S T A T U T O R Y  I N S T R U M E N T S

# WG25-33

# THE NATIONAL HEALTH SERVICE (WALES) ACT 2006

## Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025

| | |
|---|---|
| *Made* | *6 June 2025* |
| *Coming into force* | *7 June 2025* |

The Welsh Ministers, in exercise of the powers conferred on them by sections 45, 203(9) and (10) and 204(1) of the National Health Service (Wales) Act 2006(**a**) and after consulting in accordance with sections 45(3)(e) and 45(4) of that Act with the bodies appearing to them to be representative of persons to whose remuneration these Directions relate, give the following Directions. These Directions have retrospective effect and comply with the requirements of section 45(3)(e) of the National Health Service (Wales) Act 2006.

### Title, application, coming into force and effect

**1.—**(1) The title of these Directions is the Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025.

(2) These Directions are given to Local Health Boards. They relate to the payments to be made by Local Health Boards to a GMS contractor under a GMS contract.

(3) These Directions are made on 6 June 2025 and come into force on 7 June 2025.

(4) These Directions have effect from 1 April 2025.

### Amendment to the Statement of Financial Entitlements

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

### Amendment of the Table of Contents

**3.**In the TABLE OF CONTENTS, in PART 2—, in section 6., for the list of sub-headings substitute—

"General Provisions relating to the Quality Improvement Domain

(**a**) 2006 c. 42.
(**b**) 2013 No. 8.

Payment arrangements for Monthly Aspiration Payments QI year from 1 April 2025 to 31 March 2026

Achievement Payments – QI year from 1 April 2025 to 31 March 2026

Assessment of Achievement Payments where a GMS contract terminates between 1 April 2025 and 31 March 2026

Evidence and Verification

Accounting arrangements and due date for Achievement Payments

Conditions attached to Achievement Payments".

**4.**In the TABLE OF CONTENTS, in ANNEXES—

(a) for the heading "D. QI Project – Prescribing Safety" substitute "D. QI Project – Chronic Kidney Disease";

(b) for the heading "E. QI Project - Unhealthy Behaviours" substitute "E. QI Project – Improving Cardiovascular Outcomes";

(c) after "E. QI Project – Improving Cardiovascular Outcomes" insert "F. QI Project - Continuity of Care".

**Amendment of Part 2, Section 6 – QUALITY IMPROVEMENT**

**5.**For paragraphs 6.1 to 6.10 substitute—

**"6.1.** The QI domain is based on QI projects the practice will complete.

**6.2.** To be able to claim any points for achievement of projects in the QI projects domain, the practice must complete the 3 mandatory projects.

**6.3.** The 3 mandatory projects for the QI year 1 April 2025 to 31 March 2026—

(a) Chronic Kidney Disease – 70 points,

(b) Improving Cardiovascular Outcomes - 70 points, and

(c) Continuity of Care – 30 points.

**6.4.** The details of the QI projects and what tasks contractors must undertake to achieve the 170 points can be found at—

QI Project – Chronic Kidney Disease – Annex D

QI Project – Improving Cardiovascular Outcomes – Annex E

QI Project - Continuity of Care – Annex F

**Payment arrangements for Monthly Aspiration Payments QI year from 1 April 2025 to 31 March 2026**

**6.5.** Aspiration Payments are a payment made in advance of Achievement Payments being calculated under the QI domain of the QIF.

**6.6.** The contractor is only entitled to receive Aspiration Payments if they received an Achievement Payment for a QI project as part of the 2024 to 2025 QIF cycle.

**6.7.** The QI points value for Achievement Payments will be £199.

**6.8.** Aspiration Payments are to be made by calculating 70% of the 170 achievement points available at 1 April 2025 under the QI domain divided by 12 multiplied by CPI at 1 April 2025.

**6.9.** If a contractor's GMS contract takes effect after 1 April 2025 in the QIF (QI) year the monthly Aspiration Payment is to be agreed between the contractor and the LHB.

**6.10.** The LHB must pay the contractor under the contractor's GMS contract its Monthly Aspiration Payment. The Monthly Aspiration Payment is to fall due on the last day of each month.

**6.11.** If the contractor cannot evidence the completion of the QI projects, then the Local Health Board is entitled to recover any Aspiration Payments made.

**Achievement Payments – QI year from 1 April 2025 to 31 March 2026**

**6.12.** The achievement payment is the 170 points total multiplied by £199 and then multiplied by the contractor's CPI, calculated in accordance with the provisions of paragraphs 2.17 and 2.18—

(a) at the start of the final quarter of the QIF QI year for which the Achievement Payment relates; or

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

**6.13.** A contractor will be entitled to an achievement payment at 30 June 2026 if at 31 March 2026, the contractor has submitted evidence for the 3 QI projects to the Local Health Board for verification.

**6.14.** The achievement payment will also take into account the deduction of the Aspiration Payments that the contractor has received for the period 1 April 2025 to 31 March 2026.

**Assessment of Achievement Payments where a GMS contract terminates between 1 April 2025 and 31 March 2026**

**6.15.** If a contractor can evidence that they have completed the 3 QI projects, then the contractor is entitled to an achievement payment at 170 points multiplied by £199 and then multiplied by CPI (at the start of the financial year quarter during which its GMS contract was terminated) with a deduction for any aspiration payments made. If the contractor cannot evidence the completion of the 3 QI projects, then no achievement payment is to be made and the Local Health Board is entitled to recover any aspiration payments made.

**Evidence and Verification**

**6.16.** At 31 March 2026, contractors must submit evidence to the Local Health Board against the 3 QI projects for verification.

**6.17.** Contractors who do not submit evidence to the Local Health Board for the 3 QI projects or submit evidence that cannot be verified, will be subject to recovery of all aspiration payments.

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

**6.18.** The contractor's achievement payment is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year into which the date in respect of which the assessment of achievement points on which the achievement payment is based ("the relevant date") falls and the achievement payment is to fall due—

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

(b) in the case of achievement payments, at the end of the first quarter of the QIF (QI) year 1 April 2025 to 31 March 2026 into which the relevant date falls.

