RCGP response to the role of incentive schemes in general practice consultation

Background

Incentive schemes were introduced in 2004 within general practice to improve patient outcomes and healthcare delivery. GP practises that achieve set targets receive additional income in addition to their core funding. In England, general practices are incentivised through 2 main schemes, the:

- Quality and Outcomes Framework (QOF)
- Investment and Impact Fund (IIF)

The Department of Health and Social Care are consulting on the future of incentive schemes in general practice. The consultation is split into three sections:

- Feedback on the role and nature of any incentive scheme in general practice, with a focus on the current scope of the Quality Outcomes Framework (QOF) and the Investment and Impact Fund (IIF)
- Comments on possible changes in scope of incentive schemes beyond clinical indicators
- Input on reducing the administrative burden associated with the schemes and enhancing the clinician's experience of delivering it.

Throughout, this consultation response draws results on from a survey sent to our members regarding this consultation (561 responses). In addition, we held two GP workshops and consulted with our Patient and Carer Participation group to gather a diverse range of perspectives to support our response to the consultation.

Consultation response

Question 1.

Do you agree or disagree that incentives like QOF and IIF should form part of the income of general practice?

Neither agree nor disagree.

The RCGP believes it is critical that there is sufficient core funding to give practices appropriate resources and stability to deliver the care needed by their populations and incentives should not be seen as an alternative to this. As such it important that this question is placed within the context of the consistent underfunding of general practice.

Overall, we believe there may be some scope for streamlining incentives schemes and reducing the number of indicators with the attached funding transferred into core funding. However, we recognise that there is likely to be a continued role for incentives schemes within general practice in some form. As part of this, there is a requirement for changes and improvements to ensure these schemes better support general practices.
Specifically, we propose:

- A significant reduction in the number of QOF and IIF indicators (to retain in the region of 5 QOF and 2 IIF indicators) and a move to higher-level and higher-trust indicators.
- Streamlining systems to reduce the administrative burden created by the OQF and IIF indicators.
- Increasing the emphasis on health inequalities, sustainability and prevention.
- Greater flexibility in disease-specific indicators to allow for the addressing of multimorbidity and frailty.
- Increasing the scope for ICBs to deliver locally tailored, flexible incentives schemes, with appropriate consultation with GPs in those local areas.
- A significantly increased focus on quality improvement. The RCGP has previously support quality improvement modules as part of QOF and would be pleased support with the expansion of quality improvement-based incentives.

These suggested improvements are explored in detail throughout our following answers.

Question 2.

Do you agree or disagree that QOF and IIF help ensure that sufficient resources are applied to preventative and proactive care?

Disagree.

The RCGP views preventative and proactive care as a core element of general practice and something which GPs will always focus on regardless of incentives. We do not believe that QOF and IIF are effective in ensuring sufficient resources are applied to preventative and proactive care, and instead consider that sufficient resources for this should be provided as part of the core contract.
The nature of general practice as embedded within the community means that GPs have a unique role in being first hand witnesses to the wider lives of their patients. This allows GPs to identify the individual and local determinants of illnesses. However, as set out in the RCGP 'Fit for the Future' report, the promotion of preventative care and population health requires significant further financial support. This needs to be embedded into core service offerings and be a more significant focus of overall spending. In 2018, DHSC figures showed that only 5% of public funding for health was spent on prevention. To facilitate an expanded focus on prevention, GP premises must be developed to allow them to host a wider range of prevention, wellbeing and social action projects and services, all of which can help to tackle health inequalities and build strong, resilient communities.

Whilst some elements of QOF and IIF, such as indicators encouraging regular health checks, can help to promote preventative care, this is far from sufficient to ensure effective prevention. Incentives are unlikely to be the most effective means of applying resources for preventative and proactive care. A reduction in the number of QOF and IIF indicators, replaced by more up-front funding, along with greater flexibility to focus on local needs could allow practices to deliver more preventative and proactive care, in association with community and local council partners.

Question 3.

Would relative improvement targets be more effective than absolute targets at delivering improvements in care quality while also addressing health inequalities?

Yes.

