NHS Resolution

18 July 2024

FILE REF: **SHA/26165**

8th Floor
10 South Colonnade
Canary Wharf
London
E14 4PU

Tel: 0203 928 2000
Email: nhsr.appeals@nhs.net

DECISION MAKING BODY:	**GREATER MANCHESTER INTEGRATED CARE BOARD ("THE COMMISSIONER")**
GMS CONTRACTOR:	**MOUNT ROAD SURGERY 110 MOUNT ROAD GORTON MANCHESTER M18 7BQ**
DISPUTE RESOLUTION:	**NATIONAL HEALTH SERVICE (GENERAL MEDICAL SERVICES CONTRACT) REGULATIONS 2015**
RE:	**APPLICATION FOR DISPUTE RESOLUTION REGARDING IMPROVEMENT INDICATORS**

1. Outcome

1.1 Based on the information before me I am of the view that the Contractor has not met the criteria for the Quality Outcomes Framework Quality Improvement Optimising Access indicator (QIOA011 and QIOA012).

1.2 I note that neither party has submitted a claim for interest with regard to this dispute so I make no determination in this regard.

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1. INTRODUCTION

1.1 The above Contractor referred the dispute in relation to its General Medical Services Contract for dispute resolution under the provisions of Regulation 83 of the National Health Service (General Medical Services Contracts) Regulations 2015 (the "Regulations").

1.2 The Secretary of State for Health and Social Care has directed that NHS Resolution exercise the functions of dispute resolution on their behalf. I, as an authorised officer of NHS Resolution, have made this determination.

2. APPLICATION FOR DISPUTE RESOLUTION

2.1 By letter dated 14 February 2024 the Contractor applied to NHS Resolution, for dispute resolution.

2.2 I have had regard to the following documents made available to me in consideration of this matter to ensure the just, expeditious, economical and final determination of this dispute:

2.2.1 Email from the Contractor of 16 February 2024 with enclosures;

2.2.2 Email from the Contractor of 23 February 2024 with enclosures;

2.2.3 Email from the Contractor of 11 March 2024 with enclosures;

2.2.4 Email from the Contractor of 14 March 2024 with enclosures; and

2.2.5 Email from the Commissioner of 2 April 2024 with enclosures.

3. PARTIES SUBMISSIONS

The Contractor's application

3.1 In a letter dated 14 February 2024, the Contractor stated:

"Request for dispute resolution regarding decision of NHS Greater Manchester in relation to achievement of 2022/23 QOF Quality Improvement Optimising Access indicator.

Enclosures

Mount Road – QI Access FIRST SUBMISSION.pdf

Mount Road – QI Access Updated Template.pdf

GP Contractor Appeal Quality Improvement Indicator.pdf

P84050 Mount Road Surgery DCCP outcome final.pdf

GP Contractor 2nd Appeal QI Indicator.pdf

Mount Road QoF Appeal outcome.pdf

Emails.pdf

The practice was informed by email on 26 May 2023 that its submission in relation to the Optimising Access Quality Improvement indicator for QOF year 2022/23 had not been assessed as achieved (page 1, Emails.pdf).

The practice felt this decision was unfair and with support from [MM], Digital & Transformation Lead for our PCN, submitted an appeal on 30 May 2023 (GP Contractor Appeal Quality Improvement Indicator.pdf and Mount Road – QI Access Updated Template.pdf). For ease, the details of the appeal are reproduced below.

> *"The panel feedback stated "The evidence provided by the practice focused on BAU, not improvement or additionality."*
>
> *The QOF guidance does not require any degree of additionality, but the practice has in fact demonstrated this. The submitted report specifically states that the number of face to face appointments has been increased.*
>
> *Furthermore, the QOF guidance states "The overarching objective of this QI module is to contribute to improvements in access to general practice". Specifically, this can include optimising use of capacity within practice and also in wider primary care services, and considering access beyond the practice.*
>
> *The practice has clearly documented its improved use of LIVI video consultation, extended access appointments, winter pressures appointments and MARIS appointments. It has further confirmed that it amended its GP sessions to provide more early morning appointments based on a review of utilisation data. The report confirms that the additional face to face appointments were being booked and the numbers subsequently increased again. The report also confirms a reduction is patient complaints about access.*
>
> *The panel feedback is disputed as inaccurate and setting expectations beyond the official QOF guidance. In order to make changes and improvements, it is a requirement of QI methodology to begin with your BAU. However, our submission documents both improvement and additionality to what was BAU before the project started.*

We attach a more detailed QI template to support our improvement and additionality."

The appeals panel met on 28 June 2023 and the practice was informed by email the same day that the appeal had not been upheld (page 2, Emails.pdf). A formal letter detailing this decision was not received until 25 July 2023 (P84050 Mount Road Surgery DCCP outcome final.pdf and page 5, Emails.pdf).

Following the initial appeal decision, [MM] requested details of the criteria used by the panel to assess the indicator. His original request was sent to [DR] on 29 June 2023 and followed up on 11 July 2023 due to a lack of response. Despite [DR's] email of 11 July 2023 stating that details would be provided asap, these were not provided until 17 July 2023. See pages 3-4, Emails.pdf.

The practice felt the reasons given in the appeal decision were unfair and not in the spirit of national guidance provided around the quality improvement programme in QOF. It therefore submitted a second appeal on 17 July 2023 that both challenged the criteria used by NHS Greater Manchester, and their interpretation of the guidance and practice submission in reaching its decision (GP Contractor 2nd Appeal QI Indicator.pdf). Again, for ease the appeal details are provided below.

