# Developing the Quality and Outcomes Framework: Proposals for a new, independent process


# Developing the Quality and Outcomes Framework: Proposals for a new, independent process

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# Contents

# Foreword

The Quality and Outcomes Framework (QOF) was introduced as part of the new General Medical Services contract in 2004. It was a pioneering approach to improving quality of care through a voluntary incentive scheme rewarding GP practices for how well they care for patients, not just how many patients they have on their list. The ultimate purpose of QOF is to add years to life and life to years.

GP practices responded positively to the QOF, with almost universal participation and high levels of achievement from the start. The Commonwealth Fund Survey published in November 2006[1] found that GPs in the UK are leading the world in the efficient management of chronic disease, the use of information technology and the uptake of financial incentives to improve the quality of services. Research published in 2007[2] showed that care for asthma and diabetes improved more rapidly when the QOF was introduced.

Developing the QOF is key to the vision for primary and community care[3] that we developed, working closely with leading GPs and other healthcare professionals, as part of the NHS Next Stage Review. Continuous quality improvement and an increasing focus on preventing ill-health are at the heart of this vision. We want the QOF to continue to support GP practices in delivering outcomes for patients that are among the best in the world. This will only be possible if the QOF is continuously reviewed to reflect up-to-date evidence of best practice.

We intend to ask the National Institute for Health and Clinical Evidence (NICE) to oversee a new independent, transparent and objective process for reviewing and developing potential new QOF indicators as part of their role in providing guidance for the NHS based on evidence of clinical and cost effectiveness.

The current QOF expert panel has done an excellent job of assessing clinical evidence and developing indicators, reporting to NHS Employers and the BMA as part of annual negotiations on improvements to the GP contract. We consider that asking NICE to manage a new process will build on this excellent work, whilst also ensuring that the assessment of evidence is clearly seen to be independent of the subsequent process for negotiating and approving changes to the QOF.

1 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
2 Campbell S. et al Quality of Primary Care in England with the Introduction of Pay for Performance, *New England Journal of Medicine* 2007; 357 (2)
3 NHS Next Stage Review: *Our Vision for Primary and Community Care* (July 2008)

In *Our Vision for Primary and Community Care*, we undertook to discuss with professional and patient groups how this new process should work and how to give greater flexibility to PCTs to select indicators that reflect local health improvement priorities. This is why we are launching this consultation document to seek views from patients and the public, carers, GPs, nurses, PCTs and other stakeholders. We look forward to your comments.

**Ben Bradshaw**

# Executive summary

We intend to ask NICE to oversee a new independent, transparent and objective process for developing and reviewing QOF clinical and health improvement indicators for England from 1 April 2009 as part of their role in providing guidance for the NHS based on evidence of clinical effectiveness and cost effectiveness.

The main elements of the new process would be:

- Collating information to inform the prioritisation of potential new indicators, including setting up a facility on the NICE website for interested parties to submit ideas for priority topics.
- Carrying out a prioritisation process to decide on areas for indicator development and advising on candidates for new indicators in these areas based on evidence of clinical and cost effectiveness.
- Ensuring that the existing clinical and health improvement indicators are regularly reviewed.
- Setting up a primary care consideration panel consisting of a range of experts and representatives from the field to consider the relative priority of potential new clinical and health improvement topics.
- Developing and piloting potential new indicators and reviewing existing indicators, applying a methodology for assessing cost-effectiveness. NICE propose to appoint an external contractor through a competitive tender process to carry out this work.
- Carrying out a consultation on the developed indicators during the piloting phase.
- Validating the final proposals for new and reviewed indicators through the primary care consideration panel and publishing its conclusions via the NICE website.
- Giving advice on:
  - time limits for new indicators after which they should be reviewed;
  - the potential lower and upper thresholds for new indicators based on information about baseline uptake and expected increased uptake;
  - information based on the assessment of cost-effectiveness evidence to inform the financial value of indicators;
  - guidance on the application of existing indicators in the light of the latest evidence.

At national level NHS Employers (on behalf of the Department of Health) would then (as now) negotiate with the BMA on which indicators should be applied nationally (or, with the agreement of the devolved administrations, across the UK as a whole) and what the value of those indicators should be.

We are also seeking views on the proposal that Primary Care Trusts (PCTs) could in future select additional indicators from the NICE menu to reflect local priorities, using either resources devolved for this purpose or local resources.

# Introduction

1. As part of the NHS Next Stage Review[4], we announced proposals for developing the Quality and Outcomes Framework (QOF) including an independent and transparent process for developing and reviewing indicators.

2. This formed part of a wider set of proposals to support continuous quality improvements across primary and community care and to promote healthy lives. The strategy was informed by an external advisory board, bringing together leading GPs, other primary care professionals and representatives of other stakeholders, and based on extensive discussion with members of the public, with clinicians across the NHS and with colleagues from other sectors.

