Role of incentive schemes in general practice

BHF response March 2024

Incentive schemes based on clinical indicators have been part of practice income for almost 20 years. This section seeks feedback on whether these schemes are working, and if not, what the alternative mechanisms are that could encourage proactive care, outcomes and clinically led quality improvement.

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

- *Agree*
- *Neither agree nor disagree*
- *Disagree*
- *Don't know*

Please explain your answer (optional) Maximum 400 words:

Primary care plays a vital role in preventing, diagnosing, and managing acute and long-term conditions, including heart and circulatory diseases. Heart and circulatory diseases affect around 6.4 million people in England and cause just over a quarter (26%) of all deaths.

Incentives like QOF support primary care in prevention and long-term condition management. Evidence indicates that many CVD-related QOF targets such as hypertension and lipid management have good outcomes due to strong guidance and performance within primary care (National Voices, 2024[1]). Meeting QOF targets for the diagnosis, prevention and treatment of CVD supports improved health outcomes and reduces pressure on wider NHS services.

As well as incentivising quality patient care, QOF also provides rich data and insights into health conditions and their treatment. BHF makes regular use of QOF data to estimate CVD prevalence in England, for example. Data entry in medical records required for QOF also facilitates the use of the data for clinical research, the importance of which was shown during the COVID-19 pandemic (Majeed and Molokhia, 2023[2]).

Evidence from Scotland, where QOF was abolished in 2016, highlighted an associated decline in quality of care. Compared with England, researchers found a significant decrease in reported performance for 12 of the 16 quality of care indicators in Scotland one year after QOF was abolished and for 10 of the 16 indicators three years after QOF was abolished (Morales et al, 2023[3]). This included substantial reductions in blood pressure control in several conditions including peripheral arterial disease, stroke, coronary heart disease, and diabetes. These findings underscore the importance of maintaining an effective financial incentive programme within primary care.

[1] National Voices, 2024: *What would good quality assurance look like in primary care?*

[2] Majeed, A., & Molokhia, M. (2023). The future role of the GP quality and outcomes framework in England. *BJGP open*.

[3] Morales, D. R., Minchin, M., Kontopantelis, E., Roland, M., Sutton, M., & Guthrie, B. (2023). Estimated impact from the withdrawal of primary care financial incentives on selected indicators of quality of care in Scotland: controlled interrupted time series analysis. *bmj*, *380*.

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

- *Agree*
- *Neither agree nor disagree*
- *Disagree*
- *Don't know*

Please explain your answer. (optional) Maximum 400 words.

We know that QOF can be a powerful secondary prevention tool for CVD, particularly by tackling the drivers of atherosclerotic disease. During the pandemic there was a marked decline in the number of patients starting treatment for conditions such as hypertension (Dale et al., 2023[4]), although we are now seeing recovery close to pre-pandemic levels for hypertension management. However, we also emphasise the importance of tackling the wider burden of CVD and ensuring treatment is available to patients who need it now, and not solely offered as a preventative approach.

While QOF broadly works well for many CVD-related conditions, it can encourage a siloed 'one size fits all' approach to health, resulting in variation in quality and patient experience. We further recognise that some practices are forced to prioritise individual activities which are part of higher-value QOF indicators, due to capacity and financial pressures. This was recently highlighted by UCLPartners, who found that that blood pressure optimisation rates fell significantly after 31 March 2023[5], as this was the date when GP practice performance is measured for payment under QOF. The authors further note that data shows that for at least six months 'post QOF', thousands of patients have dropped out of optimal therapy, increasing the risk of heart attack or stroke.

QOF indicators should be targeted to those most in need of care – those with the highest risk and worst health outcomes. We are currently seeing record increases in premature deaths from CVD in England, which now stand at their highest level since 2008. While the drivers of this are complex, it is likely that disrupted primary care screening for, and treatment of, key CVD risk factors have a part to play in this. A future incentives framework should use patient registers to identify and prioritise those most at risk and to look at wider CVD-related conditions to ensure appropriate, proactive care, e.g. patients with inherited cardiac conditions. QOF should also explore ways to move towards monitoring and reporting on patient outcomes, rather than simply rewarding specific activities. This could incorporate pilots around reporting intervals – with high-risk patients being recalled and seen more than once year, to monitor outcomes. This would encourage best practice and better support patients to manage their health.

Targets and health inequalities

3. The way targets are set can impact on health inequalities. Currently, absolute thresholds are used for assessing QOF and IIF with some adjustments taking place to account for local disease prevalence and practice list size. All practices and primary care networks are expected, however, to meet the same targets, regardless of their current performance, practice characteristics or local population demographics.