"Further to the first appeal of 30 May 2023 which was not upheld, we make further representations that the panel introduced requirements beyond national guidance, and unfairly applied the national guidance in their assessment of our submission.

The following information was provided by [DR] in an email to [MM] dated 17 July 2023.

Apologies for the delay on this, the initial panel focused on the following criteria

- *They met the requirements as outlined in the QOF*
- *That the practice can demonstrate that this was a quality improvement project*
- *That there was additionality to the work they had done and wasn't something they had previously been paid for (for example work conducted in PQRRS)*

For Mount Road when review this the panel felt that the information provided wasn't around a quality improvement project and that a lot of the examples provided we're pieces of work we're [sic] either a contractual requirement (such of enhanced access) or work that was funded by the locality already (such as MARIS).

When it came to the appeal from [sic] to the GM Committee they we're [sic] looking for whether information that may have been missed in the original submission or whether their we're [sic] additional circumstances that need to be taken in to consideration.

At this point the GM Panel noted that it didn't meet this criteria.

We contest the third criterion used by the panel as going beyond the national guidance (https://www.england.nhs.uk/wp-content/uploads/2022/03/PRN00027-qof-guidance-for-22-23-v2.pdf), and contradictory to quality improvement methodology. Page 86 summarises the rationale for including this domain in QOF. This says it is for contractors and their staff to recognise areas of care which require improvement, and to plan

for how to achieve this. It makes no reference to whether this has to be something different to any previous projects.

Furthermore, quality improvement is an iterative and ongoing process and it is therefore not unreasonable that the same area of work may be covered by multiple successive projects.

The following paragraph is quoted from page 87. "The focus of the indicators and associated points is on contractor engagement and participation in the quality improvement activity both in the practice and through sharing of learning across their network. This is to recognise that not all quality improvement activity will be successful in terms of its immediate impact upon patient care. If a contractor does not achieve the targets which they have set themselves this would not in itself be a reason to withhold QOF points and associated payments, unless they have also failed to participate in the activities described in the guidance."

This makes clear that achievement of the points should primarily be focused on the practice engaging with the process and their plan, with outcomes not being a reason to without points [sic]. For these reasons, we object to any subjective opinions of the panel that are based on criterion three, and request these are discounted from the assessment.

With regards [sic] the second criterion, we acknowledge our plan does not use technical terms commonly associated with quality improvement methodology, but the submitted plan can reasonably be interpreted as following the principles. There is a defined aim and the report details a number of changes that were made; whilst not mentioned by name, the narrative describes a process of PDSA cycles specifically around the monitoring and increase in numbers of face to face appointments offered at the practice.

The panel feedback claims some of the appointment availability referred to was existing contractual arrangements. Whilst it is correct that extended access and MARIS appointments were contractual requirements, these are outside the direct control of the practice and are managed by the PCN or locality. The practice plan was focussing on their use of these for their patients and the guidance says that plans can focus on utilisation of wide system support. The underlying contractual basis is therefore irrelevant as that funding is for provision, not for improving utilisation as is the focus of the plan. The report states that the practice utilisation of extended access was improved which contributed to achieving the aim.

With regards [sic] the first criterion, there are many aspects of the requirements outlined in the QOF guidance. However, I would refer once again to the paragraph from page 87 which says the focus should be on engagement. The practice has clearly engaged and reported improvements in their access over the course of the project. The report also states that patient feedback was positive and complaints about access decreased.

We acknowledge that we have not described our project using common quality improvement terminology, but the narrative does describe tools used is QI methodology. We believe our report does meet the first two criteria used by the panel when assessed in line with the national guidance."

Our second appeal makes clear reference to the criteria used by the panel and gives detailed information in support of how the practice met each one, or why it felt the criteria was unreasonable or went beyond national guidance.

Despite repeated requests for an update, the practice did not hear anything further until receiving a decision letter by email on 5 February 2024 (Mount Road QoF Appeal

outcome.pdf and pages 6-7, Emails.pdf). This letter confirms the panel met on 7 August 2023 but gives no explanation for the delay in notifying the practice. As part of the second appeal, an independent review was sought from NHS Cheshire and Mersey. The narrative from NHS Cheshire and Mersey seems to focus on whether the process was fair and whether clear reasons were given for the decision reached.

The practice disagrees with the decision made by NHS Greater Manchester for the reasons explained within its two appeals. Furthermore, it feels that NHS Greater Manchester has failed to explain why they don't agree with the challenges made to their criteria and assessment; they have merely upheld their original decision.

Whilst a fair process has been followed in relation to the appeals, this has been far from timely resulting in detriment to the practice. There have been significant delays by NHS Greater Manchester throughout the process in providing formal letters and information that was requested regarding criteria. The practice has been unable to confirm its QOF achievement on CQRS whilst the appeals process was being followed. Due to the delays experienced, the practice was left with no choice but to declare its achievement following receipt of the decision letter of 5 February 2024. It did so for cash flow purposes and without prejudice to its right to request dispute resolution.

It seems unacceptable to have taken over eight months from the initial decision email to have concluded the local appeals process. The practice has acted promptly throughout and holds NHS Greater Manchester wholly responsible for it taking this long.

We respectfully request that you offer dispute resolution on the following two grounds.

- The criteria applied, and therefore the decision reached, by NHS Greater Manchester in relation to the practice achievement of the QOF indicator.

- The time taken by NHS Greater Manchester to provide formal notifications to the practice and carry out the appeals process.

Thank you for your consideration in this matter."

Representations

The Commissioner's representations

3.2 In its representations the Commissioner stated:

"Thank you for writing to me on 12 March with the application from Mount Road Surgery. We hope the below outlines the process that has taken place within the Manchester Locality to provide assurance to NHS Resolution about the process undertaken in relation to this dispute.

