Primary Medical Services Contract Reviews: a Contract Compliance Monitoring Resource Guide

April 2010
To be reviewed: April 2013
Background

A small group of PCT representatives from across the West Midlands came together to review the range of approaches to primary medical care contract reviews and in particular compliance checks. This working group was established in recognition that despite this being a fundamental requirement, the annual review of medical contracts was occurring more robustly in some PCTs than in others.

The working group felt that a resource guide for PCTs was required to enable PCTs to ensure provider compliance with contractual and statutory obligations. The working group was keen to include a range of examples of good practice used by other PCTs, as well as links to information and resources that would aid development and management of the process.

It is recognised that effective contract compliance monitoring is only one element of the business review of primary medical providers.

“I found the shared resources of other PCTs really helpful. They provided a foundation for devising contract monitoring documents for us to use and direction for developing it in the future.

As standards are common to the majority of contracts, adapting resources has saved a considerable amount of time as text can be copied and pasted as required.”

Mary Carr
Working group member
Senior Contracts Manager, NHS South Birmingham

The SHA's expectation is that all West Midlands PCTs will be monitoring contract compliance during 2010-11, as part delivering on the Primary Care QIPP priorities.
Part 1: Setting the scene

1. Introduction

High quality contracting is an important foundation for quality and efficiency and the basis of good commissioning. PCTs need to ensure that provider compliance with the terms of the contract is also monitored – a ‘house-keeping must-do’ from a Quality and Productivity Challenge point of view.

The purpose of this resource guide is to assist PCTs both in terms of increasing their contract monitoring capability and in terms of addressing capacity issues.

Across PCTs in the West Midlands there is a range of starting points particularly where PCTs have merged. Also, there are different management structures within a PCT meaning that some aspects of primary care are managed by different teams with variable levels of organisational memory and differing capacity challenges for PCTs wanting to undertake contract reviews, including contract compliance monitoring.

It is therefore not possible to produce a ‘one size fits all’ guide. Rather this resource guide provides:

- the context for undertaking contract reviews (including compliance checks)
- a range of examples of approaches and documentation currently used by West Midlands PCTs which others may wish to adopt

Note: the examples of documentation have not been critiqued by the SHA or NHS PCC. PCTs wishing to use this, should seek legal opinion as appropriate.

It should be noted that this resource guide focuses solely on the contract compliance element of overall contract reviews, i.e. monitoring that practices conform to the contractual and statutory requirements of their primary medical services contracts.

PCTs may find it useful to refer to section 6 (‘Making it Happen’) of the World Class Commissioning ‘How To’ guide on improving GP services. This can be found at:


In particular, the Department of Health guide shows how contract reviews including monitoring contract compliance form part of an overall performance cycle.

This resource guide is designed to be generic across all primary medical care contracting routes. Although depending on local PMS Agreements, PCTMS and APMS contracts there may need to be some adaptations. It is important, however that PCTs are consistent in how they implement contract compliance checks, not just across primary medical contracts, but across all primary care contracts.
The following diagram illustrates the multi-faceted nature of contract reviews and how monitoring contract compliance is an essential component. All components collectively can contribute to PCT ‘balanced scorecards’ or equivalent.

Contract Compliance Monitoring in the context of Primary Medical Service Reviews
PCTs should be aware of what this guide is not:

- This resource guide does not aim to assist PCTs in tackling poor professional performance – there are other appropriate channels for this.

- This resource guide does not aim to assist PCTs in undertaking PMS reviews specifically, nor does it provide guidance on how to review its overall commissioning intentions e.g. review of LES, with a view to renegotiating specifications or decommissioning services.

This resource guide has been co-produced by PCT primary care leads, NHS PCC and NHS West Midlands. The input of the working group is acknowledged.

2. Contract review framework

As mentioned above, monitoring provider contract compliance is a ‘must do’ for PCTs. This exercise is a key component of reviewing contracts.

It is important that each PCT is clear on the differences between the various components of contract reviews. A framework is set out overleaf and details the purpose of each component part and the potential frequency.

