

# **Report of the Review of the Quality and Outcomes Framework in England**

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## Foreword by the Advisory Group

This year, as the NHS turns 70, there is a perfect opportunity to reflect on all of the things the NHS does that are invaluable and world-leading but also where we can improve, learning from what has worked less well. This review of the Quality and Outcomes Framework (QOF) should not be considered in isolation, but as part of the wider direction set out in the GP Forward View, sitting alongside reviews of general practice premises and the partnership. Together these programmes address some of the biggest challenges facing general practice.

The Quality and Outcomes Framework is one of the biggest pay for performance schemes in the world, worth £691 million in 2016/17. It has had a clear impact on how general practice is organised and delivered, having played a major part in the standardisation of long term condition care, use of clinical IT systems and a diversification of practice teams. It comprises a significant part of practice income. However, since its introduction in 2004 the scheme has evolved but not undergone a substantial review. Over time the evidence base for what works has grown and the world around us has changed, so it is important to consider how the scheme also needs to evolve.

We now know that pay for performance is good at driving some kinds of improvement but not others, that the process of designing metrics can unintentionally narrow the focus of a scheme and crowd out harder to measure activity, such as the provision of person-centred care, and can undermine the leadership of clinicians in improving quality. However, we also know that when existing indicators are retired important activity and associated data, that we have come to rely on, can be lost.

Over a number of years, the prevalence of long-term conditions has increased, as has life expectancy, and the care of frail and complex patients is now the major focus most GPs' working day. Practices operate within a context of financial constraint across most local health systems. GPs have been feeling the impact of spending constraints in public health and social care. In response, providers and commissioners from across systems have been pulling together to collaborate and make the best possible use of limited resources to deliver sustainable high quality and effective care. Practices working together in federations and networks have started to describe the benefits to them and their patients. Working together, these networks could be equipped to impact on the NHS's biggest challenges – such as improving timeliness of cancer diagnosis, management of cardiovascular disease and the achievement of parity of esteem for mental health.

This review has taken into consideration what we have learnt from the last 14 years of QOF, the opinions of a wide range of patients, practice staff, subject matter experts and other stakeholders and has systematically considered a wide range of options for reform – from the very minimal to the very radical.

There is much on which the members of the Advisory Group are agreed: our vision is to facilitate delivery of consistently high quality care, through greater clinical leadership of quality improvement, and more sophisticated personalisation of care. To achieve this, we need to reposition QOF as a scheme which recognises and supports the professional values of GPs and their teams in the delivery of first contact, comprehensive, coordinated and person-centred care.

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There are also conclusions and proposals which involve difficult judgements that remain subject to debate. The purpose of this report is to share the findings of our review and the resulting options, to support wider discussion about how we reform and develop the QOF which inform negotiations between NHS England (NHSE) and the British Medical Association's General Practitioners Committee (GPC).

It has been a pleasure to be involved in this review and we would like to thank the people who gave their time to support it. In particular, the Technical Working Group has generously donated its expertise to explore the evidence on the existing scheme and develop the elements of potential reform that are set out in this report. We also want to thank the GPs and practice staff, patients, commissioners and charity representatives that offered their time.

Signed by members of the Advisory Group:

Ed Waller (Chair), NHS England (NHSE)



Director New Business  
Models and Primary Care  
Contracts Groups

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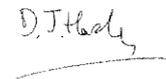
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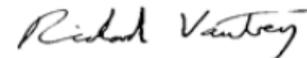
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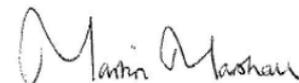
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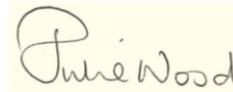
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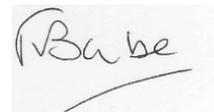
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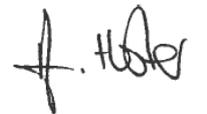
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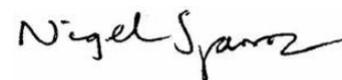
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# 1 Introduction and overview

## 1.1 Introduction

In the 'Five Year Forward View Next Steps' (NHS England, 2017) NHS England (NHSE) agreed to undertake a review of the Quality and Outcomes Framework (QOF) for general practice. This report presents the findings of that review, with the aim of stimulating discussion about how the QOF can be developed to support good quality care into the future. In order to do this we have sought to learn from past experience in England, the variations to QOF undertaken in different parts of the UK, and have considered the evolving environment in which general practice operates.

We have initiated discussions on the findings and ideas in this report by carrying out a series of engagement activities with patients and practice staff, and look forward to listening to more views over the coming weeks and months, which will inform the way forward.

The review has benefited extensively from the contributions of an Advisory Group of senior stakeholders and has also drawn widely on expertise in the field, particularly that of members of our Technical Working Group, who have been very supportive with their time and knowledge.

## 1.2 Rationale for the review

In the General Practice Forward View, NHSE acknowledged that "The QOF has created a more focussed approach to chronic disease management and provides a structured way of engaging in secondary prevention. However, some argue that it has served its purpose and requires review or even replacement and that it is a barrier to holistic management of health conditions. NHSE has agreed to undertake a review of QOF with the General Practitioners Committee (GPC) in the coming year to address these issues, whilst recognising that it is one of the best public health databases in the world and, done right, can support population-based healthcare." A similar desire to review the QOF was set out in the Five Year Forward View.

### 1.2.1 Objectives of the review

The objectives of the review were to:

- Consider the changes to the environment in general practice, and the extent to which an incentive scheme could help practices to respond;

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- Gather a deeper understanding of the functioning of current QOF and of other incentives in general practice;
- Determine future priorities for an incentive scheme for general practice, taking into account QOF's strengths and limitations and the changing environment of general practice;
- Develop proposals for reform of QOF or develop a successor to QOF that could help deliver these priorities, with those proposals informing annual negotiations between NHSE and GPC.

### 1.2.2 Environment and evidence

The environment in which general practice is operating is changing. NHSE recognises that many practices are struggling with increasing workload and in April 2016 published the General Practice Forward View committing to a range of support and investment measures over five years. Stakeholders have emphasised that QOF is an important source of income to practices and that the associated interventions have a day to day impact on the work of whole practice team, and hence changes to it have an implication for both practice finances and workload.

For some time practices have chosen to respond to the pressures of rising demands by working more closely together in collaborations or networks. Practices who have taken this approach describe the benefits they have experienced in terms of greater resilience and stronger system voice, and the benefits for their patients, through the provision of greater access to a wider range of services, often supported a multidisciplinary team. NHSE supports and encourages the shift towards working in primary care networks, and this is reflected in the most recent planning guidance for commissioners. The changing environment in which practices are working is discussed in greater depth in Chapter 2.

As one of the largest pay for performance schemes in the world, QOF has been subject to significant investigation since its introduction in 2004. The evidence examined in the review highlighted that QOF has been successful in delivering the additional investment to general practice and it has had a significant impact upon practice organisation, staffing, roles and responsibilities and the structuring of long-term condition management. However, the reported impact upon patient outcomes is more limited. This conclusion is not unique to QOF but can be observed across pay-for-performance schemes internationally and both within and without of health care.

Our engagement with practice staff, patients, commissioners and charities reflected many of the findings of the literature. Views of the strengths of QOF and the opportunities for change were wide ranging. However, most participants agreed that QOF could be changed to better support holistic patient care and professional judgement, but that it formed a core part of practice income and so care needed to be taken to avoid destabilising practices; and that the “baby shouldn't be thrown out with the bathwater”. Participants could see opportunities to improve care via collaboration, though introducing incentives at this level would require solid foundations. The literature reviewed and the views expressed in engagement are presented in Chapter 3.

### 1.2.3 Key conclusions

There are aspects of QOF which are both valued and valuable, but there is a need to refresh the scheme to support a wider view of high quality care and to align better with professional values. Underpinning any change would be the clinical vision that change should increase the likelihood of improved patient outcomes, decrease the likelihood of harm from overtreatment and improve the personalisation of care.

The three objectives that NHS England considered highest priority for a reformed scheme, following discussion with the Advisory Group, are that it:

- a. Delivers better patient care, particularly by enabling more holistic person-centred care, and incentivises on-going improvement
- b. Supports stability and sustainability in general practice, by creating space for professionalism, at a time when workload is high and the profession is reporting high levels of stress and concern
- c. Supports practices to move into a role in which they can optimally impact demand on the wider system, and so optimise the use of limited resources

The future options are laid out in Chapter 4, but in summary there was consensus around the benefits of reforming QOF for all practices, so long as this did not unduly add to workload.

### 1.2.4 Proposed QOF Changes

The detail of this would be subject to negotiation, and phased in over a number of years, but illustratively it could include:

- The modification of indicators to improve efficacy where there is good evidence (for example through a more targeted approach to population segments) – perhaps accounting for no more than half the scheme.
- Updating and rebranding of exception reporting, to be termed the personalised care adjustment for all indicators. This would operate at the individual indicator level rather than the domain level which would bring it into closer alignment with the way in which clinical decisions are taken and patient choice is expressed, improve data and reduce scepticism around the use of the mechanism to personalise care.
- Inclusion of a quality improvement domain, utilising quality improvement cycles to address ~3 priority areas each year and utilising points freed up through indicator retirement.
- Moderate retirement of indicators, identified through a transparent indicator assessment methodology – a case could potentially be made for up to a quarter of current indicators.

In addition, there was a feeling that whilst a wide-scale implementation of QOF at network level may be premature, there could be mileage in trialling this approach with a select number of sites.

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The evolution of QOF in this way would take a number of years, but the Advisory Group recognised that this was the likely direction of travel.

In sharing the findings of our review and the resulting options, this report seeks to support wider discussion about how we reform and develop the QOF which will inform negotiations between NHS England and the British Medical Association (BMA).

### **1.3 The review team**

To ensure the views and expertise of key stakeholders were brought to bear throughout the process of the review NHSE established an Advisory Group. Its membership included:

- NHS England (NHSE)
- NHS Clinical Commissioners (NHSCC);
- the General Practitioners Committee of the British Medical Association (GPC);
- a patient representative;
- NHS Employers;
- National Institute for Health and Care Excellence (NICE);
- Department of Health and Social Care (DHSC);
- Royal College of General Practitioners (RCGP);
- Public Health England (PHE);
- Care Quality Commission (CQC); and
- The Chair of the Technical Working Group.

The Terms of Reference for this group are at Annex 1. This group met six times over the course of the review. The Terms of reference for our Technical Working Group are at Annex 2.

### **1.4 The review methodology**

#### **1.4.1 Key questions**

The objectives for a reformed QOF were developed through the review process. This involved taking a baseline view of the circumstances and direction of general practice, and considering what the current QOF delivered and how it could support general practice in the future. These potential priorities for QOF were narrowed to

more specific objectives to ensure we targeted areas that general practice had strong influence over and that were amenable to incentivisation.

The review addressed the four Key Lines of Enquiry (or KLOEs) set out in Figure 1 below. This report presents the evidence considered in KLOE 1 and 2 and the options developed through KLOE 3. KLOE 4 will be further developed following negotiations.

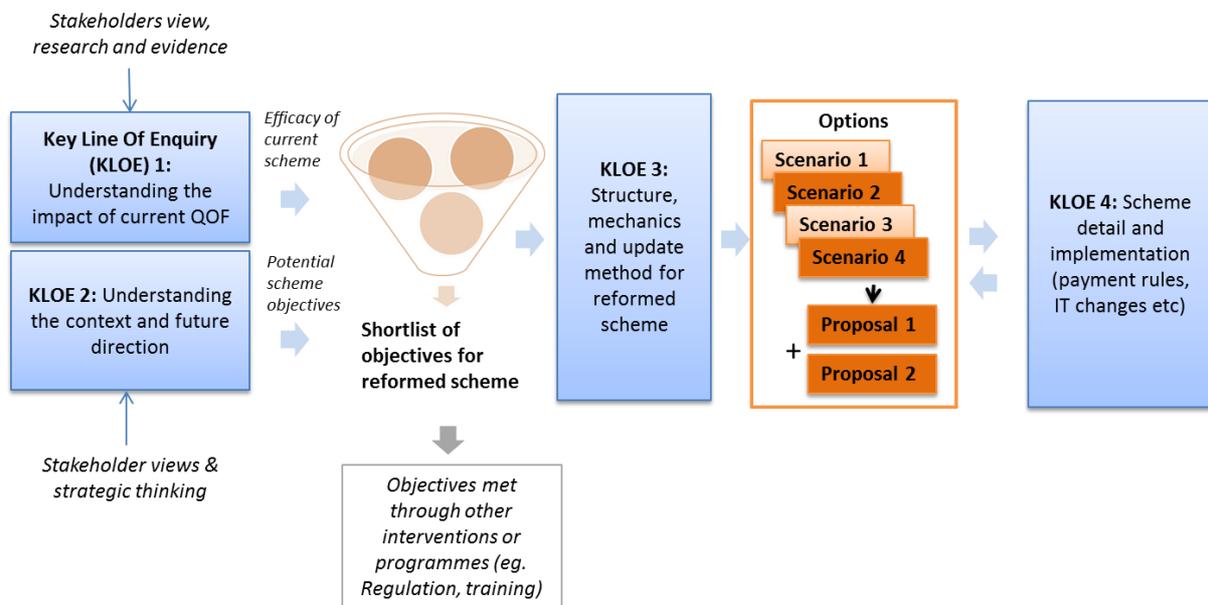


Figure 1: Key lines of enquiry for the review

## 1.4.2 Sources of information and expertise

To develop our thinking the review team drew on studies of the impact of QOF and other incentive schemes. Chapter 3 sets out the main findings of these.

### 1.4.2.1 Evidence in the literature

The review was informed by a thorough understanding of the research that has taken place into QOF and other health care quality incentive schemes. Chapter 3 gives detail of the wealth of literature available to the review.

### 1.4.2.2 Engagement

Engagement was fundamental to our information gathering and the development of options. NHSE undertook a wide range of engagement, including interviews on the strategic direction of general practice; reference groups with patients, practices and commissioners; events for charities with an interest in QOF; and discussions with clinical leaders

The section below describes how we sought input and the areas discussed. The findings are described throughout the report.

Further engagement events are taking place with these groups to consider the ideas contained in the report.

**Interviews on the strategic direction of general practice:** NHSE undertook a series of interviews on the strategic direction of general practice that any reformed scheme should support with a variety of stakeholders including think tanks, Royal Colleges and patient representatives. Chapter 2 considers the issues that were raised. Annex 3 contains a list of those that participated.

**Reference groups with patients and the public:** NHSE ran a series of reference groups with patients, carers and the public to explore their views on the strengths and weaknesses of general practice, and seek their views on the areas we should be considering for prioritisation within a reformed scheme. NHSE advertised through various routes including the National Association of Patient Participation, Healthwatch and Talkhealth Partnerships, as well as the NHSE website for patients to participate in reference groups and obtained a good response. Annex 4 describes the process we used for recruiting participants to these groups. We ran groups in Leeds, Bristol and London. Thirty seven people participated in these discussions. We also engaged with the NHSE Learning Disabilities and Autism advisory group, which involved 15 people with learning disabilities, autism or both and their family or carers.

**Reference groups with practice staff:** Through another series of reference groups we obtained the views practice staff on the strengths and weaknesses of the current QOF, the risks and opportunities of changing it and the priorities for any change. NHSE recruited practice staff to join reference groups via the NHSCC Bulletin, the BMA, the RCGP and NHSE Heads of Primary Care. Thirty-nine practice staff, expressed interest and participated including GPs, practice managers and practice nurses in reference groups in Leeds, Bristol, London and Preston.

**Reference groups with commissioners:** NHSE held discussions with commissioners to understand their experiences of QOF, the strengths and weaknesses of it, the risks and opportunities of changing it and the priorities for any change. This was advertised through the NHSCC Bulletin and NHSE Heads of Primary Care for commissioners to join reference groups. Twenty-one commissioning representatives expressed interest and joined us in four different locations to discuss.

**Event for charities:** NHSE contacted charities with an interest in QOF and invited their representatives to an event held in London. Fifty-nine charities were directly contacted and eleven attended. At this event we sought views on the strengths and weaknesses of the current QOF, the risks and opportunities of changing it and the priorities for any change. A questionnaire has also been used to gather written views from charities and professional bodies and a follow up discussion held.

**Conversations with innovators:** There are several places that have now retired or significantly changed QOF. NHSE explored with commissioners and practices their objectives in retiring or changing QOF and their experiences of the alternatives put in place. The places that have pursued alternatives to QOF are: Scotland, Wales, Dudley CCG, Somerset CCG, Tower Hamlets CCG and Aylesbury Vale CCG. Chapter 3 describes more about these schemes and the impact of them to date.

The review team also interviewed a number of CCGs that have implemented incentive schemes for primary care networks in their local areas. These discussions

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focused on the scope of such schemes, how they have been implemented and funded and how risks have been addressed.

# 2 The context for General Practice

The environment for general practice has changed significantly over the last fourteen years. Increases in life expectancy, whilst a huge achievement, have led to increases in the demands and expectations placed on GPs due to the associated increase in long-term condition prevalence, co-morbidity and frailty. Equally, the role of GPs has been changing; to both include greater engagement and collaboration with other local partners, and also to include greater accountability to regulators for delivery of high quality care. Most recently, new digital technologies are changing the relationship between GPs and patients and will continue to do so over the coming decade. It is important to take this into account to ensure that the scheme is both fit for the future and facilitates and equips general practice for the change.

This chapter describes the contextual considerations that were articulated in our strategic interviews with stakeholders including think tanks, Royal Colleges and patient representatives. Annex 3 contains a list of those that participated. These can be categorised into *changing demands on general practice*, including changes to the supply and demand for general practice services, *drivers of transformation* including moves to system working, new technologies; and delivering against a contemporary *shared view of quality* (National Quality Board, 2016).

