The new GMS contract explained

Focus on….

The Quality & Outcomes Framework – Update

This guidance note is the third in a series focussing on the quality & outcomes framework and has been produced by the General Practitioners Committee to help GPs and Local Medical Committees with the quality & outcomes framework under the new GMS contract. We would advise all GPs to read the contract document and supporting documentation, available on the BMA website at www.bma.org.uk. The GPC has produced a list of commonly asked questions and answers that can also be found at the website address.

Similarly, the NatPaCT website at http://www.natpact.nhs.uk/cms/111.php provides further information, as well as 'Frequently Asked Questions' which have been logged via their Helpline. The Guidance which has been published by the Department of Health can be found at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4070242&chk=tokzna and this provides further comprehensive support.

Although there may be some differences in process in each of the four countries of the UK, the principles of this guidance apply to all.

This guidance includes areas within the framework mentioned in earlier guidance notes that have now been clarified.

Computer Software
In previous guidance notes we mentioned that software would be available to help practices calculate points under the quality and outcomes framework as well as help with exception reporting. An interim solution has been constructed prior to national IT systems being implemented during this August (2004).

Before the beginning of each financial year, practices will agree with PCOs the level of quality points that they aspire to achieve by the end of that financial year. The aspiration payment will then be determined, and will be paid to practices in twelve monthly instalments during the financial year. This applies for the first year. For the second year, see later in this guidance note, the aspiration payment will be based on 60% of the previous year's achievements (2004/05), uprated for any increase in pounds per point.

The Interim Aspiration Utility (IAU) has been developed as a tool in England to support this process.

The IAU is an Excel workbook. Practices should have entered aspirations against all of the quality and outcomes framework indicators within the spreadsheet. The IAU will also calculate practices' aspiration payments for 2004/05 from the information entered. Practices only need to enter a percentage or, as appropriate a Yes/No response against individual indicators. Guidance for practices accompanied the spreadsheet.

Scotland and Northern Ireland intend to adapt the IAU and PCOs should have received information on this.

Wales has adopted a different corporate approach utilising MSDi's software utility "Contract Manager". All practices and Local Health Boards in Wales have been informed of this approach for aspiration setting and achievement reporting.

Disease Prevalence

Previously we reported that urgent work was being carried out to finalise the arrangements for implementing disease prevalence. This work was completed in December so that quality payments will be adjusted by practice disease prevalence as recorded by the quality and outcomes framework data and relative to national prevalences. This will apply to quality and outcomes framework achievement payments from 2004/05 and aspiration payments from 2005/06.

The aim of the prevalence adjustment to the clinical domain payments is to deliver a more equitable distribution of quality rewards in the light of the different workloads that practices will face in delivering the same number of quality points.

The rationale for a prevalence factor is because we believe that the workload associated with treating 100 patients with a particular disease is not the same as for treating 10 patients. Moreover, the link between workload and prevalence is not a direct linear relationship. Thus, we have agreed to a five per cent cut-off at the lower end of the prevalence distribution curve for each disease, to reflect the reality of the work that has to be undertaken by all practices, including those with low prevalence, if they are aspiring to high quality care in the clinical domain. Therefore if a practice's prevalence for a particular disease is above zero but within the lowest five per cent, its prevalence factor will be raised to the five per cent minimum.

Another reason for the agreement that the raw prevalence figure will not be used is because the outliers from the distribution are very wide and we did not want to create additional financial instability for practices.

After having modelled a number of transformations of the prevalence data, we felt that a minimal transformation using the square root was the best option because it would provide just rewards at both ends of the spectrum. This would provide a minimum payment that was significantly higher than the minimum using raw data while maximising rewards for practices with high prevalence, although these would be less than if using raw data.

The Quality and Outcomes Framework Management and Analysis System (QMAS) and National Prevalence Day

Disease register information will be extracted from the clinical systems of all practices at the same time, through automated links, and aggregated by the new central quality and outcomes framework management and analysis system. The QMAS will calculate the national recorded prevalence for each disease area. Practices will know approximately what their prevalence will be from the reports available on QMAS throughout the year.

From 2005, 14 February will be National Prevalence Day which is as late in the financial year as possible for including the data from manual practices, whilst enabling prompt payment of achievement rewards by the end of April.

Practices will be asked to submit data register information by 21 February from 2005. Practices which are connected to QMAS will have this data automatically submitted, but those who are participating in the quality and outcomes framework, without QMAS, will need to submit this manually. Those that do not submit by 14 March, but are participating in the quality and outcomes framework will be treated as having the lowest national contractor prevalence when their achievement payment is calculated. They will not be included in the national calculation of practice prevalence factors.

Further details on the methodology, data collection and practice evidence in relation to disease prevalence can be found in chapter 3 and annex A of the Department of Health guidance "Delivering Investment in General Practice: Implementing the new GMS contract, December 2003".

In Wales, Local Health Boards and practices will be notified of the full process (including key dates) in due course and should refer to the Welsh Assembly's version of "Delivering Investment in General Practice: Implementing the new GMS contract, January 2003".

Quality Aspiration Payments

Since the last guidance note the way the aspiration payments will be paid for 2005/06 has changed. From 2005/06 onwards they will no longer be a third of the predicted total points for quality with the

other two thirds to be paid on achievement as measured at the end of the year. However, this will remain the case for 2004/05.

