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4 December 2012

FILE REF: **SHA/16924**

PRIMARY CARE TRUST: **South Staffordshire PCT (the "PCT")**

GMS PROVIDER: **Dr Dickson, Dr Shipman, Dr Law, Dr Baldock-Grimes and Dr Hallam of Wetmore Surgery (the "Applicant")**

DISPUTE RESOLUTION: **NATIONAL HEALTH SERVICE (GENERAL MEDICAL SERVICES CONTRACTS) REGULATIONS 2004**

RE: ALLOCATION OF QUALITY AND OUTCOMES FRAMEWORK POINTS

1. **Introduction**

1.1 The above named Applicant has referred the dispute in relation to the Contract for dispute resolution under the provision of paragraph 101 of Schedule 6 of the National Health Service (General Medical Services Contracts) Regulations 2004 (the "Regulations").

1.2 On behalf of the Secretary of State for Health, the NHS Litigation Authority is directed to exercise the functions of dispute resolution, which is undertaken within the Authority's Family Health Services Appeal Unit. I, as an authorised officer of the NHS Litigation Authority, have made this determination.

2. **Application for Dispute Resolution**

2.1 By letter dated 27 July 2012, the Applicant applied to the FHS Appeal Unit of the NHS Litigation Authority, for dispute resolution of the above issue (the "**Application**").

2.2 I have had regard to the following documents made available to me in consideration of this matter:

2.2.1 the Application together with enclosures;

2.2.2 letter from the PCT to the Authority received by the Authority on 16 August 2012 (the "**PCT Representations**");

2.2.3 letter from the Applicant dated 6 August 2012 with enclosed copy of the Contract;

2.2.4 Quality and Outcomes Framework Guidance for GMS Contract 2011/12 (the "**Guidance**");

2.2.5 QOF Quality and Productivity (QP) Indicators Supplementary Guidance and Frequently Asked Questions for PCTs and Practices in England (the "**Supplementary Guidance**").

2.3 The Applicant wishes to challenge the non-award of points for Quality and Outcomes Framework indicators QP6 and QP7 for the year 2011/12.

3. **Consideration**

3.1 The Applicant is a party to a General Medical Services Contract (the "**Contract**") to

provide primary medical services at the Wetmore Road Surgery. I have been provided with a copy of the Contract dated 1 April 2012 however, this appears to be a variation of an existing General Medical Services Contract. The parties do not dispute that there was a contract in place for the year 2010/11 to which this dispute relates. Under the Contract the Applicant has the option to participate in the Quality and Outcomes Framework ("**QOF**") under the Statement of Financial Entitlements.

3.2 The Applicant is disputing the PCT's decision not to award the Applicant points in respect of indicators QP6 and QP7 of the Quality and Productivity sub-domain of the Organisational Domain of QOF.

3.3 QP6 and QP7 are as follows:

> ***QP6***
>
> *The Practice meets internally to review the data on secondary care outpatient referrals provided by the PCO.*
>
> ***QP7***
>
> *The Practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO.*

3.4 As part of the PCT's reporting for QOF indicators, the Applicant was required to complete the South Staffordshire PCT Quality and Productivity QOF Indicators 2011/12 Report Template (the "**Template**"). This Template was agreed following a GPCC meeting on the 11 May 2011 between five consortia representatives and Jim Barlow and Mark Seaton of the PCT. During this meeting it was agreed that the PCT would "*produce templates for practices to complete at the various dates and provide information re for example what constitutes a peer review*".

3.5 Although the PCT provided practices with the Template, I have not been provided with any supporting guidance or assessment criteria that the PCT applied in respect of the submissions made by practices. The Template required the practices to identify three anomalies in the data and three areas of improvement for QP6 and three anomalies compared to peer practices/the PCT practice and three areas for proposed commissioning of service design improvements for QP7. Other than the notes from the GPCC meeting, I have not been provided with any evidence of agreement by the practices in the PCT's area to the use of the Template.

3.6 The Applicant completed the Template for QP6 and QP7 and returned it to the PCT on 17 October 2011 (the "**First Submission**"). On the 9 November 2011 the Applicant received an email from Michelle Escombe of the PCT suggesting improvements to the information submitted in the First Submission.

