

Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE MARCH 2009 Edition

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The new Employer Advisory Service provided by the BMA is free of charge, and independent of the BMA's union role. It could be a very useful source of information for practices.

SUPPORT TO EMPLOYERS

In the past many may have seen the BMA as being primarily a trades union for employed doctors, and as such being not very supportive of those doctors who employ salaried doctors and other staff. This has now changed. The new BMA Employer Advisory Service is independent of the union aspects of the BMA's work and exists to provide BMA members and their practices with free, comprehensive, impartial and authoritative advice on a huge range of employer-related matters, including:

- Recruiting and employing staff;
- Contracts and terms & conditions of service;
- Appraisals and performance management;
- Disciplinary procedures and dismissals;
- Employment legislation;
- Discrimination;
- HR policies and best practice.

The BMA Employer Advisory Service can be contacted on **0300 123 1233** any time between 8.30 a.m. and 6 pm (Monday to Friday, except UK-wide bank holidays) or you can email your query to support@bma.org.uk To access the service at least one partner needs to be a BMA member.

LMC MEETING HIGHLIGHTS

See Annex A.

NEW COMPLAINTS PROCEDURE

With effect from 1 Apr 09 there will be a new complaints procedure for the health and social services. This should not come as a surprise as we issued a summary of the system in Jan 09, and the details have not changed.

The guiding document is called 'Listening, Responding, Improving: a guide to better customer care.' It and its supporting leaflets and guidance sheets can be viewed via: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095408

It is based on 6 principles:

- Getting it right.
- Being customer focused.
- Being open and accountable.
- Acting fairly and proportionately.
- Putting things right.
- Seeking continuous improvement.

For those with a legal bent the actual Regulations are the joint health and social care regulation number 309 of 2009 which may be found at: http://www.legislation.gov.uk/si/si2009/pdf/uksi_20090309_en.pdf

SUPERANNUATION

It is up to the partners to agree how best to treat the practice profits and the agreement should be recorded in the partnership agreement. The approach generally accepted as fairest is to divide practice profits according to the agreed ratios before any superannuation contributions are taken and then for each partner to pay his or her superannuation contributions ('employers' and/or 'employees') personally. The water can be muddied by seniority payments taken as personal payments and by out of hours sessions.

Payments from profits into a superannuation fund benefit the individual partners individually and have nothing to do with the partnership. The nomenclature 'employers contribution' is a nonsense; there is no employer and the whole 20% is simply a personal pension contribution.

LEGAL AID IMPLICATIONS



Recently a firm of solicitors refused to pay a GP practice its fee for providing a copy of the medical record of their patient on the basis that it was a legal aid case, and they would have to wait until the end of the case and until after their file had been costed before paying the practice their fee. The Bristol Office of the Legal Services Commission confirms that the solicitor is entitled to claim disbursements straight away and therefore does not have to wait until his file is costed before doing so. Should they need authority for this they should look at 2D-032 and 2D-160 of the Funding Code Framework.

PATIENT REGISTRATION FAQs



The BMA has produced a useful updated list of Patient Registration frequently asked questions which BMA members can read at: http://www.bma.org.uk/employmentandcontracts/independent_contractors/managing_your_practice/patregfaqs0309.jsp. Note that the GMS contract does not require practices to demand proof of eligibility to treatment from a patient in order for them to complete registration. Practices are free to operate such a policy if they wish, but it is not an obligation. If a

practice has doubts about the eligibility of an individual to NHS treatment, the matter should be referred to the PCT for investigation. Practices are under no contractual obligation to investigate matters of eligibility or to operate checks.

THE NHS CLINICAL LEADERS NETWORK



The Clinical Leaders Network (CLN) is a national, professional network for clinicians in England, enabling them to develop and exchange professional learning with their peers and to deliver service improvements in their local area.

The CLN began with a two-year pilot in North West SHA in 2006 and is now being rolled out across the country. All SHAs are due to have implemented the network by Spring 2009.