## 2.1 Changing demands on general practice

### 2.1.1 The burden of ill health

The increasing burden of ill health is well documented, driven by an ageing population and higher prevalence of long-term conditions (LTCs). The Office of National Statistics projects that by 2039, the population aged 65–84 will rise by 40% and those aged 85+ will increase by 121% (Office for National Statistics, 2014). On average, older people are far higher users of general practice than younger people. In terms of LTCs NHS Digital has projected that by 2035 the prevalence of stroke and diabetes will have risen by 123% and 30% respectively, under an assumption of no change (NHS Digital, 2013). A feature of this growth in prevalence is that there is also growth in multi-morbidity: the number of people with three or more long-term conditions is predicted to rise from 1.9 million in 2008 to 2.9 million in 2018 (NHS Digital, 2013).

Stakeholders in our interviews reflected that optimal management of single LTCs can delay the point at which people experience complications and deterioration in their health. Stakeholders acknowledged the major contribution QOF has had in embedding structured management of LTCs into general practice. It was therefore important that any gains in LTC management and secondary prevention achieved through QOF continue in the future. Some stakeholders discussed the different approach needed for people with 'stable' LTCs versus the complex care needed for those with 'unstable' and complex needs.

Some participants also reflected that QOF had sometimes supported ‘advances in the management of LTCs to the detriment of other things’ such as whole population care and continuity of care. Whilst stakeholders thought there would be benefits from a move away from a single disease approach, one or two highlighted the risk of the loss of specialist skills associated with single disease management. One stakeholder spoke of maintaining a LTC focus but ‘packaging up’ LTC management and incentivising this at a higher level than the individual practice.

### 2.1.2 Patient expectations and personalisation

Throughout our engagement, with patients and strategic organisations, the theme of person centred care and personalisation was raised. Personalised approaches are about supporting people to make decisions and take actions to do with their health and wellbeing that are right for them, and allow them to take more ownership of their own care.

According to the GP Patient Survey, overall more than 70% of patients are very or quite satisfied with their GP services (NHS England, 2017). Figure 2 shows that there have been small declines across a number of measures in the survey, which could be indicative of increased pressures on practices, as well as increasing patient expectations.

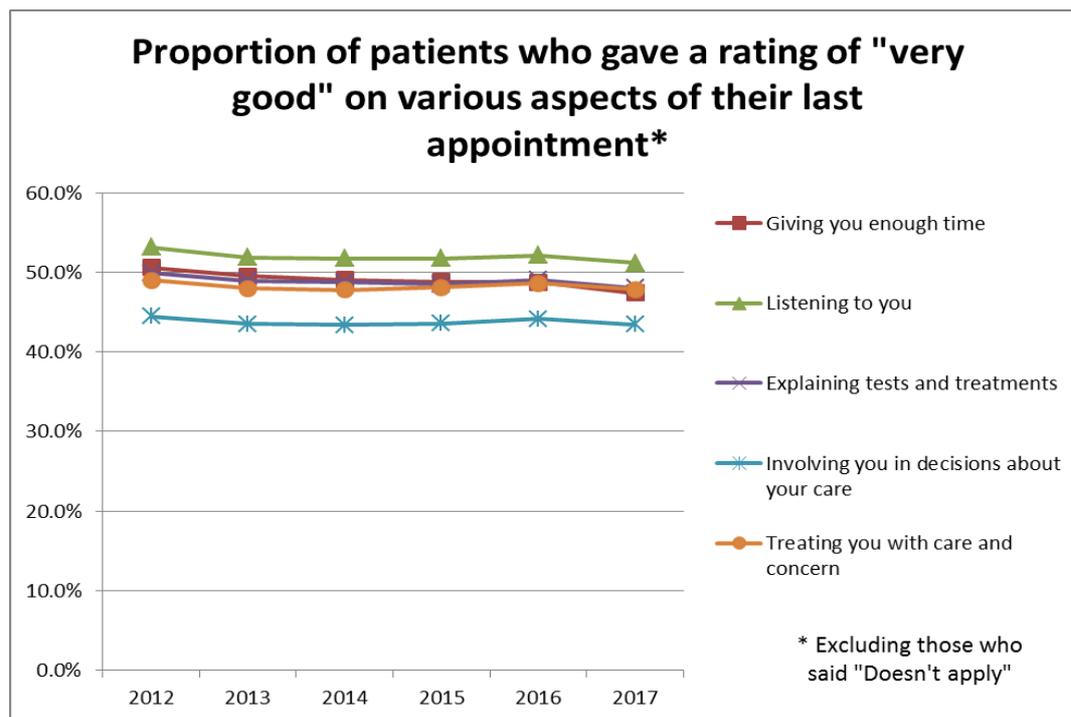


Figure 2: GP Patient Survey - patients rating aspects of care as "very good"

Stakeholders in our interviews described the need to change the ‘conversation’ with patients to focus on ‘life goals’ and help patients to find the best ways forward for them as an individual. GPs and teams need to be given the time and space to have personalised conversations with patients to allow for shared decision making. Participants described the resources / tools that could support the shift towards person centred care including links to social prescribing to include non-clinical support, greater proactive personalised care and support planning, personal health

budgets, health coaching and longer appointment times. Such changes could also support disease prevention.

The risk of over medicalisation was raised a number of times. Some stakeholders advocated for GPs to be freed up to ‘do less’ when that is best for the patient, leading to ‘preference sensitive care rather than supply sensitive care’. Relational continuity was cited as a key enabler for person centred care with one stakeholder describing how ‘continuity and coordination are key to the successor of QOF’. Nearly half of all respondents to the GP Patient Survey (46.2%) have a GP they prefer to see, a decrease of 2.4 percentage points from 48.6% since 2016. Of these patients, nearly three in five (55.6%) say they ‘always or almost always’ see them or see them ‘a lot of the time’, a decrease of 2.8 percentage points from 58.4% since 2016. (NHS England, 2017)

## 2.2 Changing workforce

Over the past ten years there has been a decline in numbers of GPs, particularly of GP providers, and an increase in salaried GPs, registrars and locums (NHS Digital, 2016). Figure 3 shows the trend in headcount. Through the GPFV NHSE is working with stakeholders to address staffing pressures. The GP Retention Scheme has been relaunched and there is a 60% increase in GPs being supported through it since September 2015. The pilot of the International GP Recruitment Programme has started bringing in appropriately trained and qualified overseas doctors and this programme has been expanded to identify a total of 2000 further doctors to work in England by 2020/21. In 2017/18 Health Education England filled 3,157 GP training places, the highest number of GP trainees ever recruited.

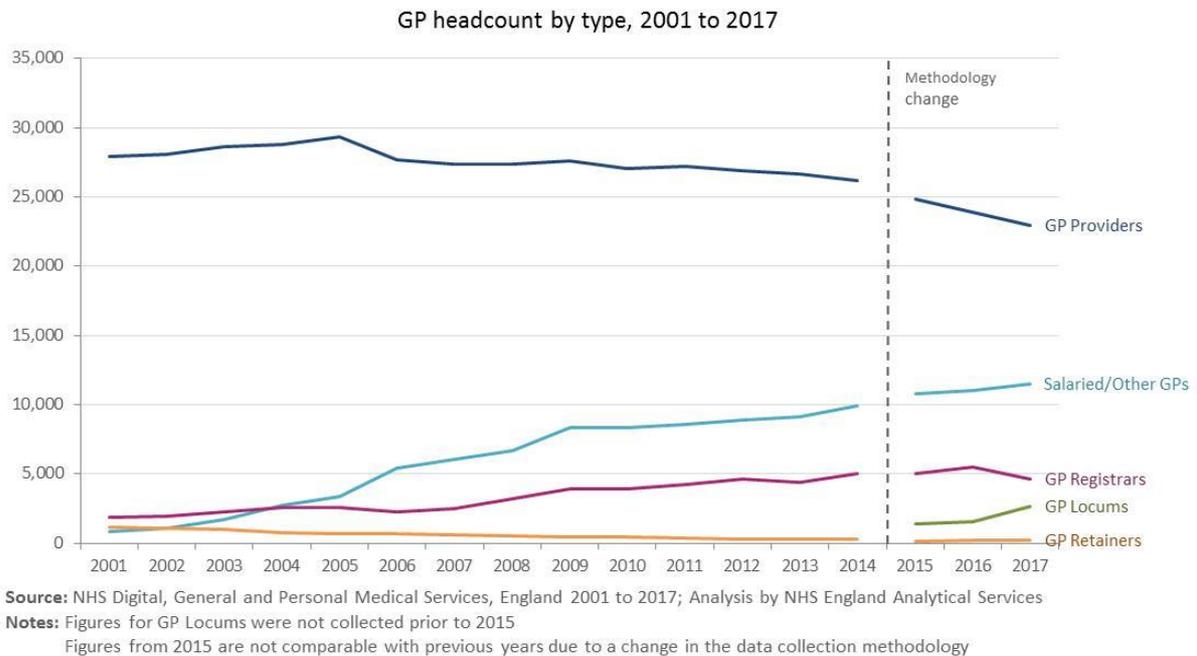


Figure 3: GP headcount by type

Although practice nurse numbers have increased slightly over the last few years, a high proportion are reaching retirement age (NHS Digital, 2018). Figure 4 shows the numbers in different age groups and the recent trend.

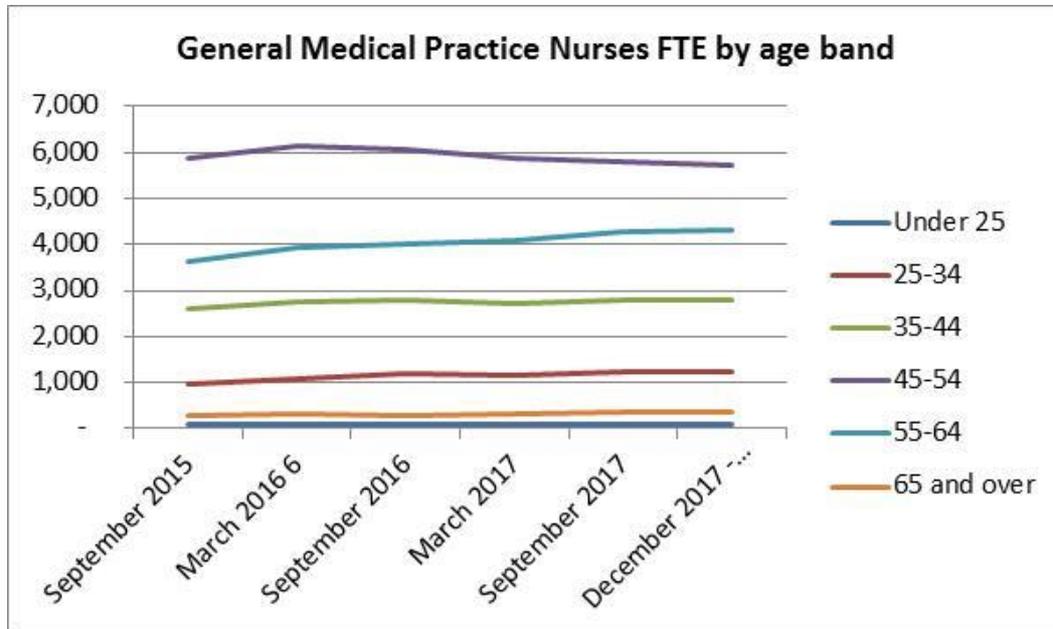


Figure 4: Practice nurses by age band

### 2.3 Drivers of transformation

The NHS is currently under great pressure to deliver ‘the triple aim’ of high quality patient care and improved population health outcomes in the face of limited resources. In order to respond to these demands, care systems are pulling together, with providers of all types and commissioners collaborating to redesign care pathways and channel funds into proactively manage care, often through integrated, community-based teams with GPs at their heart. This is in turn influencing the role of general practices, and the GPs and teams who work within them, as they are more often being relied upon to manage the care of complex and frail patients in the community, to manage and prevent deterioration of increasingly prevalent long-term conditions and play a responsive part in the system-wide management of urgent care.

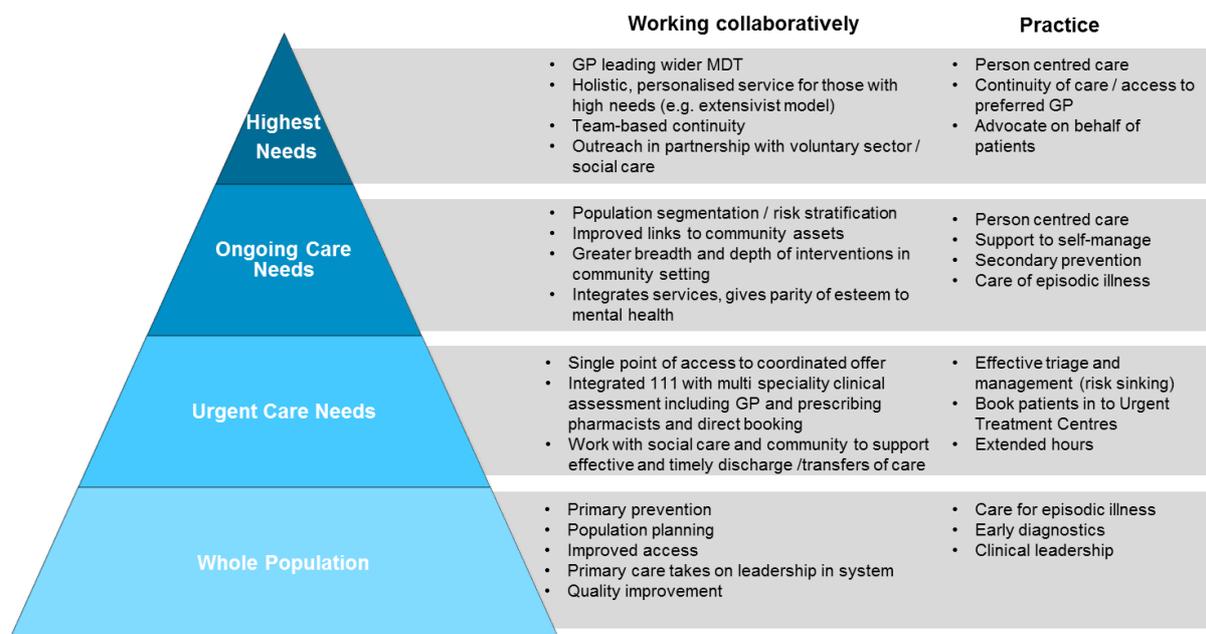
The General Practice Forward View sets out how general practice will be supported to meet these challenges. A series of initiatives are being taken forward such as the GP Resilience Programme, the General Practice Development Programme and Clinical Pharmacists in General Practice initiative that are adding investment, supporting recruitment and retention, helping GPs manage workload, developing the estate and redesigning care.

### 2.3.1 Moves to at-scale working and integration

As mentioned in Chapter 1, practices are increasingly working more closely together in collaborations or networks to enable them to respond to the pressures of rising demands. NHS England supports this move. The planning guidance for CCGs (NHSE, 2018) now sets out that CCGs should, “Actively encourage every practice to be part of a local primary care network, so that there is complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19, serving populations of at least 30,000 to 50,000.” This goes with the grain of the grassroots move by practices towards working at scale. These primary care networks are expected to help build resilience within groups of practices, and broaden the range of professionals and services that will work within and alongside practices to help manage demand, as well as offer our patients an enriched version of primary care.

Our interviews with stakeholders including think tanks, professional bodies and patient representatives revealed a spectrum of views on system integration. One stakeholder described the need to move away from ‘micro managing individual practices’. There was broad agreement that whilst integration and collaborative working are difficult to measure we need to find a way to ‘encourage a culture shift towards system working’ for the benefit of patients. Stakeholders described the need for ‘organisational development support to facilitate the transition towards system working’.

Participants recognised the potential of new models of care to enable whole population health approaches and prevention, and to tackle social determinants of health that are outside of the influence of individual practices. The Advisory Group considered the opportunities for improvement through collaborative working for different categories of need as shown in Figure 5.



**Figure 5: Population pyramid what can be delivered by practices individually or in collaboration for different population groups**

One stakeholder suggested using an asset based model of prevention, building on what people have to help them stay well, for example ‘functional ability’ for older people. Others focussed on risk management, drawing a distinction between lifestyle advice e.g. smoking cessation and whole population programmes such as screening. It was broadly felt that prevention could be better managed in wider primary care groupings than at individual practice level.

A theme throughout interviews was the widening scope of primary care and the opportunity this brings to improve care by shifting activity and resources from secondary care in to the community. This fits well with the intentions of the emerging integrated care systems, which are planning how they operate their collective resources for the benefit of local populations.

Figure 6 shows the actions that are taking place at different levels in some localities.

