QUALITY AND OUTCOMES FRAMEWORK REVIEW AND ASSESSMENT PROCESS

GUIDANCE FOR GP PRACTICES

NOVEMBER 2011
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QOF REVIEW PROCESS 2011/12

Following the establishment of the Nottinghamshire PCT Cluster and the development of closer working across County and City Contracting Teams it has been agreed to develop an integrated approach to the QOF review, assessment and pre payment verification processes for 2011/12. All practices will have received a QOF Process letter in October 2011 (see page 26). This guidance below provides further explanation of the various processes outlined in the letter.

The main changes to previous processes are:
- No QOF assessment practice visits
- All practices will self assess for organisational indicators
- Revised pre payment verification process

Practice self assessment declarations

It has been agreed that this year all practices across the County/City will be required to submit a self assessment declaration form (see Appendix 2 - page 29) by the end of February 2012 to confirm achievement of Organisational indicators, along with a practice survey/audit of patients records in respect of Records 9, Records 15/18/20, Records 19 and Medicines 11/12 (see Appendix 3 – page 35). Due to capacity issues and the fact that after seven years of inspecting the evidence of the same organisational indicators it is now considered unnecessary to continue visiting practices and no longer considered to be an effective use of assessors’ or practices’ time. We therefore do not propose to undertake routine practice visits prior to 31 March 2012 to review progress towards clinical indicators or inspect organisational evidence (except for any new practices or new practice managers who may prefer a visit to assure themselves and the PCT that all organisational procedures are in place).

We will, however, need to assess evidence in respect of the Quality and Productivity Indicators (QP1-11) introduced into QOF for 2011/12. Practices will be required to submit evidence of achievement in the form of reports detailing their internal and external peer reviews and these will be considered by primary care team commissioning managers and the Medicines Management team (for QP 1-5) and Clinical Commissioning Group Commissioning and Development Managers (for QP 6-11). Reports for QP 1 & 2 should be submitted to the Medicines Management team by end of June and September respectively. Reports for QP 6 – 11 should be submitted to the Primary Care Contracting teams no later than 31 March 2012. Final assessment of these indicators may be made during April – May 2012. We are however recommending that practices consider earlier submission of these reports in order that they can be checked and if necessary resubmitted by the practice if it is considered that they have not been completed correctly or sufficiently. City Practices have recently received detailed guidance to ensure that they complete their reports to an acceptable standard in order to be awarded the achievement points. This guidance is being shared with County QOF team.

Prepayment Verification

In order that the PCTs can be assured that standards are being maintained and to act as a control measure the pre payment verification process across City and County is to be revised:

- **Patient Records Audit** - between January/March 2012 a random selection of 5% of practices from each PCT will receive a visit from a member of the PCT Cluster’s data quality team to undertake an audit of patient records. The indicators selected for review will be:
  - Records 9
  - Records 19
  - Records 15/18/20
  - COPD 15 – selection of records where there is a record of spirometry claimed to check that there is evidence of this in the medical records
DM 21 – selection of records where retinal screening has been recorded to check that there is proof of attendance at an approved retinal screening service

Depression 1 - selection of records where screening has been undertaken to ensure that the two standard questions are being used (but this may already be included in the post payment audit by internal audit)

Depressions 5 - selection of records where new diagnosis of depression to verify that their notes record an assessment of severity 4 – 12 weeks after initial assessment (but this may already be included in the post payment audit by internal audit)

There is some possibility of overlap with indicators inspected by Internal Audit, however it may be unlikely that the same practices will be chosen for both the 5% pre payment check and the 5% chosen for the post payment check. It is proposed that all practices should be eligible for selection in both the pre and post payment checks and in the event of a practice being chosen for both the PCT will liaise with Internal Audit regarding the indicators to be inspected.

County practices are already familiar with this process and are already aware of the patient consent requirements; however this will be new to City practices - separate guidance is available (see page 6).

- **Submission of supporting evidence** - the same 5% of City and County practices will also be asked to submit documentary evidence to support a selection of clinical and organisational indicators. Practices will be asked to submit these during January – March 2012 alongside their self assessment declaration form. The indicators selected for review will be:

  - Education 6 – complaints review (copy of complaints log and minutes of complaint review meeting)
  - Education 7 – copy of at least 12 significant event review reports over the past three years
  - Education 10 - copy of at least 3 significant event review reports over the past year
  - Management 1 – confirmation of what current safeguarding procedures the practice has and how these are made available at the practice
  - Management 9 – Carers protocol which must include a reference to Young Carers
  - Medicines 8 – copy of practice leaflet, practice poster or website reference that clearly states that a patient can collect a prescription in under or up to 48 hours from the time they requested it excluding weekends and bank holidays (eg patient leaving request at 9.00am Monday morning must be able to pick it up no later than 9.00am on Wednesday)
  - CS 6 - smear audit
  - Epilepsy 9 – practice to demonstrate how patients are given required advice by providing examples of leaflets and any specific practice protocols plus a print out or summary of appointment bookings to demonstrate that face to face consultations have taken place
  - Mental Health 8 – practice to provide evidence for all patients with a remission code recorded as to why it was appropriate for that patient to be considered in remission and who made the decision for code to be applied. Practices are expected to have, and provide copy of, a protocol to guide clinicians in the appropriate use of this code and who should apply it (it is not appropriate for a non clinician to make this decision)
  - Palliative Care 2 – copy of minutes of all palliative care meetings the practice has held in last year

We intend to ask the LMC to make the random selection of the 5% practices for these verification exercises.
• **Exception reporting verification** - all practices across County and City will also undergo a review of exception reporting. In order to manage this only a few indicators will be inspected and within these indicators the focus will be on specific key exception codes. Where a higher than average level of exception reporting for these specific reasons is indicated on QMAS, practices will be asked to provide a detailed explanation for each patient exception reported. Responses will be referred for assessment by a Clinical Assessor to confirm appropriateness. This check will be new to County practices but all practices will receive a Guide to Exception Reporting (see page 9) and a QOF Hints and Tips document to support their exception reporting decisions.

• **QMAS verification of achievement** - in the first week of April all practices’ organisational, additional services & patient experience achievement (and PC2) will be checked on QMAS by the Primary Care Contracting Team to ensure that they have been correctly claimed. Any indicators that have had their field incorrectly switched to YES will be adjusted on QMAS and the practice informed.

• **Palliative Care 3** - in the first week of April Palliative Care 3 for each practice will be checked by the Primary Care Contracting Team – if a nil register is identified the practice’s performance throughout each month of the current QOF year will be checked to determine whether the practice had any patients on the register at any point through the year. If a patient is found the QOF guidance allows the practice to have the points and QMAS will be adjusted accordingly.