The RCGP is committed to addressing health inequalities within general practice and more broadly and considers that relative targets would be a helpful step in supporting practices in socioeconomically deprived areas.
Studies have shown that areas of deprivation experience high levels of unmet need within general practice (McConnachie et al, 2023). This is a pressing issue which stems from the fact that English practices in areas with the highest levels of income deprivation have on average 300 more patients per fully qualified GP than practices with the lowest levels of income deprivation (ONS, 2022). The Health Foundation have also shown that, after accounting for levels of need, GPs working in practices serving the most socioeconomically deprived patients are responsible, on average, for 10% more patients than GPs in more affluent areas (The Health Foundation, 2021). For this reason, in our recent manifesto, the College called for all funding streams should be reviewed to channel more spending to the areas of greatest need. GP incentives must be included in this review to ensure that they actively support practices in areas of deprivation rather than further disadvantaging them.
The majority of respondents to our survey believe that relative improvement targets would be more effective than absolute targets at delivering improvements in care quality while also addressing health inequalities and the College supports this proposal.
However, the implementation of relative targets would require careful consideration to avoid any unintended consequences including ensuring that practices which are already achieving highly on certain indicators are not disincentivised from making progress.

Question 3a.

In what other ways could we use incentive schemes to address health inequalities?
Relative targets would likely help to ensure that practices in socioeconomically deprived areas are not disadvantaged by not being able to access the funds associated with certain indicators.

However, they are unlikely to help deliver the additional needs adjusted funding needed by practices in those areas or to ensure an active focus on reducing health inequalities.
As such, in addition to considering relative indicators, we would suggest the following strategies:

a. Considering implementing an 'Distance from Target' approach which creates adjustments allowing areas that are underperforming (because their population is older, have complex needs, or are more socioeconomically deprived) to receive a funding increase above the average to work towards reducing the gap and getting close to the set national target.
b. Drawing on the Core20PLUS5 approach to reducing healthcare inequalities created by NHS England to act as a framework for amending GP incentives schemes so that they actively focus on address health inequalities in general practice.
c. Identifying 'Deep End practices' for additional support, to help them reduce health inequalities in their communities.

Question 4.

To what degree, if any, do you think that ICBs should influence the nature of any incentive scheme?

- *The scheme should be entirely national*
- *ICBs should be able to select local priority indicators from a national menu*
- ***ICBs should be able to select local priority indicators from a national menu and put additional local funding against those indicators***
- *ICBs should be able to choose their own indicators and put local funding against those indicators*

The RCGP believes that ICBs should be able to select local priority indicators from a national menu and put additional local funding against those indicators.
This local flexibility would be helpful in ensuring that any future incentive scheme in general practice is tailored to the needs of practice populations and promotes the most appropriate general practice activity. It could also allow for targeted support for areas of high need to address the issues specific to their population (for example, inner city deprivation or an ageing population).
A national menu is important in ensuring a degree of consistency and allowing for consideration of the evidence-base behind any indicator, something ICBs may lack capacity to investigate in detail individually.
However, the RCGP has consistently highlighted the importance of the GP voice within ICBs. ICBs have a much higher representation of secondary care specialties than of primary care. Boards are required to have only one primary care representative, meaning some ICBs may have no general practice representation at all. Any additional role for ICBs in influencing GP

incentives will make it even more critical that there is sufficient GP representation in on Boards and in these decision-making processes.

Question 5.
Do you agree or disagree that a PCN-level incentive scheme like IIF encourages PCN-wide efforts to improve quality?

Neither agree nor disagree.

The RCGP believes that PCN-level collaboration offers potential in improving quality of care across practices through the sharing of resources and experience. However, the provision of incentives at this level presents challenges for practices, where there is a shortage of funds for individual practice expenses for example.
The majority of respondents to our survey neither agreed nor disagreed as to the effectiveness of PCN-level incentive schemes.
It is important to note that research shows that the variable size, characteristics, and levels of development of PCNs can impact on their performance (Checkland et al, 2020). This means that the impact of PCN-level incentives on efforts to improve quality is likely to be varied with less well developed PCNs less able to take advantage of such schemes.