The use of absolute thresholds plays a crucial role in bringing all practices closer to nationally agreed standards, helping to ensure that the NHS is delivering value for money. The use of relative

[4] Dale, C. E., Takhar, R., Carragher, R., Katsoulis, M., Torabi, F., Duffield, S., ... & CVD-COVID-UK Consortium. (2023). The impact of the COVID-19 pandemic on cardiovascular disease prevention and management. *Nature medicine*, *29*(1), 219-225.

[5] Laura Boyd & Dr Matt Kearney, Is QOF bad for your heart? NHS Confederation, 2024.

improvement targets could acknowledge the varying starting positions and populations of individual practices.

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

- *Yes*
- *No*
- *Don't know*

Please explain your answer. (optional) Maximum 400 words.

Evidence for the effectiveness of QOF in tackling health inequalities remains mixed. While some studies have found QOF can reduce the gap between the least and most deprived practices and is a good incentive for poorly performing practices to improve, others have shown limited evidence of the direct impact of QOF on reducing health inequalities (Dixon et al., 2011[6]). However, we believe that an effective QOF programme can be a valuable tool for tackling health inequalities and improving health outcomes.

We recognise that elements of QOF currently have a fairly narrow focus on some aspects of healthcare provision and populations. Relative improvement targets could provide an opportunity for practices to better understand areas of poor performance and target certain groups or populations with highest need. We would therefore support the introduction of relative threshold targets, though would recommend these first be piloted across a variety of practices and integrated care systems to explore their feasibility. This should include areas with a range of historical QOF performances, deprivation indices and population demographics.

Primary care providers representing more deprived communities can be put at a disadvantage in meeting some targets, as the complexity of care their patients require can be greater than in less deprived areas. Offering relative targets can provide an equitable approach for primary care providers in efforts to specifically reduce local health inequalities. Greater incentives for improving care for patients with more complex care needs can go some way to ending a vicious cycle of providers losing funding in areas that need the greater levels of support.

Relative targets have the potential to be better aligned with integrated care systems and their commitment to tackling health inequalities locally. NHSE's Core20PLUS5 programme marries national oversight with local flexibility to target key populations at risk of exclusion. A refreshed QOF programme could potentially model this approach, allowing local systems the flexibility to target specific groups if needed.

4. In what other ways could we use incentive schemes to address health inequalities? (optional) Maximum 400 words.

We would encourage future QOF to minimise the use of exception reporting wherever possible. This is the practice of exempting patients from inclusion in QOF. This can include valid clinical reasons such as medicine contraindication, but also includes excluding patients who do not attend appointments at a practice (usually following 2-3 attempts at contact).

Data is not available on the reasons for exception reporting and there is little to no exploration of the reasons for patient non-attendance. By labelling these as exceptions, a practice can still receive QOF funding even if intended incentivised outcome was not achieved. Minimising of

[6] Dixon, A., Khachatryan, A., Wallace, A., Peckham, S., Boyce, T., & Gillam, S. (2011). The Quality and Outcomes Framework (QOF): does it reduce health inequalities. *NIHR Service Delivery and Organisation Programme.*

exception reporting would push practices to look closer at patient reach and further incentivise engagement with those who are not presenting.

We would encourage greater focus and analysis of exception rates to better understand what engagement barriers exist and whether there are any commonalties among certain patients or populations when it comes to non-attendance. These groups could instead benefit from targeted support, such as deploying link workers to relevant community spaces.

Role of ICBs

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

- *The scheme should be entirely national*
- *ICBs should be able to select local priority indicators from a national menu*
- *ICBs should be able to select local priority indicators from a national menu and put additional local funding against those indicators*
- *ICBs should be able to choose their own indicators and put local funding against those indicators*
- *Don't know*
- *Other*

Please explain your answer. (optional) Maximum 400 words.

As outlined in the Hewitt review, many ICBs view QOF as inflexible and desire an approach that allows for variation. While we would like to see an element of local flexibility for ICBs, a national menu would ensure continued prioritisation of certain conditions, including CVD, while enabling targeted approaches to areas of greatest patient need. It would also maintain national data collection, quality and transparency. Not all ICBs are yet equipped or prepared to accurately identify and drive forward best practice in care – including for CVD where we do see local variation in activity. One GP we consulted as part of our response to this consultation noted that QOF targets don't always align with local ICB targets, so it would be useful to have both national and local influence, to reduce variation.