3. The report said that we would:

   - discuss with the National Institute for Health and Clinical Excellence (NICE) and with professional and patient groups how this new process should work;
   - explore how to give greater flexibility to PCTs to select indicators (from a national menu) that reflect local health improvement priorities.

4. In developing these proposals, we have also taken into account the recommendations of the National Audit Office (NAO) report on GP contract modernisation[5]. The NAO recommended that the Department should:

   - develop a long term strategy to support yearly negotiations on the QOF and develop the QOF based on patient needs and in a transparent way
   - base the strategy more on outcomes and cost effectiveness
   - agree to allocate a proportion of QOF indicators for local negotiation at Strategic Health Authority (SHA) or PCT level
   - consider the case for time-limiting QOF points.

4 High quality care for all: NHS Next Stage Review Final Report (30 June 2008) and NHS Next Stage Review: *Our vision for primary and community care* (3 July 2008)

5 NHS Pay Modernisation: New Contracts for General Practice Services in England (National Audit Office, February 2008)

5. Independent research shows that QOF is reducing the gap in performance between practices in areas of high and low deprivation[6]. Our proposals are designed also to build on the ability of QOF to help reduce health inequalities and respond to the needs of our diverse society.

6. We intend that NICE should oversee a new independent process for developing and reviewing QOF clinical and health improvement indicators for England from 1 April 2009 as part of their role in providing guidance for the NHS based on evidence of clinical effectiveness and cost effectiveness. The process would involve reviewing existing QOF indicators, prioritising areas for new indicators, and developing and recommending new indicators. It would be informed by open consultation with stakeholders, including patient and professional groups, and based on best available evidence of clinical and cost effectiveness.

7. In summary, NICE would manage an independent and transparent approach to produce a national menu of approved indicators made available through the NICE website from which:

   - NHS Employers (on behalf of the Department of Health) would negotiate with the BMA on which indicators should be applied nationally (or, with the agreement of the devolved administrations, across the UK as a whole) and what the value of those indicators should be;
   - PCTs could potentially select additional indicators that reflect local priorities using either resources specifically devolved for this purpose or other local resources.

8. This consultation document sets out the proposed principles and framework for how the new process would work in England and invites comments from professional, patient and carer representatives, PCTs and other groups or individuals who may be interested.

9. Following the results of this Department of Health consultation, we envisage that NICE would publish on their website an interim process document setting out in detail how they would propose to manage the new process and the proposed methodology for assessing indicators.

6 Doran T. et al Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework, *The Lancet* 2008; Vol 372

## Other UK countries

10. We are discussing with the devolved administrations how to continue to ensure a collaborative approach to developing and reviewing indicators across the four UK countries. The major diseases are common across the UK, but there will be differences in health needs between countries and within countries. We envisage a situation where it may be possible for each of the four countries to remain within a UK framework but be able to choose indicators from a UK menu that fit with national or local priorities.

11. NICE is responsible for evidence based guidelines for England, Wales and Northern Ireland. There is already good collaboration between NICE and NHS Quality Improvement Scotland, which leads the use of knowledge to promote improvement in the quality of healthcare in Scotland.

# Proposals

## Background

12. The QOF is a voluntary incentive scheme that rewards GP practices for implementing systematic improvements in quality of care for patients. It is part of the General Medical Services (GMS) contract, though all types of practices can take part (not only those covered by the national GMS contract). Virtually all GP practices take part in QOF as set nationally.

13. Expenditure on QOF is currently just over £1 billion in England, or 15% of spend on primary medical care.

14. A brief description of the current QOF is provided at **Annex A**. QOF consists of a set of evidence-based indicators that measure the quality of care provided for patients, linked to payments for practices. The full set of payment arrangements, indicators and guidance for QOF are set out in the General Medical Services Statement of Financial Entitlements Directions (SFE), paragraphs 4-6 and Annexes D-F (a consolidated text of the SFE can be found on the Department of Health website www.dh.gov.uk). The Information Centre for Health and Social Care publishes the annual QOF achievement, disease prevalence and exception statistics together with an online database of GP practice level data on their website www.ic.nhs.uk.

15. The QOF was introduced in April 2004 as part of the new GMS contract. Changes to the QOF are made following negotiations between NHS Employers (who act on the basis of a mandate from the Department of Health) and the General Practitioners Committee (GPC) of the British Medical Association.

16. Currently the work to develop potential new indicators for the QOF and to advise the negotiating parties on the evidence base is performed by the QOF expert panel, a consortium of academic bodies coordinated by the National Primary Care Research and Development Centre (NPCRDC) based at the University of Manchester. The process involves a call for evidence which is reviewed by expert groups. Potential priorities are subject to a consensus process and an assessment by IT experts to ensure that the indicator can be operationalised. Following this, a confidential report is produced for the negotiation. The reports are published on the NPCRDC website following completion of the negotiations.