Question 6.

What type of indicators, if any, within incentive schemes do you think most help to improve care quality?

- *Clinical coding (for example accurate recording of smoking status in a patient record)*
- ***Clinical activity (for example undertaking an annual asthma review)*** *Clinical outcomes (for example stroke rates)*
- ***Quality improvement (QI) (for example local project to improve patient experience or staff wellbeing)***

In the long-term, the College believes that quality improvement should be the main focus of any GP incentive schemes. However, it will take time and require additional capacity and support for practices to be able to deliver significant QI activity. As such, in the shorter-term, we propose that clinical activity indicators should also be used.
It is important to note that while clinical activity is likely to be one of the easier types of indicators to measure and more appropriate and achievable in the short term, recording certain types of clinical activity may not automatically result in an improvement in the quality of care. We would also suggest that QI activity should be considered more broadly than projects to improve patient experience or staff wellbeing which may not directly relate to quality of care. Projects to improve patient care for those with multi-morbidities for example, could be a better example of the type of QI indicators that would improve quality of care.

Question 7.

Do you think there is a role for incentives to reward practices for clinical outcomes measured at PCN or place level?

No.

The College does not consider there to be a role for incentives to reward practices for clinical outcomes measured at PCN or place level. The varied stages of development of PCNs may mean it is challenging to measure outcomes at this or place level. Research by the Health Foundation highlights that PCN funding has not been sufficient in meeting the needs of areas with a high deprivation (The Health Foundation, 2023). This is likely due to the complex health needs that are often associates with population within areas of high deprivation.
As such, it is unlikely to be appropriate to measure or incentivise outcomes at this level while such variation continues to exist.

Question 8.

Do you agree or disagree that there is a role for incentive schemes to focus on helping to reduce pressures on other parts of the health system?

Neither agree nor disagree

The RCGP believes that there may be a role of incentives to focus on reducing pressures on other parts of the system but that this must be considered within the context of addressing the workload and workforce crisis within general practice itself and ensuring sufficient funding for general practice.
There is a significant strain on capacity across the whole health system in England, with challenges experienced in both primary and secondary care as well as wider parts of the system. As reported by The Health Foundation, reducing this burden will require strengthening policy that supports disease prevention and coordinating services outside of hospital (The Health Foundation, 2023).
This is an important area of focus and any additional funding and support for general practice to provide care in the community is welcomed. However, as outlined in the RCGP manifesto, despite moves to shift patient care out of hospitals and into the community, there has not been a sufficient transfer of NHS funding to general practice. General practice urgently needs greater investment to enable more patients to be seen within their communities, to prevent ill health and reduce the need for patients to go to hospital.
General practice already works to manage risk and support patients while on long secondary care waiting lists. Incentives alone will never be sufficient to support the continued expansion of this activity. It must be recognised that the root cause of pressures across the healthcare system is consistent underfunding and an accompanying workforce and workload crisis.

Similarly, significant efforts are needed to improve the primary/secondary care interface and reduce unnecessary associated bureaucracy. This is explored in the RCGP's interface guidance which highlights the broader cultural changes needed, of which incentives schemes could only ever be one element.

Question 9.

Do you agree or disagree that incentives should be more tailored towards quality of care for patients with multiple long-term conditions?

Agree

The RCGP and our members are concerned that current incentives schemes are too focused on individual conditions and welcomes proposals to tailor incentives more towards multiple long-term conditions.

With our aging population, we are seeing an increase in the number of people living with multiple long-term conditions. In England, it is estimated that more than 14 million people have two or more health conditions, with the most common being hypertension, depression or anxiety, and chronic pain (Stafford et al, 2021). These individuals constitute a very significant part of GPs' work, accounting for 50% of all GP appointments in England.

Despite this, the NHS standardised approach to care remains largely single disease and research has shown that GPs face challenges implementing single condition guidelines appropriately for patients with multi-morbidities (Damarell et al, 2020). There is a need for better guidance around managing an increasingly complex population, and the RCGP considers that this should also be reflected within incentives schemes.

