ROYAL PHARMACEUTICAL SOCIETY

Role of Incentive Schemes in General Practice

RPS response

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

QOF and IIF should form part of the income for general practice, but they need to be reformed.

There are currently 76 indicators for 2023/24 and it is difficult for practices to prioritise indicators and allocate staff accordingly as it is not possible to meet all the targets.

There is a large administrative workload ensuring correct codes are entered that are specific to QOF requirements, or exception codes are added to remove patients from the QOF list. In addition, the same list needs to be checked each year and coded again, adding further workload.

The clinical indicators within the QOF list have not been updated for many years and some no longer reflect current clinical practice e.g. medicines optimisation for heart failure focusses on two medication classes whereas in current practice there are now four medication classes.

IIF incentive schemes are useful to ensure practices within a PCN work collaboratively, rather than focussing on their own individual QOF targets. However, the recent reduction and removal of some IIF indicators has meant some proactive care has now reduced e.g., structured medication reviews.

A menu of options for a PCN may be more beneficial but including some mandatory incentives that align with the core requirements of the Network Contract DES.

Learning from Scotland, where QOF was dissolved in 2015 and where quality became the responsibility of clusters as well as having a quality lead at GP practice level, shows that this has led to huge variability and a widening of health inequalities. The removal of QOF in Scotland has been linked to a significant decrease in 12 out of the 16 quality-of-care indicators[1]. It also means it is difficult to benchmark standards of care in areas such as life expectancy between the most and least deprived areas.

There does need to be some form of measurement and standards around non-communicable diseases. Metrics should be focused on quality and not quantity and suggestions include metrics around working better with secondary care and increased measures around prevention.

Incentives are often needed to make things happens, for example, there has been a demise of SMRs following the removal of the SMR metric from the IIF.

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

We neither agree nor disagree on this point. Having incentive schemes does create a focus for practice and PCN activity. However, resource varies as some practices have dedicated staff to monitor and implement QOF and similarly, some PCNs also have dedicated staff to monitor IIF

[1] Morales D, Minchin M, Roland M, et al. Estimated impact from the withdrawal of primary care financial incentives on the selected indicator of quality of care in Scotland: controlled interrupted time series analysis. 2023. BMJ 2023;380:e072098.

targets, whereas others don't. So, allocation of resources can be reactionary rather than proactive and it can become a "tick box" exercise towards the end of the financial year when patients are recalled enmasse. One prominent criticism of QOF overall is that it has become a "tick-box" exercise, as practices now rely on QOF for baseline funding. QOF has shifted from a bonus to the baseline income for practices, with QOF generating, on average 8.5% of practice income.[2]

QOF can be a barrier to holistic patient care, as incentives in such a financially constrained system can push GPs to meet QOF and divert practices from providing high-quality care unrelated to QOF. Additionally, the standards incentivise easily measurable outcomes, at the expense of others (e.g. continuity of care, well-being of the patient, or patient empowerment).[3] QOF can inhibit professional judgement and autonomy, therefore limiting GPs' ability to tailor care to local communities and individual patients.[4]

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

This could be helpful. However, any targets can be counterproductive as if teams realise they are not reaching the target they abandon it or once a threshold is met, they don't focus on that area of practice anymore. So, QOF can become static as once the indicators are achieved there is no financial incentive to improve care.[5]

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

ICBs should be able to select local priority indicators from a national menu and put additional local funding against those indicators.

For example, in Hammersmith and Fulham QOF+ for cardiovascular disease management was introduced from 2008-2011.[6] This allowed indicators to be tailored to the socioeconomic and epidemiological attributes of the population.

The introduction of local QOF alternatives in Somerset led to more patient-centred care. The devolution of QOF to clinical commissioning groups improved the care of people with long-term conditions. Additionally, practices within Somerset reported that this led to "time and resource savings in both GP consultations and administration."[7] QOF must minimise the burden on already over-stretched practices while allowing flexibility to tailor care to communities that practices are serving.

A national "menu" with local flexibility would allow indicators to be adapted to local demographics. However, there is a risk that if indicators were left entirely for ICBs, there could be a deprioritisation of certain conditions. It could also further exacerbate postcode lotteries in access to high-quality care. Moreover, it is important to recognise that not every ICB has the same data and expertise required to drive forward improvements in care.

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

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[2] Moberly T, Stahl-Timmins W. QOF now accounts for less than 10% of GP practice income. *BMJ* 2019;365:l1489. 10.1136/bmj.l1489 [PubMed]

[3] Lester HE, Hannon KL, Campbell SM. Identifying unintended consequences of quality indicators: a qualitative study. *BMJ Qual Saf* 2011;20:1057–61. 10.1136/bmjqs.2010.048371 [PubMed]

[4] Forbes LJ, Marchand C, Doran T, et al.. The role of the quality and outcomes framework in the care of long-term conditions: a systematic review. Br J Gen Pract 2017;67:e775–84. 10.3399/bjgp17X693077

[5] NHS England. Report of the review of the quality and outcomes framework in England, 2018. Available: https://www.england.nhs.uk/wp-content/uploads/2018/07/quality-outcome-framework-report-of-the-review.pdf:NHSEngland [Ref list]

[6] Pape UJ, Huckvale K, Car J, et al. Impact of 'stretch' targets for cardiovascular disease management within a local pay-for-performance programme. PLOS One. 2015;10(3):e0119185.