**Conditions attached to Achievement Payments**

**6.19.** Achievement payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must submit evidence to the LHB at 31 March 2026;

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

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

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

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

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

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

**Insertion of New Annexes**

**6.** In the Annexes, in the appropriate place, insert Annex D in the Schedule to these Directions.

**7.**In the Annexes, in the appropriate place, insert Annex E in the Schedule to these Directions.

**8.**In the Annexes, in the appropriate place, insert Annex F in the Schedule to these Directions.

**Amendment of Annex J**

**9.** For "ANNEX J - AMENDMENTS" substitute Annex J in the Schedule to these Directions.

**Signed by Paul Casey, Deputy Director of Primary Care under the authority of the Minister for Health and Social Services, one of the Welsh Ministers**

**Date: 06 June 2025**

# SCHEDULE

Directions 4(a) and 6

# "ANNEX D – QI PROJECT – CHRONIC KIDNEY DISEASE

## Proposal for CKD optimisation QIP 2025-26

### Background

Chronic Kidney Disease (CKD) affects 7.62% of the Welsh population aged over 16 years (n= 196,815), and prevalence has increased by 33% over the last 12 years.[1] Of the 4 nations, Wales has the second highest prevalence of End stage kidney disease (ESKD) requiring of renal replacement therapy (RRT) per million population[2]. Within Wales, RRT services are commissioned via the Wales Kidney Network (WKN), with an annual budget of £80 million, although the total economic burden of CKD in Wales is estimated to be in excess of £320 million (extrapolated from UK spend of £7 billion per year)[3]. ESKD is associated with markedly increased mortality and poor quality of life, additionally dialysis is an expensive therapy (approx. £30K per annum). In view of this, it is imperative that patients with CKD are identified early and that appropriate steps are taken to mitigate against disease progression.

The commonest cause of CKD and ESKD is diabetes. There are currently over 225,000 patients living with diabetes in Wales[4], the prevalence of which has increased by more than 40% since 2010[5]. 40% of those with T2DM go on to develop Diabetic Kidney disease (DKD), which has been shown to accelerate cardiovascular morbidity and mortality in this already high risk population[6]. Recent data published by Kidney Care UK demonstrates a paucity of knowledge regarding the links between diabetes, CKD and CVD amongst patients and healthcare providers, with numerous opportunities missed to discuss the diagnosis and implications of DKD, and potential lifestyle modifications that can be made to reduce CVD and protect against acute kidney injury (avoidance of NSAIDS, sick day rules etc)[7].

NICE recommendations for gold standard care for patients with CKD include blood pressure and lipid lowering therapy, early use of renin-angiotensin-aldosterone inhibitors (ACE inhibitors and ARBs) and SGLT2 inhibitors[8]. SGLT2 inhibitors have been shown to reduce the risk of kidney disease progression by 37% and the risk of cardiovascular death or hospitalisation for heart failure by 23% in those with CKD, with or without diabetes[9]. Health economic analyses of SGLT2 inhibitors consistently report incremental cost-effective ratios (ICER) well below the NICE £20,000 threshold[3], where the benefits of delaying CKD progression is the main determinant of the cost-effectiveness of these drugs[10].

Despite clear evidence-based guidance for implementation, the uptake of these medications in Wales is low with only 42% of the known high risk proteinuric diabetic cohort currently prescribed SGLT2 inhibitors[4]. This prescribing rate is additionally likely to be an overestimate, given that identification of the true high risk DKD population is hindered by low rates of ACR testing, with only 58.1% of diabetic patients in Wales having an ACR check in the last 15 months[4]. The prescribing rate of SGLT2i for non-diabetic CKD (e.g. secondary to hypertension) in Wales is not known, but is estimated to be significantly lower than this, hampered in part by poor recognition of ESKD risk in this cohort, with only 17% having had an ACR checked in the last 15 months[4].

In recognition of the value-based impact for health across the entire cardiometabolic spectrum, AWPAG have prioritised SGLT2i prescribing in DM, Heart failure and CKD as one of the four confirmed National Prescribing indicators for 2025-2028. In conjunction with this, the Wales Kidney Network have been working with primary care leads to compose the All-Wales CKD Community HealthPathways. Given the potential of this QIP to embed these new All-Wales CKD initiatives into practice, AWTTC (Andrew Evans, Chief Pharmaceutical officer) and PHW (Tracey Daszkiewicz, Executive Director) have committed support for the development of CPD-approved e-module development (via HEIW) to accompany this QIP and ensure a legacy from learning across the primary care MDT.

**As in all Quality Improvement projects, it is not necessary to demonstrate an absolute improvement after an intervention. However, it is necessary to collect data 'before' and 'after' any intervention and share any learning widely. This will also support contractors and collaboratives to use and evaluate the new Accelerated Cluster Developments.**

## Aims

The **primary aim** of this QI project is to reduce kidney disease progression towards ESKD, and reduce cardiovascular morbidity and mortality in patients with CKD, by adhering to NICE recommended guidelines for the implementation of SGLT2 inhibitors.

The **secondary aims** are to collate accurate CKD registers, improve adherence to urinary ACR screening and promote education and awareness of CKD amongst patients and Healthcare providers (HCPs) inclusive of GPs, DSNs and practice pharmacists.

## Target population

All patients with

- GFR 20-45ml/min
- GFR 45- <90ml/min who additionally have a diagnosis of T2DM, or who have ACR >22.6 mg/mmol.