The majority of GP respondents to our survey agreed with the above statement. The RCGP is concerned that current incentives schemes are too focused on individual conditions. As part of an overall streamlining the number of indicators, there should be a reduction in these disease specific indicators which risk encouraging siloed working.

While one alternative could be the introduction of an additional indicator specifically focused on multimorbidity, the RCGP does not consider that this would necessarily be the best solution. Such an indicator would risk being difficult to administer and resulting in continued box ticking against a list of diseases.

Instead, alongside an overall reduction in the number of disease specific indicators, we would like to see greater flexibility within indicators to allow practices to design care in ways that work for their local populations, for example using group consultations for common conditions and encouraging check-ups that cover multiple conditions.

The RCGP has heard from patient charities that there is a preference for holistic and patient-centred care which moves away from the current single-disease indicators used within QOF. The RCGP's published work on the positive effects of relationship-based care highlights the importance of looking at the whole patient rather than focusing on one illness.

Question 10.

Do you agree or disagree that patient experience of access could be improved if included in an incentive scheme?

Disagree.

The RCGP supports efforts to improve access for patients and provide holistic relationship-centred care. However, we disagree that patient experience of access should be included in any incentive scheme.

The workforce and workload crisis facing general practice, will continue to influence patient experience of access, regardless of incentive schemes. The priority should be ensuring a properly resourced general practice able to provide a good experience of access rather than on setting targets via incentives schemes that practices may not be sufficiently supported to be able to achieve.

In addition, incentivising a focus on speed of access risks having the consequence of reducing opportunities to provide relational continuity of care, which has shown to be advantageous to patient satisfaction and clinical outcomes as well as reducing secondary care admissions and saving money for the system as a whole (The Power of Relationships, RCGP, 2021)

Research shows that when GPs are more satisfied with their work, patients experience better communication, access, and more comprehensive care (Schafer et al,2020). GPs want to deliver the highest possible standard of care and are as frustrated as patients when there are challenges with access. Efforts to improve experience of access should be well resourced as part of core activity, as well as through quality improvement strategies.

Question 11.

Do you agree or disagree that continuity of care could be improved if included in an incentive scheme?

Neither agree or disagree

The RCGP is committed to the importance of continuity of care and the benefits it offers for patients, GPs and the wider NHS including greater satisfaction, improved outcomes and reduced costs (The Power of Relationships, RCGP, 2021). It remains a priority for the College to support practices to be able to prioritise and deliver continuity of care as part of core activity. While there could be a limited role for incentives in promoting ways of working which promote continuity of care, overall, the RCGP does not believe that incentives are the most appropriate means of doing so.

There is a need for flexibility in providing continuity in the ways that works best for practices and local populations. There is also a need to recognise the limitations imposed by workforce, workload and premises challenges which may make it difficult for continuity to be consistently

achieved. On this basis, we would suggest that any efforts to support or improve continuity should be quality improvement based and properly resourced as a core role of general practice.
We look forward to continuing to engage in wider discussions planned by DHSC in relation to supporting continuity of care in general practice.

Question 12.

Do you agree or disagree that patient choice could be improved if included in an incentive scheme?

Disagree.

The RCGP does not consider it appropriate for an indicator on patient choice to be included in any GP incentive schemes. Practices will always seek to offer patient choice so far as is achievable within current workforce and workload constraints. Rather than using incentive schemes to set targets which may be unachievable in the context of current pressures, the focus should be on ensuring practices are sufficiently resourced to offer patient choice where appropriate.
The addition of detailed indicators such as those on patient experience or choice would run counter to the RCGP's overall proposed direction of travel of streamlining incentives schemes and moving to fewer, higher-level and higher-trust indicators. The majority of GP respondents to our survey disagreed that patient choice could be improved if included in an incentive scheme.

Question 13.

Do you agree or disagree that the effectiveness of prescribing could be improved if included in an incentive scheme?