There are benefits to be derived from a comprehensive approach to contract monitoring and reviews. If a PCT undertakes all aspects of contract reviews, then it will have a clear view of its practices’ performance. In turn, practices will also be clear about the PCT’s expectations of it.

Although undertaking these reviews will be time-consuming, the end result will be a close working relationship with every GP practice.
## A Contract Review Framework

<table>
<thead>
<tr>
<th>Contract review component</th>
<th>Purpose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract compliance</td>
<td>Examines practice compliance against statutory and contractual requirements. See Investing in general practice, Department of Health, 2003 Annex B   &lt;br&gt;Assures minimum standards are met including premises standards – see Premises Directions 2004, Schedule 1  &lt;br&gt;Plays a ‘future-proofing’ role in that collates information which could be used in due course as part of quality accounts (anticipated to be from April 2011). See High Quality Care for All, (DH, June 2008).  &lt;br&gt;Could assist practices prepare for CQC registration and accreditation by the RCGP (anticipated to be from April 2011). The CQC has the responsibility for registering all health and social care providers including primary care providers; primary care providers should note that they will need to demonstrate that they can meet the essential levels of safety and quality required for registration and will need to continue to meet them to maintain their registration.  &lt;br&gt;Helps built up a profile on practice that can be used for quality improvement activities such as ‘balanced scorecards’, or indeed as part a PCTs’ approach to managing poor performance.</td>
<td>Annual</td>
</tr>
<tr>
<td>Contract documentation review</td>
<td>A ‘health check’ to ensure that all contract documentation complies with Directions and regulations, and that all variations/amendments/ novations have been fully documented. Please refer to the West midlands PMS review toolkit for a complete list.  &lt;br&gt;This will be a desk-top exercise and will not need to involve the practices unless a problem is identified. It reminds PCTs and practices of their responsibilities to have up-to-date documentation.</td>
<td>Annual</td>
</tr>
<tr>
<td>Activity</td>
<td>Description</td>
<td>Frequency</td>
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<td>--------------------------------</td>
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<tr>
<td>Business review</td>
<td>Enables PCT and practices to discuss practice performance, objectives, quality standards for any enhanced services, the range of services provider, activity levels, good practice or support needs. Provides an opportunity for practices to share their future plans and aspirations, as well as issues – which forms part of the ‘provider development/market stimulation’ concept of being a WCC – see section 6.7 of the ‘Improving GP services’ - WCC ‘How To’ guide (weblink below). Opportunity to agree action plans for improvement and for practices and PCT responsibilities to be noted e.g. in terms of improving access and responsiveness, quality improvement initiatives, reducing health inequalities. Provides an opportunity for the PCT to discuss its overall strategic objectives and/or Operating Framework targets with practices and to encourage alignment of aspirations. As per Investing in General practice 2003 guidance (paragraphs 7.22-7.27), which state that the contract will be subject to a formal review process. The review will be based around an annual return from the practice, and there will also be an annual review, typically involving a visit. Enables PCT to collate information which could be presented to patients, to support the choice agenda – it helps build up a practice profile. Enables PCT to collate information which could be used in due course as part of quality accounts.</td>
<td>Annual</td>
</tr>
<tr>
<td>Quality review</td>
<td>Enables PCT to assure itself and patients of the quality of primary care services being provided. Quality reviews should cover far more than QOF. Undertaking QOF reviews/visits alone will not suffice. It should be noted that QOF is a voluntary process, and only contributes to an overall approach to supporting clinical governance. In addition to QOF, examines ‘Standards for Better Health’ compliance, prescribing patterns, secondary care referral rates, access, patient satisfaction and other clinical governance aspects. Covers all aspects of the Next Stage Review, including patient safety, patient experience, etc.</td>
<td>Annual</td>
</tr>
<tr>
<td>Quality review continued</td>
<td>Can be used as part of a quality improvement strategy for improving the quality of care – in terms of safety, effectiveness and patient experience and in order to reduce variations in quality and to ensure that high quality is a consistent part of everyone’s primary care experience. Contributes to the QIPP agenda with primary care playing a key role in driving improvements in quality and efficiency simultaneously in the light of the expected future financial context Mixture of both assurance and developmental, for all providers and not just the outliers. Helps a PCT understand any variation in quality and outcomes through benchmarking (e.g. using the PCCS tool) and any discussion that then follows. Following on, equips with the PCT with examples of innovation and good practice to share across other practices. Enables the PCT to collate information which could be presented to patients, to support the choice agenda Enables the PCT to collate information which could be used in due course as part of quality accounts</td>
<td>Enhanced services monitoring</td>
</tr>
</tbody>
</table>
2. Legal responsibilities and policy context: why monitor contracts?