## Objectives

In addition to the principal objective of improving SGLT2i prescribing rates in CKD, practices should select priority areas from the following options to build a Quality improvement project that best reflects the needs of their practice population. The outcomes of the QIP will be demonstrable improvements in the following parameters:

- **Principal objective: Develop, agree and implement a strategy to increase prescribing of SGLT2 inhibitors to those on maximum dose ACE/ARB (where tolerated and indicated):**
    - to patients with eGFR 20-45ml/min, unless contraindicated
    - to patients with eGFR 45-90 and either T2DM or ACR >22.6mg/mmol, unless contraindicated
- Develop, agree and implement a strategy to Improve coding accuracy of CKD
- Develop, agree and implement a strategy to increase annual UACR and eGFR screening

    - in patients with T2DMDevelop, agree and implement a strategy t
    - in patients with HTN
- Develop, agree and implement a strategy to improve prescribing rates of statin therapy (Atorvastatin 20mg first line) for all patients with CKD (eGFR < 60ml/min), unless contraindicated
- Develop, agree and implement a strategy to achieve BP targets:
    - < 140/90 for patients with CKD and ACR <70mg/mmol
    - < 130/80 for patients with CKD and ACR >70mg/mmol
- Develop, agree and implement a strategy to prescribe maximum tolerated dose of ACEi or ARB therapy:
    - to patients with T2DM, CKD and ACR > 3mg/mmol
    - to patients with non-diabetic CKD with ACR >70mg/mmol
    - to patients with non-diabetic CKD, HTN and ACR >30mg/mmol
- Develop, agree and implement a strategy to improve patient awareness and education of CKD and the association with increased CV risk (e.g. QR code prescribing/other signposting to online videos, face to face appointment)
- Develop, agree and implement a strategy to signpost patients to local services promoting health lifestyle change that will minimise CKD risk and CKD progression (e.g. smoking cessation, exercise)
- Develop, agree and implement a strategy to improve Community Health care practitioner awareness and education of CKD via completion of CPD-approved online training module designed in conjunction with Wales Kidney Network, HEIW, AWTTC and PHW.

*(NB Flozin targets above are based on NICE TA 942 for Empagliflozin, with expectation that NICE TA 775 for Dapagliflozin will be updated to mirror the former, change expected Spring 2025. The NICE 2021 CKD guidance, "recommending" use in DKD where ACR> 30 and "suggesting" use in DKD ACR 3-30,* ***is out of date*** *and not in keeping with individual SGLT2i TAs, nor the UKKA or KDIGO guidelines).*

## Requirements of the project

### Practice Level

• Practices will have a named QI Project lead clinician.

• Practices will use read codes CKD, HTN and DM to identify potentially eligible patients

• Practices will use the agreed search strategy for eGFR, ACR and BP to identify the target population using automated tools embedded within primary care IT systems (e.g. EMIS)

• Improvements in SGLT2i prescribing rates, as supporting by the National prescribing indicators for Wales 2025-2028, should be a primary focus. An example of a pharmacy-led model of SGLT2i initiation is detailed below. Beyond this, practices should assess their specific population needs and priority areas against the suggested objectives listed above. Having identified a target area (e.g. urinary ACR testing) the practice should design a quality improvement project that aims to address the identified need and improve adherence to national standards of screening and/or management of CKD. Practices are encouraged to

devise their own strategies to deliver improvement which may include, but are not limited to:

- **Screening/Coding focus:** Identify high risk groups (as listed in NG203 and All Wales Community HealthPathway CKD page), not currently recorded as having CKD, using available automated IT tools. Implement a screening pathway for these patients to undergo eGFR and ACR testing, with confirmatory testing as per NG203. Once diagnosis confirmed, ensure CKD coding completed and enrol in CKD monitoring and/or refer to secondary care if meets criteria as per NG203/CKD HealthPathways.

- **Monitoring focus:** Implement automated pathways to invite CKD patients for monitoring of GFR, ACR and BP testing at a frequency that is determined by patients' CKD stage, and guided by the information available on the Community HealthPathways CKD page, including onward referral to nephrology if criteria met.

- **Optimisation focus**: Implement medicines optimisation reviews of patients with CKD, with equal focus on strategies to retard CKD progression and to prevent associated CV disease. This should incorporate patient education on healthy lifestyle changes, appropriate signposting to additional local services (e.g. smoking cessation) and information surrounding sick day rules with medications. Reviews could be led by GP or ANP/Pharmacist with appropriate training (see example case below)

- **Diabetes focus:** Where practices identify low rates of compliance with annual diabetic review, and particularly the ACR/eGFR core processes within this, review options to better integrate CKD screening and management with all diabetes-focused patient interactions e.g. DSN review, foot check, medication review. Diabetes-affiliated MDT members to complete education modules to raise awareness of the link between DM, CKD and CVD and hence maximise the outcomes of patient interaction in taking every opportunity to ensure uACR test is completed, for example.

- **Education focus (Patients):** This could include setting up of group patient education sessions with particular focus e.g. diabetes, hard-to-reach communities such as ethnic minority groups, lower socioeconomic status, or dissemination of available patient information via post/QR code email/text messaging (see HealthPathways-"Information for patients").

- **Education focus (HCP's):** Demonstrate uptake and completion of CPD-approved CKD education modules for HCP in the practice inclusive of Pharmacists, Doctors, ANPs, PA's, DSNs etc.

• Practices will discuss their learning with their GMS collaborative. Minutes of this meeting should be submitted to health boards as confirmation that this discussion has taken place.

• Practices will complete a nationally agreed QI Poster for sharing at the final collaborative meeting before 31/3/2026 confirming conclusion of the project and highlighting outcomes achieved.

### Example QIP- Pharmacy-led optimisation of CKD

- Since July 2023, a Value-based Healthcare funded initiative has been operating in Aneurin Bevan Health board, utilising independent prescribing pharmacists to screen GP practices for patients with diabetes and CKD, eligible for face-to-face holistic lifestyle and medication reviews to optimise overall cardiometabolic health. In this model, the pharmacist(s) works autonomously within the practice, selecting patients using pre-specified searches within IT systems embedded in primary care, followed by more in-depth electronic notes review to apply strict inclusion and exclusion criteria, according to checklist. All recorded vital parameters, advice, medication and CKD code changes are inputted by the pharmacist directly into the GP records. (see Appendix A- Standard operating Procedure, for more detail). To date, this model has been applied to 19 GP practices across ABUHB with 100% positive feedback from participating GP practices and ≈90% positive feedback from patients, with a total of 763 patients reviewed. Furthermore, this model of pharmacy-led optimisation of DKD has potential application to other chronic disease conditions in primary care.

