

# Funding for general practice in the next decade:

## life after QOF

The tectonic plates of primary care appear to be shifting. In April 2016, Scotland abandoned the Quality and Outcomes Framework (QOF). Then, in October 2016, NHS Chief Executive Simon Stevens gave more than a hint that a similar fate awaits QOF in England. Meanwhile, Wales and Northern Ireland continue with the scheme — for now.

Wider changes are afoot. The Five Year Forward View (5YFV) has trailed the formation of two radically changed models of primary care, termed Multi-Specialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS).<sup>1</sup> In the first, federations of GPs will form single community organisations, joining forces with mental health and social care, maximising the amount of out-of-hospital care. The alternative PACS model is a form of vertical integration with either primary or secondary care taking the lead in linking hospital services with community and mental health services. Both 'new care models' are likely to have substantial funding implications for GPs. Equally far reaching is the constraint provided by the 5YFV on the Department of Health, ensuring that in future only arrangements aligned to the delivery of 5YFV objectives will be supported.

In Manchester, 'Devo Manc' became the first national example of a local authority taking control of its health and social care budget. The vision was to achieve *'the greatest and fastest improvement to the health and wellbeing of the people of Manchester'*.<sup>2</sup> In April 2016, 12 clinical commissioning groups (CCGs) and 15 foundation trusts or trusts joined together to provide health care. In practice, this model of devolution is likely to hand a greater say to local authorities in the commissioning of GP services. Again, the funding implications for GPs are unclear at this stage but are likely to be substantial.

Meanwhile, in Scotland, the changes involve the complete dismantlement of QOF. Since April 2016, Scotland has adopted an approach termed 'values based quality', representing a shift away from 'pay-for-performance'. Instead, GPs will be expected to promote quality improvement, continuity of care, clinical judgement, leadership development, generalist skills: all values closely aligned to professionalism.<sup>3</sup> What is less clear is how this will be reflected in future funding, although, for now, GP funding will be based on historical practice funding, averaged over the previous 3 years. Equally unclear are details of monitoring

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and holding to account for delivering on agreed clinical and public health targets.

### THE IMPORTANCE OF EVALUATION

Three natural experiments are taking place and each needs to be carefully evaluated from the perspective of primary care before untested solutions are imposed on a wider scale. Detailed evaluations of the Scottish experience post-QOF, of the so-called 'Vanguard sites' implementing PACS and MCP care models in England, and of Devo-Manc have been planned. These evaluations are going to be vital if we are to avoid some of the mistakes that accompanied the introduction of QOF in 2004. An early criticism was that it was imposed without being piloted. Evaluations of QOF, now in its 13th year, have given us a greater understanding of what works and what does not work.

### LESSONS FROM QOF

QOF currently consists of 77 indicators representing a mixture of clinical and public health targets. Patient experience and practice organisational targets have been removed in recent years.

For several years, QOF was hailed as the driver of quality improvement in primary care. Formal evaluation failed to bear out this impression, especially when it was discovered that many of the changes preceded the introduction of QOF. The final, more measured, conclusion appears to be that it resulted in modest changes in process indicators, may have contributed to some clinically useful patient outcomes, but made little or no significant difference to overall mortality.<sup>4</sup>

QOF succeeded in raising the profile of evidence-based medicine and refocused primary care on long-term condition (LTC) management. For some clinicians, the 'QOF prompts' were an irritating intrusion into the intimacy of the consultation. For others, the prompts acted as just that: useful reminders of some of the key clinical requirements for monitoring LTCs and providing a useful aide-memoire for patient care. It

would seem perverse if the abandonment of QOF resulted in the disappearance of consultation prompts altogether.

One accusation against QOF is that it detracted from patient-centred care. Instead, it could be seen to promote a narrow guideline-driven model of care. From its inception, QOF contained the provision for 'exception reporting', which ensured that some patients could be exempted from target achievement if deemed to be unsuitable, difficult to engage with, or on 'maximum tolerated therapy'. However, 'exception reporting' was felt by many to undermine the public health goals of QOF and possibly to be amenable to gaming. On the other hand, tight regulation of 'exception reporting' gave the appearance of stifling patient choice. Earlier versions of QOF included 'patient experience' measures. Unintended consequences finally led to their abandonment when it became clear that practices in deprived and ethnically mixed areas struggled to achieve high patient experience scores, effectively delivering a financial penalty to practices based in areas of the greatest health need.