Each Primary Care Trust is legally responsible (through the NHS Act 1977) to commission primary medical services for all of its population:

> Each Primary Care Trust... must, to the extent that it considers necessary to meet all reasonable requirements, exercise its powers so as to provide primary medical services within its area, or secure their provision within its area. [Section 16CC(1) of the National Health Service Act 1977]

**Through the NHS Constitution, patients have a number of rights:**

You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.

You have the right to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide [Section 2a of the NHS Constitution]

Therefore, PCTs are also held responsible for the quality and accessibility of services which we commission and for securing value for public money.

The contract which a PCT holds with a primary care provider is the key line of accountability for service performance. Therefore, in undertaking contract compliance monitoring, the PCT is discharging its legal responsibilities.

In support of the legal responsibility, the primary care policy context should also be considered. There are many reasons why a PCT must ensure compliance of its primary medical contracts.

**a. World class commissioning**

As a world class commissioner of primary medical services, a PCT should routinely review all of its primary medical services contracts (GMS, PMS, APMS and PCTMS). Monitoring contract compliance should be considered a fundamental building block. Without this, PCTs will fail to demonstrate they are world class commissioners. Monitoring compliance will contribute to WCC competencies 10, 5 and 8 in particular.

**b. The Next Stage Review, the Primary and Community Care Strategy and NHS 2010-15 from good to great**

The Next Stage Review and accompanying Primary Care Community Care Strategy, as well as the Quality and Productivity Challenge (formally known as QIPP) and the more recent 5 year vision for the NHS, all stress that high-quality care needs to be a consistent part of everyone's experience of primary and community care; that high quality care should be as safe and effective as possible; and that quality should be the organising principle for the NHS during the current period of significant financial challenge. Undertaking contract compliance monitoring will support the delivery of these imperatives.
c. The Quality and Productivity Challenge (formally known as QIPP)

The aims of the Primary Care and Community Care Strategy have been brought more sharply into focus over the last year with the financial challenges facing the NHS. As a result, there is a need to focus on improving quality and productivity in primary care and wider NHS services.

To improve the quality and efficiency of primary care in a systematic manner, and to help primary care better manage its wider ‘resource footprint’, there is a need to ensure a clear understanding of high quality primary care. This involves getting the best out of the provision of ‘routine’ or ‘core’ GP services and primary care’s role in committing wider NHS resources. To get the best of out the provision of GP services, PCTs must monitor compliance with contractual and statutory requirements.

d. The risks of not doing so

Lastly, the risks of not undertaking contract compliance checks are significant. Amongst other factors, PCTs risk being unable to assure themselves on quality and patient safety issues. They also risk failing to demonstrate themselves as World Class Commissioners.

3. Factors critical to success

Critical to successful contract compliance monitoring will be having board sign-up, clinical leadership, as well as sufficient capacity, capability and team-working across all departments in the PCT.

Those PCTs nationally which have succeeded in undertaking contract compliance monitoring have ensured that from the very outset, there was a common understanding of this area of work as a PCT priority, the contribution it could make to improving the quality and safety agenda for patients. The board sign-up to the chosen contract review framework and specifically the compliance component is critical. Similarly, the need to report back to the Board on the outcomes.

