Duncan Bland, PADIV, British Medical Association

The New General Practitioners (GP) contract: improving the way healthcare is delivered in the UK

Executive Summary

- The new General Practitioners (GP) contract and the Quality and Outcomes Framework (QOF) were established in 2004.
- The 2004 contract promoted consistent, high quality and evidence based clinical care around the UK.
- Data show that the quality of primary care is improving.
- The QOF is reducing inequalities in healthcare the gap in clinical achievement between practices in more affluent areas compared to less affluent areas is decreasing.
- Examples from the primary care of diabetes show the impact the QOF is having by delivering a higher standard of clinical care, resulting in real health gains for an increasing number of patients.
- Standards of non-incentivised care have been maintained while patients are safeguarded against inappropriate treatment.
- A great strength of the QOF is its adaptability it is changing to accommodate new treatments, addressing previously unmet need in the population.
- The wealth of prevalence data that GPs are collecting will be valuable to future health programmes.

Background: the Quality and Outcomes Framework (QOF)

A desire to address healthcare inequalities in the United Kingdom has been a key theme of recent government health policy (1,2). Increasingly, primary care has been seen as a crucial operational setting with which to address such inequality. Against this backdrop in 2004, a new contract for General Practice in the National Health Service (NHS) was implemented across the UK. This new contract represented a significant shift in the way that general practitioners (GPs) worked, and promoted the principles of high quality and evidenced based care, promoting consistency in care for patients across the country.

A fundamental part of the new contract was the ***Quality and Outcomes Framework (QOF)***. This framework created a system which remunerated general practices for providing quality care to their patients, funding which could be used to fund further improvements to the quality of healthcare delivered in the Practice. Linking resources with the QOF ensures that the work undertaken in general practice is adequately resourced, standards are consistent across the country, and practices achievements are recognised.

> ***Many countries are seeking to emulate what the UK has done.***
>
> *Professor Martin Roland (Director of the National Primary Care Research and Development Centre) on the QOF (3)*

The QOF comprises a range of criteria, often referred to as indicators, which are grouped into four domains: clinical, organisational, patient experience and additional services. Achievement is

measured against a set of evidenced based indicators where points and payments are awarded according to the level of achievement. Importantly, the majority of points available within the QOF are derived from the clinical domain and the care provided to patients in disease specific groups, such as diabetes or asthma. The maximum quality score for each practice in a single year is 1000 (Previously 1050). Performances of practices in England are publicly available (4).

> ***With one mighty leap, the NHS vaults over anything being attempted in the United States, the previous leader in quality improvement initiatives.***
>
> *Professor Paul Shekelle on the QOF (5)*

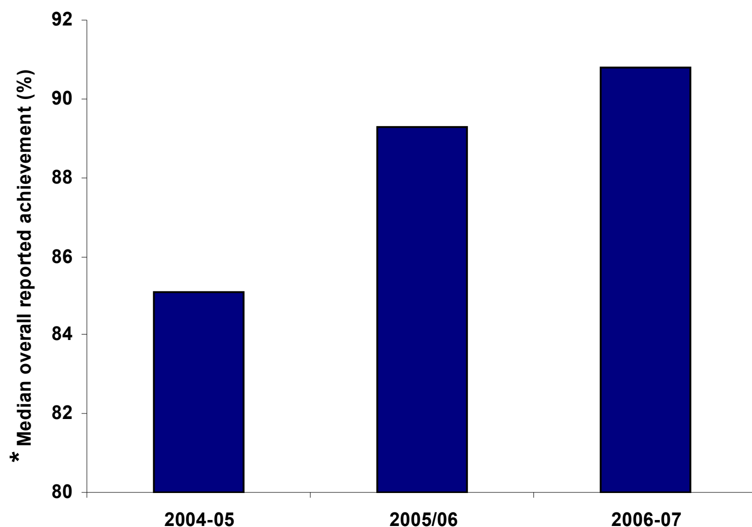
<u>How is the QOF benefiting the general population?</u>

QOF can reduce inequity in the delivery of primary clinical care

According to the widely reported inverse care law , those who most need high quality care, are less likely to receive it (6). However, since the introduction of the QOF in 2004, differences in the quality of healthcare delivered by practices located in areas of relatively low deprivation compared to practices in areas of relatively high deprivation are small. (7, 8) Furthermore, whilst clinical achievement has continued to increase overall across general practice, the gap in achievement between the most and the least deprived has continued to decrease to a non-significant level (7).

