

Before:

Paul Kelly, Chairman,

Dr. John Canning.

Mrs. Carol Dorking.

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Applicant

and

#

Respondent

DETERMINATION

1. This application for dispute resolution was heard on the 14th and 15th December 2009 at the Harrogate offices of the National Health Service Litigation Authority. The Applicant was represented by # of Counsel and the Respondent by #
2. The dispute relates to the payment of Quality Outcome Framework achievement awards for the financial year 2007/2008. The date of assessment of achievement is 31st March 2008.
3. The Respondent's position is that payments (Aspiration Payments) made during the same financial year and calculated on the basis that certain outcomes would be achieved at the assessment date but which were not achieved to the satisfaction of the PCT led to an overpayment of # which it is recovering under directions enabling it to do so.
4. The Applicant challenges the method by which the Respondent arrives at its decision that not all claimed QOF achievements were reached in the 2007/08 period. In particular she raises concerns about the lack of support from the PCT in training for herself and staff on the Vision Software used in the practice and an essential tool in maintaining QOF records; complains about the lack of support from the PCT when she was required to take off a lengthy period to look after her ill daughter; does not consider the assessment visit on 5th March 2008 adequately took into account the specialised nature of her patient demographics which has a predomination of young Asian families; that the PCT inspection team was generally biased against her; that the inspection team misunderstood aspects of the template against which the outcomes were measured, were inadequately trained in Vision Software and were insufficiently rigorous in examining the various registers, all of which led to unfairness, bias and wrong outcomes.

5. The Applicant has exhausted the internal appeal mechanism and remains dissatisfied with the outcome. It is for the Panel to re-determine the issues. Contractors are not contractually bound to take part in QOF but where they do they must bear the burden of establishing any entitlement on balance.

6. The summary of QOF indicators is divided into the clinical domain with its emphasis on maintaining disease registers identifying patient's with particular conditions and related diagnosis and disease management, the organisational domain dealing with, in essence, practice management, the patient experience domain and the additional services domain relating to services not undertaken by all practices as part of the base contract. For ease we shall follow the order of a document common to the parties entitled 'Summary of Indicators' with a handwritten notation as to whether the Respondent/Applicant disputes or agrees with the outcome.

7. The clinical domain is divided into 19 sub-sections all of which (Depression and Smoking Indicators aside) require the practice to produce a register of patients with the relevant condition. There are further sub-divisions where QOF points are allocated depending upon the management of patients on the register. Essential to the accuracy of the points claimed under the further sub-divisions is the integrity of the registers in the clinical domain. Local PCT procedures provide that if a register is shown to be more than 10% inaccurate no points can be awarded either in respect of keeping the register nor, because payments in respect of ongoing management is based on percentages of persons on the register, the further sub-divisions.

8. Of the 17 sub-sections within the clinical domain that require management of a register the inspection team considered 5 in number, namely, CKD, diabetes, IHD, cancer and hypothyroidism. The team concluded there was a 10% error in the registers examined and therefore disputed the Applicants entitlement to payment in respect of all 17 registers.

9. Guidance on QOF issued by the Department of Health (page 214 of the bundle prepared for this case) recognises the importance of the disease registers; accepts they may not be a 100% accurate and should be tested by comparing reported prevalence with expected prevalence. Guidance does not refer to the 10% test applied in this case. It needs to be borne in mind that a small practice such as this could easily be disadvantaged by applying the 10% rule, especially where there are only small numbers of patients on any given register. The need for consistency within the PCT is understood but equally there should be a means of adapting local procedures to make them more specific to the nature of the practice. Regrettably we are driven to the view that the manner of assessing the integrity of the disease registers was insufficiently rigorous and should be repeated with the 'prevalence' test replacing the '10% test'. This may mean having to review the findings in respect of all disease registers rather than the 5 that were examined.