Ensuring that the whole process is seen as open and transparent is vital. It is important to communicate set procedures for raising issues and handling problems - in advance of undertaking any contract reviews and compliance checks- so they are dealt with as early as possible and at the appropriate level of the organisation.

It is good practice for the PCT to discuss its contract compliance monitoring plans with its Local Medical Committee, especially given that many practices might consider contract compliance monitoring to be daunting. Joint working with practices in the planning stages should lead to greater acceptability by practices and indeed, the design of user-friendly documentation. Promoting the benefits to practices, such as how it will support them in preparing for CQC registration will lead to engagement.

The PCT may wish to set out and agree a fair interpretation of some of the ‘grey’ areas of the contract clauses in advance of undertaking any monitoring processes. To be successful, PCTs will need to be judged as fair and transparent by the local GP community with clearly defined principles that are universally applied. The recognition of mutual aims and benefits will assist, as will the right attitudes and behaviours based on trust.
To work through the steps involved in planning, executing, following up and evaluating the outcomes of contract compliance monitoring will require a significant amount of primary care contract manager time, as well as input from a range of other supporting disciplines. Importantly, this should not be regarded as a one-off exercise, but the PCT will need to consider the commitment required to make sure this process and the potential outcomes are sustained in an ever-changing landscape.

The PCT needs to remain focused and to deliver on this priority. The PCT may wish to consider how the timescales for contract compliance monitoring aligns with the annual commissioning and contracting cycle and the current pressure to take actions that deliver on the Quality and Productivity Challenge. Timescales are also critical in terms of providing appropriate notice periods for contractors to prepare.

4. Principles

Some of the principles underpinning contract compliance monitoring include:

- PCTs giving a clear understanding to their GP practices of what is expected of them in delivering against contractual requirements
- transparency, consistency and fairness in approach to satisfy internal and external audit requirements at PCTs
- PCTs ensuring appropriate use of, and accountability for, public money
- consistency and fairness of approach across all practices, but allowing for some local flexibility where required
- adopt a collaborative and supportive approach with practices, seeking to develop and maintain a constructive relationship with practices whilst undertaking the compliance checks
- understand the contribution to QIPP priorities
- prioritise patient safety and quality assurance - high quality care for all patients
- have clarity of purpose - information should be collected for a specific purpose – there should be clear aims and objectives of the process
- there needs to be a joined-up with other departments within the PCTs to ensure a coordinated approach. When planning any visits the PCT needs to be mindful of the impact on practices who may be receiving visits from other parts.

5. Where to start…

Section 2 above outlined a contract review framework which several components. There is no one right approach to implementing the contract review framework as a whole. The PCT should scope the totality and identify areas that should be prioritised. It will again depend on a number of local factors including the organisational culture, existing relationships with GPs and historical context.
It is recommended that PCTs start by ‘getting the basics’ right, in terms of monitoring contract compliance as the first step.

However, PCTs may wish to consider the following factors when deciding upon the best approach to take:

**The approach will depend on the PCT’s individual starting point**

- Has the contract documentation for all contracts been properly maintained or is there a risk that the PCT is acting outside of the regulations?
- Does the PCT currently undertake annual contract review visits for all practices?
- Does the PCT undertake annual reviews and objective setting of PMS?
- Does the PCT regularly monitor performance and/or report this to the Board?
- Have there been any local quality or patient safety issues which would indicate a need to improve the robustness of review processes?
- Is there currently interest from Board members in VFM issues and/or awareness of primary care policy issues?

**The approach will depend on the PCT’s culture and attitude towards primary care**

- Does the PCT want to view these reviews as a performance improvement initiative versus a performance management tool?
- To what extent does the PCT want this to be an opportunity for face to face discussion with practices, compared to a paper-based remotely operated exercise?
- Does the PCT wish to present information anonymously or on a practice identifiable basis?

