The Quality and Outcomes Framework (QOF) –

What Type of Quality and Which Outcomes?

By

Gary Jones[I], Stuart Carroll[II] and Jennifer White[III]

[I] **Gary Jones** is a Public Affairs Consultant, and a Member of the Bow Group Health Policy Committee.
[II] **Stuart Carroll** is a Senior Health Economist and Policy Analyst, and the Chairman of the Bow Group Health Policy Committee.
[III] **Jennifer White** is a Public Affairs Consultant, and a Member of the Bow Group Health Policy Committee.

1. Introduction[IV]

"National accountability moves away from organising a particular institution around large numbers of targets towards overall systems performance and health outcomes. That in turn will allow a better concentration on tackling inequalities and improving health rather than just on improving health services."[1] Speech by **Rt. Hon. Alan Milburn MP**, then Secretary of State for Health, to the New Health Network, 14th January 2002.

In 2000, Alan Milburn MP, the then Secretary of State for Health, launched the NHS Plan, which set out the **Labour** government's future vision for the NHS. The NHS Plan was hailed as a 10-year blueprint to restore and modernise the NHS to meet the public's expectations of a 21st century health service. It marked the start of increased investment, with purported radical reforms designed to change the system failures of the NHS and to put the patient at the centre of healthcare delivery. A major theme for the NHS Plan was to empower General Practitioners (GPs) to improve both patient health outcomes and tackle inequalities.

One of the key mechanisms for this vision was the Quality and Outcomes Framework (QOF)[V] – a voluntary incentive scheme for GP practices in the UK that rewards doctors based on the quality of care delivered to patients. The QOF was launched in April 2004 and pitched as a means of "delivering substantial financial rewards for high quality care"[2]. It was argued that by introducing this framework GPs would be provided with incentives to diagnose, treat, and record information for more patients than ever before.

At the time of the NHS Plan, Alan Milburn was seen as a leading Blairite and tipped by some as a future leader of the Labour Party and thus his departure from the government in 2003 was a big political surprise. In many respects, Milburn's departure has since led to a stalling of government policy on the NHS and a move away from the original Blairite vision.

Indeed, the reform programme informing the NHS Plan has disintegrated in recent years and the QOF provides a classic example of the **Labour** government's failure to pursue previously pledged policy imperatives. Milburn has himself declared as much having recently called for state control over the NHS to be reined: *"The NHS is in transition between a 20th century model of state control and monopoly provision and…a different model where the citizen has more control. The policy question is*

[IV] See **Appendix A** for a glossary of technical terms used throughout the paper.
[V] More information on QOF can be found by accessing the following link: http://www.qof.ic.nhs.uk/.

whether that journey is going to be finished or truncated. We have to take it to its final destination."[3]

Indeed, the QOF has proven to be a major source of debate since its introduction in 2004. Key areas of contention include the definition and measurement of quality; the points scoring system for rewarding good practice; and the focus of the outcomes currently forming part of the framework. It is therefore an important policy question to consider what the QOF has achieved over the last 6 years or so, and how it can be improved to tackle current and future healthcare challenges.

2. Research Objectives

The QOF is at a critical stage of development and the next few years will determine how successful the framework will be in driving up health standards. This analysis seeks to evaluate the progress the QOF has made since its introduction and consider the different ways in which the QOF can be reformed. Our research paper specifically looks at the role the QOF can play in tackling health inequalities, which is widely recognised as a persistent health challenge confronting the UK.

The first part of our analysis provides a brief background to the QOF and how it has developed over time. We then consider the wider political context and the stated policy positions of the three major political parties. Our research methods include expert interviews with healthcare professions and field research to consider the different ways that the QOF could potentially be reformed to better achieve its stated objectives. A copy of the generic questionnaire used throughout the interviews is provided in **Appendix B**. This includes considering how the QOF can be made more outcomes-orientated and whether there is a need for a greater focus to be placed on incentivising preventative and public health. We also consider those conditions currently not contained within the framework and how the QOF can be enhanced to improve the delivery of primary care and patient health outcomes.

3. How Do the GP Contract and the QOF Work?

GPs are normally the first point of medical contact within the NHS, providing open and unlimited access to all types of patients and associated health problems. The majority of GP work is carried out during consultations in local surgeries and through home visits. General Practice gives individual doctors a wide choice of where to practice, with whom and how. In a year, it is estimated that around 33,000 GPs hold approximately 290 million consultations every year. For example, in 2006-07 GP services cost the NHS some £7.7 billion, which accounts for almost 10% of all NHS expenditure[4].

The broad mix of General Practice is one of its major attractions. There can be huge variation in the needs of individual patients during a single surgery. No other specialty offers such a wide remit of treating everything from pregnant women to mental illness and to sports medicine. General Practice offers the opportunity to prevent illness and not just treat it. Most GPs are independent contractors to the NHS and this independence means that in most cases, they are responsible for providing adequate premises from which to practise and for employing their own staff.

The background and nature of General Practice has traditionally resulted in a light touch approach to regulation and performance review. GPs have never been salaried employees of the state and the origins of their independence can be traced back to negotiations that took place prior to the National Health Insurance Act of 1911. In return for accepting patients under the insurance scheme (previously all GP work was private or voluntary), the government agreed to respect GP autonomy in the way they ran their practices. When the NHS was created in 1948, this principle was carried over through the General Medical Services (GMS) Contract. As part of this agreement, GPs received payment for treating NHS patients via a capitation system based on the number of patients on their lists. This arrangement survived with a few alterations to include a salary element and provisions for direct payment for additional services until 1990.

The QOF[VI] is a voluntary system designed to remunerate general practices for providing good quality care to their patients and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the GMS Contract, which was unveiled on 1st April 2004. Although involvement in the QOF is voluntary, almost every practice in the UK takes part. This is largely because the framework represents one of the only ways GPs can make a difference to their income. The QOF contains groups of indicators against which practices score points – and receive financial rewards – according to how well they perform. The final payment is adjusted to take account of surgery workload and the relative health of patients in their area (see **Box 1**).[VII]

This represents a significant change compared with the previous system when the GP contract was predominantly based on statutory terms of service and contained very few pay-for-performance elements. In theory, the QOF is designed to give an indication of the overall achievement of a practice through a points system. Practices aim to deliver high quality care across a range of areas for which they

[VI] More information on QOF can be found by accessing the following link: http://www.qof.ic.nhs.uk/.

[VII] The clinical domain focuses on incentivising GP behaviour to ensure proper diagnosis and follow up of treatment for those diseases and illnesses considered. It is not designed to "punish" GPs who have sicker patients and therefore a higher burden of given diseases and illnesses.

score points. To reward good practice the higher the score, the higher the financial reward for the GP. The final payment is adjusted to take account of the practice list size and prevalence. Results are then published annually.