### GMS Collaborative Level

• Practices to share aggregate practice-level data on the number of CKD patients treated to target.

• Practices to discuss accuracy of data and process for refinement.

• Discuss, share best practice, and consider adaptation of QI processes if applicable across collaborative

### DHCW Level

• Currently, the diabetes and CKD modules within the primary care portal utilise audit plus for data extraction. Given the termination of this contract, DHCW to advise on appropriate replacement to enable data collation. A number of options are available and in use in England specifically for CVD prevention;

cvdprevent.nhs.uk

ECLIPSE-NHS Pathways

AstraZeneca CVRM dashboard- demonstration available on request

### Health Board Level

• Health Boards to ensure practice completion is verified via completion of a nationally agreed Poster shared at the collaborative meeting.

• Health Boards will collate the posters to allow thematic review at national level- this will additionally support the reporting of the national prescribing indicators for 2025, which will include SGLT2i prescribing on CKD.

## Verification and achievement

• Practices will need to prepare the nationally agreed QI Poster for sharing and discussion with the collaborative, and the LHB. Minutes of the collaborative meeting should also be shared as evidence of the discussion.

• A poster template and further guidance for completion will be circulated to practices by end of October 2025.

References


1. Health Economics and Outcome research Ltd report on behalf of Wales Kidney Network- (unpublished data) May 2024
2. UK Renal Registry (2023) UK Renal Registry 25th Annual Report – data to 31/12/2021, Bristol, UK. Available from https://ukkidney.org/audit-research/annual-report
3. https://www.kidneyresearchuk.org/wp-content/uploads/2023/06/Economics-of-Kidney-Disease-full-report_accessible.pdf last accessed 31/05/24
4. Primary care Information Portal, Wales. Data as of 28/05/2024
5. Primary care diabetes disease register Wales, Public Health Wales OCAT & CDSC
6. Go AS, Chertow GM, Fan D, et al. Chronic kidney disease and the risks of death, cardiovascular events, and hospitalization. N Engl J Med 2004.351:1296-305.
7. https://kcuk.cdn.ngo/media/documents/Lets_Talk_Kidneys_Report_January_2024.pdf last accessed 31/05/24
8. Overview | Chronic kidney disease: assessment and management/ng203 last accessed 31/05/24
9. Nuffield Department of Population Health Renal Studies Group; Lancet. 2022 Nov 19;400(10365):1788-1801.
10. McEwan P et al. Estimating the value of sodium-glucose cotransporter-2 inhibitors within the context of contemporary guidelines and the totality of evidence. Diabetes Obes Metab. 2023 Jul;25(7):1830-1838."

# "ANNEX E – QI PROJECT – IMPROVING CARDIOVASCULAR OUTCOMES

## Practice guidance for CVD Prevention in People with High Blood Pressure QI project.

2025-26

### Background

Cardiovascular disease (CVD) is one of the leading causes of death and disability in Wales and is a major contributor to health inequality. Chief Medical Officers across all UK nations advocate the beneficial effects of secondary prevention including risk-based advice and treatment of key CVD clinical risk factors. These key factors relate to **A**trial fibrillation, **B**lood pressure (hypertension), **C**holesterol, and **D**iabetes (**ABCD**). NICE guidance (NG136) recommend a holistic approach to CVD prevention which takes account of the person's life circumstances and includes support for healthy behaviours. Within this QI project, this approach is described as an **ABCD Plus** approach.

Supporting people to effectively manage their blood pressure through a range of approaches is an effective method for preventing adverse CVD outcomes. However, since the pandemic the task of identifying and treating hypertensive patients to target has become increasingly challenging.

GMS have a key role in the prevention agenda, as shown recently through the 2023/24 and 2024/25 Supporting Healthy Behaviours QI projects.

This project aims to support primary care clinicians, collaboratives/clusters, and Health Boards, to try new ways of ensuring patients with hypertension are registered and offered a holistic-person centred intervention. As appropriate, the intervention will include risk-based advice and treatment of key CVD clinical risk factors, healthy behaviours, and wider determinants.

### Aims

The **primary aim** of this QI project is to improve mortality and morbidity associated with cardiovascular events through the enhanced detection and management of cardiovascular risk factors within the target population.

The **secondary aim** is to support Practices/ GMS collaboratives/ Health Boards to develop and evaluate service improvement projects so that

learning from these interventions, can be shared and implemented by colleagues across Wales.

### Target Population

Any person who is recorded on their GP record as having hypertension AND their most recent blood pressure reading is ≥140/90 mmHg (people over 80 years ≥150/90 mmHg).

### Objectives

Contractors will be able to implement approaches to CVD prevention from a menu of options (see below) for people with high blood pressure by the end of the QI period 31st March 2026.

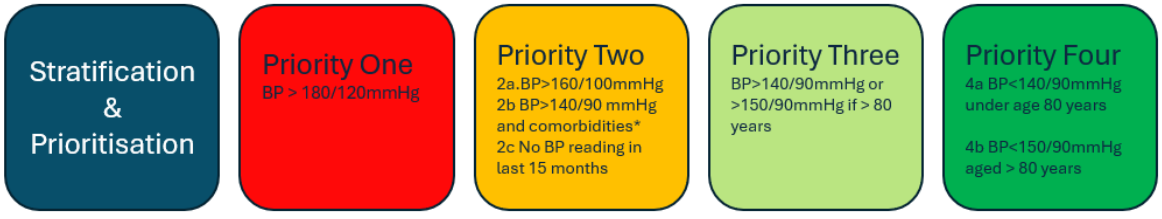
Practices will assess the impact of quality improvement projects undertaken, at the beginning and end of the QI cycle, by identifying and recording practice-level data, detailing the number of patients with high blood pressure who are treated to target.