NHSE's Core20PLUS5 model for tackling health inequalities could provide a useful template for a refreshed QOF programme. Core20 aims to reduce inequalities at both national and system level. The programme balances national areas of clinical focus, including hypertension case-finding, with targeted approaches to the most deprived 20% of the national population that need these services. This is further layered with the option for targeting outreach at specific local populations at greatest risk of exclusion.

PCN-led quality improvement

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

- *Agree*
- *Neither agree nor disagree*
- *Disagree*
- *Don't know*

Please explain your answer. (optional) Maximum 400 words.

We have heard anecdotal evidence from GPs that IIF funding has been beneficial to their practices. For example, it can help local practices to work together and pool staff to better target

specific gaps or conditions, such as by sharing specialist nurses. We have also heard how IIF enabled more people to be employed within a practice, including roles like clinical pharmacists and frailty nurses. This can provide patients more direct access to specialised, holistic support.

However, one GP we consulted noted there is often a lack of sufficient funding to employ someone to coordinate work between PCNs. They also highlighted that IIF targets can be unrealistic to achieve in a year, depending on what has to be achieved for the size of population versus the money on offer. PCNs vary in size and income and may need to employ extra staff to deliver on work.

Any PCN-level incentive would require clear strategic leadership and oversight from the ICB, with a clear protocol, service specification and analysis of unintended consequences. This would help to protect against variation between PCNs and practices, which could result in disruption to patient experience and outcomes.

Scope of any incentive schemes in general practice

This section seeks feedback on additional areas which could be considered for inclusion within future incentive schemes. We are interested in your views on the concepts that these questions introduce and recognise that we could not expand the scope without considering the total number of indicators or the funding impacts which would need to balance effort and reward.

Quality of care

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

Select all that apply.

- *Clinical coding (for example accurate recording of smoking status in a patient record)*
- *Clinical activity (for example undertaking an annual asthma review)*
- *Clinical outcomes (for example stroke rates)*
- *Quality improvement (QI) (for example local project to improve patient experience or staff wellbeing)*
- *Other*
- *Don't know*

Population levels

One of the challenges with focusing on clinical outcomes is the size of the population at which these are measured. We could choose to incentivise change in an outcome that is measured at a primary care network (PCN) level (with an average population of around 50,000 patients) or at 'place' level (250,000 and above population). It is important to note as the population level expands, individual practices have less influence, emphasising the need for collaboration and partnership within the PCN or potentially across a place to achieve shared outcomes.

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

- *Yes - at place and PCN levels*
- *Yes - at PCN level only*
- *Yes - at place level only*
- *No*
- *None of the above*
- *Don't know*

Reducing pressures on the health system

9. 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?

- *Agree*
- *Neither agree nor disagree*
- *Disagree*
- *Don't know*

Please explain your answer. (optional) Maximum 400 words.

As previously mentioned, where QOF works well, it can lead to better health outcomes for patients and reduce pressures on other parts of the NHS. Where QOF is performing well, staff within primary care should be able to initiate appropriate treatment (where relevant) without the need for referral into secondary care. This usually sees additional benefits, such as patients being treated closer to home and the potential for some primary care staff to be upskilled in certain care activities. GPs that we consulted highlighted some barriers to reducing wider NHS pressures, including a lack of primary care workforce to deliver care appropriate for that level, and poor communication between primary and secondary care. One GP recommended the use of the Advice and Guidance model to enable better coordination with secondary care.

Multiple long-term conditions

Currently, QOF and IIF are focused on improving care quality for single conditions. The patient population is, however, increasingly characterised by multi-morbidity, complexity and frailty, often benefitting from more holistic joined up care planning and delivery.

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

- *Agree*
- *Neither agree nor disagree*
- *Disagree*
- *Don't know*

If you said 'agree', how could we tailor any incentive scheme more towards quality of care for patients with multiple long-term conditions? (Maximum 400 words.)

If you said 'disagree', please explain your answer. (Maximum 400 words.)

While we recognise the potential value of a multiple conditions indicator in incentivising a more holistic and personalised approach to each patient, it is clear that primary care does not currently have the resources to deliver on such a significant expansion of QOF. Without seeing a proposed model of a QOF approach to multiple conditions, it is difficult to assess whether it would work in practice. We know that for the most part, CVD indicators have good guidance and uptake among clinicians. We would be concerned that to move away from this towards multiple conditions would risk diluting the quality of care available to patients in a condition area with huge burden of disease and progress towards improving quality of CVD care could be lost.

GPs we consulted recognised the value of a multiple conditions approach, but expressed scepticism around readiness of the system to enable this. One referred to the additional complexity of measuring activity and outcomes 'the more layers that are involved'. Another GP expressed that more training would be required for this approach, including careful thinking through of how conditions and treatments interact.

