Role of incentive schemes in general practice

7 March 2024

Department of Health and Social Care

This public consultation is an invitation to all stakeholders - including healthcare professionals, patient groups and the wider public - to share their views and insights on the role of incentive schemes in general practice.

The consultation can be found online here.

Background to the consultation

In England, general practices are incentivised through 2 main schemes, the:

- Quality and Outcomes Framework (QOF)
- Investment and Impact Fund (IIF)

These schemes aim to enhance healthcare delivery and patient outcomes by incentivising continuous improvement in clinical care and public health delivery. Practices that achieve the targets set in these schemes receive additional income to their core funding.

Quality and Outcomes Framework

The Quality and Outcomes Framework scheme was established in 2004 as an optional framework that general practices can choose to participate in. The 2023 to 2024 scheme consists of 76 indicators, each with a specific target for achievement.

The majority of QOF indicators were suspended in 2020 to 2021 and 2021 to 2022 due to COVID-19 and, as DHSC focused on recovering access, some indicators have become income protected in 2023 to 2024.

Impact and Investment Fund

In 2019, with the introduction of primary care networks (PCNs), DHSC implemented a similar scheme called the Investment and Impact Fund. Although it focuses on different indicators, it operates in a similar manner, providing additional income to PCNs that attain their targets.

As with QOF, the majority of IIF indicators were suspended in 2020 to 2021 and 2021 to 2022 due to COVID-19, with 2022 to 2023 being the first year that IIF has been fully implemented. In 2023 to 2024, DHSC reduced the number of indicators in IIF from 36 to 5, and re-targeted the funding to enable practices and PCNs to focus on improving patient experience of contacting their practice.

Palliative care QOF:

There is currently a QOF indicator for palliative care this is: *The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age.*

According to the Quality and Outcomes Framework guidance for 2023/24 a patient is included on the register if any of the following apply:

- Their death in the next 12 months can be reasonably predicted (rather than trying to predict, clinicians often find it easier to ask 'the 'surprise question' – 'Would I be surprised if this patient were still alive in 12 months?')
- They have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care e.g. they have one or more core/general and one disease specific indicator in accordance with the gold standard framework (GSF) prognostic indicators guidance or the Supportive and Palliative Care Indicators Tool (SPICT)
- They are entitled to a DS 1500 form (the DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered to be approaching the terminal stage of their illness. For these purposes, a patient is considered as eligible for these Special Rules if they are suffering from a progressive disease and are not expected to live longer than six months).

The register applies to all patients fulfilling the criteria regardless of age or diagnosis.

Questions:

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

- Agree
- Neither agree nor disagree
- Disagree
- Don’t know

Please explain your answer. (Maximum 400 words.)

We agree but it is important that these outcomes include clinical outcomes.

It needs to be ensured that loopholes are prevented, QOF has previously resulted in work and activity being moved from primary care to other services, particularly district nursing, without the payment attached.

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

- Agree

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

Please explain your answer. (Maximum 400 words.)

If you disagree, how else could we ensure that sufficient resources are applied to preventative and proactive care in general practice? (Maximum 400 words)

We agree that QOF and IIF have been shown to improve outcomes for patients and note that there is an argument for revisiting these outcome measures from the perspective of patients post-covid.

There is a QOF indicator on palliative and end-of-life care (PEoLC), which is 'the contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age'

This is an important indicator as the PEoLC register makes it possible to identify the number of people expected to be in the last 12 months of their life and those with longer-term conditions which require palliative care.

However, if these patients on the register are going to get the care they need, more resources need to be made available for palliative care services. Hospice services are an essential part of the healthcare system. However, our services only receive around one third of their funding from the Government. It is therefore hard to agree that sufficient **resources** are applied in these areas, as without the significant generosity of the public the needs of those on the PEoLC register could not be met.

This lack of resources means that currently many patients with PEoLC needs rely on their GP. Instead a preventative and proactive approach needs to be taken with their care to improve patient outcomes and prevent costly emergency admissions.

If patients are put on the palliative care register, but then do not get the care they need, the register, and therefore the QOF associated with it, loses their value.

Therefore, additional thought should be given to how QOF indicators could be introduced to help to ensure people who require PEoLC have improved patient experiences and to shine a light on where additional resources are needed, such as out of hours PEoLC support and 24/7 pharmacies in every area.

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

- Yes
- No
- Don't know

Please explain your answer. (Maximum 400 words.)

Relative improvement targets would be better otherwise practices working with harder to reach populations with worse health inequalities will be unfairly disadvantaged.

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

If the indicators could be designed to identify where GPs are taking proactive steps to meet their populations' health needs – in line with Office for Health Disparities and DHSC guidelines – then additional funding should be made available to support those GPs with service adaptions that might be necessary.

