Letters

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Mangin on QOF

I am no great lover of the Quality and Outcomes Framework (QOF) introduced to general practice for payment from the NHS. However I believe that the thrust of Mangin and Toop's editorial[1] in the June 2007 issue is wrong. I can see how the QOF may appear to some to lead British GPs to coerce patients into accepting care that they do not want, but I do not believe that this is inevitable.

I dispute 'the message that QOF priorities are the most important aspects of care.' What happened with the introduction of QOF is that the delivery of chronic care clinics by nurses has been accelerated, probably because it is perceived as a cheaper option. Unfortunately, nurses are good at following protocols and less good at asking difficult questions of the evidence behind them. This is the trend that I believe leads to uninformed treatment, but it is not due to QOF — it was already happening as the preferred method of delivering chronic disease management in primary care. The effect is that I am less likely to manage life-shortening chronic conditions such as atherosclerosis. Paradoxically, QOF has in some ways reduced the importance of these conditions.

Looking at my working week as a part-time GP, less than 6% of my face-to-face time is spent with the main purpose of delivering care for QOF-related conditions, mainly epilepsy and COPD.

The introduction of QOF has provided software that reminds me when the patient in front of me has important medical conditions which may benefit from being addressed. I can do this after the problems my patient brings to the consultation. We can have an informed discussion together considering the QOF reminders, my clinical knowledge of the evidence, and the patient's viewpoint. Informed dissent is the opposite of treatment and is built into the contract. Without informed dissent the QOF would have the intention of coercion. What the contract actually does is to reward informed discussion. This counteracts the chronic care delivery in nurse-led clinics.

The QOF merely provides a framework for doctors to manage disease. It is the doctor's own professional values and interpretation of the evidence which determines how that framework is shared with patients and the joint decisions applied.

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Reading Mangin and Toop's[1] editorial one would get the impression that the QOF only means doom and gloom. No positive effect is mentioned and the 'unwanted influence of the state' seems near. They suggest a professional education system with the aim to improve the quality of care.

This seems a very one-sided view. Is everything regarding QOF so bad? Reading June's *BJGP* provides a more balanced impression. At least two articles provide a positive effect of QOF: Steel *et al,*[2] show the substantial quality improvement for incentivised conditions. Tahrani *et al,*[3] saw significant improvement in diabetes quality indicators recording. Obviously these studies have their limitations, yet at the very least these effects should not go unmentioned.

However, Mangin and Toop[1] do not seem to look at these studies. Nor do they offer suggestions about how QOF could be improved, for example by more input from the Royal College of General Practitioners' (RCGP) regarding the evidence base of the indicators and which conditions should be covered. Instead, Mangin and Toop advocate an alternative: a professional education system, which uses evidence and feedback, guidance, and options for GPs and patients to interpret themselves. This sounds like an appealing option yet what will their system bring? Grol provides a good overview regarding which interventions lead to improved medical care.[4] This research indicates that a focus on education alone is seldom effective and, as such, Mangin and Toop's suggestion may not deliver. Combined and multi-faceted interventions are recommended and a combination of QOF with an educational system would have more chance of success. For example, one could add a system like Quality Team Development which would help to grasp the intangible aspects of care.[5]

Abandoning QOF completely, however, and going back to just education systems does not seem the way forward.

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Mangin and Toop[1] provide an interesting overview of QOF, reflecting the many useful