The QI project was established to improve access to general practice and to optimise medicines. The process asked for participating GP practices to complete a template to evidence completion of work for each of the projects and return to the Manchester locality Primary Care Team by Tuesday 2 May 2023.

A reminder was sent to all practices on 27 April 2023 within the Primary Care Update and a further reminder was sent direct to GP practices on the 2 May 2023, to ensure as many Practices as possible provided assurance.

Review panels for each project took place on Friday 5 May 2023 to review all submissions and ensure that each Practice submission had undertaken QoF QI projects related to High Dependency Prescribing and Optimising Access within 2022-

23. Panel attendees were Manchester Locality colleagues from across Primary Care, Quality and Medicines Management.

The Locality Panel set out the below criteria on how they would assess returns from practices. This was in line with the QOF framework and the spirit of the scheme.

- Have any actions been undertaken in year?
- Is there any evidence of improvement?
- Has the Practice undertaken any actions that are above and beyond BAU/Standard Contract?
- Due to the template, the content rather than volume of information should be taken into consideration. Practices will not be contacted for further detail.
- Assessment is based on the template submitted by Practices with data only used to support in cases of detailed discussion.

The locality panel felt that the information provided by Mount Road Surgery did not evidence additionality beyond existing BAU or services already offered by the locality

- Online access appointments (Contractual)
- Increasing Face to Face appointments (Contractual)
- Video Consultation appointments with LIVI (Provided by Locality)
- Enhanced access hub appointments (Contractual)
- Winter pressure appointments (Provided by Locality)
- MARIS appointments. (Provided by Locality)

The decision of the locality panel was then approved through locality governance through Primary Care Operational Group and Manchester Primary Care Commissioning Committee. (Appendix 1)

First Appeal

Following the outcome of Manchester locality panel recommendations. On the 30th of May 2023 Mount Road Surgery (P84050) 110 Mount Road, Gorton, Manchester, M18 7BQ appealed the decision requesting NHS GM set aside non achievement of the QI indicators.

The practice felt they had improved the use of LIVI video consultations, extended access appointments, winter pressures appointments and MARIS appointments. They further confirmed that they amended GP sessions to provide more early morning appointments based on a review of utilisation data. Their report confirms that the additional face to face appointments were being booked and the numbers subsequently increased again. Their report also confirmed a reduction in patient complaints about access.

NHS Greater Manchester Integrated Care Direct Commissioning Contracts Panel Decision Mount Road Surgery appeal was considered by NHS Greater Manchester Integrated Care Direct Commissioning Contracts Panel (DCCP) on 28th June 2023. In making its determination the DCCP considered the reasoning provided by the practice for non-compliance with the requirements of the indicators.

The panel determined that: -

The information provided by the practice to the Manchester locality panel as part of the practice QI submission, did not meet the requirements for quality improvement project. The examples provided by the practice were considered either contractual requirements (such of enhanced access) or work already funded by the locality (such as MARIS).

Therefore, in consideration of the above the Mount Road Surgery appeal was not upheld.

The practice was requested to amend the QI manual submission in accordance with the outcome and declare QOF 2022/23 achievement on CQRS for payment.

Mount Road Surgery was notified of the outcome of the DCCP decision on the 4th July 2023. Within the letter the practice was provided details of how they may appeal the decision within the next 28 days of receipt of the letter. (Appendix 2)

NHS GM would seek to make every reasonable effort to resolve any dispute and so, should you wish to present further appeal, which may include additional supporting information, this will be considered by the Greater Manchester Primary Care Commissioning Committee (GMPCCC). If after this we are unable to resolve the dispute, you may refer the matter to the NHS dispute resolution procedure.

Mount Road Surgery (P84050) 2nd Appeal

A subsequent appeal was made by Mount Road Surgery on the 17th of July 2023 to dispute the decision of the DCCP.

'Further to the first appeal of 30 May 2023 which was not upheld, we make further representations that the panel introduced requirements beyond national guidance, and unfairly applied the national guidance in their assessment of our submission'.

Additional consideration by Manchester Locality following the 2nd appeal

The subsequent practice appeal to GM PCCC provides significantly more evidence than that previously submitted to the Manchester Locality as part of the original submission. However, within the evidence there is no indication that the practice has worked towards an improvement plan or that there was a systematic approach within the practice to improve access. The areas included would form part of the practice contractual requirements, such as providing face to face appointments, and taken up the offers that the locality have provided, without engagement with the practice.

The Livi, MARIS and Winter Pressure appointments were all elements that were planned and delivered by the localities through PCNs. These were offers open to all practice specifically during winter, not all year round, and therefore a sustained improvement of access cannot be evidenced or achieved by the practice.

It is the commissioner view that the practice has relied on others such as the PCN or locality to improve their access rather than deliver an access improvement project internally. Additionally, they provided no evidence around whether these methods were successful or not, which was a key element to any improvement plan.

The appeal was considered by NHS GM PCCC meeting on 7th August 2023. (Appendix 3) The Committee made consideration of the additional information provided by the practice and the process followed both by the practice and the Manchester locality primary care commissioners.

However, the determination of the Committee was to uphold the original decision made by DCCP.

Review by Cheshire and Merseyside ICB

Following additional concerns by Mount Road Surgery NHS Greater Manchester sought an external review from NHS Cheshire and Merseyside ICB.

NHS Cheshire and Merseyside concluded 'The Practice have been given due consideration in line with the approach agreed with this QOF indicator through an open process and mix of expertise via the panel – and recognised appeal process. The decision, as laid out in the documents, clearly lays out why the areas are not deemed as sufficient and seems a reasonable conclusion.'