### Menu of Options for Quality Improvement Project Activity

1. **Increased identification of new patients not currently on the hypertension register** with a latest (within the last 15 months) blood pressure reading ≥140/90 mmHg (80 years+ ≥150/90 mmHg), and review, further assess, and record on register if diagnosis of hypertension confirmed.

(You may wish to focus on high-risk patients as well as those from ethnic minority groups and those from the most deprived segments of the practice population).

2. **Review of current annual hypertension recall and prioritisation process for patients on the hypertension register** aiming to improve patient response and attendance rates at their Annual Review, across the patient population to reduce health inequalities. Identify patients at highest risk and invite them for review and optimisation.




UCL Partners: Stratification and Management of High Blood Pressure

| **1.** | *Co-morbidities/ risk factors |
|---|---|
| | • Established CVD (prior Stroke/TIA, heart disease, peripheral arterial disease)<br>• Diabetes<br>• eGFR <60<br>• Obesity with BMI > 35 |

3. **Enhancement of hypertension annual review**. Improvements in processes to treat and optimise CVD risk factors (**ABCD Plus**), including support for health behaviours, are to be actioned and recorded. This will require consideration of wider needs for people to engage e.g., culturally sensitive support, or difficulties being experienced e.g., in relation to housing, financial wellbeing, mental health etc.

   Within the Annual Review process follow an **ABCD Plus** approach (as described in the Background section above):

   i. Review hypertension medication, (taking into account polypharmacy and possible frailty).
   ii. Undertake manual pulse palpation to assess presence of atrial fibrillation.
   iii. Test for total and HDL cholesterol.
   iv. Test for HbA1C as per NICE Guidance: NG28
   v. Test for Urine albumin to creatinine ratio (ACR).
   vi. Measure and record patient's weight and height.
   vii. Assess CVD risk using appropriate tools such as QRISK and review and adjust CVD risk factor medication accordingly. (taking into account polypharmacy and possible frailty).
   viii. Discuss health behaviours and signpost to support if available.[a]

**Requirements of the QI Project**

**Practice Level:**

• Practices will have a named QI Project lead clinician.

• Practices will use practice hypertension read codes, to collate baseline data detailing the number of patients with high blood pressure who are treated to target.

**a** Further information to support practices in undertaking the project and suggested QI activity is available in the Public Health Wales guide: Supporting Healthy Behaviours: A Guide for General Practice.

• Practices will collect data before and after any interventions (e.g., Using IHI Quality Improvement Methodology and by using searches and share any learning (whether positive or negative) within their practice teams, collaborative/clusters and more widely.

• Practices will complete a nationally agreed QI Poster for sharing at the final collaborative meeting before 31/3/2026 confirming conclusion of the project and highlighting outcomes achieved.


• Practices to adopt a QI methodology, including:

o Review of baseline data

o Review of their processes

o Introduction of tested small cycles of change.

How to Improve | IHI - Institute for Healthcare Improvement

Dr Mike Evans: An Illustrated Look at Quality Improvement in Health Care (youtube.com)

• Practices to review progress at least quarterly.

• Practices will discuss their learning with their GMS collaborative. Minutes of this meeting should be submitted to health boards as confirmation that this discussion has taken place.

**GMS Collaborative Level**

• Practices to share aggregate practice-level data on the number of hypertensive patients treated to target.

• Practices to discuss accuracy of data and process for refinement.

• Discuss, share best practice, and consider adaptation of QI processes if applicable across collaborative.

• The GMS Collaborative lead should bring themes for discussion to the wider cluster professionals e.g., identification of hypertensive patients, uptake variation of Annual Reviews

• The GMS Collaborative or Cluster may consider introducing collaborative/cluster initiatives to benefit the delivery of improved interventions in identified behaviours.

• The GMS Collaborative or Cluster should escalate deficiencies in systems/services or suggestions for system-wide improvement to Pan Cluster Planning Group for consideration of improved commissioning or inclusion in IMTP process.

**DHCW Level**

• A definitive data specification will be provided to DHCW to enable them to support the selection of agreed read codes and creation of a minimum data set.

• DHCW will support either a solution via dataset & business rules for each GP system supplier to implement; or make available pre-authored searches to enable Practices to undertake their own local searches.

• Develop a PCIP tile for displaying required data and for practice upload of project materials for verification purposes.

**Health Board Level**

• Health Boards to ensure practice completion is verified against agreed indicators/contractual agreement via completion of a nationally agreed Poster shared at the collaborative meeting.

• Health Boards will collate the posters to allow thematic review at national level

**Verification and achievement**

**Practices:**

• Practices will need to demonstrate achievement of one or more of the options listed in the Menu of Options for Quality Improvement Activity, by 31st March 2026, by completion of the nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB. Minutes of the collaborative meeting should also be shared as evidence of the discussion.

• The contractor should ensure that the poster details both pre and post intervention data relating to hypertensive patients treated to target.

• The contractor should ensure that the poster states where the QI activity has resulted improved outcomes.

• A poster template and further guidance for completion will be circulated to practices by end of October 2025.

**LHB:**

• LHBs will be required to verify that practices have undertaken one or more of the options listed in the Menu of Options for Quality Improvement to confirm achievement and award payment.

• This will be done by reviewing each individual practice’s nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB by 31st March 2026.”

# "ANNEX F – QI PROJECT – CONTINUITY OF CARE

## Continuity of Care Quality Improvement Project
## GMS Quality Improvement Framework 2025/26

### Aims

The aim of the continuity of care project is to enhance quality assurance processes by highlighting the importance of relational continuity in practice as a marker of high-quality care. Practices will be asked to use Quality Improvement methodology to inform adaptations to strengthen continuity of care and to report progress to collaboratives and health boards. This will be a 5-year Quality Improvement Project with a review by the GMS Quality Committee in the 3rd year to establish whether it continues into years 4 and 5. The purpose of this project is to refocus and educate practice staff about the benefits of continuity of care and then understand how to implement lasting positive changes for their individual patient populations.