Box 1: Overview of the QOF

The QOF is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not supposed to be about performance management, but resourcing and then rewarding good practice. The QOF measures achievement against a scorecard of 146 indicators, plus three measures of depth of care. Practices score points on the basis of achievement against each indicator, up to a maximum of 1050 points. In total, the QOF is made up of four domains:

- **The clinical domain**

76 indicators in 11 areas including coronary heart disease, left ventricular disease, stroke or transient ischaemic attack, hypertension, diabetes, chronic obstructive pulmonary disease, epilepsy, hypothyroidism, cancer, mental health, and asthma

- **The organisational domain**

56 indicators in five areas including records and information about patients, patient communication, education and training, practice management and medicine management.

- **The patient experience domain**

Four indicators relating to patient surveys and consultation length.

- **The additional services domain**

Ten indicators in cervical screening, child health surveillance, maternity services, and contraceptive services.

The Department of Health (DH) had indicated from the outset that the QOF would not remain a static metric of performance, with the need to revise the system in line with the development of clinical evidence, healthcare advances and new legislation. The first overhaul of the QOF came in 2006, when the maximum number of points was reduced to 1,000. The minimum and maximum thresholds for point-scoring were raised to 40% and 90% respectively for the majority of indicators, and a total of 166 points were redistributed.[VIII]

[VIII] The vast majority of points were redistributed to new indicators such as chronic renal disease, depression, dementia, obesity, palliative care, mental health, learning disability, and the management of patient records

The DH has promised to introduce a "significant reform" of the QOF from 2011 as part of its 5-year plan for the NHS. Launching its strategy, '*NHS 2010-2015: From Good to Great'*, Health Secretary Andy Burnham MP said it was time to accelerate the pace of NHS reforms to make systems more productive and improve the quality of care. On the QOF, the DH recently announced that it would be making no changes to the quality scheme in 2010-11 because of pressures from pandemic flu, but that from 2011-12 onwards there would significant reform to deliver improvements in quality and efficiency[5]. The plan states that the QOF reform is likely to mean raising performance thresholds and retiring indicators that have limited cost-effectiveness "...to make way for more stretching quality indicators".

4. Who is Responsible for the QOF?

From April 2009, the National Institute for Health and Clinical Excellence (NICE) has overseen a new independent process for developing and reviewing the clinical and health improvement indicators in the QOF. NICE is responsible for producing an annual "menu" of new, evidence-based clinical and cost-effective indicators where there is a strong case for encouraging uptake of good practice. The Institute focuses on the clinical and health improvement indicators in the QOF, which includes domains such as coronary heart disease and hypertension.

NICE also recommends whether or not indicators should continue to be part of the QOF. For example, it has been argued that where the activity being measured has become part of standard clinical practice, there is no longer a need to provide a financial incentive. This is in keeping with NICE's role in providing guidance to the NHS based on evidence of clinical and cost-effectiveness. The decision on which indicators are included in the QOF will continue to be negotiated between NHS Employers, on behalf of the DH, and the British Medical Association (BMA) and the General Practitioners Committee (GPC).

When asked about the key challenges for NICE when reviewing and updating/replacing the clinical and health improvement indicator set for the QOF**, Sir Andrew Dillon**, **the Chief Executive of NICE**, told us: *"There has been a slow start in getting stakeholder suggestions for new indicator topics that can be mapped against NHS Evidence accredited sources to put to the independent QOF Indicator Advisory Committee"*[6].

Responding to a question on how NICE's role in reviewing indicators will evolve over time Sir Andrew Dillon told us that "with a rolling programme of reviewing existing indicators and the introduction of new ones, the QOF should become a vehicle for continuous quality improvement."[7] He added that "The QOF process should lead to a wider range of clinical and health improvement topic areas included in the QOF, based on accredited sources of evidence"[8]. When asked about where do you see

NICE's role in the next 5 to 10 years in relation to the QOF, Sir Andrew said: "The NICE process is in its earliest stages with the first new indicators from the full NICE process only being apparent from 2010-11 onwards. A positive start has been made."[9]

One of the original aims behind the QOF was to address the variation in the standard of care being provided to different patient groups. In the last 10 years, there have been attempts to move towards making sure that all treatments are backed up with appropriate clinical and medical evidence. Using evidence in this way helps to ensure that ineffective and unsafe treatment is avoided. Given that this evidence is used when setting targets for the QOF, GPs who participate in the scheme are motivated towards providing the same, robust treatment to their patients.

The QOF focuses on long-term conditions where good treatment can make a difference to a patient's life. One example is trying to prevent complications by controlling blood pressure and cholesterol levels in patients with diabetes, coronary heart disease or a history of stroke.

5. Political Context

"For 2010/11, we have exceptionally agreed to make no changes to the Quality and Outcomes Framework in recognition of the pressures arising from pandemic flu. For 2011/12 onwards, there needs to be significant reform to QOF to deliver improvements in quality and efficiency."[10] NHS 2010 - 2015: From Good to Great. Preventative, People-Centered, Productive, **Department of Health**, December 2009.

"We are going to have to unpick the QOF to make it more focused on outcomes and less on process."[11] **Mark Simmonds MP**, **Conservative Shadow Health Minister**, Conservative Party Conference, October 2009.

All the main political parties are supportive of the QOF and there has been no suggestion of abolishing the current regime. However, all three major parties recognise that there are shortcomings within the current structure and all are committed to QOF reform.

The **Labour** government has conceded that, whilst QOF will remain unchanged in 2010/11 due to pandemic flu workload, performance thresholds will be increased in order to drive up standards in primary care. The government has recognised that there is a need for "significant reform" to improve the QOF. The **Conservatives** have vowed to "unpick" the QOF and replace it with a new version heavily focused on clinical outcomes and public health. They have also called for a revised QOF which specifically rewards GPs who choose to deliver services in deprived areas.

The **Liberal Democrats** have been broadly supportive of QOF accepting the role it has played in prevention, but have also called for reforms to the current system. The **Liberal Democrats** have specifically recommended ending the smoking cessation element of the framework and have more generally called for the framework to be more outcomes-orientated.

6. Outcomes over Process

"Increasingly clinicians are being judged against their patients' clinical outcomes and satisfaction – and under the Quality and Outcomes Framework, they are paid according to their performance. Now we want to start expanding this approach to other parts of the service, and start to link payment to quality rather than just activity."[12] **Rt. Hon. Andy Burnham MP**, Secretary of State for Health, 4th November 2009, at the Urban Institute, Washington DC: The Politics of Health Reform.

It is important to acknowledge the relative success of the QOF to date and the role it has played in providing high-quality care. The QOF has helped GPs to focus on key clinical areas, such as hypertension and chronic kidney disease, and to identify more diseases, as reflected by the overall rising prevalence rates recorded by practices. Evidence does suggest that since the introduction of the QOF, GP practices in deprived areas have on average improved and have made some progress in catching up with those practising in more affluent areas. However, this is very much a "side effect" of the QOF and evidence has shown that in recent years this has started to significantly tail off.

Researchers from the National Primary Care Research and Development Centre in Manchester recently published research which shows that there were significant improvements in care provided for three major diseases between 1998 and 2007 with the rate of improvement accelerating for asthma and diabetes after the introduction of the QOF[13]. However, the rate of improvement slowed after 2005 for all three conditions and the quality of aspects of care not associated with an incentive in the QOF declined for patients with asthma or heart disease. Continuity of care also immediately declined after the introduction of the pay-for-performance scheme and then has since continued to decrease at this lower level.