In recognition of the above PPV process, the Statement of Fees and Entitlements now allows PCO’s until 30 June each year to check practice achievement and make the final QOF payment. The newly introduced Quality and Productivity Indicators for prescribing (QP 3, 4 & 5) are to be measured during the months January – March 2012 by ePACT data which will not be available to the PCT until mid May. The primary care commissioning team will enter achievement onto QMAS by the end of May 2012 in order to ensure payment to practices by the end of June. Similarly, if assessment of the practice reports for QP6-11 cannot be completed by 31 March (as QOF guidance does allow practices up to 31 March to submit reports) then the primary care commissioning team will complete this exercise between April – May 2012 and will enter achievement onto QMAS by the end of May 2012.

**Post Payment Verification**
Guidance issued in May 2004 stated that an in-depth analysis of practice achievement against the Quality and Outcomes Framework (QOF) should be undertaken on a random sample of 5% of GP practices for each Primary Care Trust (PCT). This mechanism is intended to act as a control process to ensure overall compliance with the QOF.

The random sample of practices from City and County PCTs will, as in previous years, be selected in the presence of a Local Medical Committee representative and the post payment verification audits will be undertaken by the East Midlands Internal Audit Service – they are performed in such a manner as to provide an objective and unbiased opinion. In agreement with the PCT, the objective of the 5% random check is to confirm the validity of the GP practice’s achievement by reviewing patient and practice records to confirm that services claimed have actually been provided for the indicators examined and to check documentation to support exceptions reported.

**Dispute Resolution and Appeals Process**
Should a practice have concerns about any aspect of the QOF review process, they should initially be raised with the relevant PCT’s QOF Lead. The QOF Lead will endeavour to seek resolution of the problem through discussion and mediation, involving others as necessary. If the concern cannot be resolved at this level, the practice should raise it through the Informal Dispute Resolution Process and then if necessary through the Formal Appeals Process – see page 23 for full details.
PATIENT RECORDS AUDITS
GUIDANCE FOR GP PRACTICES

Introduction
Following the establishment of the Nottingham City and Nottinghamshire County PCT Cluster and development of closer working between County and City Contracting Teams it has been agreed to develop an integrated approach to the QOF review and pre payment verification processes this year.

As part of this, therefore, it has been agreed to undertake an audit of patients’ records. Their purpose will be to assess the quality of note summarising and to check accuracy and appropriateness relating to achievement of QOF indicators. The assessment team will review samples of patients’ records for information relating to a selection of organisational and clinical indicators.

This is a process which the County Data Quality Team has been undertaking for a number of years across all practices in County PCT and it has been agreed to introduce this to City PCT practices as well this year. However, as limited resources prevent this exercise being carried out with all practices across County and City it has been agreed to reduce this to 5% of County practices and 5% of City practices. These practices will be chosen by random selection in the presence of a representative of the LMC.

Audit review process
Practices will be selected in December 2011; the Clinical Audit & Data Quality Team will notify practices of their selection and confirm a visit date (if date offered is inconvenient practices will be able to rearrange this with the Clinical Audit & Data Quality Team). It is intended that all visits will be undertaken between January – March 2012. The visits will be undertaken by the PCT Cluster’s Clinical Audit & Data Quality Team (based at Birch House, Mansfield).

The visit will take one day and will require access to a PC for the full day. The visiting team will also require:
- A practice User ID and password or a smart card for access to the practice’s clinical system
- A copy of the practice’s notes summarising policy
- A random selection of the following:
  - 20 paper records coded in respect of COPD 15 (records coded as having had diagnosis confirmed by spirometry)
  - 20 paper records coded for DM 21 (records coded as having had retinal screening)
  - 20 paper records coded for Depression 1 (records coded as having been screened for depression using two standard questions)
  - 20 paper records coded for Depression 5 (records coded as having had assessment of severity 4 – 12 weeks after initial diagnosis)
- Amongst the above records it will be necessary for there to be at least 20 records for patients registered prior to 1April 2011 and at least 20 records for patients who have registered since 1 April 2011. If there are insufficient records for either of these registration periods then the appropriate number of additional notes will need to be randomly selected to make up the required 20 records.

Patient Consent
The DH Code of Practice on the confidentiality of disclosure of information advises that patient consent should normally be sought before inspection of patient confidential information. NHS Nottingham City and NHS Nottinghamshire County therefore recommend that patient consent is obtained for all records to be inspected unless the records can be anonymised. As responsibility for maintaining patient confidentiality lies with the practice’s GPs, as guardians of the patients’ records, it will be the practice’s responsibility to obtain the necessary number of consents as per the number of records detailed above.
We enclose a copy of an explanatory letter/consent slip that can be given to patients in order to obtain your consents. These can be posted to the patient and/or they can be handed to every patient visiting the surgery during a given period until the requisite number of consents has been obtained. If you have any problems obtaining the required number of consents please discuss this with the Clinical Audit & Data Quality Team.

This is a process that is familiar with County practices and has had previous support of the LMC. In 2008 the LMC investigated this issue of patient consent and were able to confirm to County Practices that they accepted the reasoning behind such an exercise and acknowledged that PCTs do have a right to inspect patients’ notes systematically for QOF audit purposes should it be necessary to do so. It was acknowledged that the risk of breaches of confidentiality arising from this type of exercise were minimal.

However some practices raised concern with regard to the additional workload that obtaining patient consent would cause and suggested that they would be willing to overlook any concerns they might have about confidentiality if the PCT was willing to give appropriate assurances of confidentiality. The LMC advised that written assurances from the PCT would not necessarily offer any greater protection to practices - a breach of confidentiality is a dismissible offence for any PCT staff member as it is for practice staff - but the PCT cannot effectively indemnify practices and as guardians of the patients’ records practices would not be able to absolve themselves of responsibility should a breach of confidentiality occur.

In conclusion, the LMC were happy to leave it to practices to decide whether to give the PCT authority to inspect patient records without consent to do so, provided that, in so doing, their practice Caldicott Guardian was satisfied that it was ethical to do so given the stated purposes of the audit and its outcome and that they understood the medico legal risks that might flow from it. Practices who do not feel that this is appropriate would be expected to obtain the necessary consents from patients themselves.

Should you have any issue with regard to obtaining patient consents please discuss this with your QOF lead (contacts as below):

**Lorna Densham**  
Clinical Audit and Data Quality Facilitator  
Medical Directorate  
NHS Nottingham City & Nottinghamshire County Cluster  
Birch House  
Ransom Wood Business Park  
Southwell Road West  
Mansfield  
Notts  
NG21 0HJ  
Tel: 01623 673033  
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**Julie Coulson**  
Primary Care Commissioning Manager  
Medical Directorate  
NHS Nottingham City & Nottinghamshire County Cluster  
1 Standard Court  
Park Row  
Nottingham  
NG1 6GN  
Tel: 0115 883 9353  
Email: Julie.coulson@nottinghamcity.nhs.uk
PATIENT CONSENT FORM

PRACTICE ANNUAL QUALITY REVIEW
ACCESS TO PATIENT RECORDS

Your practice will shortly be taking part in an annual quality review by NHS Nottingham City & NHS Nottinghamshire County. These are the organisations responsible for ensuring that healthcare is delivered to the populations of Nottingham City and Nottinghamshire County (PCT).