[7] Mahase, E. Locally adapted QOF led to improvements in patient care for long-term conditions. BMJ: British Medical Journal (Online); London Vol. 366, (Jul 23, 2019). DOI:10.1136/bmj.l4834

PCN-level schemes do incentivise practices to work together and this has been essential in some PCNs that were less well-established and need to form closer working relationships across multiple practices. Having an incentive scheme can also help with allocation of ARRS staff.

However, other efforts and initiatives are happening within PCNs that are not captured by IIF. We believe there should be a choice of options to incentive PCNs for work that is more applicable for their local population.

6. What type of indicators, if any, within incentive schemes do you think most help to improve care quality? (Select all that apply)

Clinical activity (for example, undertaking an annual asthma review)

Quality improvement (QI) (for example, local project to improve patient experience or staff wellbeing)

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

Yes, but at PCN level only. Place level is perhaps too large for member practices to feel invested in the outcomes.

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

Primary care itself is under immense pressure so we are not sure this would be helpful at this time. There are significant challenges in incentivising target achievement in socioeconomically disadvantaged areas. Analysis of Data from 2015-2019 found that practices in the most deprived areas averaged the lowest number of QOF points, and those in the most affluent areas scored the highest.[8]

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

Agree

Some current QOF indicators do not represent clinical practice as they are out-dated. Conditions do not exist in isolation. The number of patients with multiple long-term conditions is increasing and approximately half of all general practice appointments are for patients with multiple conditions.

Chief Medical Officer's Annual Report 2023 Health in an ageing society emphasised the need for change in terms of training and structure of NHS services: "Much of the medical profession is organised around single diseases or single organ systems in a way that is ill-suited to a future of increasing multimorbidity".

There should also be an increased focus on frailty.

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

Disagree

Patient experience of access is a subjective measure. It would likely be subject to a high level of variation both between patients as well as individual care episodes. It also does not necessarily align with what is clinically best for the patient. For example, a person with an expectation of speaking to a

[8] Dixon A, Khachatryan A, Wallace A, Peckham S, Boyce T, Gillam S. The Quality and Outcomes Framework (QOF): does it reduce health inequalities? NIHR Service Delivery and Organisation Programme, 2011. Available at: https://www.researchgate.net/publication/259622369.

specific clinician might be unhappy if diverted elsewhere, despite that being the correct and best course of action.

Typically, the data on these are gathered from patient surveys which can be subject to manipulation – i.e. sending only to those thought to have a good experience. We would suggest prioritising other areas for an incentive scheme.

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

Disagree

The triage of patient caseload should be led by clinicians. Although continuity of care should be encouraged it is not an absolute marker for improved clinical care, or even patient satisfaction

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

Disagree

This has the potential to increase administrative burden on practice teams to “code” patient choice. If patients can self-select appointments that would be better, but in reality, this does not happen.

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

Agree

Data is now readily available and easily accessible from BSA e.g e Pact 2, open prescribing and we know that data drives change and can improve performance.

All health care professionals would be responsible for their own prescribing, therefore there would be more shared ownership of the outcomes

In 2022/23 there were 1.18 billion prescribed medicines dispensed in the community in England and this number is increasing every year. In 2021 the Department of Health and Social Care published the National Overprescribing Review, *Good for you, good for us, good for everybody.* This made 20 cross-system recommendations to help reduce overprescribing in England and to make patient care better and safer. Some of this could be incentivised at practice or PCN level e.g RPS/RCGP Repeat Prescribing Toolkit

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

We believe metrics around working better with secondary care and increased measures around prevention should be included as well as a focus on frailty.

Metrics need to be focused on quality rather than quantity.

Metric could include capacity and access measures.

We believe that metrics need to include quality of care, which recognises important dimensions of quality of care, such as patient empowerment and continuity of care. We believe that improvements based on patient experiences and clinical outcomes would be effective in improving the quality of

care. A patient-centred framework, such as experiences (PREMs) and outcomes (PROMs) should be introduced.[9]

15. What opportunities are there to simplify and streamline any schemes for clinicians, and reduce any unnecessary administrative burden, while preserving patient care?

Currently, QOF provides a considerable component of practices' baseline income, as such other forms of practice funding must be increased so that QOF can return to its position as an incentive for high-quality care.

[9] Horrell J, Lloyd H, Sugavanam T, Close J, Byng R. Creating and facilitating change for Person-Centred Coordinated Care (P3C): The development of the Organisational Change Tool (P3C-OCT)[online first]. Health Expect 2017. doi:10.1111/hex.12631 pmid:29139220.