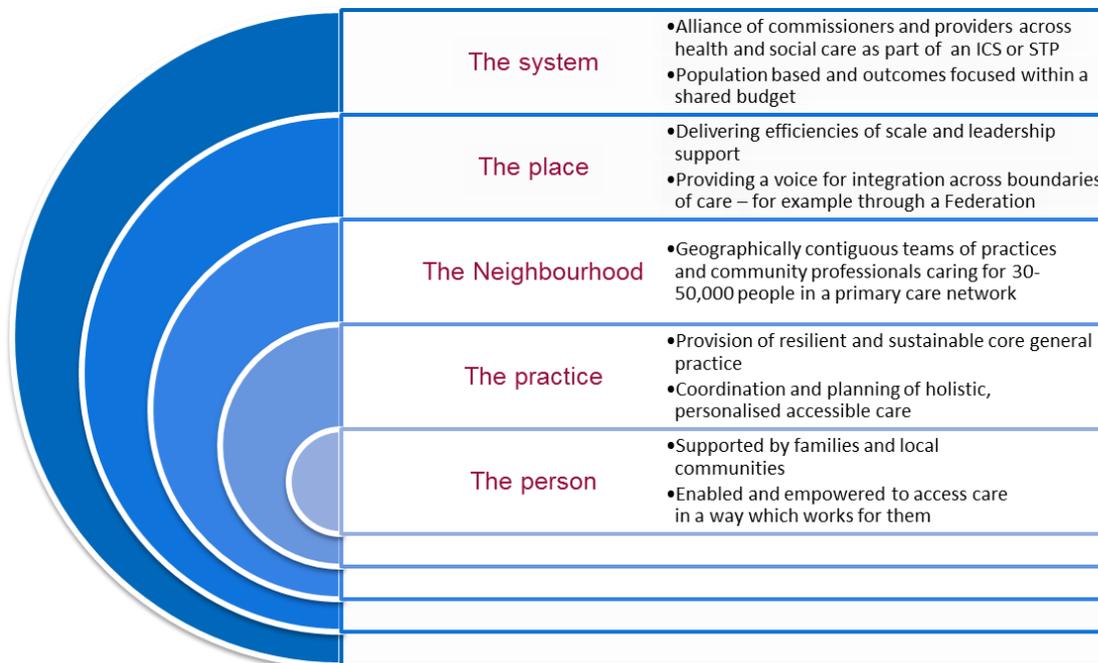


Figure 6: General practice inside a wider system

### 2.3.3 Technological change

There are a range of technological changes that are influencing the delivery of general practice.

In our patient groups we heard both a desire for greater technological solutions to support self-care, and help patients understand their condition, and a concern that technological advances could leave some patients isolated, see 3.4.2 for more detail.

The role of good data was emphasised by stakeholders. Technological improvement resulting in greater ability to store and analyse large quantities of data has created opportunities and risks. The review team was encouraged by stakeholders to identify where any opportunities existed to build on technological change, but were cautioned that QOF and general practice incentives were not the vehicle to drive such change.

Over the course of the interviews, stakeholders noted the impact of digital first models, which have seen high registrations rates from younger patients. It was noted that QOF as it currently exists could have little impact on the care provided in these practices, due to their low numbers of patients with long term conditions (LTCs).

## 2.4 A shared view of quality

In 2016 the Shared View of Quality was published (National Quality Board, 2016). This set out the broad areas of quality that would support high-quality person centred care for all, now and into the future. Figure 7 shows the areas. These indicate a wider view of quality than the clinical perspective that is currently taken through QOF.



Figure 7: Six areas of the Shared View of Quality

In March 2018 the CQC published high level guidance, developed in collaboration with a wide group of stakeholder, to support a shared view of quality in general practice. This was published on behalf of the General Practice Regulation Programme Board (Care Quality Commission, 2018) and provides a set of overarching principles for general practice, describing the detail of pre-requisites of

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care to deliver the triple aim, to improve health and wellbeing, transform quality of care delivery and to have sustainable finances.

Throughout the review we considered the scope for incentives to support the delivery of high quality care, as defined by the Shared View of Quality.

Stakeholders spoke about the importance of 'team accountability for quality' and creating time for peer-led professional teams to drive quality improvement. One stakeholder also described quality as 'clinicians holding themselves to account as to how to improve quality'. Interviewees preferred clinician driven change to top down change, and some commented on the burden of top down regulation on practices.

Stakeholders were clear that data was key to quality improvement and called for investment and education to improve data usage. Interviewees suggested that quality improvement should be paid for at the cluster level. If this approach was taken forward NHSE would need to ensure that the scheme design avoided the risk of 'tick box' culture, as some see current QOF.

# 3 Evidence on current scheme

## 3.1 Introduction

As one of the largest pay for performance schemes in the world, QOF has been subject to significant investigation since its introduction in 2004. Empirical studies have focused upon the impact of QOF upon recorded patient care, patient outcomes, changes in care which have not been incentivised, patient and professional attitudes, the organisational changes it has promoted and the impact of specific indicators.

The key findings of this body of work have been synthesised in order to inform the review (see Section 3.3). Despite the significant body of empirical work associated with QOF, attribution of cause and effect is limited. This may be due to the lack of control groups, given the widespread implementation of QOF across all practices at a single point in time, or it may be that even with such controls, the impact is limited<sup>1</sup>. Much of the academic work on QOF was undertaken within the first five years of QOF's 2004 implementation, although a number of findings have since been shown to be sustained.

To supplement and contextualise this body of published work, we also undertook a series of engagement events with patients and the public, GPs and their staff and commissioners. These engagement groups also offered an opportunity to consider how some of the problems participants identified with the current QOF could be addressed (Section 3.4). We reviewed how variations to QOF are operating (Section 3.4). The results of this, together with any implications for policy development, are also presented in Section 3.6 of this chapter. Before considering this literature this chapter briefly describes how QOF has been implemented.

## 3.2 How QOF operates

QOF was introduced in 2004 as part of a wider set of contract reforms for general practice. At the time it was the largest pay for performance scheme in the world consisting of 147 indicators addressing four domains of care: clinical care in 10 areas, organisational aspects of care, patient experience and additional services such as cervical screening. Although it is a voluntary scheme, more than 95% of

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<sup>1</sup> Widespread implementation meant that there were insufficient practices not undertaking QOF to give researchers a clear view of the counterfactual of how care would have changed had QOF not been implemented.

practices participate. It was described at the time as a bold proposal with Professor Paul Shekelle noting that:

*'With one mighty leap, the NHS vaults over anything being attempted in the United States, the previous leader in quality improvement initiatives.'* (Shekelle, 2003)

In the intervening years QOF has undergone a series of reforms and development, as have the structures which underpin indicator development and performance monitoring. These have resulted in the smaller current framework of 77 indicators which are focused primarily upon clinical aspects of care and public health and account for a smaller proportion of practice income (approximately 8% at present as compared to 15-20% on implementation). The full detail of the current QOF requirements can be viewed at <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/quality-and-outcomes-framework/changes-to-qof-2018-19>. However, the core elements of measuring and paying for performance have remained unchanged. These will be discussed below.

### **3.2.1 Calculating QOF achievement and payment**

General practices are awarded points, each attracting a payment, for doing specific activities or achieving outcomes described in a set of indicators. The number of points earnable varies by indicator. Some indicators reward practice-level activity (e.g. registers) and others reward the practice for the proportion of patients who have received the clinical care specified or who have achieved a particular outcome (e.g. number of patients with hypertension who have a blood pressure reading of 150/90mmHg or less in last 12 months).

At present there are a maximum of 559 QOF 'points' available, with each point worth an average £179.26 in 2018/19. The actual value of a point at a practice level is adjusted for recorded disease prevalence and practice list size. Practices receive a proportion of this payment through the year known as an 'aspiration payment' with a balancing payment made upon actual points achieved at 31 March each year.

QOF incorporates two main types of indicators:

- Boolean indicators – a practice receives all the points available if it achieves the indicator and none if it does not. Examples of this type of indicators are disease registers.
- Fraction indicators – a practice receives a proportion of the points available depending upon the proportion of patients for whom it achieves the indicator. These indicators have upper and lower payment thresholds with no points being awarded below or at the lower threshold and all points being awarded at or above the upper threshold.<sup>2</sup>

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<sup>2</sup> Worked examples of these can be found in the NHS PCC QOF Management Guide Vol. 1 available at: [https://www.pcc-cic.org.uk/sites/default/files/articles/.../qof\\_volume\\_1\\_updated.pdf](https://www.pcc-cic.org.uk/sites/default/files/articles/.../qof_volume_1_updated.pdf)

This calculation of achievement is made generally excluding those patients who have been exception reported from the indicator denominator – the specifics of this are set out below.

### **3.2.2 Exception reporting**

Exception reporting is the mechanism by which practices can remove a patient from the denominator of an indicator. The original contract documentation described its purpose as,

*'to allow practices to pursue the quality improvement agenda and not be penalised, where for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.'*

There are nine agreed exception criteria which are detailed in the QOF guidance.<sup>3</sup> These include reasons such as the patient not attending a review despite having been invited on at least three occasions during the preceding 12 months, patients for whom it is not appropriate to review the chronic disease parameters due to personal circumstances such as terminal illness or frailty and patients for whom prescribing a medication is not clinically appropriate due to allergies, contraindications etc.

Patients who have been exception reported continue to be included in the disease register and therefore contribute to the practice prevalence calculation. If care has been delivered and recorded then patients will be included in the achievement calculation, even if they also have a reason for exception reporting recorded.

### **3.2.3 Prevalence**

The introduction of QOF enabled the calculation of prevalence for included conditions at a practice level. Prevalence is the number of patients with a given condition expressed as a percentage of the total number of patients registered with the practice. Not only does this inform the calculation of practice QOF payment, it has also led to a better understanding of the burden of common diseases and their management in general practice.

## **3.3 Findings reported in the published literature**

Research into the impact of QOF has focused upon a number of potential effects in terms of care quality and has also sought to understand the experiences of GPs and practice staff as they responded to its implementation. The findings have been grouped here into four themes: the impact upon patient care and outcomes, the impact on practice organisation and relationships, unintended consequences and the impact of indicator retirement and incentive withdrawal.

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<sup>3</sup> Available from <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/quality-and-outcomes-framework/changes-to-qof-2018-19>

The literature presented here is not intended as a systematic review of the literature but as a narrative illustration of key findings which should be reflected upon when considering potential options for QOF reform. Readers interested in a more systematic synthesis of the body of work evaluating QOF are directed to the work of Bruce Guthrie and Jason Tang (2016), Stephen Gillam and colleagues (2012) and Lindsay Forbes and colleagues (2017) amongst others. This chapter is not a critique of the strengths and weaknesses of pay-for-performance. This has equally been the subject of a significant degree of study. Interested readers are directed to the two Cochrane reviews which have considered this (Flodgren, Eccles, Shepperd, Scott, Parmelli, & Beyer, 2011; Scott, Sivey, Ait Ouakrim, Willenberg, Furler, & Young, 2011).

As will be seen when considering the body of evidence reviewed below perhaps the most striking conclusion which can be drawn is that whilst QOF has had a significant impact upon practice organisation, staffing and the structuring of long-term condition management the reported impact upon patient outcomes is more limited. This conclusion is not unique to QOF but can be observed across pay-for-performance schemes internationally and both within and without of healthcare. It is perhaps unsurprising, given the very significant impact of social determinants on health outcomes.

### **3.3.1 Impact on patient outcomes**

Early studies into the impact of QOF upon patient care were promising and suggested that its introduction had been associated with some improvements in care. Campbell et al. in their before and after time series analysis of care quality in relation to heart disease, asthma and diabetes identified an initial acceleration of a pre-existing trend in improvements in care quality for two of the three conditions studied: asthma and diabetes which were statistically significant (Campbell, Reeves, Kontopantelis, Middleton, Sibbald, & Roland, Quality of Primary Care in England with the Introduction of Pay for Performance, 2007). However, the rate of improvement between 2003 and 2005 for financially incentivised indicators did not differ significantly from those which were not financially incentivised when compared to the rate predicted using trend data from 1998 to 2003.

The research team subsequently repeated this analysis to incorporate achievement data from 2007 (Campbell, Reeves, Kontopantelis, Sibbald, & Roland, Effects of Pay for Performance on the Quality of Primary Care in England, 2009). This further analysis suggested that early acceleration in the rate of improvement in relation to diabetes and asthma care had not been sustained, and in the case of care of patients with coronary heart disease and diabetes care had begun to plateau. Since this point achievement has remained high but has not improved further limiting the quality improvement impact. Campbell et al (2009) suggest a number of reasons as to why this may be the case including the limits of the financial incentive given the relatively high gains achieved which might impact upon personal motivation to improve further, whether the payment thresholds were set too low or whether practices had reached maximal possible achievement i.e. the ceiling of performance. This pattern of rapid improvement followed by a plateau in achievement has been replicated in other indicators, for example, rates of prescribing of long-acting reversible contraceptives (LARC) increased substantially following the introduction of a related indicator in 2008 (Arrowsmith, Majeed, Lee, & Saxena, 2014).

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Campbell et al (2009) also give an early indication of the potential 'crowding out' of non-incentivised aspects of care which had not been observed in their earlier work. Not only did these researchers observe a widening in mean scores on aspects of clinical care which were not incentivised they also observed significant falls in patient reported continuity of care (Campbell, Reeves, Kontopantelis, Sibbald, & Roland, Effects of Pay for Performance on the Quality of Primary Care in England, 2009). Attributing changes in continuity to QOF alone is challenging given that wider changes such as diversification of the workforce and a continued policy focus upon ensuring access to general practice may also have impacted upon patient's ability to see their GP of choice.

Further evidence for the potential negative impact upon non-incentivised aspects of care was published in 2011. Doran et al. (2011) examined changes in performance on 42 quality indicators of which some were incentivised and others were not. These were further sub-divided into indicators which focused upon measurement and those which focused upon prescribing. Indicator achievement was calculated using a research database and thus included a larger number of patients and practices than the earlier studies by Campbell et al. (2007, 2009) cited above. In this study, rates of achievement for non-incentivised indicators slowed during the second and third years of the scheme. By 2006/07, recorded quality for non-incentivised care was significantly below the levels predicted from pre-QOF trends and significantly below the levels reported for incentivised care, especially for measurement indicators. These findings suggest that QOF, in common with other quality improvement schemes operating in a resource constrained environment, have the effect of shifting clinician effort to those areas of care which are incentivised and publically reported.

Initial analysis of QOF performance suggested lower achievement in practices serving deprived populations raising concerns that it could be driving inequalities in the delivery of care (Dixon, Khachatryan, Wallace, Peckham, Boyce, & Gillam, 2011). Doran et al (2008) undertook a longitudinal analysis of performance on 48 clinical indicators over the first three years of QOF with practices grouped into equal sized quintiles on the basis of area deprivation. In the first year of QOF median achievement against these measures varied from 86.8% (IQR 82.2-91.5) in the least deprived quintile to 82.8% (IQR 75.2-87.8) in the most deprived. During years two and three of QOF the gap in median achievement between the least and most deprived quintiles narrowed from 4% to 0.8%. Doran et al (2008) additionally concluded that this improvement had not been achieved through practices in more deprived areas exception reporting more patients. This paper suggests that practices in deprived areas showed the greatest rate of improvement in the first three years of QOF, did not do so by making greater use of exception reporting than practices in less deprived areas and that observed inequalities in the first year had almost disappeared by the third year of implementation. However, the wider impact of QOF upon health inequalities is more nuanced and contradictory. In contrast to the findings of Doran et al (2008), Sigfrid et al (2006) concluded that in the context of care for diabetes there were statistically significant higher rates of exception reporting in practices serving a more deprived patient population. Furthermore, Dalton et al (2011) concluded that excluded patients with diabetes in their sample were more likely to be drawn from BME populations than be of white ethnicity. Dixon et al (2011) concluded that whilst the gap in performance between least and more deprived practices had narrowed, this did not appear to have reduced health inequalities.

The evidence suggests that the impact of QOF upon health outcomes has been modest at best. Langdown and Peckham (2013) concluded that whilst QOF has led to improvements in recording both diagnoses and clinical activities, evidence for a sustained improvement in outcomes is limited. That evidence which does exist is limited to initial improvements in blood pressure, cholesterol and blood glucose in patients with diabetes, although this impact may have been limited by the disparity which they noted in relation to QOF standards and guidelines. Fleetcroft and Cookson (Fleetcroft & Cookson, 2006) noted in their analysis that there was no obvious relationship between the incentive payment and likely health gain in the indicators they examined. They concluded that if the goal of QOF was improving population health, then the incentives required redesign to reflect this aspiration rather than estimated workload.

There is also little evidence to suggest that QOF has had any impact upon patient mortality. The single study which sought to examine QOF achievement and mortality rates for diabetes, heart failure, hypertension, ischaemic heart disease, stroke and chronic kidney disease concluded that the high reported rates of achievement did not seem to have reduced the incidence of premature mortality in the population when estimated at the 'lower layer super output area' (Kontopantelis E. , Springate, Ashworth, Webb, Buchan, & Doran, 2015). However, there is some emerging evidence from the National Diabetes Audit of falling rates of preventable diabetes complications (National Diabetes Audit, 2017).

There is some evidence to suggest that improvements in LTC management as a result of QOF are associated with a decrease in emergency admissions when compared to conditions which were not incentivised (Harrison, Dusheiko, Sutton, Gravelle, Doran, & Roland, 2014). This longitudinal study identified a 10% fall in emergency admission rates for the incentivised conditions of asthma, coronary heart disease, congestive heart disease, chronic obstructive pulmonary disease, diabetes, epilepsy, hypertension and stroke from 87.0 per 10,000 person years to 78.2 per 10,000 person years between 1998/99 and 2010/11. This occurred against a backdrop of an increasing emergency admission rate from 637.0 per 10,000 person years to 852.6 per 10,000 person years during the study period. Using an interrupted time series analysis the authors' estimate that the impact of QOF was to reduce emergency admissions in incentivised conditions by 16.6% (95% confidence interval 13.5-19.5%), an approximate reduction of 75,500 admissions costed at £131.5m. However, they caution that because this was an observational study it cannot be concluded that these falls in admissions are a direct or sole result of QOF and it is likely that other factors are contributing to the observed reduction in emergency admissions.