In order that a team from the PCT can accurately review the quality of care that your practice provides to its patients they need to look at a selection of patients’ medical records. The team of people looking at these records are NHS employees – members of the Clinical Audit & Data Quality Team at NHS Nottingham City/Nottinghamshire County.

The team reviewing medical records will have signed an agreement with the PCT and the surgery about keeping everything that they read confidential. No information contained in the records will be passed to anyone else. Person Identifiable Data will not be taken from the practice and all information will be regarded as confidential. Your medical records will still be held by your GP, and no copies will be taken or retained by the team undertaking the review.

If you decide that you do not want your records to be used for this purpose your objection will be respected and the care you receive will not be affected in any way.

If you are willing to give permission for your health record to be reviewed, please complete the slip below and return it to:

(Insert name of practice staff member obtaining consent)
(Insert name/address of the Practice if necessary)

If you want to discuss this with someone before reaching a decision, please contact the Practice Manager.

PATIENT CONSENT SLIP
I consent to my records being reviewed by the PCT assessment team as part of the Patient Records Quality Review that will be undertaken at this practice during the period 1 January 2012 – 31 March 2012. I understand that no information about me will be passed on to anyone else.

Name (please write in capitals): .................................................................

NHS Number (if known): .................................................................

Date of Birth: .................................................................

Signed: ................................................................. Date: .........................
EXCEPTION REPORTING
GUIDANCE FOR GP PRACTICES

1. INTRODUCTION
Following the establishment of the Nottingham City and Nottinghamshire County PCT Cluster and development of closer working between County and City Contracting Teams it has been agreed to develop an integrated approach to the QOF review and pre payment verification processes this year.

As part of this, therefore, all Nottingham City and Nottinghamshire County practices will be subject to verification of their exception reporting as part of the 2011/12 QOF pre-payment verification process. This verification is undertaken to provide assurance that practices are applying exception codes appropriately.

During April – May all practices will be subject to a check on their exception reporting as recorded on QMAS for certain selected clinical indicators. Where higher than average exception reporting is indicated, the practice will be asked by the PCT to provide more detailed information for each patient. In this event the practice will receive an Exception Reporting Query form (see page 18). This form will indicate to the practice how many patients are recorded on QMAS as having had an exception code applied for the particular exception reason. The practice will need to complete the form with details of each patient’s age and sex, the date that the exception code was applied and a detailed explanation of the reason why the exception code was applied. This information should be readily available as free text in the patient’s records. The completed form will need to be returned to the PCT within 14 days, whereupon it will be passed to a clinical advisor for assessment of the appropriateness of the exception reporting for each patient. Where it is deemed that the coding was inappropriate the practice will be notified and QMAS will be adjusted accordingly.

Please see page 19 for guidance on how to find excepted QOF patients and page 37 for exception reporting criteria codes.

The following guidance for practices has been prepared to offer clarity and information on appropriate use of exception reporting. It has been prepared based on the experience of previous checks with Nottingham City practices, but it will now, for the sake of consistency, apply to Nottinghamshire County practices as well.

The guidance has been based on common themes that have been highlighted by previous exception reporting verification checks. This is not intended to be exhaustive. As new issues come to light this guidance will be updated.

We would ask that all practices ensure that their clinicians (and support staff who are responsible for coding records) are fully aware of, and take active note of, this guidance, incorporate it in practice exception reporting policies and apply this guidance consistently throughout the practice.

This guidance will support the clinical assessment of exception reporting information that is received from practices during the pre-payment verification checks.
2. **THE BMA GUIDANCE (2006) STATES:**

- The duty of care remains for all patients, irrespective of exception reporting arrangements
- It is good practice for clinicians to review from time to time those who are excepted from treatment ie to have continuing knowledge of health status and personal health goals
- The decision to exception report must be based on clinical judgement with clear and auditable reasons coded or entered in free text on the patient record
- There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

Exceptions are patients who are on the disease register, and who would ordinarily be included in the indicator denominator. However they are excepted from the indicator denominator because they meet at least one of the exception criteria set out in the Statement of Financial Entitlements (SFE). Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice.

**The exception criteria as set out in the SFE are:**

A. Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding twelve months (INFORMED DISSENT – HIGH LEVEL CODE)

B. Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. terminal illness, extreme frailty (PATIENT UNSUITABLE – HIGH LEVEL CODE)

C. Patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels (AUTOMATICALLY EXCLUDED)

D. Patients who are on maximum tolerated doses of medication whose levels remain sub-optimal

E. Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, another contraindication or have experienced an adverse reaction

F. Where a patient has not tolerated medication

G. Where a patient does not agree to investigation or treatment, and this has been recorded in their medical records

H. Where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease

I. Where an investigative service or secondary care service is unavailable

Full BMA Guidance can be accessed from - [http://www.pcc.nhs.uk/exception-reporting](http://www.pcc.nhs.uk/exception-reporting)
3. **HIGH LEVEL CODING**

There are two types of exception code – high level and individual. Informed dissent and patient unsuitable codes are HIGH level codes and will remove patients from all indicators within the domain. They need to be used carefully to ensure that a patient is not removed from care in indicators for which they are still eligible and suitable to receive. Individual indicator codes will remove a patient from the denominator of that indicator only. Such codes include maximum tolerated therapy, treatment declined/refused codes, treatment contraindicated/not indicated/not tolerated (see appendix 1 for more information).

4. **FREE TEXT EXPLANATIONS**

All exception codes, as they are applied, should include a sufficiently detailed free text explanation to demonstrate the reason why the individual patient needed to be exception reported. Past investigations into exception reporting have indentified many cases where insufficient information has been provided by practices to explain their exception reporting decisions. Brief responses to explain the reason for exception reporting – such as “housebound”, “gone abroad”, “uncontactable”, “frail”, “bedbound”, “under the hospital”, “non compliant” etc - if this is indicative of the actual information recorded in patients’ medical records then this is not accepted as good practice. **All exception coding in patients’ notes must be fully auditable with full and clear background to the individual patient’s circumstances.**

5. **MAXIMUM THRESHOLDS**

The maximum threshold for all indicators is less than 100%. It is recognised that there will be patients that cannot achieve the indicator criteria but for whom there is no appropriate exception reporting code. Allowance is made for these patients by reducing the maximum threshold. Exception reporting is not an opportunity to exclude from the denominator all patients who do not meet the indicator criteria. For example:
- Where a patient has a seizure after being seizure free for 2-3 years and review of their medication does not suggest that any changes need to be made and this was just an unfortunate “blip”, this is not a reason to exception report them under Epilepsy 8
- Where patient has recently started treatment and QOF outcome has not yet been achieved
- Non compliance (see below)

6. **EXCEPTION CODES THAT CARRY OVER INTO NEXT QOF YEAR**

Exceptions remain active for 15 months, so exceptions coded in the last three months of QOF year will appear on QMAS in the following QOF year. If the PCT queries an exception with a practice that dates back to the previous year, even if the patient has received treatment/care within this QOF year, the PCT still needs to receive information for why the exception was applied at the time it was coded.