A letter informing the practice of this was sent on 2 February 2024. (Appendix 4)

Conclusion

It is the view of NHS Greater Manchester that it has undertaken a robust process which has provided the practice who were offered every consideration on this matter, and it has undertaken additional review, both internally and externally which supports the original decision."

The Contractor's representations

3.3 By email of 14 March 2024, the Contractor did not seek to make any representations but stated "*We attach our updated Appeal Letter with attachments which we wish to replace the original*".

3.4 The letter, dated 14 February 2024, includes a copy of the guidance "*PRN00027-qof-guidance-for-22-23-v2.pdf*" and is as above but with the addition of the following paragraph:

> "We also now make representation based on the guidance, which states that practices should complete the monitoring template and self-declare they have completed the activity and attended two peer review meetings. It says for verification that the commissioner may require contractors to provide a copy of the QI monitoring template (ref PRN00027-qof-guidance-for-22-23-v2.pdf page 108, 5. Reporting and Verification). The inference from the guidance is that assessment would be 'light touch' with the ability for a commissioner to request evidence in some circumstances. NHS Greater Manchester adopted a mandatory submission and panel assessment to determine achievement for all practices it is responsible for. This approach seems to be excessive in light of the guidance provided to contractors."

3.5 The Contractor also sought to include a new ground for consideration as follows:

> "The validity of NHS Greater Manchester enforcing a submission and review panel given the guidance clearly indicates that reporting would be on a self-declaration basis."

Observations

3.6 No observations were provided by either party to NHS Resolution on the representations which were made.

4. CONSIDERATION

4.1 As part of this consideration of the application for NHS dispute resolution, I required an up-to-date version of the Contract in dispute containing all variations agreed since the Contract was signed. This was provided and has not been disputed by the Commissioner.

4.2 I note, from the information provided to me, that the application for dispute resolution has been made within the time limits as set out in the Regulations.

4.3 The Contractor was notified by email of 26 May 2023 that they had achieved the full QOF points on offer for "Prescription Drug Dependency – QIPD009" and "Prescription Drug Dependency – QIPD010" but that they had not achieved "Optimising Access – QIOA11" or "Optimising Access – QIOA12".

4.4 In an email to the Commissioner of 30 May 2023 the Contractor appealed against the decision of the Commissioner to not award QOF points for the Optimising Access indicators. The Contractor was advised, by the Commissioner on 4 July 2023, that their appeal had not been upheld and they had a further 28 days if they wished to appeal this decision.

4.5 By email of 17 July 2023 the Contractor sought to appeal the decision of the Contractor to not award payment in respect of the QOF Optimising Access. The Commissioner considered this second appeal and on 25 July 2023 wrote to the Contractor advising that " … *in consideration of the above your appeal was not upheld*."

4.6 The Contractor submitted a further appeal within the 28 day time period as set out in the letter of 25 July 2023.

4.7 In a letter of 2 February 2024, the Commissioner stated:

"*Further to the practice's original appeal to NHS Greater Manchester (NHS GM) Direct Commissioning Contracts Panel (DCCP) on 28th June 2023, which was declined, your subsequent appeal was escalated to the NHS GM Primary Care Commissioning Committee (PCCC).*

The new information provided by the practice and this subsequent appeal was considered by NHS GM PCCC meeting on 7 August 2023.

The Committee made consideration of the additional information provided by the practice and the process followed both by the practice and the Manchester locality primary care commissioners.

NHS Greater Manchester has sought an independent review of your QOF appeal, which has been undertaken through NHS Cheshire and Mersey (NHS C&M).

In its determination, NHS C&M have concluded that:

> *The practice have been given due consideration in line with the approach agreed with the QOF indicator through an open process and mix of expertise via the panel – and recognised appeal process.*
>
> *The decision as laid out in documents, clearly lays out why the areas are not deemed as sufficient and seems a reasonable conclusion.*

It is NHS GM view that every consideration has been made locally to review this matter."

4.8 The letter concluded by advising the Contractor "*if you do not agree with our decision you may request for dispute resolution to Primary Care Appeals (PCA) …"*

4.9 The Contractor remains dissatisfied with the position of the Commissioner and has submitted an application for dispute resolution with regard to (a) the criteria applied by the Commissioner and therefore the decision made by the Commissioner in relation to the practice achievement of the QOF indicator and (b) the time taken by the Commissioner to provide formal notifications to the practice and carry out the appeals process.

4.10 I note that there is no dispute between the parties that local dispute resolution has been exhausted and that the Contractor has made an application for dispute resolution following receipt of a final decision from the Commissioner. I am content that local dispute resolution has been completed.

4.11 I have been provided with a copy of the "Quality and Outcomes Framework guidance for 2022/23" ("the guidance") which forms the basis of the payment for QOF and have been directed to "Section 5: Quality Improvement Domain". I note that the application of the guidance has not been disputed by either party.

4.12 The "Quality improvement domain", as set out at page 18 and 19 of the guidance states:

This domain applies to all contractors participating in QOF.

Optimising Access to General Practice	Points	Threshold
QIOA011. The contractor can demonstrate continuous quality improvement activity focused on optimising access to General Practice as specified in the QOF guidance	27	N/A
QIOA012. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on optimising access to General Practice as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10	N/A

4.13 Further detail of the rationale for inclusion of a Quality Improvement domain, in general, is set out at page 86 of the guidance with further information regarding "Optimising Access to General Practice" at page 100. The guidance also sets out 5 steps which the practice needs to undertake as well as giving more information about these 5 steps, examples and a reporting template for practices to use.