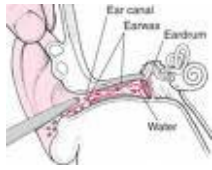
In each SHA, up to 120 clinicians attend a monthly CLN event where they discuss and debate issues directly with a key-note speaker, who will be a local or national service/policy lead or a subject matter expert. They also participate in focused Action Learning Sets, where members are given the opportunity to actively debate concerns, undertake problem solving and plan practical action that will improve the quality of their care services. Following each event, clinicians then dedicate a further clinical session per month to leading service reform within their health area. The programme is backed by Chief Executives; giving members the opportunity to make real improvements. The CLN also provides members with a framework to evaluate their methods for addressing challenging issues. GPs should have a place in this network if they wish it.

To find out more information about the CLN, visit the website at www.cln.nhs.uk or e-mail cln@nhs.net for further details.

EAR IRRIGATION ETC

The PCT has a well-established system for helping the professional development of PCT-employed nurses. This is being extended on a voluntary

basis to practice nurses. Ear irrigation is a case in point: if national evidence-based guidelines are not followed and an eardrum is ruptured during the syringing treatment then the practice (not the PCT) is liable and the practice nurse might also be in trouble with the NMC. If the right courses have been attended, or the skills properly assessed, then such accidents are less likely to happen, and the fact of attendance or assessment will act as a defence against a claim for negligence. The PCT is trying to help practices with this offer of training and assessment.



REVALIDATION

This autumn Licences to Practice will be assigned automatically to all GPs (no paper copies will be issued), unless they wish to stop practising and let the GMC know beforehand. Every year after that there will be an annual fee (currently £410) which must be paid on time otherwise the licence to practice and GMC registration will be withdrawn. No Licence; no practice. It would pay you to make sure this particular payment is not forgotten. Also every GP will need to consider how to collect enough credits each year to show commitment to that professional development which is at the heart of Revalidation. You have to start collecting from April 2009 and guidance will soon be [available on the College website](#). We still need quite a lot of detail in this area (e.g. how much training will equate to one 'credit?') but a summary of the GMC paper with the detail we have so far is at Annex B, with a link to the main paper if you need it.

CHOOSE AND BOOK

Two points this month:

- Two-week referrals are very urgent and of the highest importance. There has been an incident where one was rejected as being on an out of date form. That is unacceptable, and that fact has been clarified. For future reference, it is fine for a 2-week referral to be 'clarified' but there is no way that anyone should ever be allowed to 'reject. It.
- For interest: As at the end of 2008 Gloucestershire GPs were 33rd out of

152 in the nationwide PCT ratings for use of C&B, working on the basis of percentage of GP referrals to first outpatient appointments made using Choose and Book, with a score of 64% (compared with a top score of 100% in Wiltshire PCT area, a bottom score of 12% in Barnet and a median of 49%).

QoF

In case you missed it the first time, the list of modifications to the QoF is at Annex C. (New codes will be issued when known.) Remember that the QoF aspiration payment this coming year will be 70% but this is to compensate the hit your cash flow will take by the moving of final achievement payments for 08/09 to June. A useful QMAS bulletin from Connecting for Health is attached at Annex D.

You should also be aware that in the areas of Records 23 (Ex Smoker) and Palliative Care Register (PC03) there is a need for an emergency clinical audit to be downloaded from:

http://www.inps4.co.uk/my_vision/ngms/

and actioned before the end of the financial year. Also the version and date of downloading has to be reported at:

http://www.surveymonkey.com/s.aspx?sm=Dpi4OK1OZE4Nly_2fp7yFeOw_3d_3d

. The PCT will then be able to use the query to adjust the year-end payments for 2008/09 where required as part of the year-end review.

PATIENT RESPONSIVENESS CONSULTATION

The GPC is launching a consultation paper '*Developing general practice, listening to patients*'. This consultation will encourage GPs to discuss practice services with their patients and to feedback to the GPC examples of improvements they have made in their practices and barriers they encounter to making desired changes. At the end of the consultation process, the GPC will gather comments and case studies to inform their discussions with the UK governments and disseminate examples of innovative practice across the profession. You can help by finding out what your patients value about the practice or would like to see improved. You may already be doing it; well done.

