The Quality and Outcomes Framework: transparent, transferable, tenable?

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Aims

- To provide information to and share information between the members
- Advocacy for Primary Care towards policymakers and politicians
- Support to the development of research and establishment of a research agenda
Overview

- Transparent
- Transferable
- Tenable

www.kingsfund.org.uk/publications//gp_inquiry_report.html
Background

- Introduced in 2004 in the UK
- >£1billion per annum
- 22% GP income
- Domains: clinical, organisational, patient experience, additional services
- Largest natural experiment in pay for performance (P4P) in the world
QOF domains

- **Clinical**
  - Secondary prevention of coronary heart disease
  - Cardiovascular disease: primary prevention
  - Heart failure
  - Stroke & TIA
  - Hypertension
  - Diabetes mellitus
  - COPD
  - Epilepsy
  - Hypothyroid
  - Cancer
  - Palliative care
  - Mental health
  - Asthma
  - Dementia
  - Depression
  - Chronic kidney disease
  - Atrial fibrillation
  - Obesity
  - Learning disabilities
  - Smoking

- **Organisational**
  - Records and information
  - Information for patients
  - Education and training
  - Practice management
  - Medicines management

- **Patient experience**
  - Length of consultations
  - Patient survey (access)

- **Additional services**
  - Cervical screening
  - Child health surveillance
  - Maternity services
  - Contraception
## Hypertension

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Payment stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP1. The practice can produce a register of patients with established hypertension</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months</td>
<td>16</td>
<td>40–90%</td>
</tr>
<tr>
<td>BP5. The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less</td>
<td>57</td>
<td>40–70%</td>
</tr>
</tbody>
</table>
QOF scores

![Graph showing QOF scores from 2004/05 to 2008/09. The graph indicates an increase in scores from 2004/05 to 2005/06, followed by a slight decline in subsequent years.]
Records identified through database searching (n=575*)

Additional records identified through other sources (n=7)

Records after duplicates removed (n=423)

Records screened (n=423)

Records excluded (n=306)

Full text articles assessed for eligibility (n=117)

Full text articles excluded with reasons (n=70)

Studies included (n=47)
The contribution of the QOF

- Health care gains
- Population health and equity
- Costs and cost effectiveness
- Providers, teams and organisations
- Patients’ experiences and views
Health gains?


“no significant difference in the rate of improvement between clinical indicators for which financial incentives were provided and those for which they were not provided suggests that the pay-for-performance program may not necessarily have been responsible for the acceleration in improvement”
Incentives vs. no incentives

Population health and equity


Gaming

- Threshold effect
- Ratchet effect
- Output distortion

Exception reporting

‘We try and stick to the rules, I think occasionally people get exception reported for reasons that, perhaps, they shouldn’t be, but we have very low rates of exception reporting.’

Campbell S: *Br J Gen Pract* 2011, **61**: 183-189.
Cost effectiveness

- No relationship between pay and health gain
- Cost effectiveness evidence for 12 indicators in the 2006 revised contract with direct therapeutic effect
- 3 most cost-effective indicators were:
  - ACEI/ARB for CKD
  - Anticoagulants for AF and
  - Beta-blockers for CHD

Fleetcroft RBr J Gen Pract 2010, 60: e345-e352.
Some patients will come to you and they’ll plead with you, ‘Please don’t give me any tablets, I’ll bring my blood pressure down, I’ll do everything. I’ll bring it down’, and again they’re not horrendously high, they’re like say 140/90 or whatever ... but we’re saying to them ‘well, look we’ve checked it three times now and it remains raised, you’re clinically classed as hypertensive, we follow these guidelines and this is what we should be doing with you’. (Nurse practitioner)

Every day I come in I check (performance) ... I’m a chaser ... if you’re a chaser you have to chase yourself though. ‘Cos you’ve no credibility if you don’t deliver.’ (GP partner).

Clinical behaviour

‘And there have been 1 or 2 occasions where I went through the cholesterol, the depression, the CHD, and everything else, and “Oh, that’s wonderful, I’m finished now,” and the patient said “Well, what about my foot then?” “What foot”? [GP]

I feel actually I’m looking at the patient less than I used to, which is a shame…. I have to say to them, “I’m sorry, I’ve got to look at the computer as well and type in while you’re talking to me” (PN).

“A slim, active 69-year-old patient attending for influenza vaccine was faced with questions about diet, smoking, exercise and alcohol consumption. There was no explanation for why these questions were asked; they seemed irrelevant to having a ‘flu vaccine.’

Blood pressure and weight had to be recorded and a cholesterol test organised. A short appointment lasted almost 15 minutes without the patient having the opportunity to ask a question about any aspect of ‘flu vaccine.”

Continuity

Inverse care law

Heath, I. et al. BMJ 2007;335:1075-1076
“That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair ...” George Bernard Shaw
Successes and failures

- Improved processes, data and analysis
- Initial health benefits for individuals and populations
- Some narrowing of inequalities in processes of health care
- Opportunity costs contested
- Unintended consequences
- Negative effect on care

Quality then...

- "The overall state of general practice is bad and still deteriorating"

- "The development of other medical services ... has resulted ... in wide departure from both the idea and the ideal of family doctoring"

- "Some [working conditions] are bad enough to require condemnation in the public interest"
Now...

- Quality of most care in general practice is good
- Wide variations in performance and gaps in the quality of care both within and between practices
- Many working in general practice are not aware of variations, gaps and the significant opportunities for general practice to improve the quality of care it provides.

'What do "targets" accomplish? Nothing. Wrong: their accomplishment is negative.'

'Management by numerical goal is an attempt to manage without knowledge of what to do'.
Conclusions and ways forward