4.14 The 5 steps are:

Step 1	• Undertake an exercise to evaluate current practice demand and capacity
Step 2	• Create an improvement plan with clear aims, improvement measures, and change ideas iterative PDSA cycles – using data from cycle 1 to inform what happens in cycle 2
Step 3	• Implement the improvement plan
Step 4	• Participate in a minimum of 2 local Primary Care Network peer review meetings
Step 5	• Complete the QI monitoring template

4.15 I have been provided with a copy of the "reporting template" which the Contractor initially submitted as well as the updated reporting template which was provided with their subsequent appeals.

4.16 The Commissioner provided, in their representations, a copy of the QOF Quality Improvement Projects 2022-23 Review report dated 18 May 2023. The report sets out the key criteria the submissions were assessed on the basis of:

4.16.1 *"Have any actions been undertaken in year?*

4.16.2 *Is there any evidence of improvement?*

4.16.3 *Has the Practice undertaken any actions that are above and beyond BAU/Standard Contract?*

4.16.4 *Due to the template, the content rather than volume of information should be taken into consideration. Practices will not be contacted for further detail.*

4.16.5 *Assessment is based on the template submitted by Practices with data only used to support in cases of detailed discussion*."

4.17 The review report shows that the Contractor was not approved and the comments are "*Mount Rd – reactive, no planned action, focus on BAU*".

4.18 The Contractor submitted an appeal, using the template form, providing further information building on what they had originally submitted.

4.19 In a letter of 25 July 2023, the Commissioner reviewed the decision and stated:

4.19.1 *"In making its determination the Panel considered the reasoning provided by the practice for non-compliance with the requirements of the indicators. The panel determined that: -*

- *The information provided by the practice to the Manchester locality panel as part of the practice QI submission, did not meet the requirements for quality improvement project.*
- *The examples provided by the practice were considered either contractual requirements (such of enhanced access) or work already funded by the locality (such as MARIS).*

Therefore, in consideration of the above your appeal was not upheld."

4.20 There is no dispute between the parties that the Contractor has offered LIVI consultations, extended access appointments and winter pressure appointments or MARIS ("Manchester Acute Respiratory Infection Service") appointments. Further the Contractor has also confirmed that it has amended GP sessions to enable more early morning appointments which has resulted in additional face to face appointments and this again, as a result, numbers have increased.

4.21 The Commissioner, however, is of the view that all of these services are part of "*business as usual*" ("BAU") and that no evidence of any improvement beyond what is either contractual or provided by the locality has been demonstrated by the Contractor. The Commissioner also states that there was no evidence of an improvement plan or any quality improvement project being delivered.

4.22 The Contractor argues that the Commissioner has set expectations beyond the official QOF guidance and that in order to make changes and improvements it is a requirement of QI methodology to begin with BAU.

4.23 I note that at page 100 of the guidance it states:

"In October 2021, NHSEI published plans on how it would improve access for patients and support GP practices in doing so. One of the commitments made was to 'commission an additional QOF' improvement module, focussed on optimal models of access including triage and appointment type'. This QI module aims to complement the work already being done in practices and work being led through the National Access Improvement Programme."

4.24 The guidance goes on to state, at page 101 under "Overview of the QI Module":

"The overarching objective of this QI module is to contribute to improvements in access to general practice, in relation to the following aspects:

Understanding of demand and capacity within the practice (and PCN) and using a QI approach to optimise capacity. This will involve understanding the reasons for patient contacts and the types of appointments available as a practice and at PCN level.

a. *Undertaking a review as a practice and PCN to better understand the skills available across your team and PCN and to better match demand and optimise use of capacity. This may include reviewing areas such as care navigation and triage pathways within the Practice/PCN; staff rotas and demand patterns; use of digital tools; use of practice nurses and ARRS staff; and use of wider primary care services e.g. the Community Pharmacist Consultation Service (CPCS) and other similar schemes.*

b. *Working with your practice patients and carers to understand views around access issues, including: ease of contacting the practice to obtain advice or an appointment, communications including website, local population who are at risk of inequalities with regards to access etc, and to co-produce an access improvement plan.*

c. *Considering access beyond the practice by reviewing links/pathways with parts of the system beyond the practice and PCN e.g. local authority or third sector groups offering local services to identify opportunities for collaborative working which may support access."*

4.25 The Commissioner refused the QOF payment using a measure of "*Has the Practice undertaken any actions that are above and beyond BAU/Standard Contract"*. I note that the Commissioner has not directed me to where in the guidance this is a relevant criteria, however, as I have already quoted, the guidance provides "*This QI module aims to complement the work already being done in practices and work being led through the National Access Improvement Programme*". I consider that the word "*complement*" is indicative of the need for there to be some element of additionality and the phrase "*already being done*" is tantamount to "business as usual". I note that the Contractor has stated that additionality was beyond the national guidance, however, owing to the inclusion of this wording I do not consider this to be the case.

4.26 I note that the guidance, at page 102, states:

"Ideally the improvement plan will contain work that will support improvement in all three parts of objectives listed above; better understand the skills available across your team and PCN, understand views around access issues and, consider access beyond the practice by reviewing links/pathways with parts of the system beyond the practice and PCN.

Practices are expected to undertake quality improvement activity in both evaluating the current demand and capacity for the practice and in undertaking actions in partnership with their PCN and patients to optimise access to their practice."