### **3.3.2 Impact on practice organisation**

There is little debate that QOF has had a significant impact upon the way in which practices organise themselves in order to deliver against the targets, intra and inter-professional relationships and the structure and content of the consultation itself. Some of this reorganisation was emerging prior to QOF but was accelerated with the implementation of pay for performance, for example increased computerisation and use of prompts, greater skill mix within practices and the use of standards and audit to inform performance as a result of the National Standards Frameworks.

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In order to maximise their QOF achievement many practices identified clinical and/or administrative QOF leads that were tasked with the responsibility for ensuring that this happened. In some cases, practices developed performance management schemes for their staff linked to the achievement of maximal QOF points. This restructuring had a number of effects. In their small scale case studies, McDonald et al (2007) observed an increased use of surveillance of clinician behaviour through the use of templates to collect data on care and the emergence of a hierarchy within practices of the 'chaser' and the 'chased' with underperformance being communicated to the 'chased' potentially leading to resentment. A subsequent study suggested that there had been further changes to practice structures, increased use of information technology, a shift to a more biomedical medical care and consulting style and changes to roles and relationships (Checkland & Harrison, 2010).

The change which QOF and the wider GMS contract have had upon skill mix have supported and accelerated a professionalisation of the nursing workforce which had begun to emerge following the changes to the 1990 GP contract (McDonald, Campbell, & Lester, 2009). Both this study and those cited above observed that nurses began to take on work which had previously been exclusively undertaken by doctors, including in some practices the 'chaser' roles. A greater emphasis was placed by the nurses interviewed on the development of technical skills and knowledge, enabling them to develop expertise in long-term condition management. However, there was some concern expressed by some nurses at the time that a focus upon protocols and templates supported by clinical systems may detract from person centred care, although this was mitigated by a general acceptance of the QOF targets (McDonald, Harrison, Checkland, Campbell, & Roland, 2007).

At this time changes were also observed within the general practice medical workforce with increasing numbers of doctors were being employed in non-profit sharing salaried roles (Lester, Campbell, & McDonald, The present state and future direction of primary care: a qualitative study of GPs views, 2009). Whilst this study noted a mirroring of the development of specialist clinical interests identified in nursing staff it also noted the emergence of a hierarchical structure amongst medical staff. In some cases this was leading to resentment amongst the salaried doctors who perceived this as limiting to their autonomy and the work they performed in the practice, although it should be noted that this was a broader study of GP views which only interviewed seven salaried GPs, which limits the transferability of the results. A later study, which focused exclusively on the views of salaried GPs, was more nuanced in its findings (Cheraghi-Sohi, McDonald, Harrison, & Sanders, 2012). By this point the interviewees were generally positive about the changes which had occurred to their working lives as a result of the 2004 contract, especially the option to opt out of out of hours care. However, interviewees expressed some concerns about the impact on patient care, and loss of continuity in particular. Most had adapted to the surveillance culture which had emerged through QOF and saw their participation in this as contributing to career development.

The GP Worklife Surveys, which focus upon GPs' experiences of their working lives, ask questions about satisfaction with various aspects of their work including sources of pressure at work. The Ninth Worklife Survey (PRUComm, 2017) found respondents reported most stress with 'increasing workloads' (90%), 'having insufficient time to do the job justice' (85%), 'paperwork' and 'changes to meet requirements from external bodies (83%)', based on 1195 responses from GPs. 60%

reported high or considerable pressure associated with 'meeting requirements for quality-linked payments (e.g. QOF)', indicating that QOF did contribute to a sense of pressure in practices.

### 3.3.3 Unintended consequences of QOF

Whilst QOF was generally accepted when it was first introduced there was some concern from professionals about the effect that it might have on patient care and especially those aspects of care which were not being measured (McDonald, Harrison, Checkland, Campbell, & Roland, 2007). As noted above, some evidence of unintended consequences emerged after a relatively short period such as the negative impact upon continuity (Campbell, Reeves, Kontopantelis, Sibbald, & Roland, Effects of Pay for Performance on the Quality of Primary Care in England, 2009).

However, the majority of unintended consequences of QOF have emerged in more recent years following the introduction of more controversial indicators such as severity assessment in patients with depression, exercise assessment using a required survey and the obesity register. The main criticism of these indicators was their failure to align with professional values, although some also offer salutary lessons for implementation. Where metrics fail to align with professional values they are more susceptible to gaming and professional disengagement (Muller, 2018). Both of these unintended outcomes have been observed in QOF. As the framework was perceived to be moving further away from core professional values and incorporating indicators with low perceived value it has increasingly been described as becoming a 'tick box' exercise, which itself has a negative impact upon professional perceptions of clinical autonomy and judgement (Lester, Matharu, Mohammed, Lester, & Foskett-Tharby, 2013). The introduction of the severity assessment indicator in patients with depression was also associated with a decrease in the numbers of patients diagnosed with depression as practices moved to recording symptoms such as low mood. (Kendrick, Stuart, Newell, Geraghty, & Moore, 2015). Research undertaken to understand GP's use of these tools suggested that many GPs viewed their use as 'counterintuitive, intrusive and unnecessary' in a 10 minute consultation (Mitchell, Dwyer, Hagan, & Mathers, 2011). Using codes for low mood rather than making a diagnosis of depression avoided triggering a severity assessment within QOF. From a GP perspective this had a limited impact upon their plan of care. A stronger focus upon indicator development and testing may have identified potential pitfalls prior to national implementation.

QOF also appears to have changed the nature of consultations for long-term condition care. The reason for this is likely to be multi-factorial. Firstly, as already noted much of the work has been delegated to practice nurses with them developing disease specific expertise. Whilst this may bring a number of advantages in terms of patient care it also increases the number of professionals the patient interacts with. This may be problematic for those patients with multi-morbidity who might see different staff for the management of each condition. Secondly, the increased use of computerised medical records, care templates and prompts has shifted professionals' approaches to consultations to a biomedical focus (Blakeman, Chew-Graham, Reeves, & Bower, 2011; Chew-Graham, et al., 2013). There is some evidence that the use of computerised templates encourages a check list approach

to the consultation which can result in the patient being a passive recipient of care and constrain self-management conversations.

Prior to the implementation of QOF exception reporting had been identified as a potential source of gaming behaviour. However, there is limited evidence to support this concern. Overall rates of exception reporting have been and continue to be low. Initial analysis estimated a median exception reporting rate of 5.3% in 2005/06, although the reported range was 0-28.3% and therefore wide variation in practice (Doran, Fullwood, Reeves, Gravelle, & Roland, 2008). Indicators related to the achievement of intermediate outcomes, such as blood sugar control in people with diabetes, had higher rates of exception reporting than those related to routine checks and measurement of care. GPs themselves were sensitive to the potential misuse of exception reporting but also viewed it as clinically necessary (Campbell, Hannon, & Lester, 2011).

More recent analysis suggests that patients are more likely to be exception reported if they are older, live with multi-morbidity or in a more deprived area. These patients are also more likely to die in the following year (Kontopantelis E. , et al., 2015). This pattern of exception reporting might be clinically appropriate as these patients are less likely to benefit from single disease guideline driven care. However, this study also revealed that many exception reported patients subsequently met the care described in the indicator, especially for those with diabetes, which might indicate a lower threshold for exception reporting than previously identified.

### **3.3.4 Impact of retiring indicators**

The question of how to approach indicator retirement and how to understand the impact of this is critical to ensuring the ongoing development of any incentive scheme. In the absence of indicator retirement, pay for performance schemes either grow exponentially or risk becoming static over time. Where schemes become static, achievements against the overarching scheme objectives can diminish over time. Despite the question of how to refresh and revise incentive schemes being a key challenge for many health systems there are few studies of the impact of retiring indicators, with the majority having been undertaken in the US.

Lester et al (2010) evaluated the impact of removing incentives from four quality measures in Kaiser Permanente which mapped to QOF indicators. In this observational study they identified an approximate 3% fall in achievement per year following the removal of incentives. Petersen et al (2013) undertook a cluster randomised trial to explore the use of incentives at the individual clinician and group level for blood pressure control in the US. This study included a 12 month follow up once the incentive had been removed. They concluded that the incentive had been effective at the individual clinician level only but that improvements in care were not sustained once the incentive had been removed. In contrast to these earlier studies Benzer et al (2014) identified significant improvements in care whilst this was incentivised, which was sustained following incentive removal. Critical to this maybe the study setting: secondary care. There may be structural and organisational differences between primary and secondary care which might make it easier to sustain improvement following the withdrawal of an incentive.

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The only study to examine the impact of retiring indicators from QOF concluded that mean levels of performance were generally stable after the removal of incentives with the exception of the administration of influenza vaccination to people with asthma (Kontopantelis E. , Springate, Reeves, Ashcroft, Valderas, & Doran, 2014). However, the retired indicators were primarily process indicators e.g. blood pressure recording, for which the paired intermediate outcome indicator e.g. blood pressure control, continued to be incentivised. Therefore the intermediate outcome could not be demonstrated without completing the retired care process. This study therefore suggests that retiring measurement indicators where an incentive remains in place for the intermediate outcome is probably relatively low risk in terms of changes to care, but this conclusion cannot be extrapolated to all indicators.

To better understand potential changes in care following indicator retirement NHSE have undertaken internal analysis of performance of indicators on which data is collected through the Indicators No Longer in QOF (INLIQ) extraction, a dataset on the activity of practices in relation to a subset of retired indicators. This did not reveal a consistent pattern of change following incentive removal, although it did identify some significant falls in recorded performance (to below pre-incentivisation levels) in indicators for which there was a degree of clinical consensus about their importance and limited alternative recording mechanisms. This suggests that the observed changes in recorded performance in relation to these indicators are likely to be reflective of changes in practice, and underlying performance, rather than merely changes in recording habits. To understand the impact of this further and to explore the impact at patient level NHSE commissioned further analysis in parallel with the QOF review using patient level data from PRUComm at the University of Manchester.

This work used patient level data recorded in the Clinical Practice Research Datalink (CPRD) between 2006/7 and 2016/17 to explore the impact of retirement upon a small number of indicators. The indicators selected related to the care of patients with hypertension, chronic kidney disease, coronary heart disease and serious mental illness and focused upon blood pressure control, cholesterol management and physical health monitoring. As well as overall performance the study examined performance stratified by age, sex, recorded comorbidities, frailty (using the electronic frailty index) and deprivation.

Initial results suggest that practices are responsive to both the introduction and subsequent removal of incentives. For some indicators, performance drops to below pre-incentivised levels. This finding confirms the results of the NHSE analysis reported above. Some of this performance drop can be attributed to the significant increases in the numbers of patients with missing measurements once the incentive is removed.

Changes in achievement tend to be similar for men and women and by age group. However, men are more likely at all time points to have higher achievement than women. Similarly, younger and older patients tend to have lowest achievement rates at all time points. Falls in achievement were higher in patients without comorbidities and in patients without frailty. Patients in more deprived areas had lower levels of indicator achievement throughout the study period but there was little evidence of differential effects of indicator removal by level of deprivation.

The results suggest that any gains in performance accrued as a result of an incentive are not sustained once the incentive is removed. Falls in performance do not appear to cluster in those groups of patients where pay-for-performance has been criticised for promoting over-treatment i.e. those with comorbidities or severe frailty. Removing incentives does not appear to exacerbate existing inequalities in achievement observed in relation to sex and deprivation.

The full report of this work has been in parallel with this document and can be found at <http://www.prucomm.ac.uk/>.

### **3.4 Findings from engagement events**

A total of eleven engagement events were held in London, Leeds, Bristol and Preston in January 2018. These were attended by 39 GP practice staff, 37 patients and 21 commissioners. A separate engagement event was held with representatives of patient charities in December 2017. This was attended by representatives of 11 charity organisations.

Narratives of key findings are presented below by participant group. These demonstrate a number of common concerns about the current functioning of QOF and shared aspirations for its future development. A further round of engagement is currently underway and we will use the findings of these to inform our further thinking.

#### **3.4.1 Views of general practice staff**

A number of practice staff said that they felt that QOF had promoted a structured and standardised approach to care supported by the creation of registers, patient call/recall processes and prompts within their IT systems. This enabled them to plan their work across the year and compare their performance with others. It had supported the specialisation of both medical and nursing staff to focus upon patients living with specific conditions. In the early years of QOF being implemented this had driven improvements in clinical quality and reduced variation between practices. However, practice staff also acknowledged that the potential for QOF to drive improvement had diminished with the duration of the scheme and their limited capacity to divert resources from current activities to the analysis necessary to drive further improvements.

Practice staff reported that QOF provides a valuable core income to practices. This had supported practices to bring in new staff with different skills e.g. nurses, administrators and pharmacists and the income derived from QOF was necessary to ensure ongoing delivery of care.

The beneficial effects of QOF identified by practice staff were also identified as leading to some of its perceived weaknesses. Namely, some staff suggested that the orientation of QOF into single clinical conditions does not reflect the changing needs of a patient population which is frequently characterised by multi-morbidity, frailty and increased complexity. It was suggested that recommendations derived from single disease guidelines are often inappropriate for this group of patients.

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Whilst practices have the option to use exception reporting to personalise care in these, and other circumstances, many reported that they were reluctant to do this. Exception reporting has a negative image and staff participants reported that exception reporting is often misconstrued as 'manipulation' and that higher rates may be subject to performance management. Participants also viewed it as administratively burdensome with a significant amount of coding being required at year end.

The QOF prompts built into clinical systems were also identified as both helpful and unhelpful. As discussed above, some staff said these can function positively as an aide memoir for clinicians. Viewed more negatively they can become an intrusion into the consultation and serve to orientate the clinician away from the patient's concerns.

Whilst participants identified that the majority of indicators were evidence based, and the NICE indicator development process more robust than those used in local schemes, there were some concerns about the evidence base underpinning specific indicators, for example in relation to the obesity register. Some participants felt that the rationale for new indicators could be expressed more clearly in order to ensure clinical 'buy-in'. Concerns were also expressed that some indicators were only applicable to a small number of patients or even no patients at all. Participants found this demotivating as they were either unable to earn the associated income or perceived the effort necessary as disproportionate compared to other indicators.

Some participants queried the timeframe stated in some indicators and questioned the value of the shift from 15 to 12 months to complete activity implemented in 2013. It was felt that this added to stress at year end and was not necessarily related to the clinical value of the indicator. The annual nature of the scheme and year-end coinciding with winter pressures were noted as concerns by some and there was some discussion of changing the year-end date, staggered dates to individual indicators and rolling targets, though there were mixed views on the benefits of such changes. It was noted that some of the year end stress arose from ensuring patient records were up to date and appropriately coded, especially in relation to exception reporting.

Participants expressed some concern as to how any changes to QOF would impact upon workload and current staffing. Particular concern was expressed that any changes to QOF could move work away from nurses and administrative staff towards GPs. Participants felt that general practice was currently working at capacity with limited headroom to divert effort to new activities.

On a set of specific questions of the potential of peer review and networks to drive quality improvement participants had mixed views. The concept of peer review was thought, by most participants, to be beneficial but there were specific concerns about what would be required, how to do it and whether it would divert GPs in particular away from clinical activities. Participants cautioned against it becoming too bureaucratic, as had been the experience of the Quality and Productivity indicators<sup>4</sup>.

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<sup>4</sup> These can be viewed at: [www.nhsemployers.org/](http://www.nhsemployers.org/)

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These indicators were in place between 2011/12 – 2013/14 and focused upon practices making improvements in prescribing, peer review of secondary care outpatient referrals and emergency admissions followed by the development of care pathways to reduce these. There was a perception amongst many GPs that the implementation and monitoring of these indicators had been excessive, resulting in a number of appeals against the final allocation of points. They were also criticised for taking GPs away from clinical time and diverting their attention from the delivery of high quality patient care. Despite this, the opportunities they offered for the sharing of good practice and peer learning were viewed positively by some.

A number of potential challenges in relation to operating incentives across networks of practices were identified. These included the organisational form and who would be the lead employer for network staff, anxiety about being held responsible for other practices' performance and having clear and explicit objectives for what networking was supposed to deliver. However, participants also acknowledged that many practices were already forming networks and agreed that this suggests that there are advantages to this model.

### **3.4.2 Views of patients and the public**

Patients stressed the importance of being able to see their preferred GP. This facilitates an ongoing relationship which in turn fosters a holistic approach to care. Feeling listened to and treated as an individual were viewed as key to good quality general practice, as were other relational issues such as trust. Familiar frustrations with having to repeat information and conversations with different clinicians were also expressed. Participants noted that communication and co-ordination of care is important and requires improvement, specifically around diagnostic pathways and alignment of care across the system so as to reduce the need for multiple unnecessary appointments.

Access and the ease of obtaining appointments was viewed as important and recognised as variable across the country, although views differed on the acceptability of certain demand management approaches such as triage by receptionists. The use of technology to book appointments and check-in on arrival was supported, as was the use of alternative consultation modes e.g. Skype, although all patients thought that these should complement rather than replace traditional face to face consultations. Participants thought that electronic flags could be used to highlight patients that might require longer appointments and the Learning Disability and Autism group stressed the importance of prioritising access for certain patients to avoid anxiety when appointments are running late. With regards to people on the autism spectrum, views were expressed about expanding the health check enhanced service to support improved quality of care and access.

Participants were engaged with and supportive of self-care and felt that patients should be supported to do this more effectively. This was linked to a certain extent with a wider use of technology and signposting to alternative sources of support. Members of the Learning Disability and Autism Group particularly emphasised the importance of providing easy read information.

Most of the participants were active members of their practice Patient Participation Group (PPG). There were mixed views on the impact of these groups; it was

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suggested that they could support the development of patient education and community outreach programmes.