7. **GUIDANCE ON USE OF KEY EXCEPTION CODES**

7.1 **Informed Dissent**

A practice should only consider applying an informed dissent code if the following has occurred:
- The patient has verbally or in writing declined the treatment (disclaimer) and this has been documented and dated in the records. There should also be a note in the records that the risks of undertreatment or declined treatment have been discussed with the patient.

OR
- The practice has sent three communications to the patient inviting them to attend for review/treatment/test – **in two different forms** – each contact must be dated and this information made available at pre-payment verification check if requested. If no contact can be made by telephone (or other verbal contact)
then a third letter should be sent as recorded delivery. Please note that leaving messages with another person or on an answer machine are not accepted as valid contacts.

**Do NOT use informed dissent code where:**
- Fewer than 3 communications have been made
- Only one form of communication has been possible
- Practice has had no contact with a patient for significant period (for example, 2+ years) and where telephone lines may also be dead (see paragraph 8.4)
- Patient is known to have gone abroad (see paragraph 8.7)
- Patient is known to be in prison (see paragraph 8.11)
- Patient needs to remain included in other indicators in a domain – identify an alternative code that removes from just one indicator

### 7.2 Patient Unsuitable

A practice should only consider applying a patient unsuitable code where the patient is clinically/medically **incapable** of the care/treatment as per the individual indicator requirement.

**Do NOT use where:**
- Patient cannot tolerate increased treatment due to side effects, etc – they are still suitable for treatment/care and using this code will remove them from all domain indicators – **use max tolerated treatment**
- Patient has declined/refused treatment – **use informed dissent**
- Patient has failed to respond to three communications – **use informed dissent**
- Patient has poor compliance and regularly DNAs (see paragraph 8.6)
- There has been an erroneous diagnosis (see paragraph 8.2)
- Patient has gone abroad or is uncontactable (see paragraph 8.7)
- Housebound (see paragraph 8.8)
- Long term hospitalisation (see paragraph 8.9)
- Patient has learning difficulties and cannot attend appointments (see paragraph 8.8)
- Morbid obesity (for diabetes indicators)
- Diabetes completely managed in secondary care (see paragraph 8.9)
- Frailty (see paragraph 8.12)
- Patient needs to remain included in other indicators in a domain – identify an alternative code that removes from just one indicator

### 7.3 Maximum tolerated anticonvulsant therapy/diabetes treatment

A practice should only consider applying maximum tolerated codes for patients who are deemed to be on maximum tolerated therapy/treatment. It is agreed that this is where a patient is on multiple medications and/or on high doses where it has been clearly indicated in the free text of patients’ records that an increase in dosage or an additional medication cannot be physically tolerated – the notes should indicate which other medications have been tried but not tolerated.

Where a patient is not on high dose or multiple medications and will not agree to try others, the practice is unable to demonstrate that other options have been explored. Where the patient is not interested in changing (even though they are still fitting in the case of epilepsy indicators), they cannot be exception reported for maximum therapy/treatment. The practice must in this event document in the records that the risks of undertreatment or declined treatment have been discussed with the patient.
The practice could if it wished apply informed dissent code following and having documented actual verbal refusal by the patient – however the practice has to be aware that as this is a high level code this will remove the patient from all other indicators in the domain, which may not be appropriate for the patient. If this is the case then exception reporting is not appropriate for the patient. Where a practice cannot exception report a patient like this the practice is not being penalised - the maximum thresholds for indicators are not 100% - therefore practices have a margin of tolerance to account for such patients.

Do NOT use where:

- Patient refuses additional medication or to increase dosage (see note above and paragraph 8.5)
- Single agents except where clear reasons can be documented for not giving additional agents, such as “other (named) medications tried but patient intolerant”, etc
- Very low dosage of medications

Max tolerated exceptions queried during pre payment verification checks will require practices to submit details of their patients’ medications and dosages in order that clinical assessors can determine appropriateness of exception reporting. **Without sufficiently detailed information the exceptions will be disallowed.** It is therefore important to ensure that patients’ records have sufficient free text explanations for every exception report.

7.4 Patient Generally Excepted from Quality Indicator Group within 15 months of end of QOF period

This exception reason is generated on QMAS when the readcode chapter heading is used instead of the correct and full read code for patient unsuitable or informed dissent – for example where 9h or 9h0 is used instead of the full correct coding of 9h01, 9h11, 9h21, etc (for patient unsuitable) or 9h02, 9h12, 9h22, etc (for informed dissent). As QMAS cannot determine whether the patient was being exception reported as patient unsuitable or informed dissent it records it as patient generally excepted.

This coding will remove the patient from all indicators of the relevant domain in the same way as informed dissent or patient unsuitable.

Practices should ensure that the correct and full readcodes are carefully applied and where possible use templates to avoid inadvertently keying in incomplete codes. Please see Appendix 1 for appropriate read codes.

8. **INAPPROPRIATE REASONS FOR EXCEPTION REPORTING**

Investigations into practices’ exception reporting have identified the following common instances of inappropriate exception coding. Practices are asked to take note of the following guidance and ensure that it is shared with all practice staff responsible for applying exception codes and incorporated into practice protocols:

8.1 **Blanket exception reporting**

The overriding principle is that blanket exception reporting for any reason is not acceptable. It is not acceptable to exclude all patients above a certain age or all those with a particular diagnosis, eg dementia or cancer. It is not acceptable to use blanket exception reasons such as “under the care of the hospital” or “resident in a secure unit”, or “risk of harm with further intensification of treatment”, etc – especially where use of a high level code will remove that patient from all indicators in that domain. Every case must be considered on its own merits with individual decisions based on clinical judgement where age, diagnosis, health and functional status have all been taken into
account and documented. Each patient’s medical records/free text must include details of the individual underlying reasons/cause for them being unsuitable or incapable of receiving the specified treatment.

8.2 Incorrect coding
These include situations where, for example, patients eligible for exception reporting have the incorrect code applied – ie patient unsuitable when it should have been informed dissent and vice versa; or where coding has been applied completely in error. Practices should have an exception reporting policy in place, which all clinicians and admin staff responsible for coding are familiar with and arrangements made so that the practice can ensure consistency of practise. All staff should have had suitable training and should wherever possible be using templates to guide data input. Any queries around coding, templates, etc should be directed to the Data Quality Team/Information Facilitators.

8.3 Erroneous diagnosis
Where it is found that there has been an incorrect diagnosis, exception reporting is not appropriate. If a diagnosis is incorrect, then it should be removed to ensure the integrity of the patient’s medical record. If deleting a code and editing a consultation then full details of the reason must be documented. It is advisable to replace a deleted code with a symptom code eg delete a diagnosis code of angina and enter a symptom of chest pain on exertion with a line of free text saying “This was originally diagnosed as angina. Subsequently this diagnosis was found to be incorrect and was removed from the record”. If the patient did have the condition but it has now resolved then a resolved code must be entered in the patient’s records.