It has also been suggested that, although there has been a marked increased in many clinical indictors covered by the QOF, there is little evidence to suggest that this is a direct result of the performance-related-pay initiative.

It is clear that despite the government's best intentions, a considerable gap remains between best achievable practice and the quality of care actually being provided on the ground. To a large extent, this is a direct consequence of the government's

continued obsession with process driven targets at the expense of emphasising patient health outcomes. Focusing the QOF around clinical outcomes will help to address this unacceptable quality gap by rewarding practices that ensure patients receive the care they need to maintain their health; prevent the onset of diseases and provide more accurate diagnosis; and, in the case of chronic conditions, optimise patient management.

Indeed, it is axiomatic, or at least it should be, that the primary focus of any healthcare system should be placed on improving patient health outcomes and patient experiences. As one GP told us, *"Maybe more emphasis should be placed on quality of life measurements."*[14] This essentially means linking performance review – and associated rewards and penalties – to the outcomes that are of most important to patients, which is in turn fundamental to ensuring patient accountability and restoring professional discretion over how to treat patient needs.

However, evidence clearly shows that since its introduction the QOF has been primarily based on process measures which do not reward GPs for delivering improved health outcomes. These "process" indicators, which are essentially based around activity indices, reward practices for carrying out tasks such as blood pressure checks, whilst "outcome" measures such as assessing the optimal control of blood pressure are not routinely part of the QOF. Although there is a clear role for process measures in supporting the foundations of the QOF, there is a real danger that a lack of focus on outcomes can drive down standards and result in perverse incentives for healthcare professionals and in turn unintended outcomes.

The QOF is now well-established in primary care and it is understandable that patients increasingly expect a greater focus on the clinical-effectiveness and cost-effectiveness of quality indicators. In the early years of the QOF, a large proportion of target payments were awarded for achieving process measures, for example measuring blood pressure. Achievement of such process measures is now very high, meaning little room for improvement in many practices and thus limited scope for further health gain.

As way of policy imperative, there needs to be a much greater emphasis placed on indicators that reward practices for the outcomes achieved, for example the percentage of patients with well-controlled blood pressure. Incentives such as checking blood pressure and cholesterol in older patients should be cut from the quality framework because these tests do not predict the risk of death from heart disease. This should be replaced with outcomes-orientated targets.

Similarly, instead of rewarding GPs for recording smoking rates, the QOF should be incentivising GP activity around monitoring and promoting smoking cessation rates. After all, measuring what is most important to patients is what really counts. On this

domain, the QOF currently scores very low and is therefore in need of structural reform.

In addition, there is the problem that many process indicators often duplicate a matched indicator covering a concomitant outcome. This can often result in a phenomenon known as "multiple counting", which can be illustrated using the following extreme example. If a patient diagnosed with Chronic Obstructive Pulmonary Disease, asthma and chaemic heart disease was advised to stop smoking, the practice would receive three individual payments, i.e. one payment for the advising smoking cessation against each condition. In this case, there would be multiple payment for a single piece of medical advice.

Research undertaken in 2007 by academics at the University of Nottingham have calculated that a third of patients have more than one condition that carries quality points[15]. With rising rates of comorbidities, future reviews of the QOF framework will need to look at ways of preventing double or multiple payment, not least given the current recessionary climate and the associated resource and financial pressures attendant on the NHS.

Whilst there have been some changes to stop the practice of multiple payment, more needs to be done to ensure that the QOF system is not unnecessarily paying out and rewarding healthcare professionals against the basic principles of the system.

Following pressure from the **Conservatives**, the Darzi Review[IX] called for "process" indicators to be reduced as part of plans to give GPs greater incentives to deliver health promotion activities. When the Government handed control of the QOF to NICE, it was expected to pursue this agenda. However, the Institute has so far resisted calls for the introduction of a significantly higher number of outcome measures because of concerns that they do not accurately reflect the work performed by GPs.

[IX] In July 2007 the government asked Lord Ara Darzi, the then Junior Health Minister and eminent surgeon, to conduct a "next stage review" of the NHS in England. The then Health Secretary Alan Johnson MP said the review was a "once in a generation opportunity to ensure that a properly resourced NHS is clinically led, patient-centred and locally accountable". The initiative came seven years after the launch of the NHS Plan, which focused largely on increasing capacity in the health service and driving down waiting times. In the government's view, these centrally directed targets had been largely achieved and new priorities would instead focus on improving quality of care and ensuring better outcomes. Lord Darzi's NHS Next Stage Review sets out the government's plans for NHS reform in England over the next 10 years. Its principal focus is on driving up the standards of quality in health care and putting clinicians at the heart of change. It is also intended to be locally driven. The review is based on the reports from strategic health authorities and clinical pathway working groups that presented a vision for change in their particular localities. It is not a 'national blueprint', but a means of enabling these local visions to become a reality.

It is therefore clear that the health promotion agenda has stalled and needs to be urgently speeded up as part of a fundamental culture shift to move the NHS away from a healthcare system that rewards process measurement to a health service that recognises actual health benefits. As one GP told us, the QOF needs to be changed to give *"...clear and consistent outcomes that don't constantly change unless there is good evidence that it is needed"*[16].

As way of example, it is clear that many more points should be awarded for success with smoking cessation rather than just identifying that someone is a smoker. Whilst constant chopping and changing will inevitably make life more difficult for GPs, it is essential that NICE keep the QOF under careful and constant review to ensure the framework continues to evolve. This will help to ensure that the QOF is better aligned with prevailing health priorities, and gives more weight to achieving health outcomes rather than simply following standard clinical and process-orientated practices.

7. Greater Focus on Prevention and Public Health

"The radical structural changes to the NHS since 2002 have been costly, not just financially but in terms of disruption, loss of experienced staff and changes in working relationships both within the NHS and with other organisations. But there is no need to change tack – instead, we need quickly to find ways of identifying and tackling policy weaknesses, focus on increasing productivity and, the biggest challenge which is shared by individuals as well as government, is to tackle unhealthy behaviours." **Sir Derek Wanless**, 11th September 2007[17].

"We have a rising tide of public health problems – alcohol, smoking, drugs, teenage pregnancies – and by international standards we do badly". **Andrew Lansley MP**, **Conservative Shadow Health Secretary**, 2020health Annual Lecture on Public Health, 13th January 2009[18].

The UK is facing a public health crisis with soaring rates of obesity, drink problems and sexually transmitted infections (STIs). Dealing with these problems is a fundamental public health challenge for the NHS – and wider society – and is central to any meaningful attempt to ensure the NHS moves away from the currently reactive/curative healthcare model to a system of genuine prevention. Given the UK's eye-watering budget deficit and the parlous state of the public finances, preventative healthcare is also an economic imperative in order to deliver future cost-savings from averted illness and disease and avoidable productivity losses.