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

These safeguards come into effect on 1 Apr 09. They are to provide legal protection to those who are not detained under the Mental Health Act 1983, but are restricted in their freedom owing to their inability to consent to or accept treatment. It applies mainly to those in hospitals and care homes, typically those with significant learning disabilities or elderly people with dementia. The person must be suffering from a mental disorder. [More details are available on the Department of Health website.](#)

Doctors are eligible to undertake a mental health assessment as part of these procedures provided they are three years post-registration and have undertaken the deprivation of liberty safeguards Mental Health Assessors training programme made available by the Royal College of Psychiatrists. This is now available online, free of charge, to all NHS-funded doctors in England. [Doctors can register online.](#)

This work is not part of essential services for GPs; the Department of Health is unwilling to agree to a national fee for this work and the BMA's Professional Fees Committee advises doctors only to undertake this work if they have agreed the level and payment arrangements for the work in advance. Responsibility for payment lies with the PCT or local social services authority (LSSA) according to whether the person is in hospital or a registered home at the time of the assessment. However, in some areas, PCTs and LSSAs may have made joint local arrangements. For further information please [contact askbma.](#)

MAX'S MUSINGS

Most doctors do not kill their patients; but in these bureaucratic days doctors have to be seen to be not doing it, rather than being trusted not to. Not for nothing is there no longer a burial ground established by every hospital. So now the doctor has to fill in the Cremation Form with the former occupation of some deceased old buffer

who retired before the doctor was born. Nor is the doctor allowed to say that the old man died of old age, but has to add a litany of significant associated pathologies. 'My Goodness!' the casual reader will exclaim, 'They made them tough in those days. Small wonder he died eventually with that lot!' Bodies can be exhumed for examination, but once cremated there is no chance to gather any evidence against anyone – hence the considerable tightening up of the paperwork. But that may all change again when 'they' contemplate the possibilities of a flu pandemic. So much paper will be quite inappropriate when the volunteer pickup truck driver comes round with a megaphone crying, 'Bring



out your dead!' Incidentally, I look forward to the day when bankers, financial advisers, estate agents, rogue builders, lawyers, politicians and journalists are subjected to similar strictures

to prevent them ruining people's lives and fortunes, rather than 'merely' killing them.

Turning from death to life, I find in human relationships an undying source of interest – almost as great as my interest in the pushing out of medical boundaries. The other day I found myself wondering about the teasing and taunting of some people by others. It can frequently have the effect of taking the victim's mind off their other problems. It can stir them to action. It can direct the actions they should take. It can affect the emotions. (Depending on the application it can raise the spirits or depress them). Perhaps in some form it is already part of the bedside manner of many a good doctor. Colloquially it is called 'needling'. But it could be developed so much further. I think I shall call it 'emotional acupuncture' and develop it into a new branch of medicine. You heard it here first!

And finally:

'On the second day the knee was better and on the third day it disappeared.'

'The patient is tearful and crying constantly. She also appears to be depressed.'

'The patient has been depressed since she began seeing me in 1993.'

'Discharge status:- Alive, but without my permission.'

'Healthy appearing decrepit 69-year old male, mentally alert, but forgetful.'



This newsletter was prepared by Mike Forster, LMC Lay Secretary, & the LMC Office

MARCH LMC MEETING HIGHLIGHTS

Forest Diabetes Service. With effect from April there will be a new Forest Diabetes Service set up at the Dilke Hospital. The intention is that it should be a one-stop shop for diabetics, although not detracting from the very successful work with diabetics being carried out by local practices. Bearing in mind the increasing obesity of the population the success of this experiment will be closely monitored in case it can provide useful best practice to be applied elsewhere in the county in due course.