There was a perception amongst participants that practices could be more responsive to patient feedback. However, there was also a perception that the current GP Patient Survey did not give patients enough opportunity to describe their experiences.

Participants from the Learning Disability and Autism group noted that practice staff have a mixed awareness of learning disabilities and autism, with variation in the necessary skills of practice staff to identify and engage appropriately. They noted that this can lead to significant variation in the quality of care they receive, little reasonable adjustment to meet specific needs of individuals and in some cases increased difficulties in accessing services.

In relation to practices working in networks, participants saw a number of opportunities and potential benefits to this in terms of collaborative working, improved co-ordination and bringing services closer to home but were concerned about the potential impact upon relational continuity.

### **3.4.3 Views of commissioners**

Commissioners were generally positive about the impact which QOF has had in terms of improved access to data on the management of patients with LTCs which can be used to compare practice performance. They also thought that it had brought about valuable investment in IT infrastructure in general practice.

Participants expressed a desire for more data on quality in general practice and for it to be easier to interact with this data. The Calculating Quality and Reporting Service (CQRS) which is used to calculate core contract QOF and Enhanced Service payments to General Practices and records data on QOF achievement was identified as being difficult to use to find more detailed data. They also expressed a desire for more timely access to QOF data, perhaps on a monthly or quarterly basis, rather than the current annual report. Data on registers appeared to be the most commonly used data, although there were some concerns about the quality of this information.

In common with practice staff, commissioners identified weaknesses in the current QOF in relation to the management of more complex, potentially frail patients, the delivery of person centred care, the potential to divert the focus of the consultation away from the patient to 'staring at the screen', and the administrative burden associated with exception reporting.

Despite recognising the administrative burden of exception reporting, commissioners also expressed concern that exception reporting could be subject to misuse, as evidenced by the variation they observed between practices. However, they also acknowledged that exception reporting enabled patients to decline care incentivised by QOF without disadvantaging the practice and recognised the importance of patients being able to make choices about their care and the limitations of single disease guidelines when determining optimal care for patients with complex needs.

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Commissioners were supportive of the recent contractual requirements in relation to the identification and care of patients with frailty<sup>5</sup> and thought that there was the potential to build on this through the review. However, they also acknowledged the limited evidence base regarding the optimal management of these patients.

Commissioners reported that practices perceive the funding available through QOF as core and necessary to business continuity. As a result there is limited appetite for radical change. Commissioners also reflected on the fragmentation of practice funding which, in their view, was leading to practices needing to chase too many funding streams.

On a question regarding the potential for peer review to lead to improvements in quality commissioners held mixed views. It was perceived as having potential to build relationships with practices, but if implemented poorly, could be used as a 'stick to beat people with' rather than improving outcomes. It was felt that it could be more useful in identifying practice learning needs rather than for performance management.

Most participants expressed a preference for nationally administered schemes whether they operated at practice and network level. The main reasons for this were that local schemes were viewed as hard to comply with, relatively short term in duration and CCGs have less expertise in incentive scheme design and implementation. In contrast to this, a small number of participants commented that nationally defined schemes could suffer from limited applicability to certain patient populations.

Commissioners noted that a network level scheme could be useful and would be aligned with broader aspirations for the future organisation of primary care. A network level scheme could help to support population outcomes, specialisation of practices within a group and improved collaboration between general practice and secondary/community care. Networking also offered an opportunity to re-think the skill mix in general practice and the roles of different practice staff.

### **3.4.4 Views of national charities**

There was some overlap between the views expressed by charity representatives and those reported above. Charities in particular noted the importance of the dataset derived from QOF and felt that this information should be protected. It was felt that ongoing publication of this data, for incentivised and retired indicators, could help to ensure accountability and transparency. Some participants also expressed an interest in whether this data could be triangulated with other data sources to gain a more rounded understanding of practice performance. Charity representatives acknowledged the limitations of QOF in relation to patients with complex needs and its focus upon biomedical aspects of care, rather than holistic care. They felt that a

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<sup>5</sup> In 2017/18 a contractual requirement was added around the identification and management of patients with frailty.

change in mind-set was required in which patients are treated as individuals and encouraged to self-care to the best of their ability and to make the most of their social networks.

In terms of any future development to QOF, most charity representatives aspired to a scheme which more proactively addressed case finding, prevention, early diagnosis and health inequalities. In common with the views of practice staff expressed above they also noted the importance of clearly communicating the rationale and intent of any new indicators. They also expressed an interest in greater utilisation of patient reported measures within incentive schemes.

There was some support for looking at ways to incentivise care quality at network level. Some participants commented that such incentivisation could reduce undesirable variation between practices, but it was felt there was a risk that innovation by leaders could also be lost. Incentives could also be provided for quality improvement and education activities at network level. Some participants made observations on the risks with networks more generally, in particular they felt that there could be a risk to care continuity.

In common with other engagement groups they expressed some concern as to how a future scheme would address or account for the current pressures on general practice. However, they were more positive regarding the potential of an incentive scheme to focus upon activities which aim to reduce practice workload e.g. preventative care, early diagnosis, supporting self-management.

### **3.5 Variations to QOF**

In recent years a small number of CCGs in England have moved away from the national QOF and developed their own incentive schemes. Scotland and Wales have also developed their QOF in different directions to that seen in England. These schemes are incredibly diverse and range from a revised philosophical approach to quality improvement as is being implemented in Scotland, through to schemes which in many respects are similar to QOF in that they reward achievement against pre-determined metrics but where the selection of these metrics is determined locally, such as in Dudley CCG. Annex 5 gives the detail of these changes.

Despite these design differences, the development of these schemes has been motivated by a desire to address some of the perceived narrow focus of the national scheme, and the majority of them include a network or cluster-level component. Evaluation of these schemes to date has been limited. That which exists suggests that the schemes have been time consuming to develop, local ownership has been key to success and that they have been initially well received, though this may reflect that some schemes have had additional money, and others have had smaller numbers of indicators. Information upon the longer term impact in terms of practice performance and patient outcomes is currently lacking. We will continue to monitor the emerging evidence in order to inform QOF development in England.

### **3.6 Network based incentives in operation**

A number of CCGs have introduced local schemes to incentivise general practices to work together. We have interviewed seven of these, of which four had demand management schemes based on shared savings. We are not aware of comprehensive evaluations of these schemes, and therefore limited information is available on the impact on patient care and outcomes.

Our conversations revealed that there was variation in incentive schemes according to the maturity of the local networks. Schemes in some areas provided support for set up, for example participation in meetings, peer review and audit and the development of governance structures. Areas with more established networks were incentivising these to plan and develop shared capabilities such as hubs, population intelligence and shared back office functions. In such schemes incentive payments were generally to individual practices.

In some areas shared saving schemes had been introduced enabling networks to share the savings created through reductions in first outpatient referrals, emergency admissions and prescribing. Payment for reductions was mainly made at network level, with a requirement to reinvest the sum in further improvement of services to patients. CCGs that had implemented such schemes reported having realised early savings, although they had some concerns that this could plateau over a few years.

### **3.7 Implications for QOF development**

Findings from the published literature and the wider engagement events have identified a number of considerations for any future development of QOF. Foremost the opportunity and limitations to the role of pay for performance as a standalone approach to drive quality improvement and improvement in health outcomes. Both the literature reviewed here and broader critiques of pay for performance question whether it meets funders' aspirations in relation to the scale of its impact, especially when perverse and unintended impacts are considered. Not all aspects of care which are important to clinicians and patients can be addressed through pay for performance and a misalignment between professional values and measurement can result in decreased intrinsic motivation and perverse behaviours. This needs to be acknowledged with a response which is more imaginative and sensitive to the realities of general practice.

# 4 Vision and options for change

## 4.1 Introduction

Previous chapters have highlighted the increased and changing pressures which general practice currently faces. Our experiences with QOF over the last 14 years suggest that while many aspects of it are valued by the profession and broader stakeholders, other elements would benefit from reform. This chapter sets out the objectives for scheme reform, the associated clinical vision and the options for how this could be delivered.

The three objectives that NHS England considered highest priority for a reformed scheme, following discussion with the Advisory Group, are that it:

- a. Delivers better patient care, particularly by enabling more holistic person-centred care, and incentivises on-going improvement
- b. Supports stability and sustainability in general practice, by creating space for professionalism at a time when workload is high and the profession is reporting high levels of stress and de-motivation
- c. Supports practices to move into a role in which they can better impact demand on the wider system, and so optimises the use of limited NHS resources.

The possible routes to delivering against these priorities involve both adjusting and refreshing traditional aspects of QOF – for example retiring and modifying indicators, as well as more creative options - for example introducing a broader quality improvement domain that utilises improvement cycles. The Advisory Group also considered the relative benefits of a scheme that operates across a single practice population compared to one that operates across the population of a group of practices that form, alongside other partners, a primary care network.

### The vision

The vision for QOF reform is based on a set of clinical principles; to increase the likelihood of improved patient outcomes, decrease the likelihood of harm from overtreatment and improve personalisation of care. These aspirations are also shared with other stakeholders and are reflected in the Shared View of Quality for General Practice published by the Care Quality Commission's Regulation of the General Practice Programme Board (Care Quality Commission, 2018). The four key aspects of the vision that were agreed with the Advisory and Technical Working Groups are to:

- **Better align indicators to improve patient outcomes and decrease the risk of harm from overtreatment:** Faced with the clinical uncertainty and evidence gaps frequently associated with caring for patients living with multi-morbidity or

complexity, appropriate stratification and application of professional judgement becomes even more important. This necessitates a thoughtful approach to metric utilisation and implementation in which indicators are not only evidence based but by which we acknowledge that they may apply differently to different patient populations and individuals.

- **Better recognise the importance of personalised care and professional judgement:** In order to deliver high quality care, professional judgement needs to be combined with individual patient preferences and values in order to deliver truly personalised care. We have given consideration to the way in which any future development to QOF appropriately supports clinicians to undertake these conversations in a meaningful way and encourages patients to make informed choices about their care.
- **Better support for quality improvement:** The range of activities which can be incentivised through metrics is limited by the constraints of good indicator design, and this can crowd out other high value activity. Moving forward, we have considered how QOF could also support meaningful and professionally driven quality improvement activities that complement the use of metrics, such as significant event analyses, peer review and improvement cycles.
- **Harness the benefits of collaborative working:** As primary care networks emerge, they may present a number of opportunities to deliver against current requirements more efficiently, to provide critical mass and infrastructure to undertake quality improvement initiatives, demonstrate impact on care for patient populations that are too small and variable at practice level to measure, and to collectively design interventions and so deliver improvements that would be difficult for a practice working in isolation.

This vision for QOF development seeks to reframe QOF, not as something which is 'done to' General Practice, but as a mechanism which recognises and supports the professional values of GPs and their teams in the delivery of first contact, comprehensive, coordinated, person-centred care of the highest quality.

## 4.2 Exploring the spectrum of options

The Advisory Group discussed the strengths and weaknesses of a wide range of potential approaches along a spectrum from the very limited to the very radical. Specific consideration was given to the radical reforms being undertaken in Scotland and Wales. At the same time the group was cognisant of the 2017 Local Medical Committee (LMC) annual conference motion to retain a revised and improved QOF, based on its current form (see Annex 6 for details).

The review team and Advisory Group considered how different aspects of current QOF might evolve and refresh, how new specifics or components might be introduced, and how such changes might be combined to optimise the scheme in line with the objectives identified. For example, changes were considered in the following respects:

## **1. Changes to the indicator set**

The principal avenue for creating headroom in QOF points and/or GP workload is indicator retirement. The higher the proportion of indicators retired the greater the potential to shift away from micro-managed processes to create space for new ways of working. However, indicator retirement leads to redistributive effects on income that need careful consideration. Historically there have been calls to retire QOF entirely. This has been the approach in Scotland, where all indicators have been retired with income set at an average of past earnings, and in Wales where the majority of indicators have now been retired. The review weighed the merits of full retirement, selective retirement and no retirement. There was consensus for a moderate approach to retirement, along refreshing and renewing indicators where appropriate. More detailed consideration of this is included below.

## **2. Introducing quality improvement**

Currently QOF in England does not include any incentive for the use of quality improvement cycles within or between practices, whereas in Scotland all indicators have been retired in favour of network-level quality improvement initiatives (known as clusters in Scotland) and Wales has introduced this to a more limited extent. Learning from our engagement suggested that practices across the country would need varying levels of support in order to deliver their own quality improvement. There is a balance between delivering a programme with enough detail and structure so that practices know what is expected and can get on with delivering change, whilst learning from the implementation of the Quality and Productivity indicators (which were a part of QOF from April 2011 to March 2014) to avoid creating unnecessary bureaucratic processes which detract from professional leadership. Topic selection could be locally derived to meet local needs, or be set nationally to tackle problems that present across the country, or be a combination of the two. The Advisory Group supported the introduction of quality improvement as part of QOF and saw potential for it to operate at network level.

## **3. Personalisation**

Personalisation and person centred care could be approached in a number of ways. Some local CCGs have focussed on embedding new structured approaches to delivering person centred care through personalised care and support planning. Adaptations to the model of care supported by longer appointments and training and proactive, tailored support to patients have been applied in the practices that have taken this furthest. Within the confines of a pay for performance scheme, targets can apply at the whole population level or can apply differentially to patient cohorts or individually to patients. Targets can be adjusted individually or patients excepted from a cohort measure for different lengths of time. Consideration was given to the most appropriate mechanism both for GPs to express their clinical judgement and for patients to share in decisions about their care. There was general consensus in the Advisory Group and from stakeholders, that there were benefits to updating exception reporting, and branding it more positively as a 'personalised care adjustment'. Further discussion of this is presented below.

#### **4. Measurement and / or payment at network level**

QOF is currently applied, measured and paid at the practice level. Engagement showed that some CCGs are beginning to implement elements of local schemes at the network level, particularly where this is used as an avenue for additional investment in to primary care services. Network schemes could:

- Support certain goals for patients and populations, for example redesigning or standardising approaches to care across member practices, which are easier to deliver through participation in a network;
- Incorporate activities that can be measured in a network because an individual practice does not have the critical mass of patients to make measurement reliable; and
- Be a means to invest in the creation of networks.

Stakeholders were most positive about the first two opportunities, and there was a range of reactions to the idea of paying for a part of QOF achievement at network level. This reflects, in part, the different levels of network maturity across the country. We heard recognition of their potential to address sustainability issues but also concerns about relying on the performance of neighbouring practices. Any move to networking would need to balance facilitating those that are ready to go further with appropriate support and consideration for those that are not.

#### **4.3 Getting the balance right**

Whilst there are a number of competing views as to the optimal scale and scope of QOF reform, the Advisory Group agreed on the need to balance improving on recognised weaknesses and designing something fit for the future, against the need to support stability in general practice. There was some consensus amongst the Advisory Group that the proposals for reform described below present a reasonable trade-off between these things, in order to deliver against the vision.

##### **4.3.1 Better align indicators to improve patient outcomes and decrease the risk of harm from overtreatment**

The key features that support this aspect of our vision are the following changes to the indicator set:

1. Modification of a number of indicators to improve their impact on patient outcomes, for example by applying patient stratification to tailor targets for different cohorts of patients within a given domain; and
2. Retirement of a number of 'low value' indicators identified through an objective and moderate approach to indicator retirement;

There is increasing recognition in the international literature of the challenge of developing indicators which accurately reflect best practice for a cohort of patients

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and which support and align with thoughtful professional care. As discussed in Chapter 3, there are a number of known weaknesses in relation to the functionality of some QOF indicators. These include poorly stated objectives of measurement and practical problems arising from too few patients eligible for care at a practice level resulting in significant differences in achievement, and therefore payment, as a result of random variation.

The review included an analysis of the performance of existing indicators using an approach designed with the Technical Working Group (TWG). The perceived 'clinical value' of any given indicator will be subjective and open to debate. It was agreed that a statistical approach to assessing indicator performance was the best way to apply a judgement to the performance of the metric against a robust and (as far as possible) objective methodology and this has been applied to all existing indicators. This indicator assessment methodology is available on the website <https://www.england.nhs.uk/gp/gpfp/investment/gp-contract/>.

The methodology classified indicators into one of five categories.

- **Consider for retirement with no ongoing data collection:** where indicators have a weak relationship with the underpinning NICE guidance, low patient numbers at a practice level and/or unintended consequences in terms of practice behaviours.
- **Consider for retirement but continue to collect data:** where indicators have a good relationship with the evidence but the activity is resourced through other specific funding streams and/or the data generated is of utility for health planning and/or quality improvement activity
- **Indicator requires modification:** where indicators are not reflective of NICE guidance and an appropriate alternative exists on the NICE menu
- **Valuable clinical activity but achievement has plateaued:** where indicators reflect valuable clinical activity but achievement has appropriately plateaued. It could also include indicators where achievement has plateaued, but at a more modest level than that which was anticipated, suggesting that the incentive is having a limited effect.
- **Valuable clinical activity with scope for continued improvement:** where indicators reflect valuable clinical activity and there is potential for further improvement.

Categorisation should not be interpreted as being a reflection of the importance of the care activity or outcome being described. Rather it is an attempt to identify good quality metrics against which care can be assessed in a clinically meaningful way. Ultimately, choice of metrics to be retired or retained will require clinical judgement to be synthesised with this performance analysis.

As discussed above there are differences in opinion as to the optimal degree of indicator retirement or change. Where indicator retirement represents a real change in workload then this offers the potential to create the time and head space to consider different ways of working. However, evidence suggests that the impact of indicator retirement on the performance of recording and care delivery can be

negative and for this reason the review supported a fairly moderate approach to indicator retirement, at least in the short term, subject to more evidence being available as to how these risks can be mitigated.