**The approach will depend on the engagement of the LMC**

- How will the PCT present its findings to the GP practices? Does the PCT want to give advance notice of its intentions, so that practices can respond accordingly?
- Does the PCT want to work in partnership with the LMC and ask for their views on the approach and/or the design of the review processes, or does it wish to simply inform the LMC of its intentions?
- Does the PCT intend to involve LMCs in the process from the early stages and stress to them that the process will be transparent?
- Does the PCT need to co-ordinate its actions with other PCTs that share the same LMC?
The approach will depend on how the PCT wants to sustain this work

- Does the PCT have a clear idea of how it will sustain its approach, rather than undertaking this as a one-off exercise?
- Does the PCT want to adopt an incremental approach to reviews, will it prioritise areas of indeed certain practices according to risk, or does it intend to review everything every year?
- Does the PCT have a view about which WCC competencies in particular it wants to address through undertaking these views?

6. Prioritisation

The sections above have highlighted the benefits and the reasons why a PCT should undertake contract compliance monitoring.

However, a significant challenge to all PCTs will be the available management capacity to undertake these checks, amongst a raft of conflicting priorities. This is also similar for practices in terms of being able to manage their workload. The timing of the compliance monitoring exercise is crucial.

It is important to ensure that any review processes is not too onerous, keeping monitoring to a realistic level and avoiding unnecessary duplication. This is also relevant for contract compliance monitoring.

A PCT will need to decide on how it intends to deal with this issue. The following options for prioritisation may be helpful.

<table>
<thead>
<tr>
<th>Option</th>
<th>Benefit</th>
<th>Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCT to cover limited number of contractual clauses only e.g. only 25 C&amp;S standards, or themed indicators</td>
<td>Ability to cover all practices.</td>
<td>Leaves PCT vulnerable in other areas</td>
</tr>
<tr>
<td>PCT to focus on those areas where they have already been significant events or SUIs</td>
<td>Ensures learning from a single SEA/SUI is maximised across all practices</td>
<td>Leaves PCT vulnerable in other areas</td>
</tr>
<tr>
<td>PCT to cover all contractual requirements</td>
<td>Allows the PCT to take a more hands-off approach in subsequent years</td>
<td>Very time consuming in terms of covering all practices and then any follow-up activities</td>
</tr>
<tr>
<td>PCT to cover 1/3 of practices over a 3-year rolling programme</td>
<td>Makes workload more possible</td>
<td>Leaves PCT vulnerable for those practices not covered PCT would need to justify how it was identifying practices to be covered e.g. based on risk</td>
</tr>
<tr>
<td>Option</td>
<td>Benefit</td>
<td>Disadvantage</td>
</tr>
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<td>-----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>PCT to build contract compliance reviews into other pre-existing processes e.g. QOF visits or business reviews</td>
<td>Enables PCT to undertake these monitoring activities at the best time of year, in terms of other activities</td>
<td>Could conflict with the PCT style of other visits e.g. developmental versus performance management</td>
</tr>
<tr>
<td>PCT undertakes monitoring via submissions from practices with no face to face visit</td>
<td>Makes PCT workload more manageable</td>
<td>Loses the benefits of discussion and does not permit PCT to identify good practice and share across other practices. Visits can validate the submissions. Missed opportunity for PCT to build relationships with practices. Need to avoid the exercise being perceived as a pure ‘tick box’ exercise.</td>
</tr>
<tr>
<td>PCT requires electronic submissions rather than paper submissions</td>
<td>More efficient processes</td>
<td>Some practices may need IT support.</td>
</tr>
<tr>
<td>Practices simply submit a declaration form – enhanced by spot checks</td>
<td>Makes PCT and practice workload more manageable</td>
<td>Leaves the PCT vulnerable</td>
</tr>
<tr>
<td>PCT contract compliance monitoring undertaken by single PCT officer rather than by a team involving public health, directors, NEDs, etc</td>
<td>Easy to timetable visits</td>
<td>Does not achieve wider engagement and understanding within PCT</td>
</tr>
</tbody>
</table>
7. Risks and issues

Just as there are risks resulting from a decision not to carry out contract compliance monitoring, there are a number of risks and issues with doing so. The PCT will need to identify and assess these at the outset, which may influence its approach and any outcomes.

