nGMS & PMS Contract Action Planner Update

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SECTION 1

The Quality & Outcome Framework (QOF) Annual Visit – Brief Details

- This will take place between 01/10/04 and 31/01/05 for all practices. A team comprising of a doctor (or other clinician where agreed by the practice), a lay member and members of the PCO managerial team will visit each practice to assess progress against the QOF aspirational targets, and statutory contractual duties. In some PCO areas this will be combined with annual PMS contractual review meetings and clinical governance visits where mutually agreed.

- In the first year this visit and assessment process will be highly formative and gives both PCO and practice opportunities to discuss issues arising from the QOF, data quality and the operation of QMAS (the NHS IM&T tool that will calculate QOF points and payments - see below). It is likely the QOF, exception reporting and the operation of QMAS will throw up many uncertainties and this visit will provide the forum to address these.

- The PCO will on the visit be trying to establish some hard data:

1. Compliance with statutory contractual requirements e.g. presence of and content of practice leaflet, vaccine storage procedures, gift registers. Check all these in the text of nGMS and nPMS contracts. These should be demonstrated to be in place at the time of the visit.

2. Progress against QOF to ensure the practice is on track to achieve the points aspired to at the end of March 2005. It is hoped QMAS will be able to provide some data for this visit. For the organisational domain evidence of policies, procedures and systems will be scrutinised and these will need to be provided in advance to the PCO. Remember though none of the clinical data and organisational data needs to be complete at the time of the QOF visit for the sake of payments but will need to be by 31/03/2005. The PCO will though, look for satisfactory progress and will be able to advise if the evidence provided is adequate. Where there are concerns the PCO may review the practice again later in more detail.

SECTION 2

Checklist of Top Tips to Help Prepare for a QOF Visit

1. Look in the nGMS supplementary documents to see what evidence is required to support each element of the QOF especially the organisational domains and compile all this in a folder (paper or electronic). ☐

2. For clinical domains compare your own in house software data with that produced by QMAS-check the points tally and look for possible reasons if they don't match. Check you are using the right READ Codes and check QMAS is interacting correctly with your system. ☐

3. Send pre visit data to the PCO in an organised form - explain any gaps and give timetables/ targets for providing extra information. Explain progress towards targets. ☐

4. Hold a staff meeting to explain the QOF and QOF visit to ALL staff and where they will find policies etc. Remember the QOF assessors may well check that your staff know the detail of a policy and where to find it. ☐

5. Run a dummy visit in house before the PCO visit using an informed partner or another practice manager to play the role of the QOF assessor. This person should ask for evidence to support QOF claims in each domain. ☐

6. Be sure you have a robust policy and procedure for exception coding and be prepared to justify each code. ☐

SECTION 2

Checklist of Top Tips to Help Prepare for a QOF Visit (continued)

7. Prepare a list of queries/problems to the PCO and ASK THEM at the visit. Don't fudge problems with the QOF – address them – it is the first year and both PCO and practice will need to learn from each other. ☐
8. Don't forget to address the statutory contractual details - the PCO will be checking these - have you a gift register? ☐
9. Agree in advance with the PCO how you will protect confidentiality of patients at the visit – patient sensitive information should be anonymised wherever possible - seek guidance from your LMC or better still get them to agree a local policy with the PCO. ☐
10. Agree who will represent the practice on the visit - you need to appear informed, credible, professional and honest. Have all the data ready and accessible - PCOs love evidence of good systems! ☐
11. Never be dishonest! – this could bring in the NHS antifraud squad or result in referral to the GMC. The PCO will compare your data with other practices and look at where you deviate from this. If they are suspicious they may come back later and look in more detail. ☐