3.7 On the 29 March 2012 the Applicant submitted its final evidence for the QP indicators. On the 2 April 2012 the PCT emailed all practices to confirm that final information had been received and that further requests for information may be made in the following days. On the 3 April 2012 the PCT emailed the Applicant requesting further information. This email made clear that the Applicant needed to identify three anomalies in order to achieve QP6. A revised version of the Template was submitted by the Applicant to the PCT on 9 April 2012 (the "**Second Submission**").

3.8 On 12 April 2012 the PCT emailed the Applicant to inform them that the Second Submission was not sufficient. This was followed by an email on the 13 April 2012 setting out further detail informing the Applicant that QP6 and QP7 had not been approved. The reasons for the Applicant not achieving these indicators were that the Applicant had not highlighted three areas for improvement in its submissions. The PCT also stated that the Applicant had not been able to achieve QP7 as it had not identified anomalies in QP6 so could not discuss these in the external meeting.

3.9 The Applicant appealed the decision of the PCT in May 2012 (the "**First Appeal**"). This appeal was conducted by a panel consisting of Jim Barlow, Assistant Director of Primary Care; Sue Wilson, Clinical Governance; Dr Murray Campbell, QOF Assessor and Darrell Jackson, Primary Care Manager from another locality. The appeal was conducted by email and the outcome of the appeal was to uphold the PCT's decision. The PCT informed the Applicant of the outcome of the appeal on the 13 June 2012.

3.10 The Applicant made a further appeal on the 6 July 2012 (the "**Second Appeal**"). The Second Appeal panel consisted of Jim Barlow, Assistant Director of Primary Care; Dr Ken Deacon, Medical Director and Dr Gulshan Kane, LMC representative. This appeal was again conducted by email and the result was that Mr Barlow and Dr Deacon in the majority upheld the PCT's decision not to award the points for QP6 and QP7. The PCT wrote to the Applicant on the 20 July 2012 informing them of the outcome of this appeal.

QP6

3.11 On the 29 June 2011 the Practice was sent data for the period of April 2010 to March 2011 in order to conduct its review. The Practice held a meeting internally on 12 August 2011 in order to discuss this data in accordance with the requirements of QP6.

3.12 From the correspondence between the PCT and the Applicant it appears that the reason for the Applicant failing to meet QP6 is that it did not complete the Template i.e. it did not include three anomalies and three improvements in the boxes provided. Whilst the guidance for QP6 requires practices to identify and discuss apparent anomalies in the data in order to identify improvements it does not require a practice to identify *three* anomalies and *three* improvements. It appears to me that the drafting of QP6 is clear when compared to, for example, QP8, which requires a practice to identify *three care pathways*.

3.13 The Applicant states in the First Submission under the heading Areas for Improvement "*none identified from data supplied from the PCT*". However, the Applicant identifies under the heading Identified Anomalies *"as a practice we have no mental health data and collecting this may help us to develop a coherent standardised pathway for referring to mental health*". The PCT has not made clear in its submissions why this was not regarded by the PCT as an improvement. The 9 November 2011 email states only "*the lack of mental health data is an important issue but not an anomaly in referral patterns*". The email goes on further to give examples of improvements as "*to regularly review referrals to ENT or to peer review all referrals to ophthalmology (as already mentioned in your template)*". It appears from the PCT's comments in this email that the Applicant did identify improvements in the First Submission.

3.14 It also appears that the Applicant identified a number of anomalies in the outpatient data in the First Submission. The 9 November 2011 email comments "*the minutes would seem sufficient*" and "*you are then expected to show outpatient specialities for which your practice has identified anomalies (e.g. T&O and General Surgery as noted in your practice minutes)*". Again it appears from the PCT's comments in this email that anomalies were identified in the First Submission.

3.15 With regard to the Second Submission the email from Michelle Escombe on 13 April 2012 states *"you have not highlighted 3 areas for improvement – only the 3rd one is something the practice can do to improve decision making on referrals"*. This suggests that at least one improvement was identified in the Second Submission.

3.16 In communicating its decision to the Applicant the Second Appeal panel appears to accept that the local requirement for three improvements for QP6 was above the national requirements. However, the letter informing the Applicant of the outcome of the Second Appeal states "*the national guidance states that areas for improvement should be identified and this was not done*". This is contrary to the previous communications from the PCT that the Applicant had identified anomalies and

improvements but it had not identified three of each as required by the PCT.