## Aims and objectives of the new process

17. Reform of the QOF is integral to delivering the vision set out in the NHS Next Stage Review of quality at the heart of the NHS. The aim is to support professionals in delivering outcomes for patients that are among the best in the world.

18. In order to achieve this aim, the objectives of our proposals for the review of QOF indicators are to ensure that:

- all stakeholders have a clear opportunity, through a process of suggesting topics for consideration and through consultation, to contribute to the development of QOF indicators;
- QOF indicators address topics of importance to patients, professionals and the health of the public and help professionals address inequalities in health and make the best use of NHS resources;
- all indicators proposed for inclusion in the QOF are based on evidence of clinical and cost effectiveness;
- there is an objective and transparent system for setting the value of a QOF indicator;
- existing indicators are reviewed regularly to identify those that can be improved or replaced;
- potential new indicators are tested through piloting and considered in terms of whether they are workable;
- all processes and methods are inclusive, open, transparent and consistently applied;
- there are appropriate governance structures and clear working arrangements with other relevant parties.

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

***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?***

## Scope of the new process

19. The proposed scope of the new process is to review and develop clinical and health improvement indicators in the QOF and to recommend new indicators where there is a strong case for incentivising increased uptake of good practice, based on best

available evidence of cost effectiveness. This could include the potential development of indicators based on patient reported outcome measures (PROMs) for clinical areas.

20. We propose that new QOF indicators should be underpinned by NICE evidence-based clinical and public health recommendations relevant to primary care. As the Department continues to look to the Joint Committee on Vaccinations and Immunisation for advice on influenza and other vaccination programmes, we propose that the QOF indicators measuring uptake of influenza vaccine among at-risk groups should be outside the scope of the new process.

21. We propose that the first indicator in the Patient Experience domain (length of consultation) and the indicators in the QOF organisational domain should be outside the scope of the new process, except for those relating to recording blood pressure and smoking which are health improvement indicators (Records 11, 17 and 23 in the 2008/09 QOF). We are committed to promoting the use of accreditation schemes to drive organisational quality improvement. We are supporting the Royal College of General Practitioners to develop an accreditation scheme for GP practices, which is expected to be rolled out nationally by 2010. We will need to review with the profession the incentive arrangements for organisational quality for when the accreditation scheme is rolled out.

22. We have commissioned Ipsos-MORI in partnership with academics from the National Primary Care Research and Development Centre, University of Manchester and Peninsula Medical School, University of Exeter to develop and deliver a new national GP patient survey to measure patient experience. This will measure not just speed and convenience of access but all-round patient satisfaction with GP services. We envisage that with continued development the survey would in future serve as the basis for incentives to improve patient satisfaction. We therefore propose that the current QOF indicators linked to patient experience surveys (PE 2, 6, 7 & 8 in the 2008/09 QOF) should also be outside the scope of the new process led by NICE.

***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.***

## Key elements of the new process

23. The key output from the new process would be an annual menu of new evidence-based, cost-effective indicators where there is a strong case for incentivising increased

uptake either through nationally or locally agreed QOF indicators. Information on existing indicators would also be provided indicating how consistently they are being achieved and a review of whether it remains cost-effective to continue to incentivise these indicators.

24. We propose that NICE should achieve these outputs by:

- establishing a primary care consideration panel chaired by an acknowledged independent expert in primary medical care and including a range of experts and representatives of the field. This would include GPs, patients and carers, commissioners, practice and community nurses, social care professionals, health economists and informatics specialists. The recruitment and governance arrangements for the panel would be in accordance with the Institute's standard procedures;
- collating information to inform the prioritisation of new indicators, including setting up a facility on the NICE website to allow interested parties to submit potential clinical and public health priority topics;
- carrying out a prioritisation process to decide on new areas for indicator development and advising on candidates for new indicators in these areas based on evidence of clinical and cost effectiveness. The primary care consideration panel would consider the relative priority of all potential new clinical and public health topics suggested for inclusion in the QOF;
- ensuring that the existing clinical and health improvement indicators are regularly reviewed and providing a recommendation on whether or not they should continue to be incentivised;
- appointing an external contractor, through a competitive tender process, to develop and pilot new indicators, review existing indicators and apply a methodology for assessing cost-effectiveness;
- carrying out a consultation on the developed indicators during the piloting phase, validating the final proposals on the indicators through the primary care consideration panel and publishing its conclusions via the NICE website;
- giving advice on:
  - time limits for new and renewed indicators after which they should be reviewed;
  - potential lower and upper thresholds for new indicators based on information about baseline uptake and expected increased uptake;
  - information based on the assessment of cost-effectiveness evidence to inform the financial value of indicators;

– guidance on the application of existing indicators in the light of the latest evidence.

25. Following the publication of NICE's advice, we propose that there would be a separate process to decide which indicators should be included in QOF and at what price. At national level, NHS Employers on behalf of the Department of Health would (as now) negotiate with the GPC. PCTs would agree any locally chosen indicators with GP practices, in consultation with Local Medical Committees and other interested parties. A flowchart of the proposed new QOF review process is attached at **Annex B**.