### Specific Objectives

1. **Improve Clinical Outcomes:** Improve patient and carer experience, increase uptake of preventive interventions and reduce preventable morbidity and mortality by enhancing relational Continuity of Care, focusing on value-based healthcare approaches.
2. **Address Health Inequalities:** Prioritize relational continuity for vulnerable populations, including those with complex needs, to reduce disparities in healthcare access and outcomes.
3. **Enhance Practice Operations:** Embed relationship-based care into workflows by adapting appointment and triage systems, extending consultations for complex cases, and leveraging IT infrastructure to support continuity.
4. **Support Strategic Alignment and Evaluation:** Encourage GP practices, clusters, and health boards to measure continuity of care as a key enabler of Welsh Government strategies such as Prudent Healthcare, Value-Based Healthcare, and NHS Sustainability.

### Background

Continuity in primary care literature is mainly viewed as the relationship between a single practitioner and a patient, that extends beyond specific episodes of illness or disease. For the purposes of this project, we will be focusing on the relationship between a patient and their GP within an individual General Practice setting. Continuity is different from coordination of care, although better coordination follows from continuity. It is often believed that to achieve continuity a trade-off is required with the accessibility of healthcare providers. However, recent research (Kajaria-Montag et al., 2022) reveals that increased GP continuity is significantly associated with the reduction of requests for

appointments. Demand can be reduced though GP continuity. There are some high continuity general practices in the UK where there is no trade-off.
Two themes distinguish continuity from other healthcare attributes - these elements are care of an individual patient and care delivered over time. Both elements must be present for continuity to exist, but their presence alone is not sufficient to constitute continuity.
Continuity is not an attribute of providers or organisations. Continuity is how individual patients experience integration of services and coordination. Many measures focus on chronological patterns of care without directly measuring experienced continuity or those aspects of care that translate into connected and coherent care (https://pmc.ncbi.nlm.nih.gov/articles/PMC274066/, n.d.) This concept is crucial for ensuring high-quality care and better patient health outcomes.
Patient outcomes are enhanced by the development of trust, mutual respect and co-production with their clinician. It leads to a better understanding of the patient's ideas, expectations, family circumstances and community structure in which the patient is living. This ultimately gives the opportunity for a therapeutic relationship to flourish enhancing the overall patient experience. GP continuity leads to a progressive increase in the mutual trust between a patient and their GP (Mainous et al., 2001). All qualified doctors receive a basic level of trust from patients, but the deeper level of trust has to be earned, and continuity is the single commonest way in which this occurs.

When considering continuity of care there is always a complicated interplay between the finite resources and capacity the individual surgery has to offer; versus the demands, needs and access requirements of the specific demographics of patients they serve. Access is challenging at the best of times and prioritisation of services is complex. Whilst maintaining good access to healthcare is a founding principle of the NHS, a singular focus on improving speed of access to a workforce with finite capacity can have unintended negative consequences of deprioritising continuity of care. The purpose of this project is to refocus and educate practice staff about the benefits of continuity of care and then understand how to implement lasting positive changes for their individual patient populations.

A key aspect of Professional Collaborative and Cluster working is to support GP practice teams to identify changes that can be implemented in wider health board systems that will increase access, enhance patient experience and improve job satisfaction for GP teams.

## The Evidence Base

The evidence base underpinning the importance and value of continuity of care between a patient and their GP is substantial. This is a summary of the benefits of Continuity of Care, provided by the team at St Leonards Research Practice in Exeter (https://www.continuitycounts.com/).

1. **Better patient satisfaction**

- Several studies show that more continuity of doctor care is significantly associated with better patient satisfaction. (Fan et al., 2005; Adler, Vasiliadis and Bickell, 2010)

2. **Developing trust between patients and their GPs**

- Continuity of care GP care is associated with patients developing trust in a doctor they get to know. This reduces anxiety and provides a sense of security. (Mainous et al., 2001; von Bültzingslöwen et al., 2006)

3. **Adherence to medical advice and prescribed medication**

- Patients follow medical advice significantly more when they have continuity with their GP. The trust that develops through a good GP- patient relationship ensures more effective treatment and less waste (Youens et al., 2021) Continuity of GP care is associated with significantly better adherence by patients. (Dossa et al., 2017)

4. **Uptake of personal preventive medicine**

- Continuity of GP care is associated with significantly better uptake of personal preventive medical advice. (O'Malley et al., 1997; Christakis et al., 2000)

5. **Better quality of GP care**

- GPs with continuity identified more patients needing statins. (Youens et al., 2021) GPs made better, life-saving decisions with suspected meningitis when they knew the child and family.(Granier et al., 1998). Patients with dementia with GP continuity have reductions of delirium and incontinence, and fewer hospital admissions. (Delgado et al., 2022)

6. **Patients forgiving GPs after moderate mistakes**

- All human beings make mistakes. Lings et al. (Lings et al., 2003) found that patients who have received good continuity of care previously will forgive GPs who make moderate mistakes, with implications for time spent on complaints and litigation.

7. **Reduced collusion of anonymity**

- Clarity of responsibility and continuity reduces the risk of patients becoming lost between clinicians. (Freeman and Hughes 2010)

8. **Reduction in workload in practices**

- Patients consulting their regular GP reconsult after a significantly longer interval than if they consult another GP. The Cambridge Business School estimates that for patients with ≥4 consultations in 2 years, GP continuity could save 5.2% of GP appointments. (KajariaMontag., et al 2022)

9. **Lower rate of attendances at emergency departments**

- Patients receiving GP continuity of care are significantly less likely to attend accident and emergency departments. (Kohnke and Zielinski, 2017; Ride et al., 2019)

10. **Fewer admissions to hospital**

- In Canada (Menec et al., 2006) and in the UK (Barker et al., 2017) many studies have shown that patients with good continuity of GP care are significantly less likely to be admitted to hospital, particularly for older patients with ambulatory care sensitive conditions. Hospital admissions are one of the most expensive NHS costs.