Doran *et al* (2008) reported a significant steady improvement in achievement of clinical targets during the first three years of the QOF (figure 1) (7). By year 3, the gap in clinical achievement between practices located in the most deprived compared to the least deprived areas was a mere 0.8% (%). Similarly, Ashworth *et al* (2007) observed that the mean total QOF score increased from 960 in 2004/2005 to 1012 in 2005/2006 whilst the difference in achievement between the most and the least deprived narrowed from 65 points to just 30 points (8).

Figure 1. *The rise in median clinical achievement in general practice for years 1-3 of the QOF*



** Median achievement is derived from the proportion of patients deemed eligible by practices for whom targets were achieved.*

Does this mean health will be the same around the country?

Not necessarily. It is important to differentiate between equity in delivered healthcare around the country and wide ranging inequalities in the health of the population. An analysis of primary care of

coronary heart disease (CHD) provided within the QOF has established that while QOF can deliver high quality care equitably in contrast to the widely reported inverse care law, it would be unrealistic to expect the QOF initiative to eradicate the ill health endemic in areas of greater deprivation where, for example, CHD is acknowledged as being more highly prevalent (9).

However, careful selection of evidence based targets within the QOF has the potential to *contribute* to a reduction of health inequalities (7).

How is quality of care improving for patients?

Examples from the Primary Care of Diabetes since 2004

Diabetes that is undiagnosed and untreated can, over time, lead to numerous health complications. It is estimated that over 12% of all deaths among 20-79 year olds are a result of diabetes (10) while estimates put the number of people in England with diabetes at approximately 2.4 million (11). The need for effective prevention and better clinical management is therefore clear.

Evidence for the county of Shropshire demonstrates the considerable impact that QOF targets are already having upon quality of care and outcomes for patients with diabetes. Published data for approximately 17,000 patients show improvements in both organisational and clinical quality indicators between the implementation of the new contract in April 2004 and March 2006 (12). Improved organisational achievements can rightly be attributed to better recording of patient information including smoking status, cholesterol, and blood pressure among practices, a laudable achievement in itself and a feature of the QOF. Improving clinical achievements are however, indication of a real health gain for patients. The increasing number of patients meeting metabolic targets for diabetes is hugely encouraging, a finding that has also been observed among practices in South London (13).

A systematic review of diabetes care achieved as a result of the QOF, confirmed the trend for improvement in both process and outcome measures for patients (14). The National Primary Care Research and Development Centre has summarised graphically the sharp rise in clinical achievement in diabetes care since the inception of the QOF in 2004 (figure 2) (15).

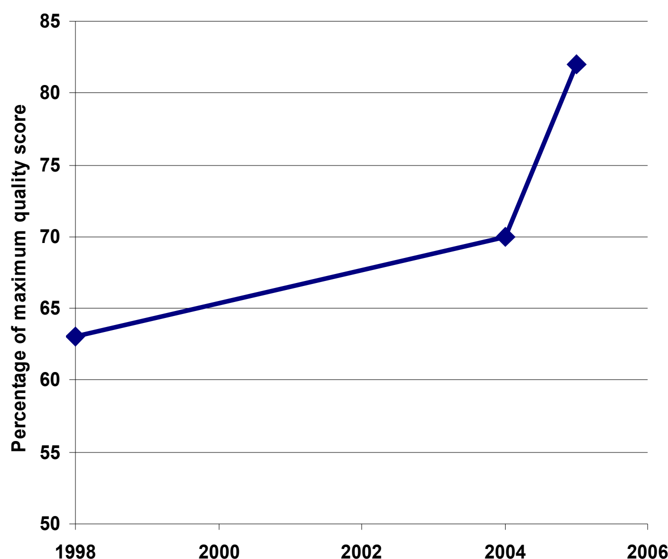


Figure 2. *The improvement in the quality of diabetes care before and after the new GP contract in 2004*

The Department of Health recently announced in their report; *Five Years on: Delivering the Diabetes National Service Framework* that **as a result of the QOF the number of patients diagnosed with diabetes is approximately 2 million**, up from 1.3 million in 2001, meaning more and more patients are benefiting from the improved care they need to manage their diabetes (16).

