIGH ROAD	BROADFORD	IV499AA
MAIN	HIGHLAND	55521	TRIEN	CARBOST	SKYE AND LOCHALSH	IV478ST
MAIN	HIGHLAND	55535	DUNVEGAN HEALTH CENTRE	DUNVEGAN	ISLE OF SKYE	IV558GU
MAIN	HIGHLAND	55540	SLEAT MEDICAL PRACTICE	FERRINDONALD	SLEAT	IV448RF
MAIN	HIGHLAND	55554	TIGH NA MARA	GLENELG	KYLE	IV408JR
MAIN	HIGHLAND	55569	CHURCH ROAD	KYLE OF LOCHALSH		IV408DD
MAIN	HIGHLAND	55573	PORTREE MEDICAL CENTRE	PORTREE	ISLE OF SKYE	IV519BZ
MAIN	HIGHLAND	55677	GRIANAN	ISLE OF EIGG	LOCHABER	PH424RL
MAIN	AYRSHIRE & ARRAN	80645	BRODICK HEALTH CENTRE	BRODICK	ARRAN	KA278AJ
MAIN	AYRSHIRE & ARRAN	80650	LAMLASH	ARRAN		KA278NS
BRANCH	AYRSHIRE & ARRAN	80650	BRODICK CLINIC	INVERCLOY	BRODICK	KA278AJ
BRANCH	AYRSHIRE & ARRAN	80650	VILLAGE HALL	KILMORY	ARRAN	KA278PQ
BRANCH	AYRSHIRE & ARRAN	80650	WHITING BAY CLINIC	ARNHALL LODGE	WHITING BAY	KA278PX
MAIN	AYRSHIRE & ARRAN	80664	SHISKINE CLINIC	INGLEWOOD	SHISKINE	KA278EW
BRANCH	AYRSHIRE & ARRAN	80664	VILLAGE HALL	KILMORY	ARRAN	KA278PX
BRANCH	AYRSHIRE & ARRAN	80664	NEWTON ROAD	LOCHRANZA	ARRAN	KA278HQ
BRANCH	AYRSHIRE & ARRAN	80664	COMMUNITY CENTRE	PIRNMILL	ARRAN	KA278JU
MAIN	AYRSHIRE & ARRAN	80679	10 KELBURN STREET	MILLPORT		KA280DT
BRANCH	ARGYLL & CLYDE	84006	PUBLIC HALL	ISLE OF LISMORE	ARGYLL	PA345UG
MAIN	ARGYLL & CLYDE	84097	ARINAGOUR	ISLE OF COLL		PA786SY
MAIN	ARGYLL & CLYDE	84129	BENORAN	ISLE OF COLONSAY		PA617YW
MAIN	ARGYLL & CLYDE	84331	WINDSOR	MAIN STREET	BOWMORE	PA437JH
MAIN	ARGYLL & CLYDE	84345	GEIRHILDA	BACK ROAD	PORT ELLEN	PA427DL
MAIN	ARGYLL & CLYDE	84350	THE RHINNS MEDICAL CENTRE	PORT CHARLOTTE	ISLE OF ISLAY	PA487UD
MAIN	ARGYLL & CLYDE	84383	GLENCAIRN GP SURGERY	CRAIGHOUSE	ISLE OF JURA	PA607XG
BRANCH	ARGYLL & CLYDE	84472	ARDMINISH	ISLE OF GIGHA		PA417AB

MAIN	ARGYLL & CLYDE	84504	SALEN SURGERY	PIER ROAD	SALEN AROS	PA726JL
MAIN	ARGYLL & CLYDE	84519	ROCKFIELD ROAD	TOBERMORY	ISLE OF MULL	PA756PN
MAIN	ARGYLL & CLYDE	84523	BUNESSAN	ISLE OF MULL		PA676DG
BRANCH	ARGYLL & CLYDE	84523	ISLE OF IONA			PA766SJ
MAIN	ARGYLL & CLYDE	84646	ROTHESAY HEALTH CENTRE	HIGH STREET	ROTHESAY	PA209JL
MAIN	ARGYLL & CLYDE	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	SHAWBOST SECONDARY 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	BREASCLETE PRIMARY SCHOOL	BREASCLETE	ISLE OF LEWIS	HS2 9ED
BRANCH	WESTERN ISLES	90079	BALALLAN PRIMARY 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 TRIANAID, CARINISH**	
MAIN	WESTERN ISLES	90120	SORELLE LODGE SURGERY	GRIMINISH	BENBECULA	HS7 5QA
BRANCH	WESTERN ISLES	90120	DALIBURGH HOSPITAL	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 – NOT ALLOTTED

ANNEX J

QUALITY AND OUTCOMES FRAMEWORK ACCESS TARGET

Background

J.1 *Our National Health – A Plan for Action, A Plan for Change* set a target to ensure that patients in every part of Scotland can get access to an appropriate member of the primary care team in 48 hours.

J.2 The Partnership Agreement: *Partnership for a Better Scotland* published in May 2003 reinforces the commitment that 'anyone contacting their GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours'.

Definition

Access to an appropriate member of the primary care team

J.3 Access to an appropriate member of the primary care team means direct contact (which may be by telephone or face-to-face) between the patient and the professional (see paragraph J.4) in line with the practice's consultation arrangements where:

- professional, clinical advice is sought and given within 2 working days in accordance with the clinical needs of the patient; and

- a professional, clinical opinion and/or diagnosis is required in order to determine a further course of action e.g. to treat, to refer or to provide professional advice.

Professional

J.4 Professional means a doctor, nurse or health visitor or other healthcare professional in the practice with which the patient is registered, who is competent to deal with the patient's clinical needs.

48 hours

J.5 48 hours means 2 working days, where a patient requests a consultation in that time, during the normal working hours of the practice, where consultations are available as published by the practice. For example if a consultation was requested on a Friday, it should be arranged no later that the following Tuesday. If the practice has identified a planned closure for staff training on the Monday, the consultation should be arranged no later than the Wednesday.

Patients

J.6 Patients means those (including temporary residents) who are registered with the practice.

Exclusions

J.7 The definition excludes:

- situations where the patient does not wish to have contact or be seen within 48 hours
- situations where the patient specifies a particular professional or individual, where an appropriate, alternative professional is available within 48 hours
- requests for emergency or urgent treatment which should be dealt with immediately or within 24 hours in accordance with clinical need
- pre-planned courses of elective treatment or care programmes where access arrangements are established in advance e.g. chronic disease management, treatment or screening programmes
- out-of-hours coverage i.e. outside the normal working hours of the practice
- planned closures e.g. public holidays or staff training

Requirements

J.8 In order to meet the 48 hour access target practices must be able to demonstrate that they have in place one (or more) of the following:

- Open access i.e. patients are seen on the same day without an appointment
- The practice has adopted the 'Advanced Access' (or equivalent) approach and can provide same day appointments
- Practice Accreditation, Training Practice Accreditation or QPA have been awarded and the access criteria have been achieved
- Telephone (or email) access to a member of the primary care team for professional advice within 48 hours e.g. a booked appointment in a doctor or nurse led 'telephone surgery'
- Formally established arrangements for triage by a doctor or a nurse either by telephone or face-to-face
- Arrangements for patients to be seen by a doctor, nurse or other health care professional within 48 hours or sooner where there is a clinical need

J.9 Evidence in support of this should be on the basis of:

Identification within practices or more widely in local health systems of the systems and processes to support the criteria listed above

and/or

Quantitative measurement of the time for a consultation from the point of request; or prospectively available appointments at a given point in time.