4.27 I note that the Commissioner has not carried out any evaluation of whether the 5 Steps set out at 4.14 above have been met, neither has it considered the four aspects set out at 4.24. I consider that, to properly evaluate whether the QI QOF has been met by the Contractor, its Reporting Template needs to be measured against these two factors (including any additional details contained in the guidance) and that this should have been done by the Commissioner. I also consider that the examples provided in the guidance are representative of what an exemplary Reporting Template would indicate. I note that it would be unreasonable to expect the Contractor to perfectly adhere to these examples, but I do consider them illustrative of the nature and type of information that should be expected. I will use the Contractor's Reporting Template, which had been expanded upon for the local appeals process, as the basis of this evaluation:

What area of practice did the practice identify for quality improvement?
Appointments/Access – Reactive Demand

We chose this area to improve patient experience and accessibility when booking appointments. Post covid highlighted areas which required change to the way we needed to work. We needed to provide different ways of accessing different appointments at different times to suit patient demand. This was identified through patient complaints and clinician input.
What was the defined “Smart Aim” of your quality improvement work?
Our smart aim was to improve patient access and appointment booking. The plan was to improve access and increase appropriate appointment type to meet patient needs over a 12-month period. This would require regular monthly reviews.
What were the changes you tested?
New appointment slot types – advanced booking, increased online patient access appointments, increased book on the day to meet demand including increased triage and face to face appointments, offered video consultation booking appointments with LIVI, extended access hub appointments, winter pressure appointments, MARIS appointments. Employed Paramedic to increase book on the day capacity and own Pharmacist offering increased triage appointments for minor ailment. Practice Nurses increased their Triage slots to meet book on the day demand. PCN access increased for our patients to have Nurse and GP appointments outside of core hours.
What changes have been adopted?
We altered the slots depending on the season, the Book on the Day demand increased during the winter months. We returned these slots to routine appointment following the results of our ongoing reviews. Paramedic, Pharmacist and Nurse availability has been adopted and works well for an evenly distributed service to our patients with extra appointments being included on Fridays as we found that Fridays was our busiest demand. Reception have been trained to offer all in-house appointments and PCN availability.
How will these changes be sustained in the future?
We have found the reviews informative and will continue to complete to attempt to meet our patient demand. Patients complaining about access will continue to be included in our reviews. We will also continue to review which appointments are being utilised, so we continue to meet our patients needs. Room availability is an obstacle in offering face to face services. We are unable to increase further the face to face demand for this reason.
What measures/indicators did you use to track your improvement?
Staff feedback, patient feedback, complaints, reviewing DNA rates (the appointment type and patterns), using appointment audit tool in EMIS Web.
Did you observe improvements in relation to these measures/indicators? Please provide details of any improvements achieved.
The waiting time for patients to be seen has been reduced. Patients complaining about access has reduced. Friend and Family feedback has been positive. DNA rates reduced.
How did the network peer support meetings and patient participation influence the practice’s QI plans on optimising access?
Gorton and Levenshulme PCN met for network peer support where we shared ideas across Practices and discussed what was working well and what wasn’t. Practices having similar demographics all identifying the need for increased book on the day appointments. Website was updated to improve ease of access for prescriptions and admin requests, telephone message amended directing patients away from the telephone lines to website for speedier admin access and/or prescription requests. Reception staff trained to offer/educate patients with the NHS app and/or patient access.

4.28 I will start by applying each of the 5 steps that I have previously referenced at 4.14. The first relates to the exercise carried out by the practice to evaluate current practice demand and capacity. I note that this should inform the area that the practice identifies for quality improvement and, to that end, that the only evidence of any exercise being carried out is an allusion to "*patient complaints and clinician input*". Aside from this,

there is no evidence of any other evaluation being carried out by the Contractor. I note that the guidance has repeated mentions of patient engagement, where this will assist with the activity, which I view as applying to the area of "Reactive Demand". I do not consider that reviewing patient complaints constitutes this type of active engagement, and I note that reviewing and responding to patient complaints is expected of the Contractor. I also note that the guidance itself refers to the impact of COVID-19 and, consequently I do not consider that the Contractors revelations of the need to change its way of working "*post covid*" constitutes any evaluation in of itself. I consider that the QI QOF is illustrative of a process whereby it is not simply realised that things need to change, but why specific elements of the practice need to change are identified followed by exactly how this can be carried out, this does not align with the statements made by the Contractor.

4.29 I also note that the general wording of the QI QOF is that of proactive research and consideration, rather than passive analysis of existing feedback. I do not consider there to be any evidence of the Contractor seeking additional information in this active way.

4.30 The second step involves creating the improvement plan. As I have noted the area of practice that was chosen was *'Reactive Demand*'. This is provided as the first example area in the guidance and refers to how demand varies throughout the week and year. I note that there is no evidence of any evaluation of the Contractor's current demand and capacity, or any deeper consideration of it if it was already meeting reactive demand in order to set this as a suitable area to focus on. I find it difficult to understand why this area was chosen, in light of the methodology set out for Step 1.

4.31 The guidance provides several suggestive outcomes that the Contractor could choose to focus on. I note that these are only suggestions, and the Contractor was free to set its own outcomes, therefore, not including any of the suggestions is not fatal to meeting the criteria. However, I do consider that these suggestions provide illustrative information on the level of detail and granularity that the Contractor should be seeking to include. I consider that the areas identified by the Contractor are vague and non-specific. I note that the QI QOF, on the whole, is about access. I, therefore, must conclude that simply repeating this cannot be an area as envisioned in the guidance.

