

## Quality after the QOF?

The Quality Outcomes Framework (QOF) for UK General Practice (GP) is one of the largest health-related pay-for-performance (P4P) schemes in the world (1). Following implementation in 2004, the scheme initially had a positive impact on quality of care, primarily achieved via the establishment of procedural baselines in the clinical management of incentivized (mostly chronic) diseases. It reduced between-practice variation in care delivery whilst also improving disease registers, the recording of clinical activities and adoption of electronic medical record systems, thus leading to an explosion in GP data and research (1,2).

Despite some successes, recent years have seen accelerated debate concerning the removal of QOF. One major criticism is that QOF does not incentivise person centred care for people with complex conditions (2,3), who require individualised support. This is not captured in the vast majority of clinical indicators, which are based on clinical guidelines.

For example, continuity of care – a critical function of primary care – is valued by patients and has been associated with improved experience, outcomes, adherence and preventative medicine, and it may be associated with reduced hospital admissions, death rates and cost of secondary care/hospitalisation (4). It can be considered a marker of a holistic approach, which is considered particularly essential for the increasing numbers of people with multimorbidity and complex health care needs (5). Yet it is currently in decline (6)), was significantly reduced after the introduction of QOF (7) and is not being captured by QOF.

In an environment of increasing patient complexity and a drive towards person centeredness, QOF – with its current focus on process indicators – is perceived by many as increasingly anachronistic. A recent systematic review summarised that “QOF is unlikely to advance progress towards the vision of the Five Year Forward View for the care of long-term conditions” (1). In response to such criticisms (with financial pressures also perhaps weighing heavily), the Department of Health (DOH) signalled in 2014 a move towards devolution of QOF to Clinical Commissioning Groups (CCGs), allowing the freedom to develop alternatives. More recently, both the NHS Chief Executive and the General Practitioners Committee (GPC) Chairman have questioned the future of QOF (8).

Recent evaluations of early experiments with QOF de-incentivisation provide some clues for the benefits and dangers of QOF de-incentivisation, and have confirmed that QOF has become unpopular amongst many professionals: it imposes an administrative burden and can act as an impediment to the delivery of tailored, person centred consultations (9,10). Removal of QOF incentives may have fostered greater person centred coordinated care (P3C) via several mechanisms, including changes to GP appointments and reallocation of resources to facilitate service re-design (e.g. via involvement in new care models) (9,10). Conversely, while most important clinical quality markers have not suffered, QOF de-incentivisation has led to less consistent record keeping (9,10), contradicting arguments that high quality data will continue to be captured (2).

If that trend was confirmed, General Practice would become more opaque and less accountable, with adverse implications for research and healthcare management. Removing basic assurances of quality of care delivery (6) could be a dangerous experiment. It would be difficult to identify “struggling practices” (e.g. those undergoing difficult transitions) that are falling below basic standards once

ensured by QOF (e.g. recalling patients with long term conditions). The subsequent increase in healthcare costs could outweigh any marginal financial gains achieved via its removal. Until a satisfactory alternative is identified, such fears are liable to confound policymakers.

A redesigned measure of “quality” could help balance the competing priorities of various stakeholders. First, it will need assurances that measurable quality is maintained across General Practice in the core functions of access, comprehensiveness, co-ordination, continuity and whole person orientation. Second, it should represent evolving notions of quality: person centredness, prevention, wellbeing and also include an expanded role for patient safety.

We propose a framework for debate, outlining five suggestions which are not mutually exclusive. They are all based on a vision for a streamlined system that aims to minimize additional burden on a discipline under huge pressure (6) and that returns a responsibility that is desired by so many GPs: the trust and freedom to tailor consultations, organise care and take responsibility for improving quality without the interference of “box-ticking” exercises. The framework also considers that data is most likely to lead to quality improvements when it is credible to GPs, with feedback that is timely, actionable and designed to drive improvements (e.g. via information sharing and learning from best practice). Key data should also be available for multidirectional feedback, including for researchers, the Care Quality Commission (CQC) and healthcare managers. These should be simple metrics that are easily understood, provide clear warning signals, and where issues of tunnel vision, gaming, and perverse incentives can be avoided. Our suggestions include both interim/transitional solutions for efficiently baselining “quality” (e.g. assuring certain standards are maintained) and a longer term view on how person centredness might be embedded into healthcare systems.

[1] QOF could be adapted to local requirements (e.g. such as QOF+ in Hammersmith & Fulham from 2008-11 (11) and Dudley LTCF (12)), retaining a core consensus derived indicator set to reduce administrative burden (“QOF Lite”). Any indicator set should represent aspects of care that clinicians and patients see as important (e.g. RCGP collaborative care), measurable and reliably recorded, thus increasing clinical ownership, confidence in data (13), and tailored to the epidemiological and socioeconomic characteristics of the populations.

[2] The use of GP contact data could be explored as a set of complementary measures of access, follow-up and continuity. Reporting could include the frequency of consultation, personnel involved (inclusive of wider members of primary healthcare team), mode (telephone, email, visit etc.), purpose, patient type, duration and time allocated for person centred care planning (4) (importantly, flexibility should be encouraged). Such a system may retain one of the key benefits of QOF (assurance of care delivery) with reduced administrative burden, while allowing clinicians the freedom to adapt models of care according to local need. This data would need to be complemented with health experience and outcome data as outlined below, thus facilitating comparisons across different delivery models. A national dataset of this type could provide a more nuanced perspective of continuity than indicators such as the “usual provider of care index”; facilitate the evaluation of trends in general practice (such as changes in practice size and complexity); and potentially support reductions in healthcare inequalities, e.g. specifically incentivizing contacts with poorly served patients.

[3] Continued enhancements to the current approaches to capturing patient experience, including measures of patient experiences (PREMS) such as the GP Patient Survey (GPPS - which currently measures self-management, shared-decision making, and person centred care planning) would

facilitate triangulation of information. Such efforts should ensure inclusiveness and target under-represented and complex patients. Direct incentivisation of PREMs would be problematic, and liable to unfairly penalising practices from e.g. deprived area. Instead, locally-directed learning from PREM data should be encouraged, as discussed in recent detailed guidance documents (5).

[4] Tools measuring health outcomes such as quality of life and other patient outcomes (PROMS) could be routinely used to monitor the performance of the system in line with DOH policy for “wider use of effective tools like PROMS, patient experience data, and real-time feedback” (Equity and excellence, NHS, 2010). A number of organisational, methodological and logistical challenges to the utilisation of PROMs/PREMs in primary care would need to be addressed during testing, evaluation and scaling (13). Investment in Computerised Adaptive Testing (CAT) for both PROMS and PREMS (similar to the NIH-backed PROMIS scheme) may help overcome the challenges presented by the clinical complexity of the GP landscape. The use of these measures also offers the potential to support self-management and wellbeing. Recent guidance for ongoing development and measurement of new models of care would also facilitate such efforts (5).

[5] Current recall systems, which are burdensome, unpopular and ill-suited for patients with multimorbidity (9), should be replaced with a more efficient and person centred management system (e.g. one system is trialling in Dudley LTCF (12)). This would require co-design with patients, GPs, managers, information specialists and researchers, with in-built capture of GP contact data. Such a system could promote continuity via mechanisms such as an intelligent booking system, altered receptionist behaviour (e.g. to promote continuity) and possibly aid with the division of larger practices into working units of smaller, coordinated teams (e.g. as proposed by others (14)).

Whatever shape future systems take, it should deliver valid and reliable data on quality assurances and intelligence, while handing more freedom to practices to conduct their own local audits and peer-to-peer learning.

## References

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