**11. Lower costs in whole health systems**

- Good continuity of GP care was associated with lower costs across the whole health system. (De Maeseneer, 2003; Bazemore et al., 2018)

**12. Lower death rate in patients**

- Two systematic reviews show that better continuity of GP care is associated with a lower death rate in patients. (Pereira Gray et al., 2018; Baker et al., 2020) A dose-response relationship, which adds considerable scientific weight to the findings, has been shown between continuity and mortality. (Sandvik et al., 2021)

As the evidence base is almost exclusively for relational continuity between a GP and their patient, this QIF project will only focus on that relationship rather than the wider multidisciplinary team. At present there is a lack of evidence that the same benefits accrue with other health professionals (Sidaway-Lee et al., 2024). However, we anticipate that by improving continuity of care between a patient and their GP, the whole multidisciplinary team will benefit.

**<u>Areas for Quality Improvement Project Activity</u>**

Practices that have high rates of continuity of care have systems that seek to maintain continuity of care for their whole population. This maximises the benefits to their patients and to their own practices.

However, as a practice you may feel that establishing continuity of care for your whole population is unachievable for you, so you may wish to focus on individuals who benefit most from relational continuity of care, for example:

- Individuals with significant mental health challenges
    - Approximately 1 in 4 adults in Wales experience mental health challenges annually
- Vulnerable people – including homeless people, asylum seekers and refugees, individuals discharged from the criminal justice system
- Older adults with frailty
    - Wales has a higher proportion of older adults compared to other UK nations, with 21.3% of the population aged 65 or older (compared to 18.6% in England)
- Patients with complex long-term conditions or multiple morbidities
    - An estimated 33% of Welsh adults live with at least one long-term condition, and 12% have multiple chronic conditions
- Populations living in socio-economically deprived areas
    - Wales experiences significant socio-economic disparity
    - These communities face higher rates of chronic illness, lower life expectancy and significantly lower healthy life expectancy

This approach to prioritising continuity for those with the greatest needs has been described as ‘proportionate continuity’. Burden of disease projections in Wales show that all of this is projected to grow over the next 20 years; finding

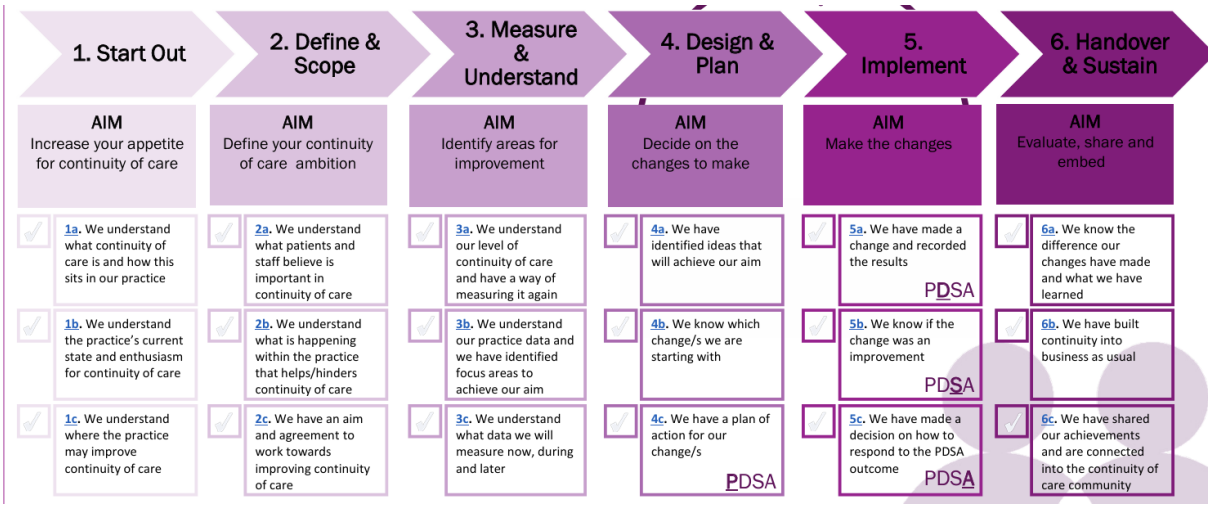
effective ways to support these groups of patients is key to long term NHS sustainability. By focusing on these demographic characteristics, the QI project will ensure that practices are clear what actions are needed to ensure relational continuity reaches those with the most to gain, addressing their unique healthcare needs while promoting equity and sustainability in general practice. However, this approach may not realise all the potential benefits for your practice that Continuity of Care can bring.

## The RCGP Continuity of Care Toolkit

RCGP has developed a toolkit with extensive resources that practices can use to educate staff and patients about continuity of care (https://elearning.rcgp.org.uk/mod/book/view.php?id=12895). The toolkit supports practices to investigate their population and practice needs, then develop a plan to make positive changes and evaluate the outcomes. The toolkit is free to access and covers a wide range of tools from patient surveys through to process mapping tools.

### Continuity of Care Quality Improvement Project Year 1

In year 1 each practice should use the step-by-step process to evaluate their current standing and then look at steps to improve. As this is a 5-year QI Project we would expect practices to have achieved a minimum of stage 3a by the end of the first year.




There are several ways to measure continuity of care within practices, including the Usual Provider of Care (UPC), St Leonard's Index of Continuity of Care (SLICC) and the modified SLICC. Due to the imminent switch to SNOMED and the ongoing process of practice migrations to EMIS, we have been unable to provide a robust set of templates and tools to measure continuity of care for all practices. We will be working with DHCW to develop these resources in time for

practices to move into year 2 and complete their first PDSA cycle with measurements of Continuity of Care.