The "Tackling Obesities: Future Choices" report, published by the government think-tank Foresight, predicted that the UK is on the brink of an obesity epidemic, with 60% of adult men and 50% of adult women set to be clinically obese by 2050[19]. An

NHS Information Centre report found that in 2007/08 there were around 863,300 admissions related to alcohol consumption and that an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis[20]. This represents a 69% increase since 2002/03 when there were around 510,200 alcohol-related admissions.

STIs are also a major cause of ill health and over the last decade rates of infection have soared in the UK. Between 2007 and 2008 alone, the Health Protection Agency (HPA) reported a 0.5% increase in the number of diagnosed STIs, with a total of 399,738 new cases reported in 2008[21].

Changing people's behaviour to achieve improved health outcomes is an extremely difficult business that involves a multitude of conflicting considerations. This includes reconciling important arguments pertaining to civil liberties and the "nanny state", and in addition poses a significant challenge for primary care. It is therefore logical to consider increasing the financial incentives for achieving better management of such intermediate clinical outcome measures and societal imperatives.

It is also important to consider raising the thresholds for the achievement of quality targets to ensure practices that provide the very best care are rewarded appropriately and proportionately. There are examples of practices that have implemented innovative schemes to target public health, with support from their primary care organisations (see **Box 2**). It is this type of innovative and creative thinking that should be encouraged and, where appropriate, held up examples of best practice across the NHS.

Box 2: The QOF Plus Scheme - Hammersmith and Fulham PCT

An example is the QOF Plus scheme in Hammersmith and Fulham PCT, which has incentivised reductions in smoking and alcohol misuse, and other areas such as cardiovascular disease prevention. Building on the success of the pay-for-performance model introduced through the national QOF, practices are rewarded with QOF Plus points for the achievement of higher thresholds for a selected number of existing national QOF indicators. These indicators were chosen as attainment would result in significant health benefits particularly in areas of Hammersmith and Fulham that are currently underperforming.

The consequences of obesity undoubtedly have a major impact on primary care. Successful management of obesity within primary care would, in the longer term, significantly reduce hospital admission rates — the costs of which are likely to be much more directly borne by primary care under current arrangements for Practice Based Commissioning (PBC).

GPs are among the only healthcare professionals who regularly see obese patients before they develop complications. Yet under the current system, the QOF is not being used effectively to incentivise GPs. Although there was a recent addition of 8 points within the QOF for setting up an obesity register, in reality this is likely to have a limited impact in dealing with the patient's underlying condition and improving long-term outcomes. It is from this premise that the framework requires urgent revision and attendant reform.

In addition, despite concerns raised by obesity experts, the QOF continues to target obesity as measured by BMI rather than abdominal circumference or the waist-hip ratio. A study by the European Heart Journal claimed that BMI was a "poor index to diagnose obesity" in patients with coronary artery disease[22]. Waist circumference should be used alongside BMI in drawing up obesity registers for quality points. Furthermore, whilst evidence for the effectiveness of short interventions in primary care in tackling obesity is limited, it is crucial that the government looks into how the QOF can be expanded to better tackle obesity. One possibility is that GPs could be allocated points for referring patients to weight management services or exercise schemes in their local area (see **Box 3**).

Box 3: Slimming World - Slimming on Referral

Slimming World pioneered "Slimming on Referral" in 2000 with a study set up in collaboration with Southern Derbyshire Health Authority to investigate the practicality and feasibility of running schemes enabling health professionals to refer patients into a local Slimming World group. This included feedback of patients' weight loss data. The study proved to be very effective in terms of weight loss success; improvements in general well-being of patients; and the overall practicality of the scheme.

Following the success of this initial trial, Slimming on Referral has been launched as a nationwide scheme. A database programme has been implemented to record weight loss and attendance information of referred members. Schemes will again operate with the use of vouchers enabling attendance and weight loss information to be easily logged within usual administration procedures and fed back to a member's GP on completion of their slimming course. Slimming on Referral is offered to primary and secondary care at a reduced cost of £44.50 for an initial 12 weeks of membership and attendance. 12-week continuation packs are also available at a reduced cost of £39.50 for patients who wish to continue after completing the initial 12 week course. Schemes can be set up to run in accordance with the requirements of individual health care teams to ensure efficient running of the scheme and coordinated monitoring of progress.

Although the Darzi Review positively set out plans to overhaul the QOF so as to place a greater emphasis on health promotion activity, the framework needs to evolve more quickly to better reflect the need for interventions around prevention in order to properly encompass general public health and wellbeing. A revised framework would help patients to achieve key public health targets, such as weight loss, smoking cessation and reduced alcohol consumption. The proportion of the framework devoted to public health is set to increase from 5% to 15%[23].

Despite this being a welcome development, and it has to be acknowledged that there are a number of practical difficulties in measuring and rewarding improvements in public health, the government should urgently review this proportion to see whether an even greater proportion of the framework can be geared towards prevention and public health. Even if the proportion can only be slightly increased this would help to potentially shape a culture that is more consciously focused on prevention rather than the traditional and prevailing model of reactive/curative healthcare.

The important work that the Rt. Hon. Iain Duncan Smith MP has undertaken at the Centre for Social Justice has highlighted the role of alcohol in blighting many of Britain's deprived communities. Alcohol dependence is common in the UK, affecting an estimated one in 13 people[24]. Primary care is an ideal setting in which to offer brief interventions as 20% of patients presenting to primary care are likely to be hazardous or harmful drinkers. This means on average each GP will see 364 excessive drinkers a year and therefore provides considerable scope for tackling the problems of alcoholism and binge drinking[25].

NHS Employers and the GPC have agreed changes to the GMS contract for 2009/10. One of these changes – cardiovascular disease in people diagnosed with high blood pressure – awards points for giving advice on safe alcohol consumption. However, this has taken a long time to be implemented and is only a tentative step in the right direction. We urgently call on the government for alcohol abuse and consumption to be firmly embedded in the QOF framework, and to form part of a wider preventative healthcare strategy throughout primary care.

8. Gender Focus

One area where there is a significant level of inequality in primary care is gender. This is illustrated by the following examples:

- The mortality rate for coronary heart disease is much higher in men than women.
- The proportion of men and women who are obese is roughly the same, although women are much more likely to take part in private sector weight

loss programmes and are more likely to be treated for being overweight in primary care.

- Women are more likely to report, consult for and be diagnosed with depression and anxiety despite these being “unisex” conditions which are not gender-specific.

Whilst it is likely that there are several reasons for these inequalities (e.g. men are more reluctant to visit their GP) it is clear that the QOF can play an important role in alleviating this inequality and incentivising GP behaviour to prioritise these inequalities.

The QOF in many respects is favourably placed to offer the dynamic mechanism to address these gender inequities yet it is currently too rigid to make a real difference. The government should therefore explore the possibility of awarding some QOF points on the basis of gender equitable distribution. In the first instance, we recommend that any such initiative be piloted in a small number of practices to assess the feasibility and desirability of this proposed change. If implemented in the right way, a greater focus on gender could make primary care more effective. One specific example is that the points awarded for recording the BMI of patients with diabetes could be revised taking into consideration the levels of men and women who have diabetes.