Information Technology:

- Electronic Access to Path Lab Results. Apparently in Wales practices have remote electronic access to path lab results, producing a considerable saving in telephony time for receptionists in GP practices, and for the staff at the path lab. It may be that if you have a midwife in the practice you can have this connection as of right; otherwise the facility would have to compete with all the other high priority pressures on the IT budget. But it would be so useful that between the PCT and the LMC we shall see what can be done to bring it about.
- GP COIN (Community of Interest Network). This expensive project would nevertheless deliver considerable operating advantages over the next 5 years that it would take to be brought into service, all resulting from the huge amount of data that will be able to be passed over the network in a very short space of time. Spin-offs might include internet telephony and off-site data storage, electronic prescriptions, viewing of x-rays etc.
- GP e-mail. The intention is to bring all practices onto the 'glos.nhs.uk' mail server, thus making maintenance of the network much more efficient, and facilitating the secure exchange of patient information where appropriate and necessary.
- Remote access by GPs at home to surgery systems. Currently a WIBNI ('wouldn't it be nice if...') but although a recent proposal it has some merit, especially in helping to ease congestion in practice premises, and as a long-stop in the event of pandemic flu etc.

World Class Commissioning. A perpetual striving for continual improvement is what made the Japanese car industry great; and now it has come to the NHS. As part of this the PCT intends to carry out annual visits to practices. Obviously if the practice is due a QoF visit then it will be piggy-backed onto that. These visits are intended to be helpful and to allow an exchange of views; the PCT wants to know and understand practices better, to gather and disseminate 'best practice' and hear from those most involved what the problems really are.

Child Protection. Much in the news at present, child protection is an important subject. The LMC discussed how it should be coordinated at practice and PCT levels. There is a suggestion that in default of anyone else being assigned the coordinating role the family GP should be responsible. This is still being discussed as there are obvious snags (e.g. if the social worker or health visitor is primarily involved and fails to tell the GP about the case.)

Document Title: Licence to Practise – Guidance for Doctors	
Document Originator: GMC	Document Date: Jan 09
Download Full Doc from:	Date of Summary: 12 Feb 09
https://gmc.e-consultation.net/econsult/Doclist.aspx?Type=D&consult_Id=61&status=&criteria=I	
Document Summary written by: Mike Forster	
<i>N.B. This summary was correct when issued. Its accuracy cannot be guaranteed in the long term, since policies and organisations change. Although every effort will be made to ensure that it is updated the Reader is urged to exercise caution if the document at the time of reading is more than a year old.</i>	
Bottom Line: If you need to be registered now with the GMC you will soon need to be licensed to practise. If you don't want a licence you will have to opt out. Licensing is an essential first step to the introduction of Revalidation (Relicensing and Recertification).	

The GMC is now consulting widely about its plans for Revalidation. Revalidation will be the process by which doctors prove to the GMC, usually every 5 years, that they are up to date and fit to practice. Revalidation will have 2 parts - Relicensing (as a doctor) and Recertification (as a GP or specialist). Since Licences to Practise do not exist yet, the first step is to give a Licence to Practise this autumn to every doctor who wants to go on practising.

A licence to practice will allow you to exercise the privileges currently exercised by registered doctors (If you wish to see it, the list of privileges is at: http://www.gmc-uk.org/doctors/information_for_doctors/privileges.asp)

The GMC is assuming that all currently practising doctors will be wanting a Licence so will be assigning them in good time, and automatically. You will be told it has happened but there will be no paper certificate issued – they are too easily forged. Those wishing to know your status can go to www.gmc-uk.org or can telephone the GMC on 0161 923 6602.

Your registration will not cease, but the Licence to Practise will be essential if you wish to practise medicine. You can thus either go for Registration with a Licence, or opt for Registration alone (if you don't want to practise but wish to keep in touch), or relinquish your registration altogether. In the latter 2 cases you can go on using the title 'Dr.' but must not do or say anything that implies you are licensed to practise. That would be a crime. In the latter 2 cases you are exempt from the Revalidation requirements.

Those who take a licence to practise will be bound by the principles and standards of 'Good Medical Practice', will be legally obliged to have liability insurance, and will have to comply with the requirements for Revalidation (maintenance of a portfolio of information about your practice, take part in annual appraisals and collecting feedback from patients and colleagues, and liaise with your Responsible Officer, once appointed). The Responsible Officer will have specific responsibilities relating to the evaluation of the fitness to practise of doctors connected with the PCO concerned.

Those who hold Registration only will not be debarred from undertaking 'Good Samaritan' acts or providing treatment in an emergency, as can any citizen.

