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Sheffield Local Medical Committee
Response to the Department of Health Consultation
Developing the Quality and Outcomes Framework:
Proposals for a New, Independent Process

Aims and objectives of the new process

Q1: Do you agree with the proposed aims of the new process? If not are there any other important aspects that should be considered?

There is only one stated aim (not plural). It is vague. Improvement in quality is always the aim of doctors working for patients. It is therefore natural that the QOF should reflect that fact. It would be interesting to know how the stated objectives will support realisation of the aims. For example, it is not necessarily true that all stakeholders in QOF (which is a contractual arrangement between GPs and the NHS) will be able to alter QOF to make it better. Lastly, there is no mention of other contractual arrangements available eg DES and LES arrangements.

Q2: Do you consider that the new process will help to address health inequalities? What do you consider that the impact on equality is likely to be?

The poorest in any society have a disproportionately high share of the poor health of that society. All health care systems have to deal with this environment. More interesting is dealing with underlying causes of the health inequalities in the first place. It is difficult to justify, with solid evidence, any claim that a health care system can achieve this. Experience of QOF to date shows (contrary to the statement by the Minister in the introduction of the consultation document) that "increase in [QOF] achievement…was not associated with area deprivation" [Doran T et al, Lancet 2008; 372].

Scope of the new process

Q3: Do you agree that the scope of the new process should cover clinical and health improvement indicators in the QOF, excluding indicators relating to influenza vaccination? This scope would cover indicators in the Clinical Domain of the QOF (apart from CHD 12, STROKE 10, DM 18, COPD 8), indicators in the Additional Services Domain and the following indicators in the QOF Organisational Domain: Records 11, 17 and 23.

Whilst recognising that ideally any evidence based intervention that could improve quality should be included in routine practice whenever possible, it must also be recognised that a contractual incentivisation arrangement such as QOF will necessarily distort clinical priorities. Exclusion of any indicator from a contractual arrangement will therefore lead to much less emphasis on that indicator in practice. Influenza vaccination is of proven benefit to at risk individuals. It will be put at jeopardy if removed from QOF. The inclusion of "customer satisfaction" in QOF produces a tension with the quality agenda. For example, telling a patient to lose weight, drink less or stop smoking may not rate highly on a customer satisfaction score, but brief interventions by GPs have been shown to be effective in all these areas.

Key elements of the new process

Q4. Do you agree with the proposed key elements of the new process and the proposed content of NICE advice?

There are numerous potential problems here.

- NICE Primary Care Panel is a government body, and its independence will be essential, with potential risk of conflicts of interests.
- The constituents of this panel will therefore be crucial.
- Existing indicators are not incentives; they are rewards for work done. This appears to be a mistaken interpretation of the current contract.
- The external contractor bidding to provide a pilot for the indicators does not sound like a normal practice, so its findings are not likely to be widely applicable.

Review of existing indicators

Q5: Do you agree with the proposed approach to reviewing existing indicators?

No (see answer to Q4). There seems to be a fundamental misinterpretation of the purpose of QOF here. The extra work being done under QOF is consuming extra resource, and this consumption of resource will not go away just because this work becomes part of normal practice. It would be better for QOF to expand. As the scheme is voluntary, practices could then choose to direct their effort in the way that best serves the need of their patients.

Prioritisation

Q6: Do you agree with the proposal to retain the principles for QOF indicators in the General Medical Services Statement of Financial Entitlements set out in Annex C?

This seems reasonable, but it should be noted that plenty of existing QOF indicators are not based on best evidence, and never were. Examples include cholesterol levels of 5 and blood pressure levels.

Q7: Do you agree with the draft criteria for prioritising new areas for indicator development attached at Annex D or do you have changes to suggest?

Proposed further criteria:

- What will be the likely burden on practices, and what resources will they require to overcome that burden?
- What reward is indicated for a practice taking on extra work and assuming additional responsibility?
- What additional insurance might practitioners need if taking on new areas of expertise?
- Relating to all criteria, which criteria will be given the most weighting, and which the least?

Methodology for assessing cost effectiveness

Q8: Do you agree with the principles proposed for assessing the cost effectiveness of QOF indicators? If not, what changes would you suggest?

The equation presented in Annex D is not acceptable. The suggestion that QOF work is to be subsumed into GMS presumably means that the QOF resource would be added to the GMS resource. If this is not to happen, practices will have to consider the following courses of action:

- Do not take up new QOF work
- Stop current activity in order to take up new QOF
- Deliver current QOF and GMS with lower grade staff at every opportunity
- Reduce profits, or seek other income streams, eg private work, in the same way that dentists have.

Commissioning of indicators

Q9: Do you agree with the proposals for the scope of the advice that NICE would publish to inform subsequent decisions on choice of indicators, thresholds and payment levels?

In addition to the indicators proposed, it would also be useful to know which indicators were considered and rejected, and the reasons why.

Frequency of QOF review and output

Q10: Do you agree with the proposals for the frequency of QOF reviews and the estimated output in terms of existing indicators reviewed and new indicators developed for the national menu?

No comment.

Transition to the new system

Q11: Do you agree with the proposals for transition to the new system?

The timetable seems less important than the substance of the proposal. Why publish proposals for the next year's contract in August, in the height of the holiday season?

Local flexibility

Q12: What are your views on the idea of reserving a proportion of nationally agreed QOF investment to enable PCTs and GP practices to agree local indicators selected from a national menu of approved indicators? Do you have any other suggestions for developing local QOFs or comparable local incentive schemes?

All QOFs distort clinical priorities. It is a question of which distortion is preferable – local sensitivity or postcode lottery.

Q13: Do you have any views on the balance between the proportion of QOF that should be determined nationally and the proportion that could be left for local decision-making?

No. QOF should be delivered locally, but alternative contractual arrangements could be used, eg LES, PBC initiatives etc. QOF should be benchmarked against national standards.

Q14: Do you have comments on the type and degree of national IM&T support that PCTs would need for extraction of data, analysis of achievement and calculation of payments to implement local QOFs or comparable local incentive schemes?

IM&T is just one part of a very cumbersome and bureaucratic system, all of which is likely to consume a lot of resource.

DR T MOORHEAD
Vice Chair