3.17 As stated at 3.5 above, in the absence of an assessment criteria from the PCT or reasons why the submissions made by the Applicant were regarded as insufficient (other than there being less than the requirement for three anomalies and three improvements) I can only conclude that the Applicant did identify anomalies and areas for improvement and met the requirements for QP6.

QP7

3.18 Dr James Shipman of the Applicant was involved in the organisation of an external meeting day for practices to undertake an external review as required by QP7. This meeting took place on 13 September 2011 and six doctors from the Applicant attended.

3.19 It appears from the documents which I have been provided with that the key reason for the Applicant failing QP7 was that it had not achieved QP6. The email of 13 April 2012 to the Applicant states "*QP7 follows on from QP6, if you have not been able to identify any anomalies and have therefore not discussed any with the peer practices then it is not possible to approve this indicator*". This reason is again given in the letter informing the Applicant of the outcome of the First Appeal which states "*the practice had not been able to identify areas for improvement (QP6) and therefore was unable to discuss with peers (QP7)*". No comment has been made in respect of QP7 in the letter informing the Applicant of the outcome of the Second Appeal.

3.20 Although the output of the internal meeting should be made available for the external meeting, this appears to be a requirement for achieving QP6 not QP7. The Guidance on QP6 states that the outcome of the internal review must be made available to the group of practices taking part in the external peer review. In the papers there is a "draft plan" for QP6 – QP11. I assume that this was prepared by the Applicant after the internal review for the Practice to take to the QP7 external review. The draft plan summarises the meeting that took place on the 12 August 2011.

3.21 I have been provided with information sent out by the practices when organising the external review meeting. The practices were expected to have held their internal reviews to "*come up with some ideas to discuss within peer groups*" prior to the meeting and that the meeting itself would "*generate ideas to be shared and modified to help each practice propose areas for commissioning or service design improvements*" in order to achieve QP7. I have not been provided with guidance from the PCT in respect of the conduct of the external review. The PCT has not provided in its submissions any documents explaining to the practices that they would need to identify three anomalies and three areas of improvement for discussion at the external meeting as part of QP6 in order to meet QP7.

3.22 The Guidance for QP7 states that "*the external review must consist of a comparison of the practice data with comparable data from the practices in the group or from all practices in the PCO area to determine why there are any variances and where it may be appropriate for the practice to amend current arrangements for the management of hospital referrals*". The Guidance makes no reference to anomalies or improvements identified either in QP6 or during the comparison of data in QP7. The Guidance only requires that the practice proposes areas for commissioning or service design improvements to the PCO.

3.23 Although the Supplementary Guidance states that "*as with the prescribing indicators, the indicators for outpatient referrals (QP6 and QP7)… require that a practice undertake an internal review followed by a peer review*", it appears that QP6 and QP7 are not dependent on each other in the same way as QP1 and QP2 (which relate to an internal review followed by an external review for prescribing indicators). Paragraph 4.14B of the Statement of Financial Entitlements (as inserted by the Statement of Financial Entitlements (Amendment) Directions 2011 which introduce the Quality and Productivity indicators) sets out that points for QP2 will only be

available where QP1 has been fully accomplished. Similarly entitlement for payment in respect of QP3, QP4 and QP5 will only be available if QP1 and QP2 have been achieved. There is no similar provision in relation to QP6 and QP7. Therefore the achievement of QP7 is not reliant on the achievement of QP6.

3.24 In the absence of a dependency between QP6 and QP7 I have not been provided with reasons by the PCT for not awarding points for QP7. The Applicant clearly demonstrated that it took part in this external review and made the output of this meeting available to the PCT including proposed areas for commissioning or service design improvements. I have not been provided with submissions from the PCT as to why the Applicant's submissions were not sufficient to meet the requirements of QP7.

4. Determination

4.1 For the reasons given at paragraphs 3.11 to 3.17 above I am satisfied that the Applicant has met the requirements of QP6 to undertake an internal review. There is no express national requirement for the Applicant to identify three anomalies and three improvements to meet QP6. I therefore determine that the Applicant should be awarded points for QP6 for 2010/2011.

4.2 I am satisfied that the achievement of QP7 is not dependent on the achievement of QP6. In the absence of a dependency, the PCT has not provided clear reasons for the Applicant to not be awarded points for QP7. The Applicant organised and participated in an external peer review and the output of this review was provided to the PCT. For these reasons I determine that the Applicant be awarded the points for QP7 for 2010/2011.

Lisa Hughes
Appeals Manager
FHS Appeal Unit