Dr. Maureen Baker CBE DM FRCGP, Honorary Secretary of Council

3 February 2009

Department of Health consultation: Developing the Quality and Outcomes Framework – proposals for a new, independent process

1. The College welcomes the opportunity to comment on the Department of Health's consultation on developing the Quality and Outcomes Framework (QOF)

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the 'voice' of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 36,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

3. The Quality and Outcomes Framework has been a successful system for quality improvement in general practice. It is an internationally respected system whose success has been underpinned by its development through professional leadership and academic input. QOF has been an effective national incentive mechanism with a very high uptake rate. QOF encourages GPs to see patients more often and to provide a higher level of service including health promotion and prevention. The RCGP supports the Department of Health in further development of the framework and would strongly urge that this continues to be done in a professionally led way with academic input and appropriately evidenced decision making. We do however have some concerns about the proposals put forward here, and believe that there are issues that need highlighting and further consideration.

Question 1: Do you agree with the proposed aims of the new process? If not are there any other important aspects that should be considered?

4. We agree, in principle, with many of the proposed aims of the document although have a number of specific concerns detailed in our response.

5. It is important to ensure that the consultative system for developing indicators is not unduly influenced by commercial lobby or advocacy groups. It is even more important, with an increased role in the QOF, that NICE has real and transparent engagement with practitioners in primary care and academics in the development of its guidelines and advice. As a UK wide organisation with a leadership role in
the development of quality improvement for primary care the RCGP is willing to play a key role in this process.

6. There needs to be more detail on how lay input to the reviewing of indicators and the processes set out here will be achieved.

7. Further, specific consideration also needs to be given to the implications for the healthcare systems in the devolved countries. The document is England focused with little acknowledgement of the importance or quality of the SIGN guidance or real discussion of the strengths and weaknesses of devolution within QOF. This needs to be looked at again.

Question 2: Do you consider that the new process will help to address health inequalities? What do you consider that impact on equality is likely to be?

8. This is difficult to predict and will depend on how the incentives are configured and the dynamics of the thresholds and priorities set. Recent work by Doran and Ashworth suggests that the Framework itself appears to be an equitable intervention. There is evidence that QOF can help reduce inequalities, however it is clear from the evidence base on health inequalities that contextual factors such as socio-economic status and ability to access healthcare and related services are more important influencers.

9. Legislating for inequalities at an indicator level is hard to achieve. One way to help ensure this is to have good quality data about pre QOF baseline uptake in areas with significant morbidity and mortality in hard to reach groups e.g. health checks for people with a learning disability and those with language difficulties. Further, stability in the framework is an important factor in dealing with inequalities. Maximising benefits for deprived populations takes time.

Question 3: Do you agree that the scope of the new process should cover clinical and health improvement indicators in the QOF, excluding indicators relating to influenza vaccination?

10. Yes and see the answer to 7

Question 4: Do you agree with the proposed key elements of the new process and the proposed content of NICE advice?

11. In principle the process outlined here seems reasonable and it is important that it not become too unwieldy and complex. See also our response to Question 7.

12. There may be too great an emphasis on basing new indicators on NICE guidance. NICE has yet to produce guidance on many issues of relevance to primary care. For example, mental health conditions are currently underrepresented.

13. The process outlined here also seems cumbersome in comparison to the current one. There appears to be a lack of senior primary care input at the moment in the
document in terms of strategic and academic leadership. This input is key to the process for the development of QOF.

14. There is no logical reason for the NICE consultation in stage 3 (annexe B) if indicators are piloted for 6 months. It takes some time to adjust service delivery and develop requisite team skills in general practice to deliver a new incentive. There must be sufficient stabilisation and lead in time to make each net of indicators work to their maximum effect.

**Question 5: Do you agree with the proposed approach to reviewing existing indicators?**

15. Yes, on the whole, however there are critical questions that still need to be addressed including what criteria should be used to decide if an indicator should be removed. A consistent plateauing of achievement in practices in all quintiles of deprivation may be sufficient to indicate that it is ‘safe’ and appropriate to remove the incentive.