The “Good Practice Guidelines for General Practice Electronic Patient Records” RCGP April 2005 states: “There is no ethical difficulty with removing or correcting inaccurate or misleading information or making clear addition to incomplete information. It is important that records do not contain information that might mislead another health professional using them. It is inadvisable to remove medically relevant information and notes must provide a contemporaneous record of consultations and information gained about patients ……. Removing relevant medical information may give the impression that the notes have been tampered with, and may make later treatment and care decisions seem unsupported. It follows that doctors should take care to ensure that the records show all significant aspects of care, and clearly identify any decisions that were later found to have been inappropriate so that in the future carers do not misinterpret the patient's medical history. If there is dispute about the accuracy of information, for example that was recorded in the past by a previous GP, doctors should take reasonable steps to ascertain the accuracy of information in the records. If this is not possible, a note explaining the patients' views should be appended to the records. This allows health professionals using the records in the future to be wary of placing undue weight on disputed information”.

8.4 Where diagnosis has not yet been confirmed
Exception reporting for this reason is not acceptable. Patients should not have diagnosis code applied until actual confirmation has been received in which case the patient would not appear in numerator and disease register. If diagnosis code has been applied before diagnosis confirmation then the practice must accept that coding has been applied in error and that as there is no exception code available such patients may skew indicator achievement.

8.5 Patients with whom practice has had no contact or consultation for period of 2+ years
Where a practice has had no contact from a patient for a significant period of time, fails to get response from numerous letters and unable to contact by telephone – the practice should suspect that the patient may have left the area and, rather than repeatedly exception reporting them, should take action to determine whether the patient needs to remain on the practice list (as per contractual obligation to maintain an accurate list). An “Are you there?” letter should be sent requesting confirmation that registration is still needed and advising that failure to respond will result in removal from the list in “x” days.

8.6 **Patient refuses/declines to increase dosage or add medications**
Where a patient refuses increased dosage or additional medications (for example patients who do not want to go onto insulin), especially where they are being prescribed single agents/low dosages and where there has been no past evidence of intolerance to medications, their records should be noted/dated to this effect and should indicate that the GP has discussed the risk of undertreatment weighed against the benefits of increased treatment – they should not be coded as maximum tolerated treatment - as they clearly are not on the maximum that the patient could tolerate. The practice could if it wished consider informed dissent but this has to be weighed against that fact that to do so would remove the patient from all other indicators in the domain and the practice would need to be able to justify this (see paragraph 7.3).

8.7 **Non/poor compliance, patients who fail to order/collection medications regularly, etc**
Poor compliance, regular DNAs of GP and hospital appointments, failure to order or collect medications, etc do not make a patient unsuitable and do not in themselves constitute informed dissent. The practice is required to keep trying with these patients. Informed dissent can only be applied if there has been failure to respond to 3 communications and patient unsuitable can only be used if there is a medical reason why the patient is incapable of meeting the indicator. Otherwise these patients are included amongst those that sit above the maximum threshold, ie why the maximum threshold is not 100%.

8.8 **Patients who have temporarily gone abroad or work abroad part of the year**
Patients who have gone abroad for more than 3 months should be removed immediately from the practice list – exception reporting is not acceptable. If patient regularly goes abroad for less than 3 months, arrangements should be made for invitations for treatment/care to go out earlier in the QOF year so that treatment/care can be arranged during periods when patient is resident – exception reporting is not acceptable.

8.9 **Housebound patients/patients with learning or other disabilities and have difficulty attending appointments**
A patient is not unsuitable for care/treatment just because they are housebound or disabled. Many indicators can be achieved by undertaking a home visit. Exception reporting is only appropriate where specific elements of care are practically/physically impossible for a housebound patient and patients should be excepted from these specific indicators only, not excepted from all care (ie do not use a high level patient unsuitable code). For those that are not bedbound it may be possible to arrange transport for hospital or GP appointments, but the practice must demonstrate that all attempts have been made to ensure patient receives the care.

8.10 **Patients under the care of hospital, secondary care, consultant, neurologist, community services, community matron, rehab units, psychiatric units, etc**
Regardless of where a patient may receive a significant proportion of their care, the practice is responsible for ensuring that all patients receive the standard of care as
outlined in QOF. If it is likely that certain QOF tests, treatment, etc will be carried out elsewhere, the practice is responsible for liaising with the other agency and obtaining the required information that will allow them to accurately record in the patient's notes that indicator requirements have been achieved. If the indicator cannot be achieved the practice needs to have obtained details from the other agency and entered these in the records before considering exception reporting. It is not acceptable to use “under the care of ……..” as the reason for not following up on the patients care and for removing them from the indicator/domain by exception reporting.

If an indicator has not been achieved yet, for example where a gradual treatment alteration is being worked through, then exception reporting is not acceptable, as the patient is not unsuitable – another example of where a patient sits above the maximum threshold.

Where patients are in-patients the practice is still responsible for liaising with the relevant agency to determine the level of care achieved – consideration should be made to making arrangements for the patient to be brought to practice for appropriate care, for the GP to visit the patient or if the patient is long term in location outside the practice boundary consideration should be given to removing patient from the practice list.

The majority of cases as described above are further examples of why the maximum thresholds are not 100%. An allowance has already been made for these patients and exception reporting is therefore not appropriate.

8.11 Patients participating in treatment studies
For example – patients involved in the diabetes ACCORD study should not be blanket exception reported. They remain the responsibility of the GP practice and are still eligible for the standard of care expected under QOF. **Ruling as 8.10 above applies.**

8.12 Patients in prison
Once a practice becomes aware that a patient is in prison (it is recognised that very often the practice does not find out straightaway), if the patient has already been in prison for more than 2 years they must be removed from the practice list and exception reporting will not be acceptable. If they have not yet been in prison for 2 years then an informed dissent code can be applied until such time that they have been in prison for 2 years and then they should be removed from the practice list.

8.13 Frailty
QOF Guidance and the SFE cite “extreme frailty” as an example of the use of the “patient unsuitable” exception code, however it must be noted that the overriding principle is that blanket exception reporting is not acceptable especially if by using “patient unsuitable” the patient is removed inappropriately from the whole disease domain. It is not acceptable to exclude all patients above a certain age or all those with a particular diagnosis, eg dementia or cancer. Every case must be considered on its own merits with individual decisions based on clinical judgement where age, diagnosis, health and functional status have all been taken into account and documented. When applying an exception code in these circumstances the medical records/free text must document more than just “frailty” or “extreme frailty” - the individual underlying reasons/cause for their frailty must be included. A brief explanation of the patient’s medical condition should indicate the severity of their frailty and only in cases of extreme frailty where, in the GPs opinion, treatment would be wholly inappropriate should the “patient unsuitable” exception code be applied.

8.14 Awaiting retinopathy service recall as new discharge from ophthalmology
The above reason for exception reporting under DM21 has been used in the past – this is not considered an acceptable reason for exception reporting. This is another example of why the maximum thresholds are not 100%.

8.15 Insulin and weight gain
Some practices have used weight gain as a reason for not increasing insulin and therefore applying an exception code. However it is not generally considered that weight gain is a contraindication to increasing insulin.