One other possibility of exploring the gender inequality is by piloting a test of 'gender-equitable distribution' for the quality framework to make sure disease registers reflect the proportion of men and women with each condition. This audit could be applied to any QOF indicators where there is evidence that there are gender imbalances that need to be addressed.

9. More Joined Up Working

In order to improve the way the QOF works, there is a need for greater joined up working with local communities. QOF data needs to be revised to give sufficient incentives for health promotion and to ensure PCTs, healthcare providers, local government and local government services provide joined up health and wellbeing services. This is central to improving patient care and service provision.

It is therefore important that QOF reports are made accessible to the public. Early patient access to services (health promotion, screening and treatment) and quicker referral to hospital as appropriate must be the lifeblood of the NHS – particularly for those population groups that have limited access to healthcare services – and should be the subject of incentivisation and performance assessment. While PCTs should be encouraged to closely monitor QOF performance at practice level, QOF

analysis alone cannot give a comprehensive assessment of the appropriateness and efficiency of treatment care pathways. In future, mechanisms within the health service such as the QOF, PBC and Payment by Results (PbR) need to work together, to produce an integrated system for monitoring and rewarding quality across the entire network of care provision.

10. Conditions Not in the QOF

Since the introduction of the QOF, a major and recurring concern has been the real impact on those conditions currently not included within the existing framework. Indeed, there are many aspects of healthcare provision within general practice that are presently excluded from the QOF.

Over recent years excluded conditions have generally shown far less improvement compared with other conditions contained within QOF targets. For example, approximately 3 million people in the UK suffer from osteoporosis, with over 230,000 fractures resulting every year[26]. Yet despite this high incidence, the condition is not included within the QOF and this has likely led to osteoporosis not being treated as a priority within primary care. This is backed up by the available statistics.

Only a small minority of fracture patients have been tested for osteoporosis and as a result are on treatment to maintain and increase their bone density. As a direct consequence, evidence from primary care studies has shown that amongst women with a past history of fracture only 5% have undergone a bone density scan and less than 10% have received treatment for secondary fracture prevention[27].

The absence of any musculoskeletal conditions from the present QOF has also led to results from a survey showing that two thirds of respondents thought that the omission of arthritis from the QOF was either worsening or making no impact on the services available to arthritis sufferers[28]. For a condition like arthritis where primary care represents a crucial time for diagnosing and treating arthritis there is an untapped potential for primary care to prevent conditions developing.

11. Health Inequalities

"When health inequalities are wider than they were in Victorian times, it's clear we need change."[29] **Rt. Hon. David Cameron MP**, Leader of the Conservative Party, May 11th 2009.

Over the last 150 years there has been a major improvement in the health of the nation. Yet, despite these huge improvements, there remain marked differences in the health of different socio-economic groups. Such health inequalities present in many different ways and for many different reasons, but one important statistical

measure is life expectancy. Findings show that the higher an individual's socio-economic group, the longer he or she is likely to live.

Indeed, there are striking differences between rich and poor areas. For example, in 2006 a girl born in Kensington and Chelsea had a life expectancy of 87.8 years compared with 77.1 years for a female born in Glasgow City, which has the lowest life expectancy in the UK. Recent government figures released by the DH show that between 2006 and 2008 life expectancy reached its highest level on record: 77.7 years for men and 81.9 years for women. Yet in the poorest parts of the country – districts known as the "spearhead group"[X] – life expectancy was 75.8 years for men (almost two years less than the average) and 80.4 years for women.

This disparity has been evidenced across different disease areas. As **Diabetes UK** told us *"...it is known that deprivation is strongly associated with higher levels of obesity, physical inactivity, unhealthy diet, smoking and poor blood pressure control. All these factors are inextricably linked to the risk of diabetes or the risk of developing serious complications for those already diagnosed."*[30]

Over recent years, governments of both colours have failed to reduce the gap in life expectancy between rich and poor. .Although people across the board are living longer, government figures reveal that the improvement has been much more dramatic among those living in wealthier areas. Under **Labour**, this gap has got wider with the life expectancy between the spearhead group and the average districts considerably wider compared to 1997. For males the gap is now 7% wider than it was 1997[31]. The problem has doubled in one year: last year the gap was 4% wider than 1997. For women the gap is now a massive 14% wider, compared to 11 per cent last year[32]. It means they are very unlikely to meet their target of reducing the gap by at least 10% by next year.

Based on the NHS Plan, a core objective of the QOF is to reduce health inequalities across the UK. However, so far results have been at best mixed and at worst disappointing. The relationship between the QOF and health inequalities is complex. Current results are conflicting with some studies showing an association between poorer QOF performance and higher levels of deprivation, whilst other evidence does not show such a clear link. It should also be noted that the number of QOF points can also be adversely affected by other characteristics of the practice, patients, the practitioner and the local area.

[X] The spearhead group consists of the 70 local authority areas in the bottom fifth nationally for life expectancy.

However, there is some encouraging research evidence at both practice and individual level. For example in some areas the QOF has contributed to reductions in inequalities in management of people with chronic diseases. There were small differences in QOF performance between practices working in deprived and affluent areas in the first year of the contract, but these differences seemed to narrow in the second year. Studies using individual patient data have also suggested that there were marked age, gender and ethnic group inequalities in the quality of care being delivered before the introduction of the QOF.

Nonetheless, it has been considered that the improvement performance of GPs in deprived areas was actually a fortuitous side effect of the QOF and that the QOF had not been designed effectively enough to address health inequalities. QOF scores do show that socially deprived areas receive a lower quality of primary care and that social deprivation is an independent predictor of lower quality. There is also evidence that the QOF has failed to make any tangible impact on reaching priority groups, which the government has identified as being seminal to reducing health inequalities.

In addition, the current payment structure of the QOF has been cited as a barrier to tackling inequalities, with payment in the clinical quality domain using an Adjusted Disease Prevalence Factor rather than true prevalence. This has penalised those practices with large numbers of patients suffering from QOF-related conditions. In some cases, this has led to two practices with the same "workload" achieving the same quality of care (defined by QOF points) getting paid drastically different amounts under the QOF if they have a different overall list size. Although the government is currently in the process of trying to amend this anomaly by making changes to the GP contract, it is perversities and flaws of this sort that badly undermine the operational integrity of the QOF.

12. New Incentives to Encourage GPs in Deprived Areas

It is clear that hitting outcome-based quality targets, whether on the clinical side or for public health, can be more difficult for some socio-economic groups relative to others. GPs working in inner-city areas may feel they have to work much harder, and invest more practice resources, to perform well against outcome-based quality targets.

This has led to a great variation in the number of GPs and registered patients in deprived areas where access to GP services is limited. For example, some areas of the country only have around 40 GPs per 100,000 eligible patients, whereas other areas have well over double this number[33]. It should be evident that addressing this disparity is fundamental to tackling health inequalities and ensuring all patients have decent access to local healthcare services.

