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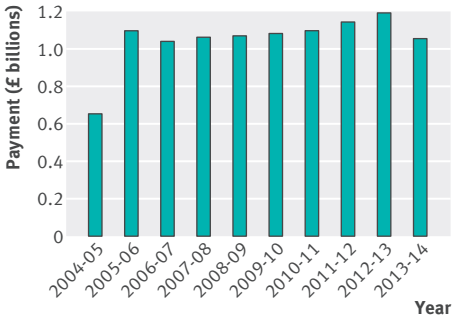
Person centred coordinated care: where does the QOF point us?

Martin McShane and **Edward Mitchell** question the validity of the Quality and Outcomes Framework and suggest how it should change in the future

The Quality and Outcomes Framework (QOF) is a pay for performance programme that was introduced in 2004 to improve care in general practice. It now constitutes roughly 13% of practice income—QOF payments in 2013-14 were £1057m (€1451m; $1613m) (figure).[1] The arguments for and against the QOF (and pay for performance schemes in general) have been hotly debated over the past decade. Its seminal impact on UK general practice is undeniable, but its influence is such that it has affected our idea of what constitutes quality improvement. It has been suggested, for example, that we equate (or perhaps conflate) good care with the recording of disease specific biomedical or process markers.[2]

The QOF is facing change. The 2014-15 GP contract deal has seen a 30% reduction in QOF points.[3] After eleven years, and billions of pounds in QOF payments, we take stock of the QOF and discuss three changes in the healthcare system that mean QOF must change.



QOF payments per year. Source: Health and Social Care Information Centre

Measuring success

The degree to which these performance gains represent real changes in care, improved recording of indicators, or better health outcomes has been questioned.[8 9] Although the difference in performance on the QOF between least and most deprived GP practices has narrowed considerably, no evidence shows that this has led to a reduction in health inequalities.[10] Evidence for the overall success of the QOF is limited due to the lack of a control group and because any effect will be small and hidden among many other determinants of population health.[11]

Whether it has been cost effective is even harder to prove, given the inherently speculative estimation of the "opportunity costs" of spending the money in other ways. Some indicators do seem to have a low cost per quality adjusted life year, such as the percentage of patients with coronary heart disease on beta-blocking agents.[12] But paying large sums of money for progressively smaller improvements in indicators is unsustainable.[13] Thus either payment should be reduced or indicators should be withdrawn.

The QOF is the equivalent of a clinical trial with only one arm—the patient has improved, but we don't know whether this was due to the "treatment." We think there is sufficient equipoise to question the value of QOF. There have been three major changes in the healthcare system that mean it must be modified—changes in our conception of quality care, changes in the patients we treat, and changes in the data available.

Evolving conceptions of quality

The medical model, until recently, has focused on single diseases, which were often communicable and fatal and had a straightforward relation between treatment and outcome. The QOF makes the assumption that the same relation exists for long term conditions and frequently incentivises the measurement and treatment of proxy physiological parameters, such as the concentrations of glycosylated haemoglobin or lipids in the blood.

But such assumptions are increasingly being challenged—for example, in the debates about whether proxy measures truly reflect outcomes, including the increasing "statinisation" of the population.[14 15] We need to move from structural and process measures, such as lipid concentrations, number of beds, or waiting times, towards health outcome measures, such as mortality, or patient reported outcome measures, such as symptom relief or quality of life. Measuring and incentivising these outcomes cannot be achieved through a pay for performance system that resides only in primary care (which, in the UK, receives approximately 10% of healthcare funding) in isolation from other elements of the healthcare system (which receive the other 90%).

KEY MESSAGES

- The QOF incentivises process measures, but there is a need to focus incentives and clinical care on the health outcomes that people want to achieve
- An ageing and increasingly comorbid population, evolving conceptions of quality in healthcare, and developments in data use mean that the QOF is no longer fit for purpose
- Process measures should still be reported, when useful, but should be considered part of good clinical care rather than driven by financial incentives
- To contribute to the goal of person centred coordinated care, any financial incentives should be designed to align across primary, secondary, and tertiary care, as well as with the wider health and social care sectors

Evolving people and healthcare requirements

The emergence of an ageing population that requires integrated health and social care means that neither primary care alone nor the entire healthcare sector will be able to achieve the health outcomes we want.