SECTION 3

Checklist of Top Tips for Managing the QOF

1. Ensure you have valid electronic disease registers. Wrongly diagnosed and thus untreated patients will count against your % achievement; undiagnosed patients will mean missing out on prevalence adjustments. ☐
2. Identify individual patients reporting against multiple indicators and targets overlapping CHD, Diabetes, Stroke/TIA and Hypertension disease areas. Don't recall them separately for each domain if possible. ☐
3. Measure and record all relevant information about a patient in one visit; using templates, reminders etc to make sure you don't miss anything. ☐
4. Make good use of IT tools including add on management and planning tools such as 'Contract Manager'. ☐
5. Assign QOF areas to each of the clinical team to become specialists. ☐
6. Annual patient reviews conducted between January and March each year will count towards 2 years' points calculation as the criteria often look back 15 months from the financial year-end reference date. ☐
7. Put your practice manager on performance related pay for delivering QOF, especially the non-clinical areas. ☐
8. Make a record of evidence supporting organisational markers met, to facilitate future PCO visits. ☐
9. Make sure you understand and have processes in place for all the practice team to record correct QOF friendly READ codes into notes. ☐
10. Be careful and prudent with 'exception' READ codes: understand how and when they should be used and have a system to justify them. ☐

SECTION 4

What is the Quality Management Analysis System (QMAS) – Brief Details

- This is a central NHS software tool that will calculate payments for the QOF. It will be crucial in determining the clinical points that attract payments. Data from the organisational domain will need to be entered manually by the practice but the clinical points will be calculated by the QMAS software from your clinical system.
- This will be totally anonymised. QMAS will only respond to and authorise payment against certain READ codes - wrong code – no points = no prizes!
- It is not certain when QMAS will be able to fully interrogate practice systems but is already working with some practice IT software systems eg (EMIS). Our experts will be producing a detailed update on QMAS in November.
- It will be able to assess progress towards aspirational targets and give monthly returns to practices and PCOs.
- It will also be used to calculate disease prevalence and compare data from practices and PCOs.
- QMAS has a training site available only on NHS net at nww.qmastraining.nhs.uk - make sure key members of your staff are accessing this and keeping up to date with QMAS progress.

SECTION 5

What nGMS Means to PMS Practices

- PMS practices are entitled to all the benefits of the new GMS Contract of rights but have to sign up to most of the new contractual issues by October 2004. If they don't agree – these will be imposed anyway (ref: PMS regulations).
- PMS will continue for now as a permanent local alternative to GMS – there will be no more central incentives to join but all old growth monies are built into the PMS baseline. If PMS practices choose to return to GMS, they are not automatically entitled to keep this growth. They have to negotiate with their PCO who can claim it back!
- PMS practices can locally vary their QOF with the PCO but it must be "broadly comparable". 174 points are deducted in 2004-2005 and 126 in 2005 from PMS quality achievements to reflect those quality elements in their baseline now rewarded in the QOF.

- Specialist PMS - Allows for PMS practices to be established to provide a range of enhanced, additional and specialised services without essential services. These can be limited companies or health trusts but private companies are effectively excluded (although they can provide all these services as APMS).
- Practice Led Commissioning – This will be available as a voluntary option for all practices – not just PMS – and guidance is expected soon. PCOs will be encouraged to establish indicative budgets at practice or locality level for community care, secondary care and prescribing and develop incentives against them. Legal responsibility for the budget and contracting would remain with PCOs – so this is not fund holding revisited!
- The NHS plan guarantees that a practice will receive an indicative budget by 01/04/05 if they request one from the PCO. Incentive schemes etc will all need to be agreed locally and may differ.

SECTION 6

Summary Timetable & Action Planner for Practices

- **September 2004** - PMS compulsory contract variations to be signed off or they will be imposed. Practices to be prepared for QOF visit with queries, data quality issues, etc and check QMAS is functional.
- **October 2004** - QOF inspection visits commence. Practices to start liaising with PCOs over enhanced services for 2005/2006 year and preparing business plans for these.
- **January 2005** - All practices can cede responsibility to PCO for out-of-hours where they have given suitable notice.
- **January to March 2005** - Golden Quarter for data recording for practices in QOF where this counts for two years for all annual reviews.
- **February 2005** - National Prevalence Day for calculating prevalence rates for QOF clinical domains.
- **March 2005** - End of first year of QOF for data recording. PCOs will need to justify spend against enhanced services floor.
- **April 2005** - QOF quality points value increased by 60% to average figure of £120.
- **April 2005** - Final data audit by PCOs on QOF. Final payment to practices to be made by June 2005.
- **April 2005** - Practice led commissioning begins where agreed between practices and PCOs.