To a certain extent, this can be addressed by ensuring that, where appropriate, payments for achieving quality targets reflect the local populations GPs serve. This is seminal to guaranteeing that those working with high risk populations are rewarded sufficiently for providing high risk care, which is in turn important for dealing with the abovementioned health inequalities. Furthermore, the revised QOF should take full account of baseline patients and the relative socio-economic circumstances of more deprived areas.

Another key issue pertains to the perverse incentives for GPs not to identify, or "case find", disadvantaged patients, and where possible to encourage people to sign up with their local practice. This is because case finding is often labour-intensive and disadvantaged patients often cost more to treat due to a higher rate of experienced co-morbidities. Furthermore, meeting any given target for treatment "quality" is often harder to achieve in high risk populations due to non-compliance issues.

Without appropriate incentives to properly case find disadvantaged patients – primarily by increasing awareness about local GP services and the desirability of signing up with a local practice – deprived areas will continue to have a relatively low uptake of life-prolonging preventive health care interventions and inadequate access to local healthcare services. It is therefore important that the QOF is reformed to contain an appropriate incentives structure to foster increased case finding across the UK.

These new incentives could take the form of a direct payment to any GP practice for each new case that is diagnosed in targeted areas where social deprivation and health inequalities are high. This could help to encourage a greater level of case finding and thereby help to prioritise the identification of patients living in disadvantaged communities.

More radically, these new incentives could also include a conditional payment to the disadvantaged individual in question to encourage compliance. However, any patient compliance incentives would require careful design and piloting given that it is easier to monitor compliance with some treatments, such as taking statins for lowering patient cholesterol, compared with than other clinical pathways, for example smoking cessation. It is also true that the areas where compliance is hardest to monitor are those areas where monitoring is most needed. Nevertheless, with creative policy some sensible pilots could be designed to test the practical value of any such initiative.

13. Devolving Power to Local Healthcare Providers

One of the central flaws of the current QOF is the setting of QOF targets at the national and central level. In a population of approximately 61 million, healthcare

needs and primary care priorities often dramatically differ from one area to another and therefore cannot be treated with a "one size fits all" approach. It is therefore implausible to believe that health experts in London can properly understand, and appropriately react to, the varying healthcare needs of different localities. It is on this precise point that the QOF falls badly short and requires fundamental reform.

For the NHS to be a genuinely patient-centred healthcare system, there needs to be a greater degree of flexibility for local commissioners and healthcare providers to select indicators that most accurately reflect local health priorities. It is from this perspective that Primary Care Trusts (PCTs) should be granted the flexibility to vary some indicators from practice to practice and we recommend that the current government, and any future government, review this policy suggestion as way of priority. Local indicators could be selected from the 'national menu' and would need to be sensitive to local needs. For example, those areas where the highest prevalence of obesity is known could potentially be applicable to trial local targets for obesity.

In order to ensure any devolution of responsibility for QOF target setting is carried out smoothly and effectively, paced reform and implementation would be all important. To this extent, we recommend that in the first instance that only around 20% of relevant indicators be devolved to PCTs with regular performance review. Any initiative along these lines could work in a similar way to Local Area Agreements (LAAs), which set out the priorities for a local area as agreed between central government and a local area (the local authority and Local Strategic Partnership) and other key partners at the local level.

Although understandable concerns have been raised that local indicators would lead to a "postcode lottery", it is also evident that central planning is an ineffective and flawed way of fostering a system that allows for the prioritisation of local healthcare imperatives. This is precisely why any devolution of responsibility for the QOF should be implemented in a paced and incremental manner. An immediate benefit of any such policy would be the facilitation of opportunities for PCTs to work more closely with local practices to pursue innovative and responsive healthcare strategies across local communities.

Furthermore, one idea worthy of further consideration is devolving more power to local communities to shape the design and evaluation of QOF indicators. As **Diabetes UK** told us: *"In order to begin to address inequalities in access to care, people from communities that are seldom heard must be included in service design so that services available are responsive to their needs"*[34]. Strengthening primary care services is a vital step in tackling persistent health inequalities. Similarly, empowering patients through greater choice and increased local decision-making is

essential if the NHS is to have any chance of optimising healthcare delivery and in turn improving long-term patient health outcomes.

14. The Impact of "Exception Reporting"

The concept of "exception reporting" was originally included in the QOF to ensure that practices, whilst pursuing the quality improvement agenda, would not be penalised for having to treat high risk populations. According to this system, when patients are exception reported from an indicator, they are not included in the calculation of a practice's achievement against that given indicator. Reasons as to why a patient might be exception reported include:

- the treatment not being clinically appropriate for a patient;
- a patient failing to turn up for treatment;
- a patient refusing to have the prescribed treatment; or
- a patient receiving a diagnosis having only recently registered with a practice.

Exception reporting applies to those indicators for which points are awarded on a sliding scale according to the level of achievement reached by the practice. The main group of indicators where exception reporting applies are clinical indicators apart from register indicators (e.g. exception reporting does not apply in Asthma 1[XI], but it does apply to all the other individual Asthma indicators).

There are currently three clinical indicator groups where exception reporting does not apply. These are obesity, learning difficulties and palliative Care. In the first two there are only the register indicators within the group so exception reporting is not applicable.

Diabetes UK expressed concern to us about the impact of exception reporting and the ability of the QOF to support the care of vulnerable populations, particularly those in residential care[35]. Concerns have been raised from other stakeholders that low-scoring practices have deliberately removed patients from disease registers and others have artificially inflated their prevalence figures to maximise financial gains. There needs to be a review of exception reporting and specifically its impact tackling the problem of health inequalities.

[XI] Asthma 1 is also known as Allergic Asthma and is is commonly seen in children. This form of asthma occurs mainly as a reaction to the allergens.

15. "Looking into the Crystal Ball" – What Should be the Future Focus of the QOF?

In this section of the report, we briefly consider where the QOF can be expanded and play a greater role. Although there are a number of areas worthy of further exploration, for the purposes of this paper we specifically consider three areas where the QOF can make a real difference in the future.

15.1 Vaccines

The introduction and expansion of vaccination programmes has been one of the most significant public health successes over the past 50 years. Immunisation is one of the best instruments to reduce health inequalities as, when provided to all citizens, it is an extremely effective and non-discriminative form of public health.

However, the success of the UK's vaccination programme is dependent on the consistent and sustained funding of vaccines and ensuring that there are high coverage rates. Although coverage rates have improved, some children are still not routinely vaccinated against diseases such as measles and whooping cough. Indeed, in 2006 sporadic outbreaks of measles occurred in the UK resulting in the first death from measles in 14 years from related complications.

The public's awareness of the importance of vaccination needs to be raised, particularly amongst parents with young children. The value of vaccines should also be raised amongst other, if not all, sectors of society. This is not least the case as populations become ever more dynamic and peripatetic, with immigration and global travel increasing the speed with which people in the UK are exposed to illness and disease.

It is from this premise that the current and future value of vaccines in helping to tackle healthcare inequalities and buttress any meaningful attempt to positively promote improved public health is significant, and it is arguable that the QOF could play a central role in raising general vaccine awareness. Given Labour's rosy rhetoric on public health and the Conservative Party's substantive commitment to a holistic and coordinated public health strategy, it logically follows that any government should want, and indeed need, to place vaccination at the heart of a serious public health reform programme.