For 2005/06, aspiration payments will be based on 60% of the previous year's achievement points that were scored in 2004/05 uprated to 2005/06 prices. The 2004/05 disease prevalence factors will apply as the payment is based on the 2004/05 achievement payment. Payments will continue to be weighted by the practice's relative list size and they will be paid in monthly instalments by the end of each month. Practices can also choose to aspire and be paid a third of aspiration, in the manner of this year's process, if they do not have an achievement (or a realistic achievement) for 2004/05.

More information can be found in chapter 3 and section C under the quality and outcome framework in the Department of Health guidance "Delivering Investment in General Practice: Implementing the new GMS contract, December 2003." Welsh practices and Local Health Boards should refer to the Welsh Assembly's equivalent of this document.

A Brief Note on the Achievement Payments
The achievement payment will be calculated automatically by the QMAS IT system, in the following way:

(i) points achievement is assessed on National Quality Achievement Day (31 March) by the QMAS system. QMAS will automatically use the data on it at 31 March to create an achievement report for each practice and send it directly to the PCT. Practices will be able to see the report, and must confirm by 7 April that it is correct, using a form on QMAS.

Welsh practices and Local Health Boards will be notified of the full process (including key dates) in due course.

(ii) for the clinical domain, the £75 per point in 2004/05 (£120 in 2005/06) is multiplied by the Adjusted Disease Prevalence Factor (APDF) for each disease area and this in turn is multiplied by the points achieved in each disease area

(iii) for the additional services domain (cervical screening, child health surveillance, maternity services, contraceptive services), the £75 per point in 2004/05 (£120 in 2005/06) is adjusted by the relative size of the practice's target population compared to the national average

(iv) for the other domains (except the additional services domain) the £75 pounds per point in 2004/05 (£120 in 2005/06) is multiplied by the points scored, including points for the holistic care and quality practice payments and access bonus

(v) these payments are added together and adjusted by the practice's list size relative to the national average (currently 5891 in England*). This produces the total quality and outcomes framework payment

*NB – the Welsh national average list size is 5885.

(vii) the aspiration payment is deducted from the total quality and outcomes framework payment to produce the achievement payment.

Recording and Reviewing Practices' Achievements
Achievement against the quality framework will be reviewed by the practice providing annual information (standardised report) on its performance together with a PCO (review) visit to the practice.

PCOs will visit practices annually to review the practice's achievement against the quality and outcomes framework indicators. The frequency and intensity of visits may decrease in future years if the PCO is confident of the practice's performance against the indicators, subject to the mandatory requirements for financial audit. Similarly, the frequency of visits may increase where there are concerns about data accuracy or suspected fraud for example.

The review will be founded on a relationship between the practice and the PCO based on the principles of high trust, evidence base, appropriate progression and development, minimising bureaucracy, and ensuring compliance with the statutory responsibilities of the PCO.

Data protection principles will apply and the information will not be used for a purpose other than the purpose for which it is collected. If the PCO is to access identifiable patient data as part of a contract review visit then explicit consent should be obtained from the patient in accordance with the Data Protection Act 1998. The NHS Code of Practice for Confidentiality says that patient identifiable information should not be used unless it is not practical to anonymise the records. The negotiating parties are currently working on a Code of Practice for access to and use of such data.

The GPC believes that responsibility for obtaining consent from the patient lies with the PCO. The type of consent provided (or withheld) should be recorded in the patient's record.

PCO Review
It will be important that PCOs are also reviewed within the quality framework to ensure consistency of approach towards all practices. This will include any necessary training for reviewers.

PCO-wide achievement against the quality framework will be independently inspected in England and Wales by the Commission for Healthcare Audit and Inspection and by equivalent organisations in Scotland and Northern Ireland.

The process to be followed during the annual review is under discussion by the GPC, Departments of Health and the NHS Confederation. Further details will be published by the end of April 2004.

Reviewing the Quality and Outcomes Framework
The framework will be updated in future years, particularly in the light of changes to the evidence base underpinning the indicators, advances in health care, changes in legislation or regulation and the need for further clarity, or so as to include new areas.

There will be a formal review process through which changes to the framework will be recommended by a UK-wide independent expert group. This will be in place before the end of 2004.

These decisions will be based on a review of the quality framework and direct monitoring of the quality standards through PCOs and indirect monitoring through academic research and tracking studies. Requests for clinical and organisational areas to be added to the framework will only occur if they fulfil the principles of the framework and attract genuine additional resources. GPs can help in this process by producing accurate statistics regarding morbidity via the quality and outcomes framework that will potentially help to make the allocation formula more robust.

The group will consider the latest evidence available and make recommendations to the four Health departments or their agents and the GPC.

However, no changes will be made before April 2006 other than in the case of a sudden change in the evidence base or the law that made a current indicator inappropriate.

Enquiries and information
Please send enquiries on the quality and outcomes framework to the GPC office at:
Info.gpc@bma.org.uk

Questions and answers
Q Do I have to shut my practice for the annual review visit?
A It is not expected that practices will shut for the annual review visit. The procedure will be designed to avoid disruption to patients and practices so far as is possible.

Q Will practices' achievements in the quality and outcomes framework be publicly known?
A Concerns about league tables of points are very valid. At present there is no intention to make practices' achievements public. However, because of the Freedom of Information Act which comes into force from January 2005, this may change. The GPC will be consulted along with other stakeholders by the Department of Health on future proposals.

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