8.16 Where a GP disagrees with the evidence/interpretation behind QOF indicator targets
All QOF indicators/targets are nationally agreed and evidence based – therefore, it is not acceptable to exception report a patient because the clinician does not agree with the evidence behind individual indicator targets. Where a GP is of a different opinion for an individual patient then the practice must accept that this patient cannot achieve the indicator target and that they will be included amongst those that sit above the max threshold and another reason why maximum threshold is not 100%.
As part of the PCT’s pre payment verification we are undertaking a check of all practices’ exception reporting as recorded on QMAS. The following indicators appear to show a higher than average percentage of practice discretionary exception reporting and require further examination. We would be grateful if you could provide the information as requested below for each patient.

Please add extra rows into the table according to the number of patients excepted:

The information required includes:
- Age/sex of each patient
- Date of exception – please remember that exceptions are applied for a period of 15 months so you may need to look back to January – March 2010 for some exceptions
- As much information as possible about the reason for these exceptions being applied - for Maximum tolerated treatment/therapy, please give as much information as possible as to why the practice considers the patient to be on maximum tolerated medication – details of the drugs and dosage the patient is taking MUST be provided as well as information on how the patient continues to be managed

Please return this form **BY EMAIL** within 14 days of receipt.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Exception Reason</th>
<th>No of patients excepted</th>
<th>Age and sex of patient</th>
<th>Date of exception</th>
<th>Please provide detailed information to explain the reason for this exception being applied. Please refer to Exception Reporting Guidance attached</th>
</tr>
</thead>
<tbody>
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</table>

Please see page 19 of “QOF Process 2011/12 – Guidance for Practices” for advice on finding excepted patients on your clinical system
To Find Exception QOF Patients in Emis LV

- From the Emis main menu select 'ST – Search and Statistics'
- Select ‘M – QMAS Uploads’
- (At this stage, if you have never used this option before, you will be presented with an ‘LV Client Update’ message – just let this run)
- Highlight the required report in the completed report section (eg the one dated 1st April for the end of year figures)
- On top menu click on ‘V – View Results’ (which opens another window)
- Click on ‘V – View (Standard Report)’ and select ‘Exception Report’ from the drop-down menu
- Scroll down until you can see the indicator you wish to deal with (eg EPILEP08)
- Click on the blue hyperlink ‘View Patients’ on the right hand side of the indicator you are dealing with (eg max tol. dose)
- The excepted patients for this indicator will be displayed to screen
- This patient list may then be printed off or stored to file

To Find Exception QOF Patients in Emis GV

- From the Emis GV main menu select ‘QMAS Uploads’
- Right click on the required report within the completed reports section (eg the one dated 1st April for the end of year figures) and select ‘V – View Results’
- On top menu click on ‘V – View (Standard Report)’ and select ‘Exception Report’ from the drop-down menu
- Scroll down until you can see the indicator you wish to deal with (eg EPILEP08)
- Click on the blue hyperlink ‘View Patients’ on the right hand side of the indicator you are dealing with (eg max tol. dose)
- The excepted patients for this indicator will be displayed to screen
- This patient list may then be printed off or stored to file

To Find Exception QOF Patients in Emis PCS

- From the Emis PCS main menu select ‘QM – QMAS Uploads’
- Right click on the required report within the completed reports section (eg the one dated 1st April for the end of year figures) and select ‘V – View Results’
- On top menu click on ‘V – View (Standard Report)’ and select ‘Exception Report’ from the drop-down menu
- Scroll down until you can see the indicator you wish to deal with (eg EPILEP08)
- Click on the blue hyperlink ‘View Patients’ on the right hand side of the indicator you are dealing with (eg max tol. dose)
- The excepted patients for this indicator will be displayed to screen
- This patient list may then be printed off or stored to file
END OF YEAR PROCESS
GUIDANCE FOR GP PRACTICES

Practices will receive an end of year letter towards the end of March 2012 which will remind practices of the processes as outlined in the timetable below:

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Action</th>
<th>By Whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>By end of February 2012</td>
<td>Signed self assessment declaration form plus any outstanding evidence required</td>
<td>Practice</td>
</tr>
<tr>
<td>By mid – end March 2012</td>
<td>Practices must have submitted:</td>
<td>Practice</td>
</tr>
<tr>
<td></td>
<td>• All outstanding evidence as required from practices for the 5% evidence check</td>
<td>PCT</td>
</tr>
<tr>
<td></td>
<td>• All QP 6 – 11 reports (all QP 1/2 reports should have been submitted by mid November 2011)</td>
<td>Practice</td>
</tr>
<tr>
<td></td>
<td>• All practice records audit visits will be completed and reports issued</td>
<td>PCT</td>
</tr>
<tr>
<td>By 31 March 2012</td>
<td>• Last opportunity to submit self assessment declaration – practice must have ensured that an email response has been received from the PCT confirming which indicators have been satisfactorily signed off</td>
<td>Practice</td>
</tr>
<tr>
<td></td>
<td>• Practices must have completed all adjustments on QMAS in respect of achievement of organisational indicators (see process below).</td>
<td>PCT</td>
</tr>
<tr>
<td></td>
<td>• Circulate end of year process letter to practices</td>
<td>Practice</td>
</tr>
</tbody>
</table>

**Process for making adjustments to QMAS**

1. Start off at homepage or login screen
2. Click into NON CLINICAL ACHIEVEMENT and make your adjustments
3. Click SAVE WORKING VERSION and then press DONE
4. Go back into NON CLINICAL ACHIEVEMENT
5. Click REVIEW ANSWERS and at the next screen click SUBMIT ACHIEVEMENT then click DONE – then REPEAT THIS PROCESS – click Review Answers/Submit Achievement/Done
6. Go into CURRENT AND FORECAST ACHIEVEMENT and check that your adjustments and your points have been updated

**PLEASE NOTE: ALWAYS REPEAT STEP 5**

*Please note that the practice is responsible for ensuring that the PCT has received and is responding to any late submissions of organisational evidence. Please do not assume that sign-off has been agreed unless this is confirmed by email.*

| 31 March 2012 | QMAS closes down at midnight - no further adjustments on QMAS can be made by the practice after this time |

AUTHOR: Julie Coulson, Primary Care Commissioning Manager, NHS Nottingham City, November 2011
**Practices should NOT sign-off QMAS at this point**

| First week of April 2012 | • PCT commences initial pre payment verification checks on all practices  
  • Exception reporting levels to be checked and practices informed of any exception reporting information required |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| Second week of April – mid May 2012 | • Practices to respond to exception reporting queries and return information to the PCT within two weeks of request  
  • PCT to check responses and forward to PCT Clinical Advisor for assessment. If necessary further information will be requested from the practice or confirmation given that responses are acceptable  
  • PCT to assess remaining QP 6 – 11 reports and advise practices of achievement  
  • PCT to make adjustments on QMAS as necessary and advise practices as appropriate |

**Practices do not need to sign-off QMAS in respect of adjustments for exception reporting queries if completed before mid May, as further adjustments will need to be made by the PCT in respect of QP3/4/5 indicators which cannot be completed until mid May at the earliest (practices that do sign off before QP adjustments have been made will have to repeat the sign off process after adjustments have been made – please see process for signing off below).**

| Mid May 2012 | • PCT receives QP 3/4/5 results from Prescribing Team - QMAS to be adjusted on practices’ behalf and practices informed  
  • Final adjustments made in respect of QP 6 – 11 indicators  
  • Practices notified of final adjustments to QMAS and asked to make final declaration and sign off |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------|

**Once practices have received confirmation that all their adjustments for QP 1 – 11 have been made by the PCT on QMAS, practices to complete their final declaration and sign-off on QMAS at this point**

**Process for signing off declaration**

1. To Sign Off your report, the user must be logged into a QOF MANAGEMENT role on the QMAS website.
2. If you cannot see the Payment section on the homepage, it may mean that you either are not logged into the correct role, or you do not have QOF MANAGEMENT access as standard.