We therefore recommend that the government consider incorporating immunisation into the QOF even if this is for functional imperatives such as checking whether patients have received standard vaccinations. This would help to give GPs the incentives to ensure patients are immunised against serious diseases and, where appropriate, earmarked for booster vaccines.

15.2 Pharmacy

The QOF provides a unique opportunity to support primary care organisations to work more closely and thereby encourage a vibrant primary care market that addresses the health needs of local communities. The role of pharmacy has changed rapidly in recent years and many pharmacists now operate on the frontline of the NHS.

Increasingly, pharmacists are taking on responsibility for a range of activities which may have traditionally been handled by GPs. This gives pharmacists significant scope to advise patients on important personal health issues and priorities. One common example relates to smoking. Given their considerable direct contact with the public, pharmacists can potentially play a significant role in helping patients stop smoking and offer invaluable expert advice on areas such as personal and public health. In a constantly changing primary care landscape, it will be important that the QOF evolves to involve those professions that are increasingly acquiring or supporting the functions of the traditional GP.

By aligning the QOF, GPs should be incentivised to work more closely with pharmacists and local pharmacies, and vice versa. The QOF scores of various healthcare professionals should be aligned gradually to allow for greater joint working. Setting the framework at the right level may take some time and it has to be acknowledged that there are potentially a number of barriers to overcome.

These barriers include the need to set a regime where it is possible to demonstrate that pharmacists were responsible for specific patient outcomes alongside the impact of the care provided by other healthcare providers. However, if the correct balance could be struck, it is clear that there is great potential for dynamic collaboration between GPs and pharmacists, which if implemented properly should lead to enhanced healthcare delivery and a concomitant improvement in patient health outcomes.

15.3 Pain

There are currently 7.8 million people who live with chronic pain in the UK[XII] [36]. Research shows that 40% of people living with chronic pain are not satisfied with the treatment they are offered[37].

[XII] Chronic pain is defined as a pain that persists beyond the normal time of healing (generally considered to be three months) or occurs in diseases in which healing does not take place.

Despite its prevalence, chronic pain remains one of the most untreated and poorly understood conditions in primary care. The majority of chronic pain is managed in primary care. Chronic pain is a personal experience and given that GPs are generally taught to diagnose conditions rather than symptoms, it is sometimes difficult for them to accurately diagnose a condition such as chronic pain. Pain services have traditionally been seen as a 'Cinderella service' only to be tried when everything else has failed. However, chronic pain is a serious condition and the QOF should be used to ensure it receives the attention it deserves.

There is currently a lack of effectively coordinated services designed to deal with pain management and the QOF could be used to make a real difference in this area. In future, consideration should be given to the inclusion of the assessment of pain and its associated disability in the QOF. If a pain indicator was incorporated into QOF, it would provide an incentive for GPs to ask a patient about their pain, treat it promptly, and reassess the patient's condition to ensure that the prescribed treatment is effective. This should help to improve the diagnosis and treatment of pain conditions across the NHS.

16. Concluding Thoughts

A key consideration for policymakers moving forward should be to look at how the QOF can be improved and reformed to better achieve its stated objectives. Given the increased importance of primary care – and the need to provide GPs with appropriate incentives and direction to focus on prevailing healthcare priorities – it is difficult to doubt the virtue and desirability of having a framework that seeks to foster enhanced quality and associated health outcomes. This is particularly the case when working from the premise that there is a need for the NHS to become more patient-centric and to focus more on improving service deliverability.

The problems and shortcomings currently informing the QOF are not so much a consequence of its philosophical purpose, but rather the practical elements determining its operational functioning. There is something perverse about a framework that claims to be about ***quality*** and ***outcomes*** yet is so operationally geared towards emphasising process and targets. Although this is pungently redolent of the **Labour** government's failed approach to wider health policy – namely layering the health service with levels of bureaucratic reporting, process-driven targets and administrative performance management – it is particularly totemic of the disintegration of the NHS Plan. It is against this backdrop that the QOF represents something of a missed opportunity and is now in need of reform to revamp its mission statement and to ensure its natural focus is *less about* process and absolute activity and *more about* patient needs and health outcomes.

With the general election looming, the NHS is bound to feature prominently across the election campaign. This has been exemplified by the **Conservative Party's** recent launch of its NHS Draft Manifesto and the publication of its Green Paper on public health. More than that, it is guaranteed given that the NHS is David Cameron's number one priority – a priority that the Leader of the Opposition has so personally, and almost emotionally, committed himself to over the last 3 years or so.

Whoever forms the next government – and it is our preference for this to be **blue** rather than **red** and preferably without any potential shade of **yellow** – the interlinking issues of how to improve patient health outcomes; enhance NHS service deliverability; and safeguard the significant investment earmarked for the health service will be as challenging and important as ever before. Public expectations in relation to the NHS have acutely sharpened and beyond that there is a growing societal need for better healthcare delivery as the population ages and service demands increase.

Although the QOF in itself is not a vote-winner and is unlikely to register on the public's political radar, it is important as way of policymaking priority for facilitating the results the public wants to see. Indeed, there is an understandable public demand for improved quality, better patient health outcomes and "more bang for our buck" from a health service that has received such weighty public investment and been subjected to so many reconfigurations. Primary care and GP activity are particularly seminal in this regard. Furthermore, if any future government is genuinely serious about public health and moving the NHS away from its current model of curative/reactive healthcare to preventative healthcare model, then reforming the QOF to align with this philosophical aspiration and practical imperative is central to any credible attempt at achieving long-term policy success.

As the **Conservatives** have correctly said, the QOF needs to be "unpicked". They have been less clear on how it would be restitched. Although we make no claim that this paper constitutes the fully stocked haberdashery store, we believe it contains some of the key sewing notions and small wares to truly place quality and outcomes at the heart of the QOF. Let outcomes, a greater emphasis on public health, and more integrated working be the future of the QOF. By doing so, the QOF's own value and future might just be restored.

17. Summary of Key Findings and Recommendations

1) Outcomes over Process

- Whilst the QOF has been a relative success in supporting the drive to increase standard of care, there is strong evidence that standards have **tailed off** in recent years.

- Currently, **"process" indicators**, which are essentially based around activity indices, reward practices for carrying out tasks such as blood pressure checks, whilst **"outcome" measures** such as assessing the optimal control of blood pressure are **not** routinely part of the QOF

- In order to drive up standards, there is an urgent need for a greater focusing on **outcomes indicators over process**.

- Incentives such as checking blood pressure and cholesterol in older patients should be cut from the QOF because these tests do not predict the risk of death from heart disease and should be replaced with **outcomes-orientated targets**.

- Instead of rewarding GPs for recording smoking rates, the QOF should be incentivising GP activity around **monitoring** and **promoting** smoking cessation rates.