10. Irrespective of the outcome of repeated assessment there are some sub-divisions in the clinical domain disease registers about which we can make positive findings and these are as follows:-

MH9. The Applicant labours under a fundamental misunderstanding of her responsibilities to patients in this category. She believes her responsibilities extend to the limited role of taking blood pressure and recording height and weight whereas MH9 has a much broader ambit. Given the Applicants basic misunderstanding it follows there can be no evidence to support payment under MH9 and this item should be disallowed.

MH6. There is no evidence to support compliance and should be disallowed.

High value indicators relating to blood pressure readings apply to a number of disease registers. The Respondent's findings are that readings frequently appeared without any audit trail as to how and under what circumstances the readings were obtained i.e. patient's own reading at home/in surgery with/without appointment. It was also noticeable that a number of b/p entries were dated during the week-end prior to the assessment. By way of explanation the Applicant says she runs the practice partly on a walk in basis, sometimes seeing 100-120 patients per day, so blood pressure readings would have been taken and recorded opportunistically. We find that explanation unconvincing and symptomatic of the chaotic way in which the practice keeps its records. No payment should be allowed in respect of any blood pressure readings in respect of any register.

Symptomatic of the poor record keeping is that full asthma reviews were recorded in only 4 cases of the 10 reviewed and those 4 were carried out by a drug representative nurse. Separate records were

kept but the findings were not transferred to the patient notes. Again we found the Applicant's explanation that she only noted adverse findings on the reviews she undertook as unconvincing. There was no evidence of a co-ordinated asthma review. Conversely there was evidence of an inconsistent approach within the practice to the management of asthma. Payment should be made only in respect of the reviews undertaken by the drug representative nurse – 4 in number. It is the responsibility of the practice to have clear unequivocal evidence available to support all claims. The explanation tendered by the Practice Manager in paragraph 33 of her statement is late and unconvincing.

There was no clinical evidence for the finding of dementia in the single patient who comprised the register. The Applicant's assertion that she knew the Patient and that was her clinical finding is not an evidence based diagnosis. Further there was no evidence to show, even if the Patient did suffer dementia s/he received the individual assessments required by DEM2. Payments relating to Dementia should not be allowed.

In respect of Cancer Indicator 3 – cancer care review – only one of the reviews had any details which were near to the requirements described within the indicator, other notes failed with sufficient clarity to identify ongoing care and treatment in accordance with best practice. This payment should not be allowed.

Med 7. The Applicant informed the inspection team she had 6 patients on injectable neuroleptic medication to whom she administered injections on a regular basis. Upon further inquiry she revised this to 4. No evidence was made available to show these injections were made. Claim refused.

Epilepsy 7 and Dem 2 both require a practice review. Based upon our findings relating to reviews generally within the practice neither should be allowed. There is no evidence from which it can be safely concluded that appropriate reviews were undertaken.

11. Within the Organisational, Patient Experience and Additional Services Domains we make the following findings in respect of disputed indicators:-

Records and Information 8. Plainly allergies which remain only on the paper records means clinicians need to refer to both paper records and the computer to observe a complete picture. This is not wrong but is undesirable. This payment should be allowed.

Records 9. There is no linking between medication and the condition for which it is prescribed. This payment should not be allowed.

Record 11. Notwithstanding our comments on blood pressure matters in the disease registers there is sufficient evidence under this heading to justify payment.

Record 15. This is now accepted for payment by the PCT on the basis of 60% achievement and should be paid accordingly

Record 17. As 11 above is accepted so too should this indicator assuming QMAS reaches appropriate level of 80%

Record 18 and Record 20 As part of the internal appeal process in respect of these issues the Respondent, with the consent of the Applicant invited North West Internal Services to consider aspects of the practice. The report is dated August 2008 and at paras. 3.32 to 3.58 it considers at length shortcomings in note summarising. We have considered that report together with the evidence of Dr. Manning –one of its authors – and the Applicant and are satisfied that the reservations emerging from the report is a fair reflection of Dr. Manning's findings. No useful purpose is achieved by setting out the report which confirms our view that record summaries were generally inadequate, inaccurate and not contemporaneous.