4.32 Step 2 also involves the setting of SMART goals. This refers to the acronym of "*specific, measurable, achievable, relevant, and time bound*". I note that the guidance provides specific examples of what could be measured in relation to this, and several SMART aim examples. The Contractor stated Smart Aim was, "*to improve patient access and appointment booking*". I do not consider that this is a Smart Aim, when compared with the guidance and provided examples. Notably I do not view it as being in anyway specific. I note, again, that improving patient access is the overall aim of the module. Each of the SMART aim examples are granular, and relate to a singular element which will, on the whole, contribute to the aim of improving access. I also note that there is no explanation of how "*improving access*" would be measured, and by which criteria that, relates again to the issue of specificity and does not align with the expectations of the guidance. There is a list of measures/indicators used to track improvement, but I consider these to be a generic list of factors, that are not related to the specified aim. Whist DNA (did not attend) rate is a measurable indicator, the Contractor has not stated how this was demonstrative of improving access.

4.33 I note that it was time bound, by 12-months, with monthly reviews, but it is unclear what exactly were the factors which were being reviewed monthly. It is unclear how the Contractor could successfully complete this aim after 12-months as "*improving*" does not have an achievable end goal. I also consider that "*improve appointment booking*" is unclear as to what the Contractor intended by this, or if it was worked towards by any of the subsequent information. Finally, it is unclear how this is relevant to the area of "*reactive demand*".

4.34 I note that the central point of Step 2 is the creation of an improvement plan. The Commissioner has stated that there is no evidence that any improvement plan was

worked towards. I note that the Contractor has alluded to a plan "*focussing on their* [MARIS appointments] *use of these for their patients*" and also "*to improve access and increase appropriate appointment type*". It is unclear how either of these relate to the stated area for quality improvement of reactive demand. It is also unclear how these plans relate to the identified Smart Aim. I consider that there should be a clear line of logic from the area, to the Smart Aim, through the measures/indicators, resulting in the changes tested. I find it difficult to identify this in the Reporting Template provided, and note that there are several different aims instead. The Contractor has stated improving patient experience, improving patient access, improving patient accessibility when booking appointments and also improving appointment booking as different possible aims, which I do not consider demonstrative of a comprehensive and thought-out plan which was then actioned. The sheer number of unrelated changes, I also find hard to reconcile with the existence of a plan. The Contractor states that the website was updated, and so were the telephone messages, but it is unclear why this was carried out, and why it is not mentioned in any other section of the template or how it relates to the area or aim.

4.35 I note that the Contractor has stated the narrative described PDSA cycles ("*plan, do, study, act, process*") in relation to face to face appointments. I assume that this is in relation to decreasing Book on the Day demand outside of winter. I note that "*Winter Pressures*" is common knowledge, to the extent that the NHS faces higher demand during winter. Therefore, increasing appointments during this period, does not require any in-depth study or analysis. I also note that the Commissioner has stated that Winter Pressure Appointments were actually a locality led service. The PDSA cycles are also supposed to be used in all elements of Step 2, not just one specific, annually recurring and well known example. I also note that the area "*reactive demand*" refers to changes throughout the week and the year, hence making a change for winter, and then changing it back when it is no longer winter, is not illustrative of any deeper understanding of reactive demand that should have been gleaned through the utilisation of the QI process set out in the guidance.

4.36 I am again mindful of the guidance, with states that targets should be based on their "*baseline audit or search results*", should be "*challenging but realistic*", and be "*incremental*". I note that no audit or search was carried out, so this method could not be utilised. There is mention of the appointment audit tool in EMIS Web, but not what was actually being audited, or that a baseline was ever established. I consider that without any demonstrable measurability then it is not possible to consider if this aim was challenging. I finally consider that it is not demonstrated how the 12-month goal is incremental.

4.37 As a general note, I consider that the two different Reporting Templates provided by the Contractor are not consistent. Elements of the first template are omitted in the second, with the aims being wholly different. I note that the purpose of the amended Reporting Template was stated by the Contractor to be "*more detailed*" and "*to support our improvement and additionality*". However, I consider that the substantial differences in content between the two are indicative of the lack of a coherent plan which could be easily transposed into the template, rather than expanding upon the information already provided. Thus I consider it difficult to see how the requirements of Step 2 have been applied, as there does not appear to be a clear, measurable aim, methodology for evaluation of progress or completion point which would be indictive of an improvement plan.

4.38 Step 3, implementing the plan: I consider should be demonstrated through what changes were tested and consequently adopted. I am of the view, that since I do not consider there to be a plan, it would be impossible to implement it. However, I will evaluate this Step for the sake of completeness. I note that the Contractor has provided several changes in its Reporting Template. I refer also to the Commissioner, which states that several of these changes were services offered or were contractual. There were:

4.38.1 Online access appointments (Contractual),

4.38.2 Increasing Face to Face appointments (Contractual);

4.38.3 Video Consultation appointments with LIVI (Provided by Locality);

4.38.4 Enhanced access hub appointments (Contractual);

4.38.5 Winter pressure appointments (Provided by Locality); and

4.38.6 MARIS appointments. (Provided by Locality).

4.39 I note that the guidance does not explicitly state that the improvement has to be a standalone piece of work or that it cannot be incorporated as part of a PCN project. I note that the guidance specifically makes reference to working with the PCN, as set out above. I am of the view that work being carried out as part of the BAU and through either the different contractual arrangements or the locality, which may be as part of work being carried out through a PCN, should be able to be included as part of the QI QOF indicator.

4.40 However, I consider that the guidance is clear that the QI QOF is about optimisation of capacity and is as much about the process behind implementing changes as it is about the changes themselves. Therefore, utilising existing methods will only contribute to meeting the criteria where it can also be shown that it was done in accordance with the guidance. I do not consider that implementation of contractual requirements, as is, demonstrates any element of optimisation of quality improvement. I note the example from the guidance of "*Optimising use of capacity and the mix of appointment modes to match patient presentations and demand (encompassing not just general practice but also community pharmacy, Accident & Emergency, NHS 111 and others)*". I consider this to be very different to simply "*providing different appointment types*".