### HEALTH INEQUALITIES

At its best, the NHS should be one of the most equitable systems, free at the point of care with universal access. At first, QOF appeared to be associated with reductions in inequalities, particularly for low-performing practices in deprived areas.<sup>5</sup> Later research findings have shown that clinical targets can stifle achievement with little attempt to exceed predefined targets, a lack of incentive to achieve targets in hard-to-reach patients (such as the homeless or those with serious mental illness), and, conversely, targets achieved more readily in less deprived patients and populations.<sup>6</sup>

Exception reporting may contribute to patient-centred care, but evidence has emerged that 'exceptions' are applied unevenly and are more likely to be applied to patients with multimorbidity, diminishing the potential of QOF to contribute to reductions in health inequality.<sup>7</sup> Multimorbidity has become a central feature of primary care, features

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strongly in 5YFV, and yet is poorly addressed by the current approach to incentivising single-condition targets, which may promote over-treatment and polypharmacy in frail older patients with multimorbidity.

Half the life expectancy gap between highest and lowest deprivation quintiles is attributable to smoking.<sup>8</sup> QOF currently incentivises the recording of smoking status and ‘an offer of support and treatment’ for all smokers, with additional incentives for patients with LTCs. A more vigorous approach including provision of smoking cessation clinics for patients with the greatest health need (for example, patients with COPD, heart failure, or schizophrenia) has not been incentivised.

QOF incentivised a population approach to primary and secondary prevention, particularly of cardiovascular disease, with the potential greatly to enhance the reach of proven healthcare interventions, resulting in both a reduction of inequality and advances in public health. It always seemed anomalous that other healthcare interventions such as immunisation, several types of screening, NHS health checks, and alcohol harm reduction, to name but a few, were not included in a more holistic system of quality metrics.

### THE NEED FOR MORE FUNDING

The simple answer to the question about general practice funding in the next decade is that general practice needs more. Funding has been on a downward spiral since the heady days over a decade ago when QOF was first implemented. NHS funding has been redistributed with a smaller share allocated to primary care; in the 8 years since 2005/2006, there has been a 6% fall in real-terms expenditure on primary care.<sup>9</sup> This has occurred against a background of substantial demographic change, increased patient demand, and a shift of care from hospitals into the community, all of which have brought primary care to the brink. Whatever the new systems being planned for primary care, they are likely to be doomed to failure unless accompanied by adequate funding.

### A SALARIED GP WORKFORCE

The argument for a salaried workforce, and for alternatives to being salaried to GP

partners, has been growing. GP employment may become an integral component of various new models of care including the new MCP/PACS schemes, with contracts held by CCGs, trusts, or local authorities. As such, the old pay-for-performance incentives are likely to operate in a different fashion if a minority of the workforce are self-employed independent contractors. In its place, more corporate ways of rewarding performance are likely to emerge, in return for delivering achievement aligned to the organisational, patient, and public health priorities of the new employer. Uncertainty about employment comes at a price. Until there is greater clarity, or interim measures are agreed such as incentivising deferment of retirement, the lack of a clear career structure and employment terms may act as a deterrent to GP recruitment.

### FUNDING GENERAL PRACTICE

So where does this leave us? We need a system to promote quality that retains some of the strengths of QOF and supports the management of some of our most challenging patients with multimorbidity. It should be explicitly patient centred and aim to narrow health inequalities neglected by QOF. The new system should work equally with a self-employed or salaried workforce. It also needs to be evidence based and derive learning from the current three natural experiments taking place in Scotland, Manchester, and the English Vanguard schemes. Rhetoric around the end of the QOF era has largely been positive, but proposed linkage in a new GP contract between financial rewards and reductions in acute hospital admissions might be a retrograde step. Current evidence is that integrated care in the community does not significantly reduce acute admissions.<sup>10</sup> Future funding should be more clearly linked with those aspects of primary care shown to be effective.

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### Competing interests

Mark Ashworth sits on the National Network of Quality in Primary Care Measures and Indicators group (NHSE).

### Provenance

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