SECTION 7

A Reminder of the nGMS Contract Details

- From April 2004 this is a contract between the PCO, LHB or Health Board and the practice, rather than the individual GPs. Practices will need to amend their partnership agreements to cover this and other aspects of the new contract, in particular quality pay.

- The contract defines three levels of GP services:

Essential Services - The ongoing care of those who are ill, with illnesses or symptoms of illness and terminal care which all GMS practices will provide.

Additional Services - Services for which practices have preferential provider status unless they choose to opt out of providing them. Realistically most practices will provide them. These cover:

- Cervical screening
- Contraception
- Child health surveillance
- Ante and post natal maternity care
- Basic minor surgery (cryotherapy, simple excisions)
- Adult and childhood immunisations (excluding influenza)

If practices permanently opt out from providing these services they lose funding from the global sum and their preferred provider status for providing them in future.

Enhanced Services - These cover services delivered to a higher standard or extra services provided by practices and normally require special equipment or skills. Practices do not have preferred provider status for any of these except access, quality information preparation and childhood immunisation. The three separate types are:

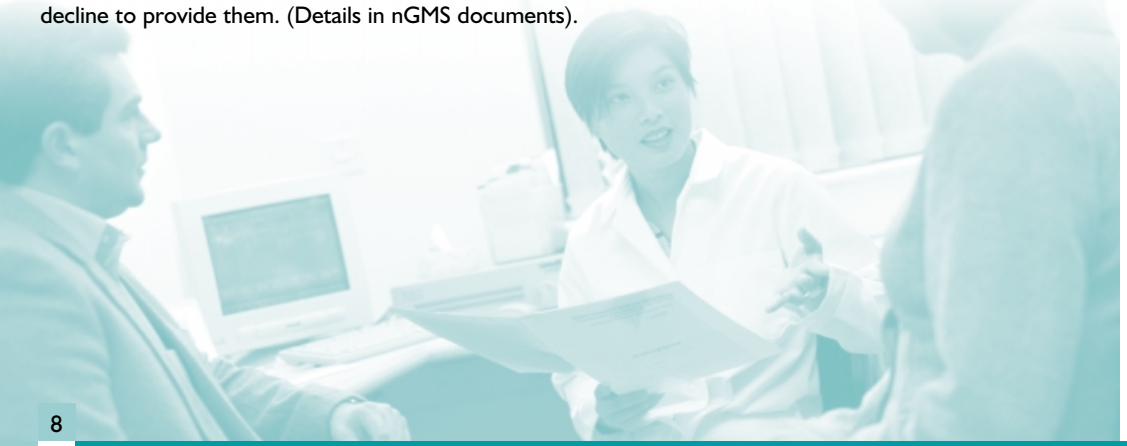
A Directed Enhanced Services

These must be commissioned by PCOs but with the exception of those mentioned above not necessarily from practices. They comprise:

- Violent patients
- Advanced minor surgery
- Access
- Quality information preparation (2003-2005 only)
- Childhood immunisation
- Influenza vaccination

B National Enhanced Services

These are services commonly provided by practices for which national benchmark specifications and pricing have been developed. PCOs are free to deviate from these pricings but practices are free to decline to provide them. (Details in nGMS documents).



C Local Enhanced Services

These are contracts negotiated locally between PCOs and local providers, which can include practices but also include PCOMS (PCO Medical Services) or Alternative Providers of Medical Services (APMS).

Where practices are not funded to provide enhanced services, they can cease to provide them but are advised to give adequate notice and discuss this with their local LMC and PCO.

Seniority - This has been enhanced for GP practices that need to decide and inform PCOs whether they wish to allocate this individually or on a shared practice basis.