If the QOF has potential to improve the quality of primary care of chronic disease such as diabetes, has quality of care been sacrificed elsewhere?

No. Although there is increasing evidence from the QOF that care which is better resourced, and where practices are rewarded for providing better quality care can improve health outcomes for patients, there is no evidence that quality elsewhere is reduced (17). Steele *et al* report that the standard of care provided for conditions not presently managed within the QOF has been maintained (17). The unique and extensive data on quality of care that QOF has already provided may enable a revision of other evidence based targets in the future.

Do performance incentives within the QOF encourage GPs to treat or prescribe inappropriately?

A misconception concerning the QOF was that it would lead to GPs prescribing drugs too frequently, including to patients who were unlikely to benefit from them. Although the prescribing of QOF-relevant drugs was increasing prior to the introduction of the new contract in 2004, this rate slowed significantly after the first year of the contract and was slower than the rate of prescribing for non-QOF drugs (18).

The QOF contains a process which allows GPs to exclude patients from care quality indicators. This is known as exception reporting. This process is designed to safeguard patients against inappropriate treatments and ensure patients have choice over their own treatment. Evidence for England indicates that rates of exception reporting are low and that enabling patients to be excluded where it is deemed appropriate adds value to the QOF ensuring that patients receive only the care they need (19).

Does care provided within the QOF stay the same? Will the QOF only be used to provide care for certain conditions?

The QOF has continued to evolve since the inception of the new GP contract in 2004. It has been amended to improve the diagnosis and management of some of the most prevalent chronic disease and continue to address unmet health needs among the population, including depression and dementia. In part this is made possible by the extensive data that QOF is already providing about the health of the nation.

The screening and management of chronic kidney disease (CKD) was introduced to the QOF in 2006 and is a fine example of QOF adaptability. Although the short time frame since the introduction of CKD presently prevents analysis of published QOF CKD data, preliminary comparisons can be drawn from data for similar CKD screening initiatives.

Why was CKD introduced?

The addition of CKD was increasingly relevant due to its associations with diabetes and hypertension treatment of both conditions was already delivered within the QOF. It is estimated that CKD is present in 5% of the population, although prevalence increases with age. The introduction of CKD required GPs to set up a register of all patients over the age of 18 with stages 3-5 of the disease (stages 1-2 are less clinically significant).

Screening of at-risk patient groups, such as those with diabetes and hypertension, has already been identified as an effective intervention to delay CKD progression and reduce disease and mortality (20, 21). Screening of moderate risk patients, such as those with a family history of CKD risk factors is also effective in identifying persons with previously unidentified or poorly controlled CKD risk (20).

Published data for CKD care within the QOF is expected to show equally positive outcomes, satisfying previously unmet need within the UK population.

Does the delivery of high quality care within the QOF reduce hospital admissions?

Social deprivation is a strong predictor of hospital admissions (22) and clearly there are many complex issues relevant to understanding both the fundamental basis for deprivation, and its relationship with the utilisation of healthcare services. However, with such a strong emphasis upon improving the care of chronic disease, the QOF certainly has raised the potential of primary care to reduce hospital admissions and there is already preliminary evidence that higher quality care within the QOF is associated with lower admission rates (23). Asthma UK has reported that national variation in the quality of routine care of asthma within the QOF is associated with rates of asthma admission (24).

Summary

The QOF: a unique public health initiative

The 2004 UK GP contract is unique in international terms, providing an unprecedented empirical benchmark on the quality of healthcare delivered within primary care, but it has also supplied valuable new information on the prevalence of chronic disease in the UK population. Now, in 2008, there is an increasing body of evidence which highlights the positive impact that the QOF is already having upon chronic disease, both in terms of the quality of healthcare delivered and the outcomes experienced by patients themselves. There is also very encouraging evidence that QOF is reducing the inequity in healthcare.

