

Quality after the QOF?

Before dismantling it, we need a redefined measure of 'quality'

The Quality and Outcomes Framework (QOF) for UK general practice is one of the largest health-related pay-for-performance (P4P) schemes in the world.¹ In 2004, the scheme initially had a positive impact on quality of care, primarily achieved via establishment of procedural baselines in the clinical management of incentivised (mostly chronic) diseases. It reduced between-practice variation in care delivery while also improving disease registers, recording of clinical activities, and adoption of electronic medical record systems, leading to an explosion in general practice 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 indicators, which are based on clinical guidelines.

For example, continuity of care — a critical function of primary care — is valued by patients and associated with improved experience, outcomes, adherence, and preventive 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 essential for the increasing numbers of people with multimorbidity and complex healthcare needs.⁵ Yet it is currently in decline,⁶ was reduced after the introduction of QOF,⁷ and is not being captured by QOF.

REMOVING QOF: THE RISKS

In an environment of increasing patient complexity and a drive towards person centredness, 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 freedom to develop alternatives. More recently, both the NHS Chief Executive and the General Practitioners Committee (GPC) Chair have questioned the future of QOF.⁸

"Removing basic assurances of quality of care delivery could prove a dangerous experiment ... Until a satisfactory alternative is identified, such fears are liable to confound policymakers."

Recent evaluations of experiments with QOF de-incentivisation provide clues for the benefits and dangers of QOF de-incentivisation, and have confirmed that QOF has become unpopular among 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 (for example, via involvement in new care models).^{9,10} Conversely, although 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 delivery⁶ could prove a dangerous experiment. It would be difficult to identify 'struggling practices' (such as those undergoing difficult transitions) that are falling below basic standards once ensured by QOF (recalling patients with long-term conditions, for example). 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, coordination, 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 that are not mutually exclusive. They are all based on a vision for a streamlined system that aims to minimise additional burden on a discipline under huge pressure⁶ and that returns a responsibility that is desired by so many GPs: the 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 are most likely to lead to quality improvements when they are credible to GPs, with feedback that is timely, actionable, and designed to drive improvements (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' (assuring certain standards are maintained) and a longer-term view on how person centredness might be embedded into healthcare systems.

REMOVING QOF: THE ALTERNATIVES

First, QOF could be adapted to local requirements (for example, such as QOF+ in Hammersmith & Fulham from 2008–2011¹¹ and Dudley LTCF (Long Term Conditions Framework),¹² retaining a core consensus indicator set to reduce administrative burden ('QOF Lite'). Any indicator set should represent aspects of care that clinicians and patients see as important (for example, 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.

Second, the use of general practice 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), purpose, patient type, duration, and time allocated for person-centred care planning (importantly, flexibility should be encouraged).⁴ 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. These 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, for example, specifically incentivising contacts with poorly served patients.

Third, 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 deprived areas. Instead, locally directed learning from PREM data should be encouraged, as discussed in recent detailed guidance documents.⁵

Fourth, 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'.¹⁴

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 general practice landscape. The use of these measures also offers the potential to support self-management and wellbeing. Recent guidance for development and measurement of new models of care facilitate such efforts.⁵

ADDRESS FOR CORRESPONDENCE

James Close

Community and Primary Care Research Group, University of Plymouth Peninsula Schools of Medicine and Dentistry, Plymouth Science Park, Derriford, Plymouth PL6 8BX, UK.

Email: james.close@plymouth.ac.uk

Fifth, 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 (for example, 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 general practice contact data. Such a system could promote continuity via mechanisms such as an intelligent booking system, altered receptionist behaviour (to promote continuity), and possibly aid with the division of larger practices into working units of smaller, coordinated teams (for example, as proposed by others).¹⁵

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.

James Close,

Research Fellow, Community and Primary Care Research Group, University of Plymouth, Plymouth.

Richard Byng,

Professor in Primary Care Research, Community and Primary Care Research Group, University of Plymouth, Plymouth.

Jose M Valderas,

Professor of Health Services & Policy Research, University of Exeter; President, International Society for Quality of Life Research (ISOQOL), Exeter.

Nicky Britten,

Professor in Applied Healthcare Research, Institute of Health Services Research, University of Exeter Medical School, Exeter.

Helen Lloyd,

Senior Research Fellow, Community and Primary Care Research Group, University of Plymouth Peninsula Schools of Medicine and Dentistry, Plymouth.

Provenance

Commissioned; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

DOI: <https://doi.org/10.3399/bjgp18X697589>

REFERENCES

1. Forbes LJ, Marchand C, Doran T, Peckham S. The role of the Quality and Outcomes Framework in the care of long-term conditions: a systematic review. *Br J Gen Pract* 2017; DOI: <https://doi.org/10.3399/bjgp17X693077>.
2. McShane M, Mitchell E. Person centred coordinated care: where does the QOF point us? *BMJ* 2015; **350**: h2540.
3. Kontopantelis E, Springate DA, Ashworth M, et al. Investigating the relationship between quality of primary care and premature mortality in England: a spatial whole-population study. *BMJ* 2015; **350**: h904.
4. Pereira Gray D, Sidaway-Lee K, White E, et al. Improving continuity: THE clinical challenge. *InnovAIT* 2016; DOI: [10.1177/1755738016654504](https://doi.org/10.1177/1755738016654504).
5. Lloyd HM, Pearson M, Sheaff R, et al. Collaborative action for person-centred coordinated care (P3C): an approach to support the development of a comprehensive system-wide solution to fragmented care. *Health Res Policy Syst* 2017; **15**(1): 98.
6. Baird B, Charles A, Honeyman M, et al. *Understanding pressures in general practice*. London: King's Fund, 2016.
7. Campbell SM, Kontopantelis E, Reeves D, et al. Changes in patient experiences of primary care during health service reforms in England between 2003 and 2007. *Ann Fam Med* 2010; **8**(6): 499–506.
8. Bostock N. GPC backs 'bold step' as Simon Stevens says QOF has reached end of the road. *GP Online* 2016; **20 Oct**: <https://www.gponline.com/gpc-backs-bold-step-simon-stevens-says-qof-reached-end-road/article/1412823> [accessed 24 May 2018].
9. Lloyd H. *An evaluation of the Somerset practice quality scheme (SPQS)*. 2015. <http://www.swahsn.com/wp-content/uploads/2016/06/Evaluation-of-the-Somerset-Practice-Quality-Scheme-July-2015.pdf> [accessed 24 May 2018].
10. Close J, Witts L, Horrell J, et al. Evaluation of the Somerset practice quality scheme (SPQS): PHASE 2. 2017. http://p3c.org.uk/SPQS_Phase2_ExecSummary.pdf [accessed 24 May 2018].
11. Pape UJ, Huckvale K, Car J, et al. Impact of 'stretch' targets for cardiovascular disease management within a local pay-for-performance programme. *PLOS One* 2015; **10**(3): e0119185.
12. Singh K, Ellins J, Miller R, et al. *Evaluation of Dudley quality outcomes for health: final report*. ICF, 2017.
13. Greenhalgh J, Dalkin S, Gooding K, et al. Functionality and feedback: a realist synthesis of the collation, interpretation and utilisation of patient-reported outcome measures data to improve patient care. *Health Serv Deliv Res* 2017; **5**(2).
14. The Stationery Office. *Equity and excellence: Liberating the NHS*. Norwich: TSO, 2010.
15. Barker I, Steventon A, Deeny SR. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. *BMJ* 2017; **356**: j84