Superannuation - This has been improved and all NHS income, including working for accredited OOH providers and PCOs, is superannuable. This is now allocated on practice profits and practices will need to ensure expenses do not erode their superannuable income. Advice from a specialist medical accountant is vital.

Legal Status - All GMS and PMS practices can choose to be health service bodies or private contractors. The latter appear to have all the benefits of the former but retain their right to take legal action against their PCO. Therefore, private contractor status may be the preferred option.

OOH Opt Outs - All practices can opt out of Out-of-Hours from January 2005 provided they have given their PCO nine months notice of their intention. At 6% of global sum per GP and with most practices on MPIG, this price will ensure most practices opt out. For PMS practices the cost is around £6,000 per GP. (£3.31 per patient). Those continuing to provide OOH will be paid as a special additional service but must meet rigorous quality standards.

Funding Streams - Most of previous GMS funding is now included in the global sum payment with the exception of:

- Premises funding
- Dispensing
- IM&T funding
- Geographical payments
- Retainers/flexible career scheme
- Maternity/flexible career scheme
- Golden hellos

Some payments for quality are now represented in the QOF, eg, chronic disease management pay.

The Carr Hill Formula - This was designed to redistribute funding to primary care on a needs-based formula. When applied to practice budgets it seemed to give most practices less funding than they had received previously so was replaced by the MPIG (Minimum Practice Income Guarantee), which guaranteed practices their previous income (as per a PMS baseline). The formula is due to be reviewed in 2006 but the MPIG and PMS have effectively prevented any redistribution of resources from historical baselines. Approximately 90% of GMS practices will be on the MPIG payment method from April 2004.

PCO Primary Care Allocations - All previously centrally held non-cash limited GMS monies are now locally cash limited in each PCO's primary care baseline allocation - which includes PMS baseline and growth monies. Thus practices will need to agree with their PCO all allocations of monies not included in their global sum or baseline.

Premises Funding - New monies for premises have been allocated to a lead PCO in each SHA area. PCOs have to agree amongst themselves the distribution of such monies. These monies can be used to cover new flexibilities, eg, GP premises, as detailed in the contract documents but realistically these will be seriously restrained by cost.

The Quality and Outcome Framework (QOF) - This represents the major new reliable income stream for most practices. It is applicable to both GMS and PMS although can be varied locally for PMS. Practices can achieve points to a maximum of 1050. If verified by the PCO as accurate, the practice is legally entitled to these payments. The domain areas are detailed below with appropriate points values. Points are worth on average £75 during the first year (2004-2005) of the contract. This is based on an average practice list size of 5981 patients. This average figure rises to £120 in 2005-2006. Prevalence of disease will have a significant impact on this value for each clinical area. This will be measured on National Prevalence Day - the 14th February each year, and will feed into revising points values up or down.

The practice will receive 33% of their aspiration total in advance in monthly payments during year one 2004-2005. In year two 2005-2006 the practice will receive 60% of their previous year's achievement similarly in advance.

How QOF Achievements are Calculated and Reported

The QOF indicators or searches follow the Logical Query Indicator Specification defined by the National Programme for IT. These are followed by the GP clinical software suppliers detailing timescales and READ codes needed to record data in the GP clinical system. The achievement for each indicator (eg, number of people with blood pressures recorded in last 15 months out of eligible diabetic population) will be sent automatically to a central software package called QMAS (Quality Management and Analysis System). QMAS will allow practices to assess their current achievement compared to their aspirations and, later on, to compare their current position with other practices in the PCO. QMAS provides this data to the PCO to verify achievement and also links to the NHAIS 'Exeter' payment system.

Domains

Clinical (550)

CHD including LVD (121)
Stroke/TIA (31)
Asthma (72)
Epilepsy (16)
Hypothyroidism (8)
Diabetes (99)
Hypertension (105)
COPD (45)
Mental Health (41)
Cancer (12)

Organisational (184)

Records and Information (85)
Practice Management (20)
Patient Communication (8)
Medicines Management (42)
Education and Training (29)

Additional Services (36)
Holistic Care (100)
Patient Experience (100)
Quality Practice points (30)
Access Bonus (50)

NOTES