References

1) *PSA Delivery Agreement 18: Promote better health and wellbeing for all*. 2007. http://www.hm-treasury.gov.uk/media/5/A/pbr_csr07_psa18.pdf

2) Department of Health. *Tackling health inequalities: A Programme for Action*. 2003. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268?IdcService=GET_FILE&dID=10311&Rendition=Web

3) Roland M. The Quality and Outcomes Framework: too early for a final verdict. *Br J Gen Pract*. 2007 Jul;57(540):525-7

4) *The NHS Information Centre for Health and Social Care - The Quality and Outcomes Framework* 2006/07. http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework/the-quality-and-outcomes-framework-2006-07 (Accessed August 2008)

5) Shekelle P. New contract for general practitioners. *BMJ*. 2003 Mar 1;326(7387):457-8

6) Tudor Hart J: *The Inverse Care Law. Lancet* 1971, i:405-412.

7) Doran T, Fullwood C, Kontopantelis E, Reeves D. 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. *Lancet*. 2008 Aug 11. [Epub ahead of print]

8) Ashworth M, Seed P, Armstrong D, Durbaba S, Jones R. The relationship between social deprivation and the quality of primary care: a national survey using indicators from the UK Quality and Outcomes Framework. *Br J Gen Pract*. 2007. **57**(539):441-8.

9) Strong M, Maheswaran R, Radford J. Socioeconomic deprivation, coronary heart disease prevalence and quality of care: a practice-level analysis in Rotherham using data from the new UK general practitioner Quality and Outcomes Framework. *J Public Health*. 2006 Mar;28(1):39-42. Epub 2006 Jan 25.

10) Yorkshire and Humber Public Health Observatory. *Diabetes Attributable Deaths*. 2008. http://www.yhpho.org.uk/download/public/1480/1/Attributable%20deaths%20_template2.pdf

11) Data extrapolated from Yorkshire and Humber Public Health Observatory. *PBS Diabetes Prevalence Model Phase 3*. 2008. http://www.yhpho.org.uk/download/public/1478/1/PBS%20Phase%203%20-%20%20Findings.pdf

12) Tahrani AA, McCarthy M, Godson J, Taylor S, Slater H, Capps N, Moulik P, Macleod AF. Diabetes care and the new GMS contract: the evidence for a whole county. *Br J Gen Pract*. 2007 Jun;57(539):483-5.

13) Gulliford MC, Ashworth M, Robotham D, Mohiddin A. Achievement of metabolic targets for diabetes by English primary care practices under a new system of incentives. *Diabet Med*. 2007 May;24(5):505-11. Epub 2007 Mar 22.

14) Khunti K, Gadsby R, Millett C, Majeed A, Davies M. Quality of diabetes care in the UK: comparison of published quality-of-care reports with results of the Quality and Outcomes Framework for Diabetes. *Diabet Med*. 2007 Dec;24(12):1436-41. Epub 2007 Oct 29. Review.

15) National Primary Care Research And Development Centre. *Spotlight - What should happen to the Quality and Outcomes Framework*. November 2007. http://www.npcrdc.ac.uk/Publications/QoF_spotlight.pdf

16) Department of Health. *Five Years on: Delivering the Diabetes National Service Framework*. 2008. http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Diabetes/index.htm (Accessed August 2008)

17) Steel N, Maisey S, Clark A, Fleetcroft R, Howe A. Quality of clinical primary care and targeted incentive payments: an observational study. *Br J Gen Pract*. 2007 Jun;57(539):449-54.

18) MacBride-Stewart SP, Elton R, Walley T. Do quality incentives change prescribing patterns in primary care? An observational study in Scotland. *Fam Pract*. 2008 Feb;25(1):27-32. Epub 2008 Feb 2

19) Doran T, Fullwood C, Reeves D, Gravelle H, Roland M. Exclusion of patients from pay-for-performance targets by English physicians. *N Engl J Med*. 2008 Jul 17;359(3):274-84. Erratum in: *N Engl J Med*. 2008 Jul 31;359(5): 546.

20) Brown WW, Peters RM, Ohmit SE, Keane WF, Collins A, Chen SC, King K, Klag MJ, Molony DA, Flack JM. Early detection of kidney disease in community settings: the Kidney Early Evaluation Program (KEEP). *Am J Kidney Dis*. 2003 Jul;42(1):22-35.