To check - there is a blue line at the top of the QMAS website that shows what role you are signed in with. If it does not say QOF MANAGEMENT then you may need to log out and log back in again. When you log back in, you should have the option to select a role. From here select QOF
If the above is of no avail, it means you do not have the required access rights, and will have to find someone at the practice who has this role to help you sign off.

3. From the homepage go into the APPROVE ACHIEVEMENT FOR PAYMENT under the Payment tab.
4. Once you have viewed your report and checked your figures – POINTS & POUNDS - and are happy with them, click on the grey NEXT button and this takes you to your declaration.
5. Read/check the declaration statement carefully and click SUBMIT
6. The page will show a confirmation statement to advise that the declaration has been made
7. Please note that if the PCT has to make any amendments to the end of year data after you have completed the above process, the practice will have to repeat this process again to approve the adjustments that have been made and any amended final achievement. Simply repeat the same steps as above to sign off again.

<table>
<thead>
<tr>
<th>End of May 2012 onwards</th>
<th>Practice PCT/Practice PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If no outstanding queries practices to complete final declaration and sign-off on QMAS as above</td>
</tr>
<tr>
<td></td>
<td>In the event of outstanding queries – all attempts to be made to resolve before 30 June allowing final adjustments to be made and final declaration and sign-off completed</td>
</tr>
<tr>
<td></td>
<td>Following practice declaration and sign-off PCT to complete payment request on QMAS to generate payment</td>
</tr>
</tbody>
</table>

30 June 2012

- Practices to be paid in full where queries have been resolved
- Practices will be paid in part where queries have been raised but are still in dispute

After 30 June 2012

Practices where queries are still in dispute will be paid the remainder of their final achievement once all queries have been resolved.

PCT
QUALITY OUTCOMES FRAMEWORK (QOF)
DISPUTE RESOLUTION AND APPEALS PROCESS

Purpose
This document describes the process that will be followed when a General Practitioner (GP) or the LMC on behalf of their constituent GPs appeals against a decision of the NHS Nottingham City or NHS Nottinghamshire County QOF Assessment Teams.

Where a GP is dissatisfied with a decision of the QOF Assessment Team, they should in the first instance, contact the relevant PCT QOF Team Lead to describe why they are dissatisfied. The GP should inform the QOF Team lead of their dissatisfaction within 15 working days of being notified of the decision. The QOF Team lead should review any further evidence submitted and respond within 10 working days.

Stage 1 – Informal Disputes Resolution Process
If after discussions and review with the QOF Team Lead the GP remains dissatisfied, he/she should request a review by the QOF Disputes Resolution Panel. The request should be made within 15 working days.

The QOF Dispute Resolution Panel shall consist of:-

- Assistant Director of Commissioning (Primary Care)
- LMC Representative and/or mediator depending on the nature of the appeal
- GP Clinical Advisor
- PCT QOF Lead

The panel should be established within 20 working days of the request. However, appeals relating to Post Payment Verification Visits will be held at one single meeting when all visits have taken place. Therefore it may not be possible to adhere to this timescale.

The practice will be invited to submit any further evidence to support their appeal.

The Panel may request further information to assist decision making. This process will constitute a review of written evidence. No oral evidence will be required at this stage.

The Panel should receive the information at least one week before the meeting.

All documentation should be anonymised.

The Panel’s decision will be communicated in writing to the General Practitioner within 3 working days of the Panel meeting. If this is not possible, the General Practitioner will be kept informed of the reason/s for the delay and progress until the panel’s decision can be communicated.

Stage 2 – Formal Appeals Process
Where the GP remains dissatisfied with the decision made by the Informal Disputes Resolution Panel, he/she should request a review by a PCT appeal panel.

An appeal panel shall consist of: -

- A Chair person appointed by the PCT from amongst its Non Executive Directors
- A Non-Executive Director of the PCT

AUTHOR: Julie Coulson, Primary Care Commissioning Manager, NHS Nottingham City, November 2011
- A further Non-Executive Director of the PCT or a member of the Professional Executive Committee
- Professional advice will be sought from an appropriately qualified professional who will attend the panel.

No member of the panel will have had previous involvement in the consideration of the case or have had any interest in the case.

Appeals will normally be heard within 20 working days of receipt of the request for appeal. The outcome of appeals will be communicated in writing to the applicant within 3 working days.

The PCT will inform the parties in writing of the date of the appeal hearing. At the same time, the PCT will request that within 14 days of the date of this letter or by 10 days prior to the date of the appeal hearing, whichever is the sooner, copies of any further documentation which the parties wish to use at the hearing together with the name and office of any other person that will attend the appeal be submitted.

The parties shall not rely on any facts or contentions or additional documentation, which have not been available to the PCT in making its original decision unless, the Chair of the Panel in consultation with Panel members, gives his/her consent.

The panel will hold an oral hearing except where the GP has confirmed in writing their willingness for the appeal to be determined in their absence, based on the documentary evidence.

The appeal hearing shall be in private. The persons entitled to attend are:

- The GP or representative body
- A GP may be accompanied at the hearing by one other person who may assist him/her in the presentation of the case
- Head of Performance, Quality & Safety/QOF Lead to present the case
- Any person whose attendance is required for the purpose of giving specialist advice to the panel

**Procedure at Hearing**

Confidentiality regarding all information discussed at the hearing will be observed by all parties to the appeal at all times.

At the hearing of an appeal before the appeal panel, the following procedure shall be observed:

- The GP shall state their case in the presence of the representatives of the PCT
- The representative of the PCT shall have the opportunity to ask questions of the GP or their representative
- The members of the appeal panel shall have the opportunity to ask questions of the GP or their representative
- The PCT’s representative shall put his/her case in the presence of the GP or their representative
- The GP or their representative shall have the opportunity to ask questions of the PCT’s representative
- The members of the appeal panel shall have the opportunity to ask questions of the PCT representative

Any person attending the hearing for the purpose of giving specialist advice to the panel shall be admitted to the hearing and parties, representatives and panel members shall have the opportunity to put questions to him/her. He/she will then be released from the proceedings.
The GP or their representative and the PCT representative shall have the opportunity to sum up their cases if they so wish. In their summing up, neither party may introduce any new matter.