Some of the risks include:

- The potential for an adverse impact on relationships with GP practices and the LMC, if it is seen as a ‘tick-box’ bureaucratic exercise
- Risk of wasting time, effort and damaged relationships if the PCT does not follow through agreed actions to conclusion or acts inconsistently either across practices or over time.
- The financial risks of engaging legal expertise if disputes arise – this can be mitigated if the PCT has a policy in place and an agreed approach, and if the PCT operates consistently within the regulations

Some of the issues include:

- the contract compliance monitoring process might result in an increased workload for PCTs and the need to escalate some issues
- the PCT management capacity to sustain an ongoing contract compliance monitoring process and evaluation of outcomes
- the need to pull in various data sources, including evidence of compliance from practices - which could make the process complex
- trying to define some of the ‘grey’ areas in the contractual clauses
7. Mapping contract reviews against WCC competencies

The contract review framework and potential outcomes have been assessed against the WCC competencies. For further details on how these relate to the commissioning of primary medical services, see:


<table>
<thead>
<tr>
<th>Competency 1 – locally lead the NHS</th>
<th>Competency 2 – work with community partners</th>
<th>Competency 3 – engage with public and patients</th>
<th>Competency 4 – collaborate with clinicians</th>
<th>Competency 5 – manage knowledge and assess needs</th>
<th>Competency 6 – prioritise investment</th>
<th>Competency 7 – stimulate the market</th>
<th>Competency 8 – promote innovation and improvement</th>
<th>Competency 9 – secure procurement skills</th>
<th>Competency 10 – manage the local health system</th>
<th>Competency 11 – make sound financial investments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract compliance</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Contract documentation review</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
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<tr>
<td>Business reviews</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Quality reviews</td>
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<tr>
<td>Enhanced services monitoring</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>Y</td>
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<td>Y</td>
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Part 2: GETTING STARTED... AND CLOSING THE LOOP!

8. Step-by-step guide

In terms of getting started, PCTs may find the monitoring and development cycle (below) is helpful:

4. **Acting**
   - Agree a written plan to ensure the practice is able to meet their contractual requirements
   - Prioritise areas for future review
   - Report areas of concern to the appropriate departments
   - Feed into future investments and strategic planning as appropriate
   - Modify the monitoring process if necessary

3. **Studying**
   - Review and reflect on the outcomes of the compliance checks within the PCT
   - Identify and discuss any areas for development that may have been highlighted by the report with the PCT and the practice
   - Review feedback from the practice
   - Identify areas of concerns
   - Review the monitoring process

1. **Planning**
   - Analyse current available information about the practices compliance with contractual and statutory requirements
   - Review information from complaints/PALS
   - Discuss the PCT monitoring proposals with the LMC
   - Obtain Board level approval of process
   - Agree internal process and timescales
   - Explain compliance monitoring process purpose to all GPs/Practice managers
   - Schedule the monitoring visits
   - Issue guidance to all practices

2. **Doing**
   - Collate relevant available information and pre-populate a proforma/report - send to the practice
   - Engage with practice during any monitoring visit, using the opportunity to talk about their performance, the contract and PCT plans
   - Analyse any evidence submitted by practices and generate a draft written record of checks
   - Written record sent to practice for factual validation
   - Final record sent to practice and PCT
   - Request feedback from the practice
9. Step-by-step process explained

The annual contract compliance monitoring process follows a logical step-by-step path. These steps are designed to guide PCTs through the process and are by no means prescriptive or exhaustive.