26. We would not expect NICE to take on the task of developing business rules for QOF indicators, but there would need to be close links between the process of prioritising, developing and piloting indicators and the process of assessing technical feasibility of indicators and developing business rules for data extraction to measure achievement. We anticipate that the Information Centre for Health and Social Care would provide the expertise and information governance arrangements needed to develop business rules for extracting data on indicators developed through the new system.

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

## Review of existing indicators

27. It is not in our view sustainable to expand QOF in order to reflect the latest evidence on effective care. Our view is that QOF should continuously evolve, with some indicators being replaced, for example where the activity being measured has become part of standard practice and no longer needs to be incentivised.

28. We propose that the primary care consideration panel would initially consider the information on existing indicators and reach a view as to:

- they have been sufficiently embedded in practice that they should not require continued incentivisation and are recommended to be retired;
- they are being only partly achieved and it is recommended that they should continue to be incentivised, but further information on cost effectiveness is needed;
- they are being only partly achieved and it is recommended that they should continue to be incentivised, taking into account information on cost effectiveness;
- they are being only partly achieved and, taking into account information on cost-effectiveness, it is recommended that the level of incentivisation or the thresholds may require adjustment in order to be consistent with other indicators.

29. We propose that all the existing indicators in the QOF should in time be reviewed by the consideration panel. The priority sequence in which existing indicators would be reviewed by the panel would be informed by the contractor appointed by NICE and any review dates which might be established as part of the GMS contract. The contractor would receive information about achievement levels for existing indicators from the Information Centre and would collate and provide information about the cost effectiveness of existing indicators where available.

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

## Prioritisation

30. A number of principles established when the QOF was developed are set out in the GMS Statement of Financial Entitlements and are reproduced at **Annex C** to this document. We believe that these principles continue to be valid and we propose that they should remain as currently set out in the Statement of Financial Entitlements.

31. In addition to these principles, we consider that the process for prioritising new areas for indicator development could be made more open and transparent than it is now, to the benefit of patients and professionals. This would ensure that QOF indicators address topics of importance to patients, professionals and the health of the public and help professionals address health inequalities and make the best use of NHS resources.

32. It is very important that patients, carers, professionals and other stakeholders should have confidence in the new process for prioritising new indicators. Hence the proposal for NICE, as an independent statutory body, to oversee the process and to establish a primary care consideration panel which would include a range of experts and representatives in the field, including primary care clinicians, patients and carers.

33. We propose that the panel should consider the relative priority of all potential new clinical and health improvement topics suggested for inclusion in the QOF against a set of published criteria established following this consultation exercise. **Annex D** contains a draft of the proposed criteria for consultation. These criteria will be reviewed in the light of the results of this consultation and published in the Government's response.

34. The proposed new process includes eight months for development and piloting of potential new indicators with a cohort of representative practices. We envisage that NICE would also carry out a consultation with stakeholders on the indicators during the piloting phase, validating the final proposals through the primary care consideration panel and publishing its conclusions via the NICE website.

35. This would represent a significant increase in transparency as compared to the current system. Although there have been two major calls for evidence by the QOF expert panel, their advice and recommendations are given to the negotiating parties in confidence and not published until after the end of the negotiations when the indicators have been decided. There are no established and open criteria for setting priorities for the development of new indicators.

***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?***

***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?***

## Methodology for assessing cost effectiveness

36. We have asked NICE to develop a potential analytical methodology for assessing cost effectiveness of QOF indicators informed by research undertaken by York University and the University of East Anglia[7]. **Annex E** outlines the general principles that we propose should underpin the methodology. This methodology once fully developed would provide the basis of the proposed process for providing information on the value of indicators and advising on a menu of indicators.

37. Wherever possible the Institute's advice would be based on evidence of cost effectiveness. However there will inevitably be some interventions with good evidence of clinical effectiveness but without research on cost-effectiveness. The Institute would develop a transparent approach to assessing the relative value of indicators with good clinical evidence but without evidence of cost effectiveness.

38. Decisions on the value of QOF indicators have not up to now been informed by systematic information on the cost effectiveness of the interventions being incentivised. There is evidence that some QOF payments do not currently reflect the value of the indicators in terms of health benefit.[8] Part of the rationale for the proposed new process is to provide the negotiating parties (NHS Employers and the GPC) and the Department of Health with an assessment of the evidence on cost-effectiveness in order to inform decisions on the value of indicators.

7 A joint executive summary of the reports of this research is now available on the York University website at: https://www.york.ac.uk/inst/che/research/appliedresearch.htm#past).

8 Fleetcroft R, Cookson R. Do the incentive payments in the new NHS contract for primary care reflect likely population health gains? *Journal of Health Services and Research Policy* Vol 11, No 1 2006.