The GMC will withdraw both the Licence to Practise and your registration if the annual retention fee (£410 for 2009-10) is not paid, or new addresses are not provided when you move, or if there has been fraud or error in the initial grant. Obviously withdrawal will also happen when you ask to be removed, or a GMC fitness panel orders your suspension or erasure, or if you die.

The GMC will withdraw just the Licence to Practise if you request it, or if you fail to maintain the proper insurance or indemnity arrangement, or if you do not comply with the relevant regulations, or fail to provide the information required for revalidation or if the information provided is inaccurate or cannot be verified.

Loss of your Licence means you must immediately stop practising in UK; this is serious, and its impact on partnerships should also be addressed in your agreements.

QOF Changes and New Indicators for 2009/10¹

NHS Employers and the General Practitioners Committee (GPC) agreed a package of QOF changes for 2009/10. All of the new indicators detailed below will be reviewed prior to the start of 2011/12, in the light of changing priorities for health and healthcare.

Heart Failure (9 new points)

One new indicator (which moves the current HF DES for England into QOF):

HF 4: The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers. (9 points; thresholds 40 – 60%)

Chronic Kidney Disease CKD (11 new points)

Five additional points will be allocated to existing indicator CKD 5:

CKD 5: The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-1) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded). (5 additional points (so the indicator will be worth 9 points in total); thresholds 40 – 80%) While this indicator will not change, the guidance will be changed.

One new indicator:

CKD 6: The percentage of patients on the CKD register whose notes have a record of an albumin: creatinine ratio (or protein: creatinine ratio) value in the previous 15 months. (6 points; thresholds 40 – 80%)

The negotiating parties have confirmed that the majority of pathology laboratories in the UK have the capability and capacity to provide these tests.

Sexual Health - contraception (8 new points plus 2 points from current CON indicators, CON 1 and 2 which will be removed)

Three new indicators, as recommended in the 2008 expert panel report:

SH 1: The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year. (4 points)

SH 3: The percentage of women prescribed an oral or patch contraceptive method in the last year who have received information from the practice about long acting reversible methods of contraception in the previous 15 months. (3 points; thresholds 40 – 90%)

SH 4: The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription. (3 points; thresholds 40 – 90%)

¹ Copied from: http://www.bma.org.uk/images/QOFchanges200910_tcm41-178932.pdf

Anxiety and Depression (20 new points)

One new indicator:

DEP 3: In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5 – 12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care. (20 points; thresholds 40 – 90%)

We also agreed that the depression section of the QOF guidance should be amended as follows:

Currently - "For the purposes of QOF measurement 'at the outset of treatment' is defined as within one month of the initial diagnosis."

Revised - "is defined as within 28 days of the initial diagnosis."

Cardio Vascular Disease CVD – Primary Prevention (13 points)

Two new indicators:

PP 1: In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis using an agreed risk assessment treatment tool. (8 points; thresholds 40 – 70%) For the purposes of QOF measurement, 'at the outset of diagnosis' is defined as within three months of the initial diagnosis.

PP 2: The percentage of people diagnosed with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet. (5 points; thresholds 40 – 70%)

Diabetes (7 new points plus 28 current points)

There are currently two indicators with HbA1c targets (DM7 and DM 20) which have been subject to changes. We will also introduce a new indicator. The three indicators are as follows:

DM 23: Replaces DM 20 (which has a HbA1C target of 7.5 or less and is worth 17 points) The percentage of patients with diabetes in whom the last HbA1c is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months. (17 points; thresholds 40 – 50%)

DM 24: New The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months. (8 points; thresholds 40 – 70%)

DM 25: Replaces DM 7 (which has a HbA1C target of 10 or less and is worth 11 points) The percentage of patients with diabetes in whom the last HbA1c is 9 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months. (10 points: thresholds 40 – 90%)

COPD (2 new points)

One revised indicator:

COPD 13: Replaces COPD 11: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months. (2 additional points so the indicator would be worth 9 points; thresholds 50 – 90%)

Reallocation of Points

The following points will be removed:

Indicator	Current value	New value	Points removed
PE2	25	0	25
PE6	30	0	30
SMOKING 3	33	30	3
SMOKING 4	35	30	5
BP 4	20	18	2
CHD 6	19	17	2
AF 3	15	12	3
CON 1	1	0	1
CON 2	1	0	1
Total			72