A desire to develop indicators which can be applied across a whole population of patients with a given condition can inadvertently result in both the over-treatment of patients with severe needs, and the under-treatment of less complex patients. Discussion in the Technical Working Group considered the potential utility of patient stratification based upon factors such as disease severity and frailty.

This approach has been applied to the diabetes indicators in the first instance as a test of concept. Diabetes indicators apply to patients ranging from 17 years old to those at the end of their life and there is increasing recognition of patients' changing needs across the lifespan (Strain, 2018).

NHSE facilitated a small group of key stakeholders, including the BMA, NICE, patient representatives and the diabetes policy team and National Clinical Director, to explore the feasibility and practical implications of developing diabetes indicators so that they differentially apply to patient groups with different care needs, as illustrated in Figure 9. In this scenario, stratification is guided by the patient's frailty score, calculated using the electronic frailty index (thus linking this contractual requirement to improvements in care). Targets for patients without frailty, for whom optimal control of blood sugar control (HbA1c) and blood pressure reduces their risk of longer-term complications, could be set in line with guideline recommendations. Indicators aimed at the care of patients with severe frailty who are at risk of preventable harm through over-treatment could focus, not upon target levels of control which would need to be determined on an individual basis, but upon personalisation of care and de-escalation of treatment where this is judged to be best for the individual.

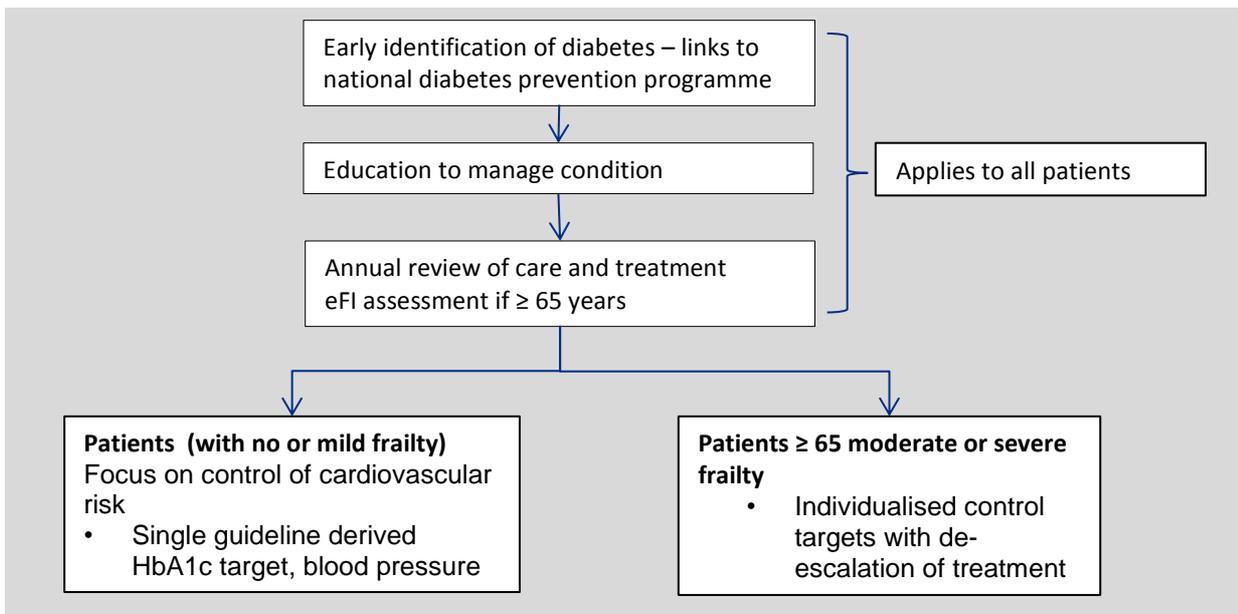


Figure 8: Possible refinement of diabetes indicators

Annex 7 explains how this could impact on individual indicators.

A number of other clinical areas may also benefit from a stratified approach – for example hypertension or asthma.

#### **4.3.2 Greater recognition of the importance of professional judgement and personalised care**

In combination with the stratification approach described above, the key proposal that supports this is to increase the personalisation of care is to:

- Replace exception reporting with a newly termed ‘personalised care adjustment’, that uses more explicit criteria for excepting patients on an individual indicator level.

Management of uncertainty and the navigation of competing treatment options is a critical function of general practice and fundamental to holistic care. The current mechanism for the expression of professional judgement and personalisation of care, exception reporting, currently remains a critical feature of QOF. During the engagement events professionals expressed concerns that exception reporting can be interpreted externally as poor care. Commissioners and practices need to be able to differentiate those patients who have not received care or been reviewed from those who have made informed choices: the ‘true’ and potentially modifiable care gap.

There was general consensus in the Advisory Group and from stakeholders, that there were benefits to reframing exception reporting more positively as a ‘personalised care adjustment’. The review team proposed that this adjustment would operate at the individual indicator level rather than the domain level which would bring it into closer alignment with the way in which clinical decisions are taken and patient choice is expressed. This could build upon the work undertaken by NICE to develop more appropriate mechanisms for recording patient choice and shared decision-making. A personalised care adjustment would reflect the following three broad categories: care described in indicator unsuitable for patient because [select reason e.g. medication intolerance or allergy], patient chose not to receive care [select reason e.g. after a shared decision making discussion], patient did not respond to offers of care.

This approach would represent an evolutionary development of the current process to one of greater specificity and transparency. A number of GPs shared with us that they often added free text to the patient record to explain an exception reporting decision so more granular coding would reduce the need for them to do this.

As computer prompts are removed once an exception code is added some practices choose not to add exception codes until the end of the financial year. However, this strategy can have unintended consequences - an increased workload at year end, contributing to practice pressure and staff stress and unwarranted scrutiny as exception codes are entered during a narrow time window. To deliver this, NHS E would need to work with system suppliers to ensure that all computer prompts remain available to support opportunistic care even where an exception code has been entered, especially where these codes relate to patients not responding to invitations.

### 4.3.3 Better support for quality improvement

The key proposal in this area is:

- To introduce a quality improvement domain with two national cycles and one local cycle to be undertaken each year.

The Technical Working Group and Advisory Group have advised on learning from the Quality and Productivity indicators. Having considered this, and having explored the merits of approaches taken in Scotland and Wales, this section outlines how a Quality Improvement domain would work in a revised scheme.

The proposal starts with a modest ambition of practices completing 2-3 quality improvement activities a year. National priority areas would be identified through their potential to address quality and efficiency, and to support those activities that do not naturally lend themselves to metric development but are highly valued by patients and engage practices on a professional basis. Examples of potential topics include medicines safety, End of Life Care and Shared Decision Making. Local priority areas could be agreed by practices and commissioners.

Quality improvement activity can be undertaken by practices individually, but there was consensus that this it would be easier and have greater impact if it drew on local networks to share ideas and experiences as well as provide peer challenge and review. Figure 9 gives an overview of a possible Quality Improvement domain.

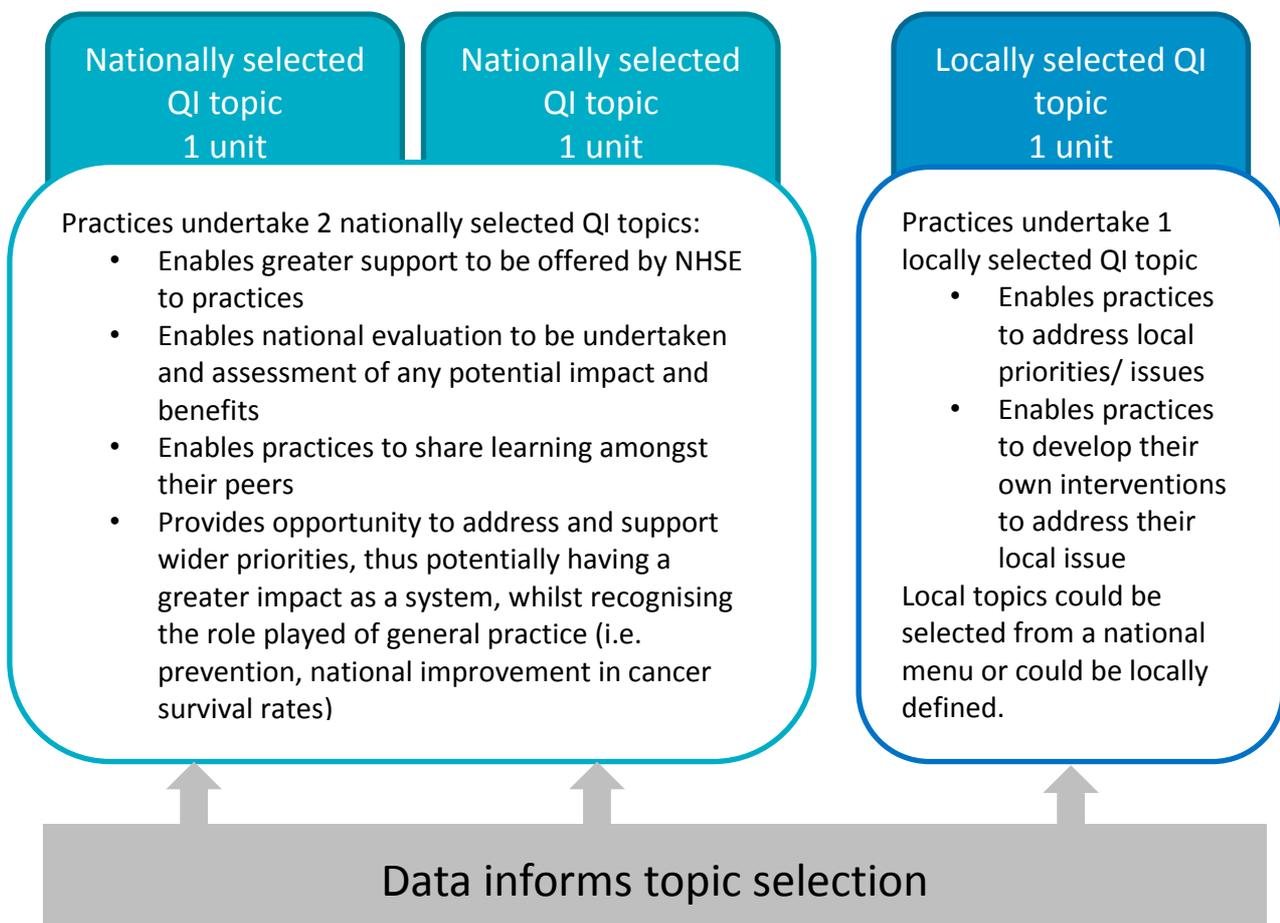


Figure 9: Overview of the Quality Improvement Domain

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For each national quality improvement topic a package of resources and suggested improvement activities could be available for practices to lift 'off the shelf' and implement. Not only would this provide additional support to those practices who are relatively inexperienced with quality improvement it could also ensure a degree of consistency in relation to the time and effort required to complete each activity. A fine balance would need to be struck between developing a programme with enough detail that practices can easily understand what they need to do but without it becoming overly bureaucratic, especially in terms of reporting and verification. For example, a focus upon prescribing safety could utilise tools to:

- Identify patients at risk of potentially harmful prescribing;
- Review these patients' care, complete of a root cause analysis to identify where systems could be strengthened to reduce rates of potentially harmful prescribing; and
- Re-run the diagnostic tool to evaluate whether any changes have successfully reduced these rates - sharing of results and changes to practice with peers.

### **4.3.4 Better support for collaborative working**

This section sets out proposals for:

- Working with a select number of sites to trial a QOF scheme that operates primarily at network-level, providing an opportunity for more efficient delivery of interventions, and to build an evidence base for the ability of networks to deliver against on key system priorities, and thus secure associated future investment.

Practices are increasingly working together to deliver services and ensure their future sustainability. Networking has been the focus of many local quality schemes and Scotland and Wales have used reforms to QOF to roll out a national requirement that practices move in to clusters.

A 'network' level scheme could support a shift towards collective responsibility for improving care for a larger footprint of patients, including through undertaking joint QI activity. Networks offer practices the scale and scope to deliver on national priorities, making them a natural vehicle for investing further in primary care. Collaborating practices can change their approach to service delivery and population health to achieve goals that cannot reasonably be expected of individual practices. For example, networks could standardise the management of patients with suspected cancer symptoms or do more to promote cancer screening programmes to improve early diagnosis of cancer. Networks have the scale to develop sub specialisms and introduce new roles in the community. For example GPs with a Special Interest (GPwSI) in mental health supported by mental health therapists working to improve the physical health of people with Serious Mental Illness (SMI) (a cohort of patients where practice numbers are low in individual practices but whose morbidity and mortality could benefit hugely from new approaches to their care). At the same time, networks have a larger voice in the local health economy and are able to work with local system partners to optimise patient flow, for example by playing a key role in their integrated urgent care system.

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Whilst there is some emerging evidence from Scotland and similar initiatives that have focussed on incentivising collaborative working, the risks and benefits of developing an incentive scheme to operate at a network level are largely as yet unknown. Any moves in this direction would benefit from formal evaluation in the English context before being offered to networks nationally. Trialling a network alternative would build the evidence base to support the argument for increasing the proportion of NHS investment that is directed towards primary care.

A network alternative could include the following components:

- **Read across from the practice level scheme** - Any new elements of the practice level scheme would read across, at least for now, in to a network alternative to ensure that new elements are embedded for every practice – this would include any new or modified indicators and the quality improvement component.
- **A greater degree of indicator retirement** - Through closer peer to peer working, networking practices could do more to self-govern against variation in performance. Therefore, to create space to implement new ways of working more indicators would be retired in a network alternative. Trialling would provide an opportunity to assess the impact of indicator retirement on recording and care delivery. The approach to retirement would be built on the indicator analysis methodology available on the website, and continue to be based upon an assessment of indicator performance rather than a debate about the value of the clinical activity.
- **Network level metrics** – a number of network level metrics would be measured and paid at the network level. These metrics would capture the impact that a network can have on patient care that an individual practice cannot. With larger patient populations it may also be possible to gently shift the focus of an incentive scheme towards outcomes – though this would need careful design to ensure sensitivity to change in practice finances and acceptability to professionals. Within a network level scheme there may also be further opportunities to reform existing indicators which have known weaknesses at the practice level. For example, there are known issues with the quality of spirometry performed at a practice level which could be addressed in a network. A trial of network level QOF could present a greater degree of uncertainty (at least in the short term) to a volunteer site. Any network metrics would therefore need to deliver cost effective benefits whilst offering a genuine incentive to willing participants. The right level of conditionality will need to be determined so that volunteering practices can be confident to invest their time and efforts in to new ways of working.
- **Shared savings** – whereby networks that realise savings in their local health economy share in a proportion of those savings, to be reinvested in services for patients. Shared savings, or gain share, are not unique to networks and some CCGs are already implementing similar schemes, which we are seeking to learn from. A national template, or set of guidance, trialled first with a select group of sites could facilitate achievement of system efficiencies, increase income for reinvestment to primary care networks, help us to understand the risks and benefits to practices, patients and commissioners and ease the route for other areas to follow.

Whilst it would not be beneficial to prescribe the detailed form and function of these local collaborations there may be certain structural requirements necessary for a quality scheme to function at this level. These could include: a degree of collaborative maturity, a strong presence in the local system and practice arrangements to share data and accept payment. When it was introduced in 2004 QOF was supported by an Enhanced Service which focused upon helping practices to prepare for the introduction of the scheme. Similar national support could be directed through the contract to adequately resource networks to be 'ready' to deliver a network quality scheme. This would need to recognise that practices have been coming together with varying degrees of formality and often with support from their CCG for a number of years; a foundation on which to build.

#### **4.4 Emerging view**

There was a broad consensus among the Advisory Group members that the opportunities identified to improve the current scheme have merit. The network components naturally attracted a greater level of debate, which is one of the principal reasons for trialling the initiative before investing in a wider roll out. There was also a consensus the review offered a real opportunity to consider the future of the framework and that no change to the framework as a result of this work would represent a lost opportunity to improve patient care. However, the Advisory Group considered that there was little support for very radical change due primarily to the destabilising effect upon practice income and a shared perception of the value of structured long term condition care.

The Advisory Group recognised that there are many views on the future of QOF within and outwith of the profession and encourages clinicians and other practice staff to engage with the debate.

# 5 Next Steps

The review of QOF has involved effective collaboration between all the contributing organisations and academics that, in combination, have developed a range of options that support the goals of our health system, the care of individual patients and address the concerns of clinicians. NHSE would like to continue working in close collaboration with our review partners as we continue to learn from existing QOF variations, refine and further develop proposals.

QOF is notable for its grounding in a robust evidence base and for the quality of research which has been undertaken on it historically, and from which this review has benefitted. It is important that future reforms remain subject to effective evaluation, and NHSE would hope to scope with academic partners a robust approach to this.

The credibility of QOF also derives from the comprehensive indicator development process run by NICE who have been key partners in this review. NHSE welcomes the decision by NICE that they will review their indicator development process and will ensure it is responsive, flexible and effectively designed to support the future of the scheme.

QOF forms part of the GMS contract, and as such proposed changes to QOF are subject to negotiations with the British Medical Association's General Practitioners Committee. NHSE looks forward to continue to work with GPC, who have been key contributors to this review, to support the continued delivery of high quality and sustainable general practice.

NHSE would like to thank all those that gave their time and expertise to support the work of the review. In particular we are grateful for the support we have had from the Advisory Group, Technical Working Group and all those that participated in our engagement events.

We look forward to debating the outputs of this report, and to working with patients and the profession to further improve on the findings and ideas set out here.