<table>
<thead>
<tr>
<th>Planning</th>
<th>Doing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step one.</strong></td>
<td>Collect and collate all of the relevant information and evidence that is available from within the PCT. Pre-populate any monitoring proforma for each practice.</td>
</tr>
<tr>
<td><strong>Step two.</strong></td>
<td>Send the pre-populated information to the practice, the practice allowing ample time to complete/validate/sign and return to the PCT prior to the visit.</td>
</tr>
<tr>
<td><strong>Step three.</strong></td>
<td>Analyse the information and any supporting evidence that has been returned and circulate to all members of the monitoring team. This information will form the basis of the agenda for the monitoring check with the practice. It is recommended that you share the documentation with the practice prior to the visit.</td>
</tr>
<tr>
<td><strong>Step four.</strong></td>
<td>Conduct the monitoring visit and complete the compliance check documentation with observations, findings and comments. Ensure good record keeping with appropriate narrative to underpin findings or decisions.</td>
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<td><strong>Step five.</strong></td>
<td>Obtain Board approval for the chosen monitoring process.</td>
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<tr>
<td><strong>Step six.</strong></td>
<td>Share and explain the monitoring process with all of the GPs and practice managers in your area. Issue guidance to all practices about how the process will work, what you will be monitoring and the timescales.</td>
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<tr>
<td><strong>Step seven.</strong></td>
<td>Prioritise the contract compliance checks using data from a range of sources within the PCT e.g. the complaints department, clinical governance department, infection control department, etc.</td>
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<tr>
<td><strong>Step eight.</strong></td>
<td>Schedule the contract compliance visits with the practices.</td>
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</table>
At all times, ensure optimum record keeping.
During the planning stages (and in dialogue with GP practices and LMCs), be aware of the contractual levers available, particularly around the contractual requirement for practices to provision of ‘any information reasonably required’. See:

**The National Health Service (General Medical Services Contracts) Regulations 2004**

**Provision of information**

77. - (1) Subject to sub-paragraph (2), the contractor shall, at the request of the Primary Care Trust, produce to the Primary Care Trust or to a person authorised in writing by the Primary Care Trust or allow it, or a person authorised in writing by it, to access –

a. any information which is reasonably required by the Primary Care Trust for the purposes of or in connection with the contract; and

b. any other information which is reasonably required in connection with the Primary Care Trust’s functions.

**The National Health Service (Personal Medical Services Agreements) Regulations 2004**

**Provision of information**

73. - (1) Subject to sub-paragraph (2), the contractor shall, at the request of the relevant body, produce to it or to a person authorised in writing by the relevant body, or allow it, or a person authorised by it, to access –

a. any information which is reasonably required by the relevant body for the purposes of or in connection with the agreement; and

b. except where the contractor is a Primary Care Trust, any other information which is reasonably required by it in connection with the relevant body’s functions
10. Index of resources

To assist PCTs in undertaking contract compliance monitoring activities, a number of West Midlands PCTs (from the working group) have agreed to share their documentation relating to contract reviews and contract compliance monitoring.

Please note: the examples of documentation have not been critiqued by the SHA or NHS PCC. PCTs wishing to use this, should seek legal opinion as appropriate.

1. NHS Heart of Birmingham
   - Contract Review
   - Contract Visit template
   - PEC paper

2. NHS Coventry
   - Registration and Screening Service
   - Guideline for de-registering patients
   - Guideline for registering patients
   - Full review papers
   - PMS work plan
   - Reduced visit papers

3. NHS Dudley
   - GMS Framework
   - PMS Framework
   - Contract compliance document

4. NHS Shropshire County
   - Balanced Scorecard (draft)

5. NHS Solihull Care Trust
   - Final template

6. NHS Walsall
   - Clinical Governance Workbook
   - Explanation of approach adopted

7. NHS Wolverhampton
   - Excellence in Primary Care development framework
   - Managing Independent Contractors

Good practice from NHS Suffolk and NHS South West Essex has also been included:
   - GP Performance Framework
   - Breach Notice
References and other resources

Department of Health (2003) Investing in general practice. See:

Department of Health (2003) Investing in general practice Annex B. See:

Department of Health (2003) Delivering Investment in general practice. See:

Department of Health (2004) The National Health Service (General Medical Services – Premises Costs) (England Directions). See:

Department of Health (2007a) World class commissioning: vision, 3 December 2007. See:

Department of Health (2007b) WCC competencies, 3 December 2007. See:

Department of Health (2008a) High quality care for all: NHS Next Stage Review final report, 30 June 2008. See:

Department of Health (2008b) National Primary and Community Care Strategy, July 2008

Department of Health (2009a) Primary care and community services: improving GP services, 27 January 2009. See:

Department of Health (2009b) NHS 2010-15 From Good to Great. See:
Department of Health (2010) NHS Constitution Handbook. See:

Links to other useful documents:

Primary Medical Services, useful documents, May 2009:

Balanced scorecard for general practice:

The development of a quality scorecard to support primary care contracting and commissioning:
www.pcc.nhs.uk/uploads/primary_medical/october_08/scorecard_1_1.pdf

Building Foundations: Managing Primary Medical Contract Changes, 23 June 2009:

Primary Medical Care: Contract Management: Breaches, Sanctions and Terminations:
For further help and advice

For further information, advice or support, PCTs may wish to contact:

• Patricia Barnett, Programme Consultant - Primary Care and PBC NHS West Midlands at patricia.barnett@westmidlands.nhs.uk
• Marion Todd, West Midlands Primary Care Commissioning Advisor, NHS PCC at marion.todd@pcc.nhs.uk

NHS PCC also provides Building Foundation training for Primary Medical Services – see www.pcc.nhs/events for further information

Acknowledgements

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• Patricia Barnett, NHS West Midlands
• Carol Marston, formerly NHS PCC
• Marion Todd, NHS PCC
• West Midlands PCTs
### Annex B: Contractual and statutory requirements

<table>
<thead>
<tr>
<th>Contractual and Statutory Requirements</th>
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<tr>
<td>1. The practice provides patients with a leaflet which is available to patients and includes:</td>
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<tr>
<td>- practice opening hours</td>
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<td>- whether an appointments system is operated by the practice for doctor and nurse appointments</td>
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<td>- how to access a doctor or nurse</td>
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<td>- a description of the services provided by all members of the team and how patients can obtain them</td>
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<td>- how to obtain repeat prescriptions</td>
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<td>- how to make a complaint or comment on the provision of service</td>
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<td>- a description of patients’ rights and responsibilities</td>
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<td>- how the practice uses personal health information.</td>
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<td>2. The practice has an agreed procedure for handling patients’ complaints which complies with the NHS complaints procedure and is advertised to the patients.</td>
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<td>3. Where patients are requesting to join the practice list, the practice does not discriminate on the grounds of:</td>
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<td>1. race, gender, social class, age, religion, sexual orientation or appearance</td>
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<td>2. disability or medical condition.</td>
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<td>4. The practice adheres to the requirements of the Medicines Act for the storage, prescribing, dispensing, recording and disposal of drugs including controlled drugs.</td>
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<td>5. Batch numbers are recorded for all vaccines administered.</td>
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<td>6. The practice has a policy for consent to the treatment of children that conforms to the current Children’s Act or equivalent legislation.</td>
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<td>7. The premises, equipment and arrangements for infection control and decontamination meet the minimum national standards.</td>
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<td>8. The practice ensures that all healthcare professionals who are employed by the practice are currently registered with the relevant professional body on the appropriate part(s) of its Register(s) and that any employed general practitioner is a member of a recognised medical defence organisation and registered on a primary care performers list (or equivalent).</td>
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<td>9. All professionals working in the practice are covered by appropriate indemnity insurance.</td>
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<td>10. All doctors have an annual appraisal.</td>
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<td>11. The practice has a system to allow patients access to their records on request in accordance with current legislation.</td>
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<td>12. There is a designated individual (data controller) responsible for confidentiality.</td>
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<td>13. If the records are computerised there are mechanisms to ensure that the data are transferred when patients leave the practice.</td>
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<td>14. If the team uses a computer, it is registered under, and conforms to the provisions of the Data Protection Act.</td>
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