The number of people with three or more long term conditions is set to increase from 1.9 million to 2.9 million by 2018, and this will be associated with an extra cost of £5bn a year.[16] Following guidelines, a 70 year old woman with three chronic long term conditions and two risk factors would be prescribed 19 different doses of 12 different drugs at five different times of the day.[17] Clearly we need to be increasingly judicious in the application of modern medicine, lest we replace the burden of chronic disease with the burden of diagnosis and treatment. The best way of doing this is not to presume what people want from their care (for example, low cholesterol) but instead to ask them what is important to them and to arrange their care around those things—that is, to deliver "person centred coordinated care."[18]

The BMJ's recent roundtable debate concluded that measuring and incentivising person centred care, as defined by patients, will have a key role in delivering what's important to patients in the future.[19] Such incentives would enable self care, "patient activation," and coordination of care, and would encourage "more than medicine" support for people.[20]

Primary care will have to adopt different tactics to deliver good care for an ageing, comorbid population, involving a generalist in a care coordination role, who provides informational, relational, and management continuity for patients navigating an increasingly complex health and social care system.[21] Perhaps surprisingly, this may not require development of new processes—as Angela Coulter said in *The BMJ*'s debate, "We've got measures to determine if person centred care is delivered. We just need to use them." Such measures must be used sensitively, away from the consultation room, unless they form part of the good clinical care that patients have a right to expect from their doctors. By becoming a technocratic, process driven exercise, consultations influenced by the QOF have been accused of contributing to the distortion of evidence based medicine.[22]

Primary care will have to adopt different tactics to deliver good care for an ageing, comorbid population

The system we have described would look very different from the QOF. It would consist of nationally agreed quality process indicators linked with patient reported outcome measures and quality of life measures that span the health and social care systems. Eventually other systems and sectors could be incorporated, such as education, employment, local community, and arts and leisure.[23]

Collection of clinical data

A system that measures and incentivises the things that are important to patients will still, of course, be reliant on data. The quickly evolving quality and quantity of data in health and social care create an opportunity for quality improvement.

One of the great achievements of the QOF was to "kickstart" the adoption of electronic medical record systems, which led to this explosion in available data. Although pay for performance payments may have been a major impetus to start collecting computerised data, the collection and use of such data during a consultation are now routine and should be thought of as a by product of good clinical practice. Thinking about how we use the petabytes of clinically recorded data needs to move forward.

Every general practice in the country receives regular, benchmarked, prescribing data through the Electronic Prescribing and Financial Information for Practices system, without being paid. A similar approach could be applied to key clinical indicators that are captured automatically in electronic medical records, which include a wide range of information from consultations as well as hospital and community based services.

A national set of quality process indicators that would be accepted as good practice could be derived from the experience of developing QOF indicators, but they would not be financially incentivised.[24] They could incorporate or redeploy many of the currently unconnected incentives, such as enhanced services, commissioning for quality and innovation frameworks, quality premiums, and best practice tariffs. They could be extracted from electronic medical records automatically, subject to appropriate consent and information governance factors. Benchmarked and themed reports could be produced on a monthly or quarterly basis rather than on the current QOF driven annual cycle.

A three to five year schedule of incentives, aligned across health and social care, both locally and, where appropriate, nationally, would allow alignment with the NHS *Five Year Forward View*,[25] rather than incentivising a series of disconnected, organisation based programmes.

Removing financial incentives from structural or process measures has been thought to discourage GPs and other healthcare professionals from capturing the high quality data they rely on. However, data indicate that performance is generally maintained after removal of indicators from the QOF.[26] This could be due to "routinisation" of data collection or because indicators tend to be included in pay for performance schemes if they are associated with professional values and intrinsic motivation. Regular, benchmarked reporting of clinically relevant data can also be a powerful stimulus to professional behaviour and good clinical care.[27]

Pay for outcomes

Although the QOF has had a major impact on general practice in the UK, it is difficult to assess its effects on health outcomes. The changing healthcare landscape and the needs of people using services require that any pay for performance programme be based on outcomes, contribute to person centred coordinated care, span multiple care economies, and contribute to evolving models of data usage. The QOF does not satisfy these criteria. This does not mean that the capture and reporting of structural and process measures should not continue, but it does question whether they should continue to be linked to routine payment. Future incentives should be part of a coherent programme that pays for outcomes, rather than for performance. Where process measures are used (or underlie outcomes measures), they should be collected through good clinical practice rather than constitute a means to payment.

We need to initiate a debate on how to move away from paying for the capture of process data, which should be a normal part of good clinical care, and we need to create a new transparent system of incentives that will support primary care, the NHS, and the wider health and care economies to deliver person centred coordinated care.

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