39. QOF payments form part of a wider range of NHS income streams for GP practices, including 'global sum' payments (a weighted measure of the number of patients registered with a practice) and payments for providing enhanced services. All these different income streams are designed to cover both the costs involved in running a GP practice and a reasonable net income for the contract holder.

40. In our view, the income earned through achievement of individual QOF indicators should not be regarded as linked to the specific costs of providing the interventions associated with that indicator. Rather, the purpose of QOF should be to provide the initial incentives to embed within general practice best evidence-based care that will continue to improve patients' care and health.

41. We therefore propose that, in assessing cost-effectiveness, NICE should regard the costs of providing the interventions in question as being met from overall GP contract funding, not specifically from the individual QOF payment for that indicator.

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

## Commissioning of indicators

42. At the end of the indicator development cycle, we envisage that NICE would publish advice on:

- the existing indicators which have been reviewed, with recommendations on whether or not they should continue to be incentivised and in what form.
- an evidence based menu of NICE-approved indicators and accompanying guidance
- recommended review dates for new indicators (and indicators that have been reviewed and recommended for continuation);
- the potential lower and upper thresholds for new indicators based on information about baseline uptake and expected increased uptake;
- an assessment of evidence on cost-effectiveness to inform subsequent decisions on the value of new or continuing indicators;
- any updates required to existing indicators and accompanying guidance in the light of the latest clinical evidence.

43. Having received this advice, NHS Employers (on behalf of the Department of Health) and the GPC would (as now) negotiate national changes to the QOF. PCTs would also be able to use the advice to inform local negotiations with GP practices over any local indicators. In both cases, the two parties would use NICE's advice to reach a view on:

    - which indicators should be selected, taking into account the resources available;
    - lower and upper thresholds for payments;
    - the level of payment (or QOF points) available for each indicator.

44. The size of the national QOF, both in terms of the number of indicators and the overall number of QOF points available, would depend as now on the overall level of resources devoted to the QOF following negotiations between NHS Employers and the GPC on the GMS contract. Decisions on any local QOF payments would be made locally, taking into account any resources specifically devolved for this purpose.

45. The negotiations between NHS Employers and the GPC, together with any changes made as a result of recommendations made by the Doctors and Dentists Review Body, could result in changes in the financial value of a QOF point or changes to the financial adjustments made to reflect relative list size and disease prevalence. In advising on cost-effectiveness, NICE would need to have regard to the value of a point (and the QOF payment adjustment rules) existing at the time that its guidance is published.

***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?***

## Frequency of QOF review and output

46. A flowchart of the proposed QOF indicator development process is attached at **Annex B**. The new process, including prioritisation, indicator development, piloting, consultation and validation is expected to take 18 months. Following this there would need to be time for negotiations between NHS Employers and the GPC and any local negotiations between PCTs and GP practices. We anticipate therefore that each QOF review cycle would take two years in total, from the point at which information is gathered on potential new indicators to the final set of indicators being in place at the start of a new financial year.

47. There are currently 88 indicators within the proposed scope of the new process[9]. We propose that the aim should be to review these existing indicators over a period of three to four years. This would involve reviewing about 20-30 indicators a year.

48. This would require a rolling programme of overlapping review cycles for this initial period, with recommendations on existing indicators and potential new indicators being published once a year. After that initial period it would make sense to review the frequency of the cycles in the light of experience and an assessment of the speed at which the evidence base moves on. In the longer term it might be more sensible to consider changes to QOF on a biennial basis.

49. Turning to the number of new indicators to be developed, NICE would need to take account of the prioritisation and ranking process and consider how many of the topics should progress to the indicator development stage. Based on experience of the QOF so far, we anticipate that three out of every four indicators would fail in the development process, so four times as many indicators as the desired output would need to be put to Stage 3. We propose that, without any prejudice to subsequent negotiations, NICE should aim to develop around 10 new clinical indicators over each QOF review cycle (i.e. an output of 10 new approved indicators a year during the initial 3-4 year period of overlapping QOF reviews).

***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?***

## Transition to the new system

50. We intend that NICE should take over management of the process of developing and assessing indicators from April 2009, when the contract between NHS Employers and the current QOF expert panel comes to an end. There will need to be a transitional process for moving to the new system in order to inform QOF decisions for 2010/11. We propose that, at the point of transition, NICE should receive the reports already published by the QOF expert panel on recommendations for new indicators[10] and any that are in progress at the transition point.

9 Clinical indicators (excluding flu indicators), additional services indicators and health improvement indicators in the organisational domain

10 Published reports are available on the National Primary Care Research and Development Centre website, http://www.npcrdc.ac.uk

51. NICE would then consult the primary care consideration panel on priorities for review of existing indicators and for development of new indicators for 2010/11. They would manage a streamlined version of the indicator assessment process, based on evidence of clinical effectiveness and, where available, cost effectiveness. These recommendations would be subject to validation by the primary care consideration panel and published by NICE. The aim would be to publish recommendations for 2010/11 in August 2009, prior to negotiations between NHS Employers and the GPC on changes to the QOF for 2010/11.