16. Clear and transparent rules need to be developed to guide this critical area of QOF. It is also important to continue to monitor achievement once an indicator has been removed in case achievement falls and there is a need to reconsider. It is important to guard against reversion in the way the framework is developed and reviewed. The evidence base for all new indicators must maintain the same robust standards as for the current indicators. Further, both the positive and negative effects of new indicators must be evaluate through piloting – well intentioned outcome measures can have unintended consequences for patient service delivery.

17. There is as yet no evidence base to inform this (although work between Kaiser Permanente and NPCRDC may shed some light on this area in Spring 2009).

**Question 6: Do you agree with the proposal to retain the principles for QOF indicators of Financial Entitlements set out in Annex C.**

18. Yes

**Question 7: Do you agree with the draft criteria for prioritising new areas for indicator development attached at Annex D or do you have changes to suggest?**

19. There are three main problems with the draft criteria set out here:

**Over focus on outcomes**

20. There is too great a focus on outcomes. Measuring outcome at practice level is **impractical** as practices operate under very different circumstances, and many outcomes may relate to social and demographic characteristics of the population rather than the primary care they receive. This could create perverse incentives to not register sicker or more complex patients.
21. **Costs**: Final health outcomes are difficult, expensive, time-consuming and often impractical as measure of quality care in primary care.

22. There are **attribute** difficulties. Death, as an outcome, is rare in the context of primary care, and almost always not a direct reflection of care in primary care.

23. **Timing**: outcomes may take a long period of time to observe.

24. **Interpretation**: observed outcomes may be difficult to interpret if the processes that produced the outcome are complex.

25. **Ambiguity**: good outcomes can often be achieved despite poor processes of care (and indeed vice versa).

26. One way to overcome some of these issues would be to develop quality indicators that are adjusted for patient characteristics such as co-morbidity, disease severity, socio-economic status and ethnicity. This process, however, is also not without its difficulties.

**Process for updating the framework and the role of NICE**

27. There is no real discussion of what happens to good ideas for new indicators in areas where there is no NICE guidance. The current system enables rapid reviews of important areas not yet addressed by NICE- there does not appear to be this flexibility in the proposed system.

28. Much of the evidence base gathered for the development of clinical guidelines and developed through the consideration of single diseases in hospitals. Often these guidelines do not take account of patients with multiple conditions. Inappropriately aligning these guidelines with QOF has the risk of skewing outcomes in primary care. It is important that measures which are not developed in this way, but clearly have benefits for primary care are considered for inclusion e.g. integrated care, personal continuity of care.

29. Further we exercise caution in the way in which NICE guidelines are used to inform QOF indicators. Incentives to implement multiple sets of guidelines through QOF indicators in a single patient with co-morbidity could be inappropriate. Primary care deals with patients with multiple conditions and GPs must take a holistic view on clinical care. For example patients should not always be prescribed all the medicines that would otherwise be appropriate to the single diseases when suffering from multiple conditions. This must be taken into account in the way that QOF is updated and implemented.

**Patient Reported Outcome Measures (PROMs)**

30. We fully support the need for patient experiences and input to be incorporated to the process. However, there is perhaps too great a focus on PROMs. At the moment the science/measure themselves and science behind the interpretation is not robust enough to be reliable and therefore the rewards or penalties attached to PROMs may be inappropriate. To fully evaluate the role of these measures in routine practice, studies need to use PROMs that capture issues of importance to patients and to measure impacts relating to the patient–provider
relationship and patient contributions to their well-being. Until studies evaluate PROMs as a means to facilitate patient-centred care, their full potential in clinical practice will remain unknown.

**Question 8** Do you agree with the principles proposed for assessing the cost effectiveness of QOF indicators? If not what changes would you suggest?