QMAS – End of Year Communications

February 2009

This bulletin gives QMAS users and Administrators advice and guidance on the changes to QMAS for year end 08/09

The Statement of Financial Entitlement (SFE) for 2008 can be found by following the link below:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_089663

Deadline for end of year payments

PCTs are reminded that they now have until the end of June following the year end before achievement payments fall due. This was agreed as part of the GMS contract negotiations for 2008/09 in order to give PCTs longer to carry out pre-payment verification. Aspiration payments were raised to 70% to compensate practices for the effect on cash-flow,

PE7 & PE8

It has been brought to our attention recently that the thresholds for these indicators are incorrect. NHS CFH is working with the system supplier to ensure that the correct thresholds are in place in time for PCTs to enter the scores on or after 11 May. For information, the correct thresholds are:

PE7 70-90%

PE8 60-90%

GP's are reminded that DH has informed PCTs not to approve end of year payments until the PE7 & 8 results have been entered into QMAS. This is expected to be May.

Any GP's with questions should contact their QMAS Administrator at the PCT

Guidance can be found by following the link below:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092085#

Records 23 (Ex Smoker)

We are aware that there is an issue with records 23. This issue relates to non-smokers aged 25 and under and ex-smokers being required to have their status recorded within 15 months in the current business rules. The indicator requires smoking status to be recorded within the last 27 months. The business rules for 2009/10 will be amended to ensure that smoking status under this indicator is only required to be recorded within the last 27 months.

The QMAS team are in discussions with GP System suppliers to provide a local query that will include non smokers aged 25 and under and ex-smokers in the achievement figures provided that their smoking status was recorded within the last 27 months.

PCTs will be able to use the query to adjust the year end payments for 2008/09, where required, as part of the year end review. Alternatively PCTs can follow the QOF guidance for Records 23 for checking records manually.

PC03

We are aware that there is an issue when checking the palliative care register (PC03). Currently the business rule states that the register contains patients for 3 years rather than the previous 12 months. This discrepancy will not affect payments as there is no prevalence adjustment for the palliative care register, but it will be corrected in the next set of business rules.

National Prevalence Day (NPD)

GP's are reminded that NPD has moved from 14 Feb to 31 March in line with the year end submission. This means that GP's no longer need to make a separate submission for NPD. Manual and automatic Practice submissions should continue to be made at year end.

User Passwords

Users are reminded that accounts should be accessed before year end to ensure passwords are correct and accounts live. If users cannot access QMAS then please contact your PCT QOF Administrator to request a password reset. We would also like to remind users that you must use your own account when accessing QMAS. Password will not be re-set for anyone but the account holder.

Frequently Asked Questions

This section outlines the most common questions asked of the end of year process.

Who in the practice can sign the on-line achievement declaration?

It is entirely a decision for each practice to make. In most practices it will be either the senior partner or the practice/business manager.

In what way can a PCT adjust my achievement report?

A PCT can adjust the following:

- Numerator
- Denominator
- Boolean value (Yes/No)
- Points (PMS Points Deduction only)
- Practice list size (only for those list sizes NOT provided by Exeter)
- Disease register size
- Additional service target populations

Once the PCT has completed the adjustment, the end-of-year achievement is recalculated. Holistic Care Achievement will also be recalculated based upon the PCT adjustment.

We are a manual practice. What do we do for National Prevalence Day – 31 March 2009?

If you do not have an automatic feed into QMAS this data will no longer have to be entered manually via QMAS web forms and the web forms will no longer be available. Practices must make their normal year end submission and this will be used to calculate their National Prevalence figures. If a manual practice has no access to a personal computer with NHS net access they will need to ask their PCT to enter the data for them.

Is there any training available on the end of year process?

Yes. Training materials, including tutorials and user manuals, are available for practices and PCTs at the QMAS training website: www.qmastraining.nhs.uk There are a number of other QMAS-related FAQs available on the same website at: <http://www.qmastraining.nhs.uk/qmastrain/faq.htm>