52. The process of gathering evidence, assessing cost-effectiveness, piloting and consultation to provide advice for changes to the QOF for 2011/12 would also begin in April 2009.

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

## Local flexibility

53. It is already possible for PCTs to agree local variations on QOF with their contractors. In the case of local contracts with Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contractors, the PCT is free to propose a completely different set of indicators to the national QOF. While GMS contractors have the right to take part in QOF as nationally negotiated, it is open to PCTs to seek to negotiate local variations or additions with their GMS contractors. In practice, however, the national QOF covers nearly 100% of the registered population[11] and we are aware of very few examples of local QOFs.

54. The advantage of introducing greater local flexibility would be to help PCTs invest resources in ways that best meet the health needs of their local population. Some PCTs currently express concerns that the QOF does not always reflect local priorities. At present, the practical scope for introducing local variation is limited for various reasons:

- the need for technical expertise in the development of evidence based indicators and business rules for extraction of clinical data from GP systems;
- the IM&T support required to extract data from clinical systems and to link this with payment calculations.
- the absence of any decisions to set aside part of the £1 billion national investment in QOF to make room for local investment.

11 National Quality and Outcomes Framework Statistics for England published by the Information Centre for Health and Social Care at www.ic.nhs.uk

55. We believe that the expertise required for the development and assessment of indicators is most efficiently provided at national level because it requires a critical mass of rare skills. Hence the proposal that PCTs should have flexibility to select local indicators from a national menu published by NICE with advice on cost-effectiveness. We would look to NICE to consider what additional information might be needed by local commissioners (e.g. scaling to reflect local populations) to inform decisions on local indicators.

56. We envisage in future that the majority of QOF will continue to be decided nationally following negotiations between NHS Employers and the GPC. This assumes that there will continue to be a significant number of areas where there is a strong case for applying the same incentives for evidence-based care across the country.

57. Any decision to reserve a proportion of the nationally agreed investment in QOF for locally-selected indicators would be a matter for future consultation with the GPC. We would nonetheless welcome stakeholders' views at this stage on the case for treating a proportion of the QOF in this way, i.e. enabling PCTs to decide locally with GP practices what local indicators to select from a NICE-approved menu. This could help PCTs address particular health needs within local populations or variability in adoption of evidence-based care across different parts of the country.

58. PCTs would be free to invest their own additional resources into local voluntary incentive schemes based on indicators chosen from the NICE-approved menu.

59. Turning to the issue of IM&T support, the development of the GP Extraction Service (GPES) by the Information Centre for Health and Social Care should in time allow PCTs to make requests for data extraction from GP systems to measure progress against locally selected indicators. Further details of the proposals for development of GPES can be found on the Information Centre website (www.ic.nhs.uk.).

60. We expect that the infrastructure available to support development of local QOFs would not be in place until 2011/12 at the earliest. This is the first year in which the new prioritisation process would result in a published menu of indicators. The ability for PCTs to obtain achievement data on the full menu of indicators will also depend on progress in the development of GPES. There are other options available for PCTs to obtain data extracted from GP systems, but these have limited scope and limited flexibility to link to local payment systems.

***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?***

***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?***

***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?***

# The consultation process

## Responses

61. You can comment:

> by email to: **QOFConsultation@dh.gsi.gov.uk**

> by post to: **Quality Team, Primary Medical Care, Room 2E56, Quarry House, Quarry Hill, Leeds LS2 7UE**

62. A summary of the consultation questions is attached at **Annex F. Responses** should be submitted by **2 February 2009**.

## Criteria for consultation

63. This consultation follows the 'Cabinet Office Code of Practice', in particular we aim to:

- consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy;
- be clear about what our proposals are, who may be affected, what questions we want to ask and the timescale for responses;
- ensure that our consultation is clear, concise and widely accessible;
- ensure that we provide feedback regarding the responses received and how the consultation process influenced the development of the policy;
- monitor our effectiveness at consultation including through the use of a designated consultation co-ordinator; and
- ensure our consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

The full text of the code of practice is on the Better Regulation website at: Link to consultation Code of Practice

## Comments on the consultation process itself

64. If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator Department of Health
3E58, Quarry House
Leeds
LS2 7UE
e-mail: consultations.co-ordinator@dh.gsi.gov.uk

**Please do not send consultation responses to this address.**

## Confidentiality of information

65. Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

66. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

67. The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

## Summary of the consultation

68. A summary of the response to this consultation will be made available within three months of the end of the live consultation period and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

# Annex A: Description of current QOF

1. The QOF contains four domains: clinical, organisational, patient experience and additional services. Each domain contains indicators that define the specific process or outcome that practices participating in the QOF are asked to achieve for their patients. For example one of the clinical indicators in Coronary Heart Disease (CHD) is:

   *The % of patients with CHD who are currently treated with a beta blocker (unless a contraindication or side effects are recorded).*

2. Clinical indicators are based on the best available evidence of the effectiveness of interventions in primary care. Achievement is measured automatically by extracting data from GP clinical systems. PCTs assess achievement against the other types of indicators on the basis of evidence provided by practices.