21) McGill JB, Brown WW, Chen SC, Collins AJ, Gannon MR. Kidney Early Evaluation Program (KEEP). Findings from a community screening program. *Diabetes Educ*. 2004 Mar-Apr;30(2):196-8, 200-2, 206. Review.

22) Donnan PT, Dorward DW, Mutch B, Morris AD. Development and validation of a model for predicting emergency admissions over the next year (PEONY): a UK historical cohort study. *Arch Intern Med*. 2008 Jul 14;168(13):1416-22.

23) Downing A, Rudge G, Cheng Y, Tu YK, Keen J, Gilthorpe MS. Do the UK government's new Quality and Outcomes Framework (QOF) scores adequately measure primary care performance? A cross-sectional survey of routine healthcare data. *BMC Health Serv Res*. 2007 Oct 17;7:166.

24) Asthma UK. *The Asthma Divide: Inequalities in emergency care for people with asthma in England*. 2007. http://www.asthma.org.uk/document.rm?id=322

A case study of the Quality and Outcomes Framework (QOF) in General Practice

By Dr Nigel Watson of The Arnewood Practice, New Milton, Hampshire

How has the QOF improved patient care in your practice?

I think the QOF has had a positive impact on GPs and patients. I recognise that some people are sceptical about how much impact measuring what GPs do has on patient care, but it isn t simply a "tick-box" exercise. QOF has focussed the efforts of GPs on *how* they deliver care to their patients and not just the outcome.

My practice achieved max points in year 1 and 2 and last year achieved 998 points.

In my practice each GP has responsibility for a particular clinical area in the QOF. For example, I am responsible for CHD, heart failure, stroke and epilepsy.

CHD

We have audited patients with CHD and we are able to see clear improvements in both cholesterol and Blood pressure control. The percentage of patients who are treated with an ACE inhibitor (a drug used to treat hypertensive patients) has also increased. This is a direct result of the practice identifying and treating more patients with hypertension.

Epilepsy

For some time at our practice, we felt that we could do more to support the 80 patients with epilepsy and we suspected that for some, their epilepsy was not as well controlled as it could be, it was also clear that many on repeat prescriptions did not come to appointments for review. It was also clear that some patients were not taking their medication as prescribed.

So now we send a letter in the month of their birthday and request that the patient returns the letter with the questions answered, we ask:

- *The date of their last epileptic fit*
- *Frequency of fits*
- *Did the patient take the medications prescribed and the dose stated - interestingly many did not.*
- *Did they suffer any side-effects from their medication?*

Interestingly when we did this before all the letters did come back to me, if there were any issues I contacted the patient and asked them to make an appointment to be reviewed by their GP. Patients have been very positive. Two patients who had not experienced a fit for years were referred to a Neurologist to consider coming off their medication. In addition, several patients who had accepted having fits as par for the course have been invited to the practice to have their medication reviewed and in some cases increased to try to get better control.

How has QOF changed the away in which care is delivered within your practice?

We now call patients in the month of their birthday and invite them for blood tests, then an appointment with the nurse for an annual review. If they have diabetes, CHD and a stroke for example, they only need one appointment.

Patients with a long term condition and who often had their care delivered opportunistically now receive a higher standard of care - it is now more organised, and specific targets are measured, explained and we strive to meet them when appropriate.

We have invested in more doctor and nurse time with the additional resources provided by the QOF.

We are now 6 months into the year - I am looking at those patients with CHD, stroke and epilepsy who have birthdays in April to August - and have identified those who have not attended for review and they are then sent a further invitation. If they still fail to attend, the patient’s GP is informed and then generally the GP will contact the patient directly by telephone.

Should GPs not have been providing this care anyway, even without the QOF?

Undoubtedly, some of the care we should be providing, but what the QOF now requires is much more extensive clinical care and the additional resources the QOF provides allows more clinical time directed towards this.

I think back to 1988 when we did an audit of our diabetic patients - there were 200 at the time, in a practice list of 10,000 - care was not as good as we thought so we set up a practice diabetic clinic and have steadily increased the time we spend doing the clinic. In 2008, we have a practice list of 12,800 and 540 diabetic patients, with QOF we now have evidenced based targets which enable us to measure the quality of care we offer and strive to improve this on an ongoing basis. That is one of the great features of the QOF - it encourages evidence led practice which is helpful to GPs but is also benefiting patients.