The panel may at its discretion adjourn the appeal in order that further information may be produced.

The GP, their representative and the PCT representative shall withdraw and the panel shall consider the case in private.

The outcome of the hearing will be confirmed in writing within 3 working days.

If the appellant is aggrieved at the panel’s decision he/she may refer the Appeal directly to the NHS Litigation Authority.

Reviewed: November 2011
Next Review date: November 2012
Dear Dr

QOF Review Process 2011/12

I am writing to confirm the QOF review process for 2011/12. Following the establishment of the PCT Cluster and development of closer working between County and City Contracting Teams it has been agreed to develop an integrated approach to the QOF review and pre payment verification processes this year.

Review of Organisational indicators
It has been agreed this year that all practices (City and County) will be required to submit a self assessment declaration to confirm achievement of Organisational indicators, along with a records assessment audit in respect of Records 9, Records 15/18/20, Records 19 and Medicines 11/12.

We do not intend to undertake routine QOF review visits prior to 31 March 2012 (except for any new practices or new practice managers who may prefer a visit to assure themselves and the PCT that all organisational procedures are in place) or to routinely require any additional documentary evidence for organisational indicators except where indicated on the declaration form (QP indicators and in some cases Palliative Care 2).

Enclosed please find:

- A self assessment declaration form that lists the QOF organisational indicators. This states the declarations that the practice must be able to make in respect of each individual indicator in order to claim achievement – please ensure that the practice has reviewed all indicators and has the necessary evidence in place should the practice be selected for a pre or post payment verification audit.
- A records assessment audit sheet – practices will need to undertake a survey of a random selection of patients records and record on the attached audit sheet whether the records meet the relevant indicator criteria or not. Please note the instruction for Records 9 to record the number of repeat meds for each of the 50 randomly chosen patients and the number of these drugs that meet the indicator requirement

Please arrange for these forms to be completed and returned to your Contract Manager by 29 February 2011 in order that they can be checked, indicators agreed and signed off in plenty of time before 31 March 2012 (please keep a copy for your records). Please return electronically if possible.

If the forms are not returned, are incomplete or any indicators have not been met by 31 March 2012,
we will be unable to agree achievement of these indicators and QMAS will be adjusted to reflect this. Please ensure that a partner has signed and dated the declaration form before it is returned.

**Quality and Productivity Indicators**

- **QP 1-2 Prescribing** – practice reports for these indicators should, by now, have been submitted to your Medicines Management teams in accordance with the agreed submission dates and will be in the process of being assessed by the Medicines Management Team and primary care team QOF assessors. Practice achievement will be confirmed by the Primary Care Team to enable you to add your achievement to QMAS.

- **QP 3-5 Prescribing** - ePACT data to measure achievement of the prescribing indicators will not be available to PCTs until mid-May 2012. The Medicines Management Team will be responsible for confirming practice achievement to the Primary Care Team so that points can be entered onto QMAS no later than the end of May 2012.

- **QP 6-11 outpatient referrals and emergency admissions** – please ensure that your reports (using the templates provided) are submitted to your Contracting Manager (Julie Coulson for City and Mark Yates/Jayne Bouch for County) no later than 31 March 2012. Any reports that arrive with the PCT after 31 March 2012 will not be considered. Assessment of practice reports will be undertaken April – May 2012 by the Primary Care team QOF assessors. QMAS will be adjusted accordingly.

Please add your achievement on QMAS for QP1-2 and 6-11 by 31 March 2012 just as you do for the other Organisational Indicators. According to the QMAS Technical Team these will be YES/NO fields. Achievement on QMAS will be checked following assessment of QP practice reports.

**Pre-payment verification (PPV)**

PCTs are obliged to undertake some form of pre payment verification to give assurance that payments are being made to practices appropriately. It has been agreed to revise the pre payment verification process across the County and it will now take the form of:

- **A practice visit to undertake an audit of patient records**
  A random selection of 5% of practices from each PCT will receive a visit from a member of the PCT Cluster’s data quality team to undertake an audit of patient records. This will take place between January – March 2012. We appreciate that for City practices the records audit will be new and we will be discussing with you the need for either patient consent to be sought or for the practice to accept the signing of a confidentiality statement by the visiting PCT staff. This process already has LMC approval for County practices.

- **A more detailed examination of clinical and organisational indicators**
  The same 5% of practices will also undergo a more detailed examination of a selection of clinical and organisational indicators. For this the practice will be required to submit (between January – March 2012), alongside their self assessment declaration form, documentary evidence in respect of a selection of organisational and clinical indicators. This evidence will be checked for compliance with indicator requirements.

- **An assessment of appropriateness of exception reporting**
  During April – May 2012 all practices will undergo an exception reporting check. A small number of indicators will be examined in respect of a few key exception codes and high levels of exception reporting will be queried with the practice. The practice will be informed of the number of patient exceptions recorded by QMAS and for each of these patients the practice will be required to provide details of the reason, as documented in the patient’s medical records, why the patient was exception reported. This information will be referred for assessment by a Clinical Assessor. To assist this assessment and enable timely decisions to
be made, we would recommend that practices ensure that free text explanations are always included in a patient’s records so that these can be extracted and provided if requested by the PCT.

Further information detailing the pre payment verification process will be circulated separately, but should you have any queries regarding data quality, read codes, etc please contact either Lorna Densham – Data Quality Facilitator (County) or Dani Clarke/Norma Lovelace – Information Facilitators (City).

Payment
The Statement of Fees and Entitlements allows PCO’s until 30 June each year to check practice achievement and make the final QOF payment. We will endeavour to fully sign off the practice’s QOF as early as possible but please be aware that payment may be delayed if any of the above Pre Payment Verification checks are delayed.

Post Payment Verification
As in previous years, a separate random 5% selection of practices will be chosen from each PCT to undergo post payment verification by Internal Audit.

QMAS
QMAS functionality for the 2011/12 changes to QOF will be available towards the end of October. As QMAS has been unavailable for a period of time it is likely that your password has expired. If you find this to be the case please contact your QMAS Administrator (Lorna Densham for County or Julie Coulson for City) and they will arrange for it to be reset for you.

If you have any questions on the QOF review, assessment or sign off process for 2011/12, please contact Lorna Densham (County) or Julie Coulson (City) for clarification. If you require any further information about individual indicator requirements please remember to check out the “Green Book” QOF Guidance for 2011/12 which can be downloaded from: http://www.bma.org.uk/images/qofguidancefourthversion2011_v2_tcm41-205262.pdf

Yours sincerely

Jon Holliday
Assistant Director for Primary Care Commissioning
NHS Nottingham City and Nottinghamshire County

Encs: QOF Self Assessment Declaration form
Patient records assessment audit sheet

NB: Copy of letter and enclosures will be emailed shortly to practice managers/practice QOF leads

AUTHOR: Julie Coulson, Primary Care Commissioning Manager, NHS Nottingham City, November 2011