4.41 I also note that the changes identified in the Reporting Template and the observed improvements do not follow from the area or the Smart Aim identified. As I have noted, the QI QOF is a process driven domain. As such, the reasons why actions are carried out should follow the quality improvement process. I congratulate the Contractor for its actions in increasing access, however, I do not consider that these have been driven by any form of quality improvement programme. I note that the Contractor has stated that "*We acknowledge that we have not described our project using common quality improvement terminology, but the narrative does describe tools used is QI methodology*". I am unclear where the QI methodology has been used by the Contractor. I consider that increasing the number and type of appointments would, inevitably, increase access. However, this is not an optimised approach to access. The QI QOF is about quality, not quantity, and as such each change and outcome should reflect the area, the aim and the plan. I do not consider this to be the case, based on the Reporting Templates provided.

4.42 I note that the Contractor has stated the following:

"*The focus of the indicators and associated points is on contractor engagement and participation in the quality improvement activity both in the practice and through sharing of learning across their network. This is to recognise that not all quality improvement activity will be successful in terms of its immediate impact upon patient care. If a contractor does not achieve the targets which they have set themselves this would not in itself be a reason to withhold QOF points and associated payments, unless they have also failed to participate in the activities described in the guidance*

This makes clear that achievement of the points should primarily be focused on the practice engaging with the process and their plan, with outcomes not being a reason to without points [sic]."

4.43 I consider that this analysis is wholly correct. To that end, the fact that the Contractor did, in fact, increase access, does not, in of itself, mean that the QI QOF has been met. If the process by which that aim has been met does not utilise the very clear process set out in the guidance, then it is irrelevant if the outcome of increasing access is achieved. I therefore do not consider that evidence of changes being made is demonstrative of any improvement plan being followed.

4.44 I further note the response from the Contractor to "How did the network peer support meetings and patient participation influence the practice's QI plans on optimising access?" in which they confirmed their attendance at the Gorton and Levenshulme PCN network peer support meetings where ideas were shared. I am therefore of the view that Step 4 was met. Step 5 was to "complete the QI monitoring template" which the Contractor did when they submitted their initial form for consideration.

4.45 I note that there is no dispute between the parties that the Contractor completed Steps 4 and 5.

4.46 Finally, I have considered the overview of the QI QOF, as set out at paragraph 4.24. I note that the Contractor need not support improvement across all three objectives, but I would expect there to be a number of these met. I consider that the only area that appears to have been engaged with is

"*Understanding of demand and capacity within the practice (and PCN) and using a QI approach to optimise capacity. This will involve understanding the reasons for patient contacts and the types of appointments available as a practice and at PCN level*"

However, I do not consider that any understanding of demand and capacity was carried out, as I have explained above. I also do not consider that the reasons for patient contact or the type of appointment available were considered, based on the information provided by the Contractor. Finally, as I have already had regard to, there is a lack of any evidence of optimisation within the evidence provided, there is only a demonstration of increased capacity on the whole. I do not consider that any of the other three areas covered by the overview have been engaged with, beside attending PCN meetings.

4.47 Having reviewed the 5 Steps set out in the guidance, I consider that the submissions of the Contractor do not demonstrate how Steps 1, 2 and 3 were either carried out or complied with. I note that evidence provided does not accord with the examples in the guidance, and, even with the additional information included in the appeal letters, I do not consider that the proactive, specific, process from the QI QOF has been followed. I also do not consider that the overarching objective of the QI QOF has been met, due to the lack of evidence relating to understanding, evaluating, reviewing, and optimising capacity. As such, I agree with the conclusion reached by the Commissioner that the Quality Improvement Domain threshold has not been met.

4.48 I note the Contractor also seeks to dispute the validity of how the Commissioner carried out the review of the QOF submission as well as the time taken for the various appeals to be heard by the Commissioner and for a final decision to be issued. Whilst I can appreciate the perceived frustration from the Contractor with regard to the length of time that has elapsed since the initial submission of the QOF paperwork, I am mindful of the work that has been put in by the Commissioner to this dispute in the form of two appeals and also having the decision process reviewed by another ICB.

4.49 I am of the view that the processes in respect of the reviews of the appeals were carried out by the Commissioner in line with their agreed procedures and that the final decision set out the right of the Contractor to apply for dispute resolution in respect of the substantive matter, which they have exercised.

4.50 With regard to the validity of how the Commissioner sought to review QOF submissions, I note that at section 5 "Reporting and verification" it states:

"Verification - Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require a written record of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exceptional circumstances, then they will need to demonstrate other active engagement in network peer learning and review."

4.51 Whilst the Contractor is able to "self-declare" that they have completed the activity described in their QI plan, I note that it is open to Commissioners to request information from the Contractors. I note that there is no set criteria in the guidance as to when the Commissioner may request this information. On this basis, I take no view on the internal processes of the Commissioner as to whether or not they decide to require contractors to provide a copy of their monitoring template.

4.52 I note that the application for dispute resolution was made within the time limits as set out in the Regulations following a thorough local dispute resolution process. I take no view on the process followed by the Commissioner or the time taken to review the appeals and subsequent decisions and make no decision in this regard as this is not a matter for consideration by NHS Resolution.

5. DECISION

5.1 Based on the information before me I am of the view that the Contractor has not met the criteria for the Quality Outcomes Framework Quality Improvement Optimising Access indicator (QIOA011 and QIOA012).

5.2 I note that neither party has submitted a claim for interest with regard to this dispute so I make no determination in this regard.

Head of Appeals
NHS Resolution