Record 19. We accept evidence of the Respondent that summary codes were added to patient records before notes were received by the practice. Read codes had been added but they did not

accurately reflect that the information/summary was accurate. Many inconsistencies were found. The indicator has not been achieved.

Record 21. Requires the ethnic origin is recorded for 100% of new registrants. No evidence of this was provided in March on the date of the inspection but evidence in the form of a computer printout as part of the present process. We heard that the system had moved from manual to electronic in the year in question and that it was the practice's contention that the indicator had been met. We did not see any evidence of this and the print out received did not show 100% compliance. The Indicator is not to be paid

Information for Patients 7. In her statement (Para.16.1) the Applicant says "..... I used to see 100 to 120 patients a day with and without appointment." This is impossible with only three hours of surgery per day as set out on the engraved board outside the premises. A "Closed for Lunch 1-2" is also engraved. There is evidence from the PCT that calls within usual opening hours are unanswered or answered by an answering machine (random call 17.50 hours 14th April 2009). There is also evidence from employee contracts (page 272) that the Receptionist at least must arrive on time for morning and afternoon surgeries – indicating a clear break in provision. We are not satisfied to the required standard that patients are able to access a receptionist via telephone or face to face for at least 45 hours per week, Monday to Friday and this payment should be disallowed.

Education 9. Typical of the Applicants approach to her responsibilities for providing evidence to justify QOF payments is her late response to the issue of staff appraisals. There is now evidence of appraisals but submitted after the review but bearing dates as if they were in existence at the time of the review causing us to doubt the accuracy. Payment should not be made.

Practice Management 3 – Status of Hepatitis B of doctors and relevant staff. In otherwise generally unimpressive evidence the Applicant's son satisfies us that, in the absence of any clear definition of "relevant practice employed staff", he was an occasional visitor rendering clerical assistance and not formally employed. As such his Hep B status was not required. However there is and remains no evidence of the status of the locum #. We recognise she practices elsewhere but that may well be in a discipline which does not require her Hep B status to be ascertained. No payment to be made.

Practice Management 6. Person specifications and job descriptions. From the dates on the face of the documents they should have been available on the date of inspection, rather like the appraisals, but again they have been produced late. Payment should not be made.

Practice Management 7. Late evidence of the testing of various appliances is inadequate to satisfy the wide ambit of this provision, requiring as it does clearly referable systems, a defined responsible person, clear recording, pre-planned schedules and system for reporting faults. Payment should not be made.

Medicines Management 7 – see above

Medicines Management 10. No evidence is achievement is produced. Should not be paid.

Medicines Management 11 and 12 – medication reviews. The Respondent's own inspection protocol (page 153) required either a computer print out or manual check of fifty or more records in both sub categories. In the end the inspection examined 14 sets of patient records in both categories. Again late evidence by way of a computer printout provided by the Applicant indicates the outcome had been achieved in both categories. We also have in mind the additional evidence of # (paras. 3.59 to 3.68 of her report) on the subject matter of M.M. 11 and 12. That evidence relates to the quality of the record keeping and identifies shortcomings. She concedes only a small number of records were

examined. At the inspection it was open to the Respondent to accept the computer evidence which it may very well have done. Not without reservation and partly in the interests of finality, payments under both sub-categories should be made.

Patient Experience Domain PE1. Length of consultations. The practice operates a somewhat idiosyncratic consultation system with some appointments and some walk in patients. Of itself there is nothing wrong but there does appear a consistent failure to note down lengths of consultations. Against that the Respondent gave a 4 under this heading following the inspection – a clear pass. Fairness requires this heading be paid.

Patient Experience 5 – Patient surveys. The report on activities undertaken within the reporting year was not available on the date of inspection nor at any time up to the 31st March 2008. A document was submitted late (348) but without date or any indication on its face that it was prepared or at least in the course of preparation during the relevant period which distinguishes it from other material we have been prepared to accept late. Payment should not be met.

Dated 20th January 2010.

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Paul Kelly,

Chairman for and on behalf of the Panel.