- There is a clear problem that many **process indicators** often **duplicate** a matched indicator covering a concomitant outcome. More needs to be done to ensure that the QOF system is not unnecessarily paying out and rewarding healthcare professionals against the basic principles of the system.

- Whilst constant chopping and changing will inevitably make life more difficult for GPs, it is essential that NICE keeps the QOF under **careful and constant review** to ensure the framework continues to evolve.

2) Greater Focus on Prevention and Public Health

- The UK is facing a **public health crisis** with soaring rates of obesity, drink problems and STIs.

- Dealing with this crisis is central to any meaningful attempt to ensure the NHS moves away from the currently **reactive/curative healthcare model** to a system of **genuine prevention**.

- Although there was a recent addition of 8 points within the QOF for setting up an obesity register, in reality this is likely to have a limited impact in dealing with the patient's underlying condition and improving long-term outcomes. It is from this premise that the framework requires urgent revision and attendant reform.

- Despite concerns raised by obesity experts, the QOF continues to target obesity as measured by BMI rather than **abdominal circumference** or the **waist-hip ratio**. Waist circumference should be used alongside BMI in drawing up obesity registers for quality points.

- Whilst there are a number of practical difficulties in measuring and rewarding improvements in public health, the government should **urgently review** the proportion of the framework which is geared towards prevention and public health.

- We urgently call on the government for **alcohol abuse and consumption** to be firmly **embedded** in the QOF, and to form part of a **wider preventative healthcare strategy** throughout primary care.

3) Gender Focus

- There is currently a significant level of **gender inequality** in primary care.

- The government should therefore explore the possibility of awarding some QOF points on the basis of **gender equitable distribution**.

4) More Joined Up Working

- In order to improve the way the QOF works, there is a need for greater **joined up working** with local communities.

- We recommend that QOF reports are made **accessible to the public**.

- However, there are limitations with QOF so other mechanisms within the health service such as PBC and PbR need to work together to produce an **integrated system** for monitoring and rewarding quality across the entire network of care provision.

5) Conditions Not in the QOF

- Since the introduction of the QOF, a major and recurring concern has been the real impact on those **conditions currently not included** within the existing framework.

- The absence of any **musculoskeletal conditions** from the present QOF is a particular problem and should be reviewed.

6) Health Inequalities

- Whilst over recent years there has been a major improvement in the health of the nation, this improvement has been much more dramatic among those living in **wealthier areas**.

- Overall, the QOF's performance in reducing health inequalities has been at best **mixed** and at worst **disappointing**.

- The current payment structure of the QOF has been cited as a **barrier to tackling inequalities**, with payment in the clinical quality domain using an Adjusted Disease Prevalence Factor rather than true prevalence.

7) New Incentives to Encourage GPs in Deprived Areas

- Under the QOF, GPs working in inner-city areas may feel they have to work much harder, and invest more practice resources, to perform well against outcome-based quality targets.
- Due to **case finding** being labour-intensive, and disadvantaged patients often costing more to treat due to a higher rate of experienced co-morbidities, there are incentives for GPs not to identify, or "case find", disadvantaged patients.
- It is important that the QOF is reformed to contain an **appropriate incentives structure** to foster increased case finding across the UK.
- New incentives could also include a **conditional payment** to the disadvantaged individual in question to encourage compliance.

8) Devolving Power to Local Healthcare Providers

- One of the central flaws of the current QOF is the setting of QOF targets at the **national and central level**.
- It is implausible to believe that civil servants in Whitehall can properly understand, and appropriately react to, the varying healthcare needs of **different localities**.
- For the NHS to be a genuinely **patient-centred healthcare system**, there needs to be a greater degree of flexibility for local commissioners and healthcare providers.
- It is from this perspective that PCTs should be granted the **flexibility** to vary some indicators from practice to practice and we recommend that the current government, and any future government, review this policy suggestion as way of priority.
- We recommend that in the first instance that only around 20% of relevant indicators be **devolved to PCTs** with regular performance review.
- Furthermore, one idea worthy of further consideration is devolving more power to local communities to shape the **design and evaluation** of QOF indicators.

9) The Impact of "Exception Reporting"

- Concerns have been raised that **low-scoring practices** have deliberately removed patients from disease registers and others have artificially inflated their prevalence figures to maximise financial gains
- There needs to be a **review of exception reporting** and specifically its impact tackling the problem of health inequalities.

10) Looking into the Crystal Ball" – What Should be the Future Focus of the QOF?

- We recommend that **vaccines**, **pharmacy** and **pain** are immediately considered for inclusion in a renewed and revamped QOF.
- For the NHS and primary care services to be **properly joined up** – and to ensure that some services and disease areas are not "left behind" – it is important that the QOF represents an **inclusive framework** and provides appropriate incentives to encourage healthcare professionals to emphasise currently overlooked and excluded areas of **healthcare delivery**.

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9. All other anonymous participants.

Further Information

For further information on this policy paper and the Bow Group Health Policy Committee, please contact **Stuart Carroll** (Chair of the Health Policy Committee) on health.policy@thebowgroup.org.

Appendix A – Glossary of Technical Terms

Body Mass Index (BMI) – A statistical measurement which compares a person's weight and height.

British Medical Association (BMA) – A professional association that represents UK doctors and acts as an independent trade union, scientific and educational body, and publisher.

General Medical Services (GMS) contract – A UK-wide contract between general practices and primary care organisations, to deliver primary care services to their local communities.

General Practitioner (GP) – A medical practitioner who provides primary care and specialises in family medicine.

General Practitioners Committee (GPC) – The National Committee which represents all GPs.

Local Area Agreements (LAAs) – Agreements that set out the priorities for a local area agreed between central government and a local area, and other key partners at the local level.

National Institute for Health and Clinical Excellence (NICE) – The independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

NHS Employers – An organisation which represents trusts in England on workforce issues including pay and negotiations.

NHS Plan – Strategy published in July 2000 by the Labour Government which set out its future vision for the NHS.

Payment by Results (PbR) – A system of reimbursement for NHS providers that uses a standard national price or "tariff" for each individual episode of treatment provided .

Practice Based Commissioning (PBC) – A policy introduced by the Labour government which devolves responsibility for commissioning services from Primary Care Trusts (PCTs) to local GP practices.

Primary Care – The collective term for all services that constitute a patient's first point of contact with the NHS, e.g. GPs and dentists.

Primary Care Trusts (PCTs) – An organisation that provides some primary and community services or commissions services from other providers. PCTs are also involved in commissioning secondary care.

Appendix B – Generic Interview Guide

It should be noted that variations to the standard interview guide were made as and when appropriate.

1. How effective do you feel that the QOF has been in improving the quality and distribution of GP services to reduce health inequalities?

2. Do you feel that there are any areas that the QOF could be improved to help reduce health inequalities?

3. Do you feel that the introduction of the QOF has led to a decline in the caring aspects of the general practitioner's work?

4. Do you feel that the QOF has a clear enough focus on outcomes?

5. If not, do you feel there are any ways that the QOF could be reformed to increase the focus on outcomes?

6. Generally do you feel there are any changes that could be made to improve the QOF?

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