Comments on this report may be submitted to [england.qofreview@nhs.net](mailto:england.qofreview@nhs.net) .

## Annex 1: Terms of reference for Advisory Group

### Review of the General Practice Quality and Outcomes Framework in England

#### Advisory Group membership and terms of reference

Ed Waller (Chair)	NHS England (NHSE)
Arvind Madan	NHSE
Dominic Hardy	NHSE
Julie Wood	NHS Clinical Commissioners
Richard Vautrey	British Medical Association, General Practitioners Committee (GPC)
Andrew Green	British Medical Association
Ciara Greene	British Medical Association
Fiona Barber	Patient Representative
Andrea Hester	NHS Employers
Stephen Golledge	NHS Employers
Gillian Leng	National Institute for Health and Care Excellence (NICE)
Ed Scully	Department of Health and Social Care (DHSC)
Helen Stokes-Lampard	Royal College of General Practitioners (RCGP)
Martin Marshall	Royal College of General Practitioners
Allison Streetly	Public Health England (PHE)
Mark Ashworth	King's College London
Nigel Sparrow	Care Quality Commission (CQC)

#### *The review of QOF in England*

The Quality and Outcomes Framework (QOF), established in 2004 as a key component of the GMS contract, provides funding for practices on the basis of the quality of care delivered to patients, as described by a set of quality indicators. GMS and PMS practices receive about £685 million a year through QOF which comprises about 7.2 per cent of the total net payments to GP practices. Achievement over recent years has been high and stable.

The General Practice Forward View said:

*QOF has created a more focussed approach to chronic disease management and provides a structured way of engaging in secondary prevention. However, some argue that it has served its purpose and requires review or even replacement and that it is a barrier to holistic management of health conditions.*

The Forward View Next Steps reconfirmed that NHS E would “seek to develop and agree with stakeholders a successor to QOF. In the contract negotiations for 2017/18 it was agreed that QOF would be reviewed.

NHS England is therefore undertaking a review of QOF, drawing on lessons from other primary care incentives and taking account of the wider context in primary care (e.g. including the movement to at-scale working, workload burden on practices, workforce and retention and opportunities from new technology). The Review will conclude in Spring 2018 with its outputs used to inform subsequent negotiations, led by NHS Employers, with GPC England, on the GMS contract.

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The approach for this review will be to work with the profession, and other stakeholders, to develop proposals which deliver additional resilience and sustainability within general practice (acknowledging current pressures), and to deliver value to patients (which is dependent on a sustainable, resilient and innovative general practice). The GPC has raised, and NHS E agrees, that a significant proportion of QOF is treated as core income by practices, and is already committed to delivering important practice activities.

To ensure the views and expertise of key stakeholders are brought to bear throughout the process of the review NHS England has invited them (see appendix 1) to participate in an Advisory Group. However, the output of this group is advisory and will not bind negotiating parties, nor predetermine future negotiations.

### *Purpose of the Advisory Group*

The Advisory Group will provide advice to the review on all areas under consideration, including:

- The impact of the wider context in primary care, which forms the backdrop to the review (for example trends towards at-scale working, new technologies, changing workforce mix)
- The impact of the existing QOF including the evidence base for indicators and the impact of changes or removal of indicators that have occurred since 2004;
- The role of incentives and enablers in primary care to support delivery of quality, improvement and transformation, focussing particularly on QOF;
- Options for the future and the likely impact of these;

It will also:

- Advise on how to ensure an appropriate level of stakeholder and patient engagement on key questions and challenge, and system-wide collaboration with relevant partner organisations, in order to maintain credibility of findings (including how priorities are traded-off)
- Ensure that any interdependencies are known and have been considered, and issues or conflicts are resolved appropriately;
- Advise on and review work from the Technical Working Group, Project Team and any Reference Groups;
- Provide stakeholder views on options, and the impact of these compared to the current QOF;
- Provide appropriate updates, as agreed back to the represented organisations on the progress of the review.

In providing its advice, the Advisory Group will consider the sustainability of general practice.

It is not within the Advisory Group's remit to determine the contractual implications or decide any final changes.

The advice given by the Advisory Group is likely to be reflected in an NHS E publication that sets out the findings of the review. This would be subject to further engagement and consultation as appropriate, and would not bind members of the advisory group who had provided input. The advice of the Advisory Group will also be sought on the timing of such a publication.

Note, declarations of interest were collected from all Advisory Group members.

## Annex 2: Terms of reference for Technical Working Group

### Membership

Dr Mark Ashworth (Chair)	Dr Liz Thomas (NHS Employers)
Rachel Foskett-Tharby (NHSE)	Professor Tim Doran
Lindsay Gardiner (NHSE)	Professor Matt Sutton
Kathryn Yates (Royal College of Nursing)	Dr Julian Flowers (PHE)
Professor Ruth McDonald	Vickie Priest (CQC)
Professor Martin Roland (RCGP)	Rosemary Stevenson (NHS Improvement)
Professor Jose Valderas	Mark Minchin (NICE)
Dr Holly Hardy (GP)	Dr Andrew Green (GPC/BMA)
Uma Datta (CQC)	Gemma Ramsay (NHS Digital)
Raechel Newell (NHS Employers)	

#### Background

The Quality and Outcomes Framework (QOF), established in 2004 as a key component of the GMS contract, provides funding for practices on the basis of the quality of care delivered to patients, as described by a set of quality indicators. GMS and PMS practices receive about £685 million a year through QOF which comprises about 7.2 per cent of the total net payments to GP practices. Achievement over recent years has been high and stable.

The General Practice Forward view said;

*'QOF has created a more focused approach to chronic disease management and provides a structured way of engaging in secondary prevention. However, some argue that it has served its purpose and requires a review or even replacement and that it is a barrier to holistic management of health conditions.'*

The Forward View next steps reconfirmed that NHSE would 'seek to develop and agree with stakeholders a successor to QOF'. During the contract negotiations for 2017/18 NHSE and the GPC agreed that QOF would be reviewed.

NHS England is taking forward this review over the next 6 months. It will draw upon lessons from other primary care incentives and take account of the wider context of primary care including moves to at scale working, workload burden, workforce and retention and opportunities from new technologies. The review will conclude in Spring 2018 and its outputs used to inform subsequent negotiations with GPC England on the GMS contract.

The review will consider the appropriate use of an incentive scheme and the role of financial incentives alongside other support options to promote improvement and development in primary care. Options for any future scheme will be developed within fixed system resources, however these resources may be used in a different way in the future. Mechanisms for payment may also differ from the current QOF methodology. Future scheme development may include creating scheme options rather than a single scheme.

It will be supported by an Advisory Group comprising of key stakeholders. However, the output of this group is advisory and will not bind negotiating parties, nor predetermine future negotiations. The review will also be supported a Technical Working Group.

### ***Role of the Technical Working Group***

The role of the Technical Group will be to provide NHS England with advice on the following aspects of the wider review:

- Interpretation of empirical evidence on the impact of QOF and incentives more generally.
- Theoretical models of incentive use, development and impact.
- Identification of questions which require additional empirical work.
- Suitability of available data for this work and how to handle data limitations;
- Reviewing progress of external work and final outputs.
- Advising on strengths and weaknesses of different incentive structures and the options for a reformed scheme.
- Advising on measure development and indicator retirement in relation to options for a reformed scheme.
- Testing and understanding the impact of options for a reformed scheme in terms of impact upon practice sustainability and patient care
- Advising on implementation issues and likely support requirements
- Identification of risks and limitations associated with the work or resulting recommendations.

The group will provide its advice to the QOF Review Team, New Business Models, NHS England. The work of the group will be shared with the Advisory Group by the Funding and Incentives Team. We may ask the Chair to present findings to the Advisory Group. The review governance structure is detailed in Appendix 1.

### ***Frequency of meetings and ways of working***

An initial face to face meeting will be held in October 2017 with monthly meetings thereafter until March 2018, or as otherwise agreed by the group. It is anticipated that meetings will be virtual with the exception of the meetings in October and February. Meetings will be no longer than 2 hours duration. Members should aim to attend 100% of meetings.

## Annex 3: Strategic interview participants and discussion areas

Organisation	Participant
<b>Royal College of General Practitioners</b>	Martin Marshall – Vice Chair of External Affairs RCGP and Professor of Healthcare Improvement at UCL
<b>The King’s Fund</b>	Beccy Baird - Senior Fellow in Health Policy
<b>British Medical Association</b>	Dr Richard Vautrey - Chair of the GPC
<b>Public Health England</b>	Dr Allison Streetly, OBE - Deputy National Lead Healthcare
<b>Society for Academic Primary Care</b>	Professor Joanne Reeve- Professor of Primary Care Research, Hull Medical School Professor Kate O’Donnell- Professor of Primary Care Research & Development, University of Glasgow, Chair of the Society for Academic Primary Care
<b>Nuffield Trust</b>	Dr. Rebecca Rosen- Senior Fellow Dr Charlotte Paddison- Deputy Director of Policy
<b>Care Quality Commission</b>	Professor Nigel Sparrow, OBE - Senior National GP Advisor
<b>The National Institute for Health and Care Excellence</b>	Professor Gillian Leng, Deputy Chief Executive and Director of Health and Social Care. Mark Minchin - Associate Director, Quality Judith Richardson - Deputy Medical Director
<b>National Voices</b>	Don Redding - Director of Policy and Partnerships
<b>Patient Representative</b>	Fiona Barber
<b>NHS Clinical Commissioners</b>	Julie Wood - CEO
<b>National Association of Primary Care</b>	Nav Chana - Chair of the National Association of Primary Care

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With these participants we discussed the following areas:

- the macro trends that could change the context in which general practice operates
- what this could mean for what general practice delivers, and
- how we may need to future proof any changes to QOF as a consequence.

## Annex 4: Selection of patients for reference groups

As part of the review, the QOF Review Team were keen to seek views from patients and the public about the quality of care they experience in general practice to help shape the thinking about what changes could continue to support quality care in general practice in the future.

The aim was to establish three representative reference groups, in Bristol, Leeds and London of up to 16 people each to help support focussed discussion, giving people optimal opportunity to engage. Characteristics for gender, age, ethnicity and whether or not people had LTCs were used to establish a diverse group. Locations were selected to enable people to participate around the country.

An advert was sent out requesting expressions of interest from the public to be involved. Almost 200 people responded. All people who expressed an interest were sent an information sheet and form to complete and return. The information sheet noted that spaces would be limited and therefore not all people would be guaranteed a place on the reference group, but that in the event interest was high the information shared would be used to ensure a mix of people with different ages, gender and ethnicity. In addition, information provided on whether or not people have a LTC would be used to support reaching the maximum group size.

In the event selection was required, the process was managed by a member of staff who had not had any previous contact with the people who expressed an interest in the groups.

The methodology for selecting reference group members was based upon the information received in the completed forms. Anyone who initially expressed an interest, but did not return the information form was removed.

For those respondents who returned the information form, they were selected following examination of characteristic based on the information supplied.

Respondents were split into three groups based on their preference of the three locations for the reference groups. There was a high level of interest from both men and women, so gender was broken down using an equal split of eight men and eight women per location. To obtain a representative and mixed sample of patients, ethnicity and age groups were then considered. Where any of the age or ethnicity groups were under-represented, the respondents were automatically selected. Where any of the age or ethnicity groups were over-represented, the respondents were randomly selected. A low number of respondents were in the under 60 age cohorts and the non-white ethnicity cohorts, so these respondents were all selected.

All remaining respondents were then selected through an anonymous random process to reach group target numbers of 16 people per location.

The final list of selected respondents was double checked to confirm a range of age, ethnicity and variety in people with or without a LTC, using the information on types of LTCs to give a diverse group.

## Annex 5: Descriptions of local variations to QOF

### Aylesbury Primary Care Development Scheme

#### (Now Buckinghamshire Primary Care Development Scheme)

##### *Overview and Aims*

The Aylesbury Primary Care Development Scheme covers practices in Aylesbury Vale Clinical Commissioning Group and Chiltern Clinical Commissioning Group. It is a single scheme which is designed to replace Quality and Outcomes Framework (QOF), CCG Quality Improvement Schemes (QIS) and care and support planning schemes. The scheme was initially stand alone for Aylesbury Vale but as the CCG federated with Chiltern CCG it was subsequently offered to practices in both areas.

The Aylesbury scheme aims to maintain and improve care quality by supporting a shift towards a person centred, care planning approach whilst encouraging initiatives which support primary care transformation at scale. It is based from a consensus that much of what is currently paid for in QOF does not need to be incentivised financially and many transformative actions do not need to be incentivised at a micro level.

The scheme began in 2015 with a focus on care and support planning in diabetes, dementia and respiratory<sup>6</sup> through the Year of Care model. Payment according to QOF performance was suspended and instead practices received funding according to their 2014/15 QOF attainment. In 2017 this scheme has been expanded to cover broader developments in primary care, including cluster working, IT systems, care and support planning and a refined list for management of LTCs. Payment is given according to completion of some gateway achievements and delivery of some specific care delivery measures.

##### *How it works*

The scheme is designed to replace Quality and Outcomes Framework (QOF), Quality Improvement Schemes (QIS) and care and support planning schemes.

The development programme consists of a 3 tier model:

- *Foundation Gateway* – all participating practices would be required to achieve the Foundation gateway in year 1 – expectations of the Foundation gateway includes EMIS Implementation, increased ERS usage, GP Cluster / Network development / Standardisation of protocols and templates and participation in the Grasp AF audit and National Diabetes Audit.

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<sup>6</sup> Multiple separate QOF indicators are grouped into each of these categories. For example, the Diabetes group contains clinical activity related to QOF indicators around diabetes, hypertension, CKD, CHD and stroke & TIA – as well as the Public Health Indicators on CVD, Blood Pressure, Obesity and Smoking. The Diabetes group contains only the current Diabetes indicators. The Respiratory group contains COPD and Asthma

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- *Care Delivery* – (only available to those practices that have achieved all elements of the Foundation gateway) - expectation for this level includes supported self-care through care & support planning, adherence to local Right Care clinical pathways, meeting directed prescribing, diabetes, AF and EoL targets.
- *Care Delivery alternative* – achievement of refined list of QOF indicators (diabetes, hypertension, COPD, heart failure).

Payment is made according to the following:

- *Foundation Gateway* - Practices receive a one off payment which will support achievement of a series of gateway commitments. These include items such as implementation of EMIS, use of Electronic Referral System, commitment to developing cluster-based working and ongoing audit *Care delivery* – Practices receive a payment based on their 14/15 QOF achievement for the domains in which they commit to introduce a care planning approach.<sup>7</sup>
- If choosing to deliver the scheme practices will benefit from a suspension of QOF payments being linked to QOF achievement. This means that the practices will still be responsible for maintaining their QOF registers and appropriate clinical care, but that full QOF data collection is not directly linked to the achievement payment.

### *Implementation*

The programme has been implemented on a staged basis, beginning with care and support planning and then expanding to wider primary care developments. It has also expanded to cover more practices and have much more coverage in Chiltern CCG in addition to Aylesbury Vale.

The scheme has been adopted by more practices as it has developed because people have got more confident about the operations and motivations of the scheme. In the first year two-thirds of practices participated and in the second year all practices were involved. The scheme has always been voluntary, and increased adoption has shown that the new option has been more attractive to GPs than remaining on QOF. This is because the new scheme puts less pressure on QOF adherence and more focus on patient care, and the new scheme enables access to additional QIS monies.

Aylesbury have also found that developing the programme locally has had a number of benefits, including the relationships of trust with local CCGs and the ability to solve issues between partners.

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<sup>7</sup> The domains practices can sign up to are:  
Level 1 - Diabetes, CVD, Hypertension, CKD, Obesity and Smoking domains of QOF  
Level 2 - Level 1 plus Dementia  
Level 3 - Levels 1 & 2 plus Respiratory

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The CCGs still continue to monitor performance against QOF indicators, and reporting of these to the CCG is a condition of participation. This is enabled by all practices using EMIS Enterprise. Participating practices are required to sign up to Calculating Quality Reporting Service (CQRS) and the General Practice Extraction Service (GPES). Monitoring is done in order for the CCG to be able to give assurance to NHSE that key clinical processes are still being completed. At the end of the year, of the 18 practices participating (AVCCG), only one had a significant decrease in QOF performance.

The majority of others maintained indicators within a 5% tolerance, which commissioners believe is enough to suggest that GPs are continuing to do the work which is incentivised within QOF.

### **Dudley Quality Outcomes for Health**

#### *Overview and Aims*

Dudley CCG has created a new contractual framework for primary medical services. The scheme was initiated because there was consensus that QOF was no longer fulfilling its function of incentivising quality and created administrative and measurement requirements that could be simplified. The replacement scheme consolidates existing QOF indicators and includes indicators relating to Local Incentive Schemes (LIS) and Directed Enhanced Services (DES). The whole programme is called the 'Dudley Quality Outcomes for Health' (DQOFH).

The main aims of the framework are to:

- simplify and rationalise QOF;
- drive up standards and address unwarranted variation;
- facilitate holistic management of individuals with LTCs, including an increased focus on care planning;
- focus measures and incentive payments on actions seen as having a strong evidence base and;
- develop outcomes that could be shared between primary and secondary care.

The original set up was that practice payments were not linked to the framework in 2016/17 (practices received block payments based on historic QOF scores). In 2017/18, practices would receive 50% block payment, with the other 50% linked to the achievement of specific indicators, and there was a view to moving to a fully outcomes based incentive contract in 2018/19. Following extensive consultation with the practices, in 2018/19 Dudley Quality Outcomes for Health incorporates 17 of the previous QOF measures.