**We therefore recognise that the first year of the QI initiative will be one of research, preparation, and education of patients and staff.**

This broad approach allows each practice to develop quality improvement projects that are unique to their situation rather than being too prescriptive. However, for those practices that require more support or focus, a menu of project options is attached at Appendix 1

**Practice Level requirement of the QI Project**

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- Practices will have a named QI Project lead clinician.
- There is access within the practice to the RCGP Continuity of care tool kit..
- There is 'whole practice' sign up to continuity principles and application.
- Educational needs of staff and patients are addressed to explain the rationale that continuity is at least as important as access.
- Practices will review internally monthly.
- Practices will discuss progress with their collaborative quarterly.
- Practices will work through the  key areas described above.
- There is explicit acknowledgement that any benefits will take around two years to manifest in terms of improved outcomes, reduced practice workload etc, and will be proportional to the scale of the improvement.
- Practices will complete a nationally agreed QI Poster for sharing at the final collaborative meeting before 31/3/2026 summarising progression of the project.

**Collaborative Level**

- Practices to share aggregate practice-level data.
- Discuss, share best practice, and consider adaptation of QI processes across collaborative.
- The Collaborative lead should bring themes for discussion to the wider cluster professionals.
- The Collaborative should consider introducing collaborative initiatives to benefit the delivery of improved interventions in identified behaviours.
- The Collaborative should escalate suggestions for system-wide improvement to Pan Cluster Planning Group for consideration of improved commissioning or inclusion in IMTP process.

**Health Board Level**

- Health Boards to ensure practice completion is verified against agreed indicators via completion of a nationally agreed poster template at the end of year 1.

- Health Boards will collate outcomes to allow thematic review at a national level at the end of each year of the project.

**DHCW Level**

- Develop a PCIP tile for displaying required data and for practice upload of project materials for verification purposes
- Develop templates and digital tools to assist practices in the measurement of mSLICC

## References and Further Reading


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# Appendix 1

**Suggestions for Quality Improvement projects**
**Objectives and Targets for Quality Improvement over the 6 key areas**

Note these are aimed to be suggestions and are not prescriptive. They detail projects for a full PDSA cycle and not what would be expected within Year 1 of the project. It is only included due to previous requests for guidance on the types of projects to be undertaken in previous QI cycles. There are plenty of suggestions via the RCGP toolkit on improving continuity of care. We would recommend that practices set realistic timeframes and specific goals to suit the needs of their staff and patients. The outcomes need to be demonstratable to be able to share at cluster and health board level. Tools are provided to support this via the RCGP toolkit.

**<u>Define Continuity goals and Demographics</u>**

- **Objective:**
- Set practice-specific continuity goals tailored to demographic data
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- **Sample plan:**

- Set up personal patient lists or identify one or more high-priority patient cohorts (e.g., frail elderly, socio-economically deprived) – 3 months
- Set improvement target to raise the mSLICC for these groups
- Reassess mSLICC, reflect on any changes and plan for next intervention.

**Measure and understand improvement measures**

- **Objective:**
- Use metrics to benchmark and track continuity improvements

**Sample plan::**

- Establish baseline data for the mSLICC
- Establish baseline patient satisfaction
- Set improvement target to raise the mSLICC
- Reassess to monitor change in mSLICC and patient satisfaction within 12 months
- Critically evaluate findings and create plan for the following 12 months

**Design options for Continuity and Plan Implementation**

- **Objective:**
- Implement operational changes to enhance continuity of care using PDSA cycle
- **Sample Plan:**
- Assess baseline staff and patient satisfaction
- Adopt new interventions (e.g., micro-teams, continuity-focused triage systems)
- Reassess baseline staff and patient satisfaction and analyse
- Critically evaluate findings and create plan for the following 12 months

**Implement Changes, Study Results and Act**

**Objective:**

- Evaluate the effectiveness of interventions to reduce hospital admissions for ambulatory care-sensitive conditions using PDSA cycle

**Sample plan::**

- Assess baseline rate hospital admission in target cohort
- Adopt new interventions
- Assess hospital admission rate in 6,12- and 18-months' time
- Publish a report on outcomes and lessons learned
- Ensure effective changes are embedded into routine practice
- Create practice plan for the following 12 months

## Appendix 2

Resources for practices wanting to learn more about continuity of care, its benefits and implementation. Includes patient information leaflets and guides to improvement and adoption.

https://www.continuitycounts.com

https://elearning.rcgp.org.uk/mod/book/view.php?id=12895”

# "ANNEX J – AMENDMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(x) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2019 which were made on 30 September 2019;

(y) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2019 which were made on 14 October 2019;

(z) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2020 which were made on 24 March 2020;

(aa) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2020 which were made on 22 June 2020;

(bb) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2020 which were made on 15 July 2020;

(cc) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2020 which were made on 16 September 2020;

(dd) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2020 which were made on 2 November 2020;

(ee) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2021 which were made on 19 April 2021;

(ff) The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2021 which were made on 31 August 2021;

(gg) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.3) Directions 2021 which were made on 1 December 2021;

(hh) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2022 which were made on 29 March 2022;

(ii) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2022 which were made on 8 June 2022;

(jj) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2022 which were made on 4 November 2022;

(kk) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2023 which were made on 29 November 2023;

(ll) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2023 which were made on 20 February 2023;

(mm) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2023 which were made on 29 March 2023;

(nn) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2023 which were made on 3 August 2023;

(oo) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2024 which were made on 8 February 2024;

(pp) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2024 which were made on 18 April 2024;

(qq) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.3) Directions 2024 which were made on 10 October 2024;

(rr) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2024 which were made on 26 November 2024;

(ss) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2025 which were made on 6 February 2025; and

(tt) Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.2) Directions 2025 which were made on 22 April 2025."