31. There is very limited evidence on cost effectiveness of indicators with data on QALYS available for only 12 of the current clinical indicators. Data on lives saved can only be calculated for 19 of the 80 clinical indicators. Structural, diagnostic and measurement indicators are particularly difficult to address in this respect. It is not clear from this document how much future cost effectiveness work will rely on modelling which itself relies heavily on a series of assumptions. It is also not clear to what extent practice workload will be considered in any cost effectiveness equation. Further details on operation of the cost effectiveness assessment will be needed.

32. The primary focus of QOF must be the maximisation of the quality of clinical care. Though we understand the need to consider cost effectiveness there should not be an undue focus on this.

**Question 9** Do you agree with the proposals for the scope of the advice that NICE would publish to inform subsequent decisions on choice of indicators, thresholds and payment levels?

33. Yes. Publishing a menu of worked up indicators with predetermined thresholds will make the process more transparent and reduce the risk of decisions being unduly influenced.

**Question 10** Do you agree with the proposals for the frequency of QOF reviews and the estimated output in terms of existing indicators reviewed and new indicators developed for the national menu?

34. The feasibility of a 10 clinical indicator change for the first 4 years and then biennial reviews is dependent on a number of other factors including which ten indicators are removed to make space and the professional ‘buy in’ to the new system.

35. It appears that up to 40 indicators may have to be piloted at any one time to develop 10 workable indicators. This could be overambitious.

36. The workload for potential pilot practices also suggests that there needs to be some financial payments available to recognise the significant and ongoing workload they will undertake.

**Question 11** Do you agree with the proposals for transition to the new system?
37. This section of the document is a little unclear. It appears that 20 existing clinical indicators will be reviewed in each of the four transition years but that piloted indicators will not be available for introduction until April 2012 at the earliest. Changes in 2010 and 2011 will therefore be based on existing (and presumably updated) expert panel reports? Some clarification on this is needed.

**Question 12**: What are your views on the idea of reserving a proportion of nationally agreed QOF investment to enable PCTs and GP practices to agree local indicators selected from a national menu of approved indicators? Do you have any other suggestions for developing local QOFs or comparable local incentive schemes?

38. QOF is a national framework and as such is unable to fully adapt to local health economy needs. We believe that local priorities should be funded through the existing mechanism of Local Enhanced Services (LESs). Local enhanced services if properly managed can address specific local health needs or requirements.

39. The RCGP is a UK wide organisation and is willing to play a key role at the national level with NICE in developing national indicators and to support SHAs and PCTs to develop services locally. Development of QOF must have strong involvement from all the four UK health departments.

40. Further, many of our members have raised concerns at the management ability of PCTs to deliver local quality improvement. There is already variation as to how QOF is monitored across PCTs and introduction of local flexibility to QOF could exacerbate this. A national QOF, with the existing mechanism for Local Enhanced Services, acts as a guarantor of consistent quality in patient care across the country. We are not convinced that local QOF could be managed by PCTs and it could adversely affect the consistency of care offered to patients.

**Question 13**: Do you have any views on the balance between the proportion of QOF that should be determined nationally and the proportion that could be left for local decision-making?

41. We believe that QOF should be a national framework for the reasons stated in the answer above. Local priorities can be met through Local Enhanced Services and the proportion of investment for LES determined at that level.

**Question 14**: Do you have comments on the type and degree of national IM&T support that PCTs would need for extraction of data, analysis of achievement and calculation of payments to implement local QOFs or comparable local incentive schemes?

42. GPES is not going to be able to provide an adequate IM&T function for at least 3 years. PRIMIS is currently providing some IM&T support but will need to be supported in this role if local QOFs are implemented before 2011/12. Consideration needs to be given to how the introduction of new indicators will impact on the use of these systems.
Further consideration also needs to be given to how different IM&T systems operate across the devolved countries and the impact this will have on the operation of QOF.

Yours sincerely

Dr Maureen Baker
Honorary Secretary of Council

---


3. Dorea e.a. August 2008 *Lancet*