Dudley Clinical Commissioning Group (CCG) is a Multi-Specialty Community Provider (MCP) vanguard site.

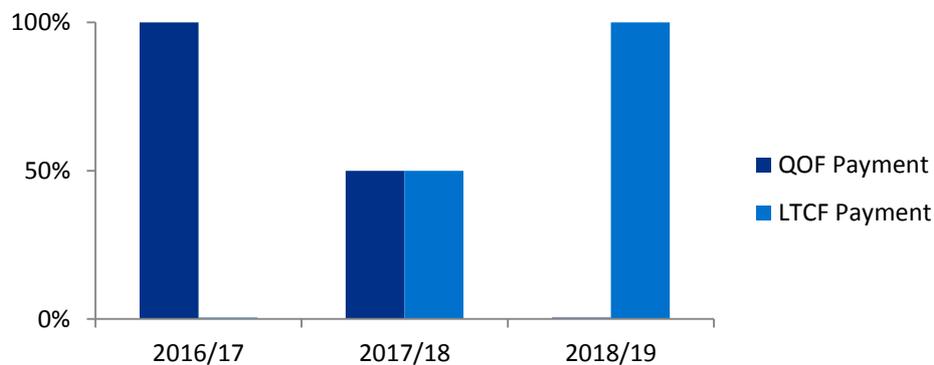
#### *How it works*

The design of the scheme is done through a specifically designed template on EMIS Web, which brings together the multiple reporting systems under QOF into a single

template. It is expected that practices will offer patients a single 'holistic review' for all their LTCs, where this is feasible. It is also expected that all patients with LTCs will have a care plan with patient centred goals reviewed at least annually. This is implemented within wider changes to the model of care in Dudley, with aims for more multidisciplinary support within primary care and improved links with community services.

Making payments according to the framework has been transitional. Payment was given according to previous QOF achievement in 2016/17, split 50/50 between previous QOF achievement and Long Term Condition Framework (LTCF) achievement in 2017/18 and will be given fully according to outcomes achievement in 2018/19.

**Figure 10: Transitional payment from QOF to LTCF**



DQOFH achievement is currently given according to achievement against seventeen indicators from the previous QOF system<sup>8</sup> plus the following:

- CC1-9: Access standards
- G1: Completion of holistic assessments
- G3: Completion of care plans
- LD1: Completion of holistic assessments for patients with learning difficulties
- Audits: completion of relevant audits including an audit of the end of life/palliative care register, an audit of appointment availability, participation in the National Diabetes and local diabetes audit and an annual audit of repeat prescribing practice.

### *Implementation*

The framework was piloted in early 2016 in 12 GP practices. It was offered to all practices from April 2016 onwards, and 40 out of 4 practices signed up to deliver it in 2016/17 with an additional 3 practices in 2017/18. To join the scheme practices

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<sup>8</sup> The QOF indicators included are:

BP002,CS002, AST002, AST003, AF006, AF007, COPD002, COPD003, DEM004, DM007, DM008, DM009, DM002, DM004, HYP006, HF002, HF004

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agree to opt out of QOF, Direct Enhanced Services (DES) and Local Improvement Schemes (LIS), with associated monies for these schemes rolled into the pot for the QOF alternative scheme.

The CCG has used £1million of the NHS Transformation Fund as part of the New Care Models programme for primary care development. Some of this has been used to support the implementation of the framework.

An evaluation of the scheme was completed by ICF, University of Birmingham and Midlands and Lancashire CSU in April 2017.<sup>9</sup> Its findings included the following:

- The CCG had taken a collaborative approach in developing the framework
- Thoughts on whether it is easier to use and more efficient in comparison to the Quality and Outcomes Framework (QOF) were mixed.
- Some practices have retained existing clinic structures whilst others have made more significant changes to their organisation of appointments
- Some clinicians reported a lack of confidence and skills to do holistic, multi-condition reviews for patients. There are some training needs

The scheme has identified a wide variation in care planning between practices which will be addressed as part of the on-going primary care developmental programme.

### **Somerset Practice Quality Scheme**

#### *Overview and Aims*

The Somerset Practice Quality Scheme was developed in response to concerns that the clinical skills of GPs were not being used to best effect in helping patients with the most complex needs. There was consensus that QOF over medicalises consultations, did not incentivise integrated multi-disciplinary working, and did not align with system wide priorities.

The scheme breaks the link between payment and performance. The scheme is structured into 3 workstreams; integration, sustainability and quality improvement. Each workstream includes contractual requirements without financial incentives. The 2018/19 specification has slightly changed to help practice strengthen quality improvement. Structured workstreams for 2018/19 include; Quality Improvement, Person Centred Care and specific actions to support the CCG Integrated Assurance Framework indicators

The aims of the scheme have included:

- Encourage more integrated models in general practice

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<sup>9</sup> Evaluation of Dudley Quality Outcomes for Health: final report available at: <https://midlandsandlancashirecsu.nhs.uk/about-us/publications/new-care-models/215-pcareoutcomesframework-full/file>

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- Encourage wider primary care, delivered at scale
- Encourage shared patient records
- Free up time for GPs to focus on other areas
- Encourage more holistic care and support planning

### *How it works*

Payment is not given according to performance against indicators. Instead participating practices are required to fulfil a number of obligations. These requirements can be put in place by the CCG because they have got co-commissioning responsibility for primary care. The requirements for each workstream are as follows:

#### Integration:

- Practices will meet together at locality level with other NHS primary and secondary care providers to discuss priorities for service integration, based on local clinical knowledge
- These discussions will lead to a shared local plan, identifying areas where new ways of working can be piloted
- These plans will be shared with the CCG which will facilitate alignment of local plans with the wider transformation plans, including the Better Care Fund and Five Year Strategy
- Practices will work together with other NHS and social care providers to pilot elements of that plan
- The quality improvement events which the practices attend also extend invitations to secondary care representatives.

#### Sustainability:

- Practices will work collaboratively to discuss and assess their sustainability, using resources provided by the CCG and Area Team and supported by the LMC
- Practices will work together at locality level to discuss the opportunities and threats of joint business developments and new models, ranging from sharing staffing all the way to lead provider networks and accountable care organisations
- Practices will develop proposals for shared working that improve sustainability and quality. These proposals will be shared with the LMC, Area Team and CCG
- Practices will pilot new ways of working within the financial year

#### Quality Improvement (introduced in in 2016-2017):

- Participating practices to appoint a QI Lead, who will attend a minimum of two training/network events during the year
- Individual practices to complete two cycles of improvement on a project of their choice, from a menu of six topic areas: (safety, prescribing, referral, audit, patient experience, person-centred care)
- For 2018/19, practices have been given 3 clinical priority areas in which to use quality improvement methodology to improve patient outcomes

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Given the link between certain QOF indicators and the CCG Integrated Assurance Framework, the 2018/19 specification has reintroduced the requirement to meet two QOF actions; increase numbers of people on Learning Disabilities registers and review dementia care plans. These two areas, although linked to the assurance framework, are also priority areas for the CCG.

Participant practices submit an update report every quarter to provide assurance that they are meeting the requirements of the service. They complete a template which is sent to them in the service specification and then the panel discuss the submission.

Practices which take part are paid on the basis of 12/13 QOF achievement, with a suspension of payment for against QOF indicators. Payment is given monthly with a year-end final payment. Previous QOF payments are adjusted to prevalence need lists and list size.

### *Implementation*

Somerset was the first locality to introduce an exception to QOF. There was some concern from national and local bodies about the dangers of deviating from the national contract framework and risks to clinical practice and how quality of GP practices would be measured without QOF. In the first year of the scheme two-thirds of the practices took up the scheme. In 17/18 sign up was about 75% of practices. Based on the data collected, achievement on some indicators dropped significantly. This caused obvious concerns about a correlated drop in performance and quality. The independent evaluation concluded that patients continued to be cared for effectively but much of the coding was not being done because payment was not attached. The CCGs view was that there was much activity in primary care which concerned coding for payment rather than coding for quality. Because of the drop in indicators, the CCG has come into criticism for perceived 'poor performance' as they appear low down in league tables according to QOF measurement.

The evaluation also found that the scheme had led to more rapid implementation of person-centred co-ordinated care in the participating practices.

Having the scheme has made a difference for recruitment and retention. Two-thirds of GPs appointed since the scheme started cited whether or not they had to do QOF as a factor in where they would choose to work. GPs are interested in what it would be like to practice without QOF.

## **Tower Hamlets Primary Care Networks**

### *Overview and Aims*

Tower Hamlets has a long established programme of Network Improved Services delivered through a network model, these are locally commissioned 'additional' enhanced primary care services, tailored to local need. Ten services are commissioned including, LTCs and mental health. Every practice in Tower Hamlets is part of a larger network of 4-5 practices.

The scheme is designed around the following principles and aims:

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- Person centred, holistic care
- Self-Care
- Freeing up capacity for Primary Care
- Reducing complexity
- Focus on outcomes
- Reducing health inequalities
- Maintain safe/effective/efficient services

Alongside the clinical metrics in the Network Improved Services programme a review of the 'enabling functions' has taken place, with the aim to have a consistent and single process for the following in networks:

- Audits
- Multidisciplinary Team Meetings
- Training
- Meetings

### *How it works*

The scheme has been developed alongside a local QOF offer, which at its most simple is a suspension of QOF. Money previously allocated according to QOF performance is now allocated straight to practices and not performance related. However the money is channelled through networks and distributed by each network. This has been kept separate from the Network Improved Services as the Primary Care Committee perceived that combining them could be too complex and difficult to manage and could lead to double counting and payment for activity should some practices choose to remain with the national QOF scheme.

Networks and practices are required to sign up to a number of pre-requisites to receive the QOF allocation. These are:

- Networks are required to report against how the QOF funds have been allocated and are encouraged to assess individual practices needs as part of this process
- Networks are asked to ensure there is agreement across all participating practices as to how the QOF funding is used and allocated. All individual practices retain the right to 'veto' any network proposal if they do not agree with their network approach

### *Implementation*

Tower Hamlets CCG have delegated co-commissioning arrangements and has used this as a motivation to review QOF. The scheme was started after the CCG commissioned a review of primary care activity, with the aim to reduce the burden on practices wherever possible - this included a review of QOF.

28 out of the 36 practices in Tower Hamlets have chosen to participate in the local QOF scheme and opt-out of national QOF.

Practices must continue to record and allow extraction of data on indicators formerly incentivised through QOF. For the first year CCG Clinical leads have identified 25 existing QOF indicators for monitoring. These have been accepted across Tower

Hamlets as good practice and they are monitored more regularly than QOF recording previously was, with live data being received every quarter.

Leads at Tower Hamlets CCG perceive NHSE to have been supportive of the approach.

## **Scotland National Framework for Quality and GP Clusters**

### *Overview and Aims*

Scotland has embarked on a large scale programme of transformation of primary care.

In April 2018 it introduced a new contract for general practice. The aim of this is to refocus GPs as expert medical generalists, supported by a wider primary care multi-disciplinary team. There are a range of changes that support this, including an approach to service redesign, a new funding formula and associated financial support, responsibility at cluster level for quality planning, improvement and assurance, a premises fund that supports a long term shift away from practices owning their own premises and new opportunities for clinical and non-clinical employed practice staff as well as support being provided by additional staff employed by health boards.<sup>10</sup>

To support this long term vision, Scotland removed QOF in its entirety in 2016/17, transferring the money into global sum and instead established a quality improvement initiative based around cluster working.

The changes agreed in removing QOF were for practices to support development work for integrating health and social care, through a comprehensive national approach to GP 'cluster working' and to engage in developing a framework for quality and leadership.

The motivations for doing this in Scotland were:

- There was contention about to what extent QOF had contributed to quality
- Concerns within the profession about the volume of bureaucracy associated with QOF
- A rejection of the effectiveness of financial incentives to improve quality
- A rejection of centralised power for driving quality improvement, instead embracing the motivations of individual clinicians within local networks

### *How it works*

The starting point for achieving this was through the Transitional Quality Arrangements (TQA). The TQA proposed that every practice was to nominate a Practice Quality Lead (PQL) and every cluster to nominate a Cluster Quality Lead (CQL), thus aiming to ensure every GP in every practice would have a role in continuous quality improvement. The PQL would engage with the CQL thereby

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<sup>10</sup> Details can be found at: <http://www.gov.scot/Publications/2017/11/1343/downloads>

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providing a mandate for the CQLs to improve quality in the wider health and social care system.

To provide assurance and support the peer review quality process (clusters), data for an agreed dataset would continue to be collected via a new contractual change.

The previous QOF payment is allocated to practice based on historic QOF achievement.

### *Implementation*

Scotland has made a number of changes to their QOF in recent years. The first of which was in 2013/14 when they retired 77 points and the second in 2014/15 when they retired a further 264 points. From 2016/17, Scotland agreed to retire the remaining 659 QOF points thus ending the framework in its entirety. These 659 points were transferred into a new payment stream within the global sum.

In ensuring clinical services associated with the 659 points continued, it was agreed that practices would still provide all of the elements of the care that they considered clinically appropriate.

Early evaluation has taken place in Inverclyde<sup>11</sup>, an area with 16 GP practices formed into four clusters, which was selected in September 2015 to pilot the new model of care. The evaluation reflects the following learning, “Healthcare staff require substantial support for data collection, extraction and analysis, which the recent expansion of Local Intelligence Support Teams is designed to provide. The internal role of GP Clusters in relation to improving the quality of care for their combined patient populations requires time to develop new trusting relationships. Their external role in relation to reorienting the NHS in Scotland towards integrated new models of primary care requires close collaborative working and practices, particularly with Integrated Joint Boards. Early and comprehensive engagement with the wider healthcare team and with service users is of paramount importance in moving forward. It is also important to ensure that the most deprived communities benefit as much as the more affluent.”

There are further plans to evaluate the approach being taken but information is not available on this at the time of writing.

## **Wales**

### *Overview and Aims*

The QOF in Wales has changed considerably over the last few years with the scheme reduced significantly in size.

Changes have been made in order to:

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<sup>11</sup> [www.sspc.ac.uk/media/media\\_573766\\_en.pdf](http://www.sspc.ac.uk/media/media_573766_en.pdf)

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- Reduce the bureaucracy of the scheme
- Alleviate workload pressures
- Support the development of primary care clusters
- Monitor possible risks of removing QOF indicators

### *2017/18 changes*

The plan for 2017/18 was to make 567 points available across three domains: 202 points for active QOF, 165 points for inactive QOF and 200 points for the cluster network domain. They were as follows:

#### *Active clinical QOF*

Indicators remaining within the active clinical QOF domain continued to set out the targets, interventions or measurements to be recorded within a specific time period. Achievement of these indicators triggers payments in the usual way.

#### *Inactive clinical QOF*

Inactive QOF was a set of agreed retired indicators for which practices continued to receive payment based on 2016/17 achievement. These 17 indicators are deemed to have limited value in managing a patient's condition or could be monitored through enhanced services (e.g. diabetes) or linked to national clinical audit (e.g. COPD). Of these inactive indicators, eight were designated as subject to peer review during 2017/18 to provide assurance on the quality of care.

#### *Cluster Network Domain*

The cluster network domain was originally developed in 2014/15 replacing the then Quality and Productivity (QP) domain. Through this new three year development programme practices would be enabled to strengthen their ability to operate as a cluster / locality network, thus aiming to improve:

- coordination of care,
- the integration of health and social care, and
- collaborative working between communities and networks to reduce health inequalities

#### *Suspension*

In January of 2018 the Welsh government agreed to suspend QOF in recognition of pressures that practices were experiencing. Under this suspension practices were paid the full amount for the cluster domain, provided they had shared the three year Practice Development Plan and GP Sustainability Assessment Framework (apart from the financial information) with the Local Health Board by 31 May 2017. Payment for the active clinical domain for all indicators other than flu was based the higher of the 2017 achievement and the 2018 achievement. Payment for FLU001W and FLU002W continued to be made for actual 2018 achievement.

### *2018/19 changes*

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It has been announced that the active clinical QOF will be reduced to disease registers and flu indicators, in order to alleviate workload pressures. The cluster network domain will be reduced to engagement in five meetings over the year. At the time of writing, the Statement of Financial Entitlement giving full details is not available.

## **Annex 6: Local Medical Committees Conference motion on QOF, 2017**

The conference believes:

- (i) that disinvestment from QOF is no longer desirable as QOF has shown quality improvements and provides good data
- (ii) that evidence based chronic disease management is an important form of general practice funding and needs to be maintained
- (iii) that GPC England should develop and agree with government a revised QOF which should be evidence based and clinically relevant
- (iv) that indicators should have clinically appropriate timeframes for data collection.
- (v) That successful indicators should not be retired, and that new indicators should attract new funding when they are introduced

## Annex 7: Possible implications for diabetes indicators

Indicators	
Patients (with out moderate or severe frailty)	Patients ≥ 65 moderate or severe frailty
The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed.	
The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less	No specific indicator; excluded from indicator aimed at patients without frailty.
The percentage of patients with diabetes without moderate or severe frailty, on the register, whose last measured cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	No specific indicator; excluded from indicator aimed at patients without frailty.
The percentage of all patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I or ARB.	
The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.	The percentage of patients with diabetes with moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.
The percentage of all patients with diabetes, on the register, with a record of a foot examination and risk classification: <ol style="list-style-type: none"> <li>1) Low risk (normal sensation, palpable pulses)</li> <li>2) Increased risks (neuropathy or absent pulses)</li> <li>3) High risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer), or</li> <li>4) Ulcerated foot</li> </ol>	
The percentage of all patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry onto the diabetes register.	
The percentage of all patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March.	

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