3. Each indicator is worth a number of points. Currently there is a maximum of 1000 points available.

   **Domains in order of size**

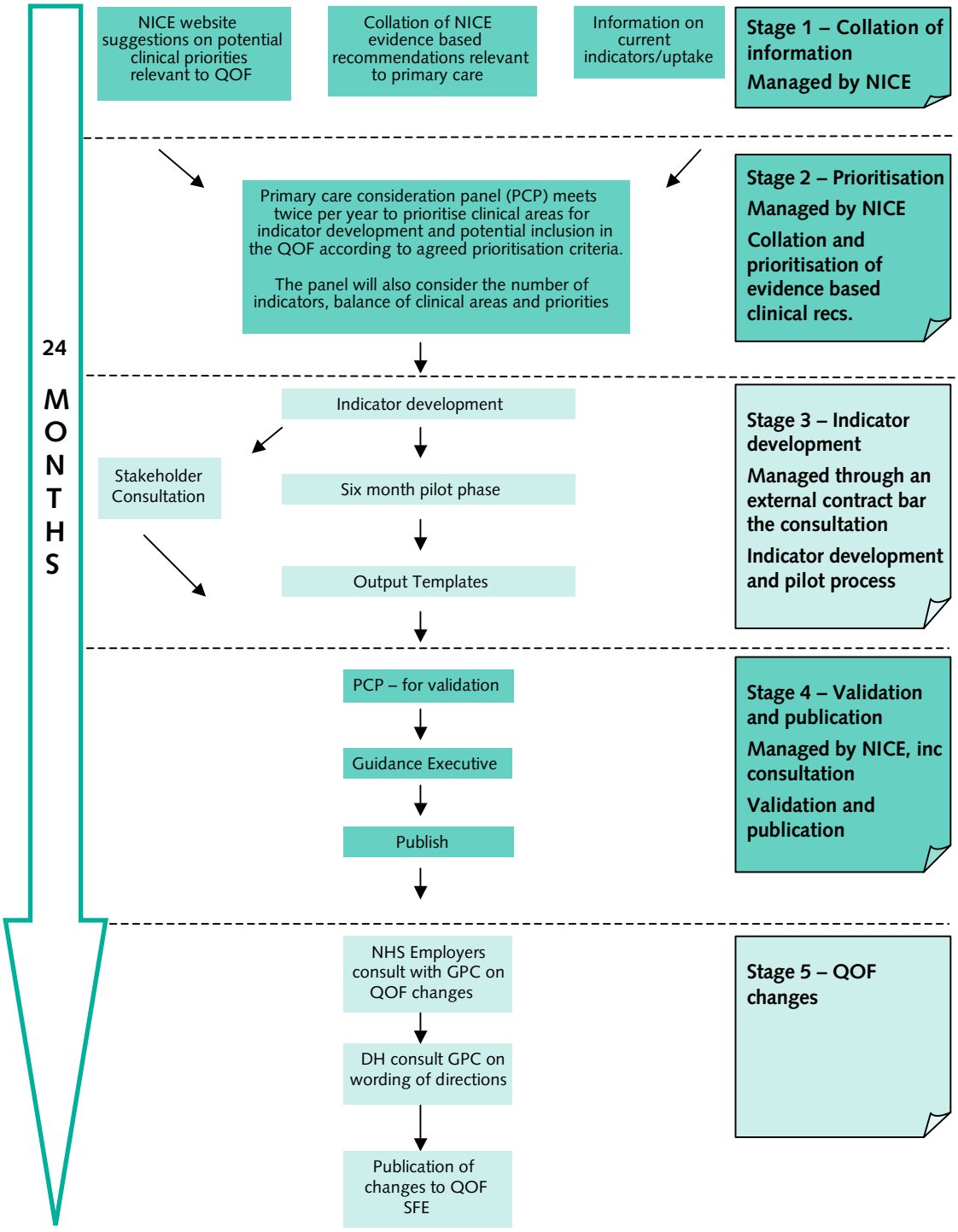
| | |
|---|---|
| Clinical | 650 |
| Organisational | 167.5 |
| Patient Experience | 146.5 |
| Additional Services | 36 |

4. In 2004/5 each point achieved was worth £77.50. In 2005/6 and following this rose to £124.60 as part of the Government's planned increase in investment in primary medical care.

5. For some indicators, points are rewarded in full for achievement or not at all. However, most of the indicators in the clinical domain reward practices for the percentage of patients for whom they achieve the indicator. Practices receive a proportion of the points available within lower and upper payment thresholds, for example 40-90% of patients. Practices are permitted to except patients from an indicator on certain grounds set out in the directions. Excepted patients do not reduce the achievement score.