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

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

Please explain your answer. (Maximum 400 words.)

ICBs should be able to select local priority indicators from a national menu and put additional local funding against those indicators. This is essential for ensuring the ICBs can work as intended and are able to maintain a level of autonomy in order to meet local need. ICBs should be aware of their local population need and service demand and so should be able to put some local emphasis on certain measures. However, there should be ongoing oversight from NHS England of whether ICBs have a sufficient understanding of their populations' health needs as 2023 research found that commissioners responsible for end-of-life care in ICBs did not have in depth knowledge of local inequalities as they had no robust data. [1]

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

- Agree
- Neither agree nor disagree
- Disagree

[1] https://assets.kingsfund.org.uk/f/256914/x/ba501077d3/dying_well_at_home_2023.pdf

- Don’t know

Please explain your answer. (Maximum 400 words.)

The QIP framework with local objectives has worked well as a whole through previous Clinical Commission Group (CCG) led schemes in which payment was proportionate to contract size. There does need to be negotiation with services about deliverable outcomes.

6. What type of indicators, if any, within incentive schemes do you think most help to improve care quality? (Select all that apply)

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

If you said ‘other’, please describe the nature of the indicators you think would be effective in improving care. (Maximum 400 words.)

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

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

If you selected ‘none of the above’, please describe how you think we could best focus on clinical outcomes? (Maximum 400 words.)

8. Do you agree or disagree that there is a role for incentive schemes to focus on helping to reduce pressures on other parts of the health system?

- Agree
- Neither agree nor disagree
- Disagree

- Don’t know

Please explain your answer. (Maximum 400 words.)

We agree. Primary care is vital in controlling pressures on the wider system. Incentives that would tackle major problems like an absence of out of hours care GP care would make a tangible difference to patient outcomes at the end of life and would significantly reduce reliance on emergency admissions and the wider system.

- In many cases, GP surgeries not providing urgent nighttime or weekend appointments means their urgent activity can roll onto the community caseload. As we have outlined earlier in the response, QOF can result in work and activity being moved from primary care to other services (such as district nursing) without the payment attached. Therefore, it is essential that incentive schemes also look at helping to reduce pressures across the system to ensure they do not inadvertently result in increased pressure elsewhere.

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

- Agree
- Neither agree nor disagree
- Disagree
- Don’t know

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

This is important as a patient may fit the criteria for multiple targets if they have multiple conditions. Trying to optimise follow-up or treatment for an individual condition may lead to burdensome polypharmacy, or burdensome clinical appointments.

Continuity of care (such as seeing the same GP, attending one- stop shop clinics and being under the care of a Multidisciplinary Team) is essential in ensuring quality care for those with multiple long-term conditions. Therefore, implementing measures on continuity of care and patient satisfaction may be more appropriate in these instances.

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

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

- Agree
- Neither agree nor disagree
- Disagree

- Don’t know

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

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

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

- Agree
- Neither agree nor disagree
- Disagree
- Don’t know

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

This could be measured by surveying patients or looking at the percentage of appointments that patients have with their nominated GP.

The national shortage of healthcare professionals does need to be taken into account. Shortages mean that primary care teams may have no choice but to use agency locums, which can disrupt continuity of care. The usage of locums should also be measured to help identify areas where patients are continually not receiving continuity of care and where support may need to be targeted.

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

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

- Agree
- Neither agree nor disagree
- Disagree
- Don’t know

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

We agree but note that patient choice is a lower priority as often patients prioritise good local care and not having to travel over choice.

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

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

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

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

We strongly agree this is an area to target in the incentive scheme.

It is important the individual disease guidelines are balanced with a need to avoid polypharmacy; clinician and pharmacy guidelines are needed to ensure this.

STOPPFrail (Screening Tool of Older Persons Prescriptions in Frail adults with limited life expectancy) is an example of a good screening tool for deprescribing (https://academic.oup.com/ageing/article/46/4/600/2948308).

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

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

1) Any incentive must take into account where primary care might try to offload the activity, if they are working in partnership the payment should follow the activity.

2) As referred to earlier in our response, we know that a PEoLC approach to patient care - in line with the WHO definition - can have positive outcomes for patients, while also reducing pressure on the wider system and incentives are not yet sufficient for encouraging this approach.

There is a QOF on maintaining a palliative care register, however this register is not held in every area, which is impacting the care that terminally ill people in these areas can access.

As well as looking at new areas for inclusion, there also needs to be consideration given to how existing incentives can be strengthened in areas of particular importance. So, for example, work needs to done to incentivise areas that don't have a palliative care register to put one in place.

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

There need to be good links between GP IT systems and the systems which are measuring the outcomes.