An interim test approach that might be worth exploring could include more targeted checks for common co-morbidities within specific conditions - e.g. patients with CVD could be checked for COPD or renal disease etc. As in previous answers, we would expect this to be piloted initially, in close consultation with relevant patient representative groups.

Patient access

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

- *Agree*
- *Neither agree nor disagree*
- *Disagree*
- *Don't know*

If you said 'agree', how could patient access be incentivised and measured? (Maximum 400 words.)

If you said 'disagree', please explain your answer. (Maximum 400 words.)

We are not clear what patient experience of access refers to – it would likely encompass several clinical touchpoints in order to be meaningful but would likely be incredibly challenging to effectively record and monitor. This indicator could sit best within a health inequalities approach, This would require meaningful, proactive measurement of patient experience and service quality, rather than tick-box assessment of whether a patient simply received an appointment. However, without further insight into what this would look like, we cannot comment further. GPs we consulted all mentioned workforce shortages and how these inevitable affect patient access. One GP also highlighted that access is important but it can be a trade-off with continuity of care and that there are not enough GPs to enable both effectively.

Continuity of care

Continuity of care can refer to the relationship between a named GP and their patient, or team-based continuity where patients are happy to see different professionals as part of their overall care.

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

- *Agree*
- *Neither agree nor disagree*
- *Disagree*
- *Don't know*

If you said 'agree', how could continuity be measured and incentivised? (Maximum 400 words.)

If you said 'disagree', please explain your answer. (Maximum 400 words.)

Our BHF lived experience advisory panel consistently raise the importance of continuity of care. Panel members highlight the frustration of having to repeat their medical history to different practitioners and how this often eats into precious and limited appointment time. We also note recent research that has highlighted how time between primary care visits is substantially longer when the patient sees the same doctor they have seen most frequently over the past two years, even when there is no meaningful difference in consultation duration[7]. The authors note that this

[7] Harshita Kajaria-Montag, Michael Freeman, Stefan Scholtes. 'Continuity of Care Increases Physician Productivity in Primary Care.' *Management Science* (2024). DOI: 10.1287/mnsc.2021.02015

continuity results in better patient outcomes, better patient and GP experience, reduced secondary care use, and a productivity benefit for the GP practices themselves.

However, despite clear benefits, measurement of continuity could be challenging and complex, and we are unsure whether QOF is the best vehicle for this approach. As in our previous answer, the GPs we spoke to all said that the system is not sufficiently resourced (both funding and workforce) to reach this goal. However, one GP suggested it might be possible at PCN-level, but not at individual GP practice level.

Patient choice

Patients have a legal right to choose where they receive their elective care.

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

- *Agree*
- *Neither agree nor disagree*
- *Disagree*
- *Don't know*

If you said 'agree', how could we incentivise and measure patient choice in any incentive schemes? (Maximum 400 words.)

If you said 'disagree', please explain your answer. (Maximum 400 words.)

We are seeing record waiting times for elective cardiac care across England and welcome any opportunities for patients to have better choice around where and how they receive their elective care. However, we are conscious that patients from more affluent areas are more likely to avail of options such as travelling further from home for elective procedures. Therefore, any indicator focused on patient choice will likely require careful consideration around content, data capture and the role of inequalities. GPs we spoke to said that resource and capacity can be stumbling blocks to offering choice. Two GPs indicated this is somewhat already available through the Choose and Book system. One GP found this approach successful, but another noted that waiting lists are now too big to offer meaningful choice.

Effective prescribing

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

- *Agree*
- *Neither agree nor disagree*
- *Disagree*
- *Don't know*

If you said 'agree', how could we incentivise effective prescribing in any incentive schemes? (Maximum 400 words.)

If you said 'disagree', please explain your answer. (Maximum 400 words.)

Other comments

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

Minimising administrative burden

We have heard that QOF and IIF can become 'tick box exercises' that distract clinicians from focusing on the needs of their patient and using their clinical judgement. This section seeks your

feedback on how we can reduce the administrative effort associated with any scheme, including regarding the number of indicators and the processes associated with delivering the schemes.

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

The GPs we spoke to pointed to improved IT systems as one clear way to simplify administrative burden. One GP noted that come January, a lot of their time is spent auditing the QOF list and codes, to ensure they are correct and they can receive maximum payments. They noted that locums and other temporary GPs are not as motivated to monitor and check on codes, so the regular practice GPs have to review their workloads for QOF reporting.

Two GPs recommended an IT development structure that has QOF and IIF tool embedded within it. This could draw together all relevant information and avoid GPs having to go back through patient notes and free text to ensure everything is coded correctly.