Agree

The RCGP is committed to improving effectiveness of prescribing within general practice with a particular focus on sustainability and reducing over-prescribing. We consider that there is a role for incentive schemes to help promote good practice in this area.
{HYPERLINK "https://www.nhsbsa.nhs.uk/statistical-collections/prescribing-costs-hospitals-and-community-england/prescribing-costs-hospitals-and-community-england-202122" \t "_blank"**}**. Incorporating cost effective and sustainable prescribing practises within general practice, could further efforts to reduce over-prescribing, save money and address the climate emergency. The RCGP strategy highlights the importance of tackling the climate emergency and the associated need to consider the sustainability of prescribing, with clinical

work (predominantly prescribing) accounting for 60% of carbon emissions in primary care (Greener Practice).
The majority of GP respondents to our survey agreed that there could be a role of incentive schemes in improving the effectiveness of prescribing, with 76.7% saying this could help to reduce over-prescribing and 68.4% saying this could promote more environmentally sustainable prescribing. The RCGP considers that this should be done at a high-level, addressing reductions in over-prescribing and more environmentally sustainable prescribing overall, rather than detailed or prescriptive indicators regarding specific medicines, for example.

Question 14.

What opportunities are there to simplify and streamline any schemes for clinicians, and reduce any unnecessary administrative burden, while preserving patient care? (Maximum 400 words.)

There is a significant need to reduce unnecessary bureaucracy and administrative burden on GPs to free them up to spend more time with patients and focus on delivering holistic, person-centred care.
A number of options for simplifying incentive schemes and reducing unnecessary administration were supported by GP respondents to our survey. 61% felt that reducing the requirements for detailed evidence and replacing this with higher-level indicators would improve the situation. 63.7% suggested reducing the number of QOF and IIF indicators overall. Considering improvements to processing requirements specifically, 70.4% were supporting of investing in and improving automation functions within GP IT systems to reduce the administration associated with incentive schemes.
Many GPs also saw the potential in increasing the time period that incentive scheme measurement cycles cover with 39.7% supporting the status quo of 1 year but 47.2% suggesting that cycles from 18 months to over 2 years could be considered.
Overall, as outlined throughout, it is the College's view that reducing the number of QOF and IIF indicators and replacing them with higher level indicators, creating a more trusting environment would allow GPs to focus on delivering the best, tailored patient care.

Question 15.

If you think there are any other areas that should be considered for inclusion within an incentive scheme, please list them here. (Maximum 400 words.)

In the long-term, it is the RCGP's view that incentives schemes should focus more on quality improvement. However, this would need to be accompanied by an increase in resourcing and support, including organisational development and change management support, to allow for effective quality improvement activity and embedding of new ways of working. It is important to consider both the long and short-term direction for the future of GP incentives. In the short-term, it is important for incentives schemes to be reformed to reflect the best way to provide

the highest quality patient care within the current constraints facing general practice. As previously mentioned, we would expect this to include a reduction in the number of indicators and a refocussing with high-level indicators that address health inequalities, sustainability, prevention and multi-morbidities, rather than disease specific process measures.

The learning from Wales and Scotland where QOF has been replaced/removed is limited. The lack of collected data and the capacity to measure patient outcomes has made it difficult to accurately conclude on the impacts of removing OQF. The removal of QOF in Scotland was a deliberate choice made on the understanding that we had reached the limit of the benefits that QOF had previously offered, with the recognition that new systems of quality would need to be introduced. Research on the estimated impact on withdrawing from QOF in Scotland has suggested a drop in certain measures of clinical activity in general practice. It is in part drawing on this evidence that informs the College's view that incentive schemes should remain in some form in England, albeit in a more streamlined fashion. However, it is important to note that more robust data gathering, and analysis is needed to understand the full implications of changes in other nations.

While there is evidence that QOF has been effective in increasing and maintaining some levels of care processes with associated indicators, the vast majority of studies – including a review by NHS England in 2018 – have found that, as currently designed, it has not been effective in delivering improved health outcomes (Forbes et al, 2017; Ashworth and Gulliford, 2017; Ahmed et al, 2021; NHS England, 2018).

Any incentive schemes in general practice should be reviewed regularly to ensure that indicators are evidence-based and continue to be effective in promoting the highest quality patient care in a way that also meets the needs for GPs.