6. The total number of points scored by the practice is multiplied by £124.60 to give a raw QOF achievement payment. The final sum paid to practices is adjusted to take account of practice list size and disease prevalence in order to weight money more fairly according to workload and need.

# Annex B: Flowchart of Proposed QOF Indicator Development process



# Annex C: Principles underpinning the QOF

The following principles relating to the Quality and Outcomes Framework (QOF) are set out in the General Medical Services Statement of Financial Entitlements at Annex D.

1. Indicators should, where possible, be based on the best available evidence.

2. The number of indicators in each clinical condition should be kept to the minimum number compatible with an accurate assessment of patient care.

3. Data should never be collected purely for audit purposes.

4. Only data which are useful in patient care should be collected. The basis of the consultation should not be distorted by an over-emphasis on data collection. An appropriate balance has to be struck between excess data collection and inadequate sampling.

5. Data should never be collected twice i.e. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.

# Annex D: Draft selection criteria for areas for developing indicators for the quality and outcomes framework

1. Is the area within NICE's remit? In particular,

   (a) is the proposed topic within NICE's remit?

   (b) has NICE already provided guidance or is NICE developing guidance on the proposed topic?

   (c) is the proposed topic one in which primary medical care practitioners have a significant contribution to make in terms of improving patients' health, for example through case finding, diagnosis, referral, treatment or health promotion advice?

2. Would development of indicators promote the best possible improvement in public health and wellbeing and/or patient care, and the reduction of inequalities in health, given available resources? In particular, are one or more of the following satisfied?

   (a) Do the proposed indicators relate to one of the public health or NHS clinical priority areas, or to other health-related government priorities?

   (b) Do the proposed indicators address an area of action where introduction of evidence-based indicators in primary medical care would lead to cost effective improvements in the delivery of health care?

   (c) Are the consequences of the changed indicators on other health and social care sectors well understood? Are the costs (financial and human resources) for other sectors proportionate given the likely scale of benefit? Are they affordable and deliverable in the short term?

   And, for **public health topics**, the following.

   (d) Do the proposed indicators address an area of public health action that promotes population health or well-being, and/or relates to a significant burden of avoidable disease, disability, injury or early death in the population as a whole or in specific population sub-groups?

   And, for **clinical topics**, one of the following.

   (e) Do the proposed indicators address a condition which is associated with significant morbidity or mortality in the population as a whole or in particular subgroups?

(f) Do the proposed indicators relate to one or more interventions or practices which could:

i. significantly improve patients' or carers' quality of life; and/or

ii. reduce avoidable morbidity; and/or

iii. reduce avoidable premature mortality; and/or

iv. reduce inequalities in health relative to current standard practice if used more extensively or more appropriately?

3. Would it be timely for NICE to develop indicators on the proposed topic? In particular:

(a) Is this an area of QOF where existing indicators are coming up for review?

(b) Would new indicators support implementation of new NICE guidance or National Service Frameworks which are in development or recently published?

(c) Is there emerging evidence for developing new indicators with direct health benefit in areas where there are currently no indicators or where the existing indicators are not measuring direct health benefit?

(d) Is there a degree of urgency for introducing indicators caused by factors other than those listed above, for example, is there significant public concern, is this a new disease, or is this emerging as an important new area for public health action?

(e) Would the indicators still be relevant and timely at the expected date of use?

# Annex E: Methodology for assessing the cost effectiveness of QOF indicators – general principles

1. It is proposed that NICE should oversee the process of developing and reviewing QOF indicators. A key requirement is that new indicators should be based, as far as possible, on evidence of cost effectiveness. Review of the cost effectiveness of existing indicators will be constrained by the availability of cost effectiveness evidence.

2. The proposed underpinning assumptions that will be used to determine cost-effectiveness are as follows:

   An indicators can be considered cost effective when **net benefit** (as defined below) is greater than zero:

   *Net benefit = (monetised benefit – delivery cost) – QOF payment*

   The **delivery cost** of undertaking the indicator should be the cost to deliver the treatment/intervention offset by any savings where new treatments replace older treatments.

   The **monetised benefit** from implementing the indicator should be derived from expected increase in quality adjusted life year (QALY). NICE will for the purposes of assessing the cost effectiveness of QOF indicators need to identify an appropriate QALY threshold cost. This is expected to be within the range £20,000-£30,000, below which NICE generally considers something to be cost effective.

   The **QOF payment** is considered to be additional to the cost of delivering the indicator; it is regarded for the purposes of cost effectiveness as an initial incentive to embed within general practice best evidence-based care that will continue to improve patients' care and health.

# Annex F: Summary of consultation questions

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

*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?*

*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.*

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

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

*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?*

*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?*

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

*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?*

*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?*

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

***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?***

***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?***

***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?***



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