

# Paying GPs to improve quality

## Auditing payments under the Quality and Outcomes Framework

Health briefing, February 2011

**The Department of Health introduced the Quality and Outcomes Framework (QOF) in 2004 as part of a new contract for general practitioners (GPs). It incentivises GPs to improve their services to patients, including improved clinical care and better outcomes. It operates through a system of points which are awarded for levels of achievement against set criteria and for which GPs then receive financial reward. Around £1 billion is paid out each year to over 8,300 GP practices under the QOF.**

This briefing is not about the overall impact of the QOF and its value in improving care. It focuses on how primary care trusts (PCTs) discharge their duty to ensure payments are properly made and in doing so can be certain that the right patients

are being provided with the right services under the QOF, challenging practices where this is not the case. There is wide variation, from good to poor, in how PCTs do this. We have set out what good practice should be. It involves good understanding and use of data, better targeted assessments and better trained assessors.

It is clear that there are considerable differences in the proportion of patients that practices reach to meet their QOF targets. Some patients may be missing out on a service. The differences also raise questions about the administration of the payments. Subject to any revisions to the QOF, the proposed NHS Commissioning Board will have an opportunity to introduce a consistent and rigorous national approach.

## What we did

- 1** The Audit Commission's review focused on QOF payments, specifically on exception reporting, arrangements for conducting visits to practices by PCTs and action taken. We did not look in detail at other payments to GP practices, such as the global sum, or payments for enhanced services.
- 2** In addition, we looked at information produced by the NHS Information Centre on exception reporting and exception rates, as well as reports on overall achievement under the QOF.
- 3** We did not look at completeness of disease registers. However, GPs' QOF scores will be affected if they do not identify and include appropriate patients on disease registers as the number of patients needing a service will be understated. The care of those patients may also be affected.
- 4** In carrying out our review, we collated the findings of external auditors who had carried out work at 12 PCTs, ranging from discussions with key staff to detailed reviews. We also spoke directly to three PCTs to confirm our findings. The arrangements for auditing QOF payments in the 12 PCTs varied from good to poor. It is not possible to say where other PCTs stand in this spectrum.

## QOF payments

- 5** Payments under the GP contract, introduced in 2004, are made under 'a high trust system' (Ref. 1). This policy approach sets the framework for PCTs.
- 6** Payments to GP practices are of three types:
  - the global sum (this represents by far the biggest proportion and is formula-based);
  - QOF payments; and
  - payments made for enhanced services (known as DES, directly enhanced services, or LES, locally enhanced services).
- 7** The QOF is a way of rewarding GP practices for meeting higher standards in quality of care. It is not a performance management system. The QOF system is voluntary, although most GP practices take part. Practices score points across four areas known as 'domains', covering:
  - clinical care;
  - organisation;
  - patient experience; and
  - additional services.
- 8** The clinical domain is the largest. It comprises 86 indicators across 20 clinical areas and is worth up to 697 points out of the 1,000 available (69.7 per cent) (Ref. 2).

**9** Achievement under the QOF has always been high and from the start was higher than expected – over 90 per cent in the first year against an expected 75 per cent achievement.

**10** In 2009/10, GP practices achieved an average of 936.9 points, 93.7 per cent of the 1,000 points available under QOF (Ref. 2). This was slightly lower than the previous year because of changes in the QOF, especially the change to the Patient Experience domain. The average payment to GP practices was £118,770 at £126.77 per point.

**11** Of GP practices, 1 per cent achieved the maximum 1,000 points and less than 15 per cent of GP practices achieved less than 90 per cent of the available points. At PCT level, performance varied from 878 points to 972 points. In the clinical domain achievement fell to 95.9 per cent from 97.8 per cent in 2008/09 (Ref. 2).

## Exception reporting

**12** The clinical indicators carry with them the concept of exception reporting, which allows GPs to ‘except’, that is exclude certain patients from their returns for payment. This is set out in the national QOF guidance (Ref. 3) and includes, for example, those who refuse to attend reviews when invited, or where a ‘good practice’ medicine cannot be prescribed because of contra-indications. The guidance also includes a much vaguer criterion of ‘patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, for example terminal illness, extreme frailty’.

**13** With every indicator there are potentially three groups of patients: those who are excepted; those who have not been reached; and those who receive a service. The middle group is represented in the percentage of QOF points below 100 per cent that a practice scores. There are two possible explanations for patients in this group: either they should be exceptions but the GP has not recognised them as such; or they have simply not been reached. It seems likely that most practices will have some patients who they do not reach.

**14** The NHS Information Centre for Health and Social Care publishes a great deal of information about exception rates and QOF performance more generally. The overall exception rate, across all clinical indicators, was 5.41 per cent in 2009/10. This is up from an overall rate of 4.87 per cent in the previous year (Ref. 3). In 2009/10 22 GP practices exception-reported fewer than 30 patients. Equally, 30 GP practices exception-reported more than 3,500 patients. There seems to be little difference in QOF scores between practices that except relatively few patients and those that except relatively many.

15 Exception rates between PCTs varied from 3.81 to 7.65 per cent (Ref 3). Figure 1 below shows the overall exception rate by PCT.

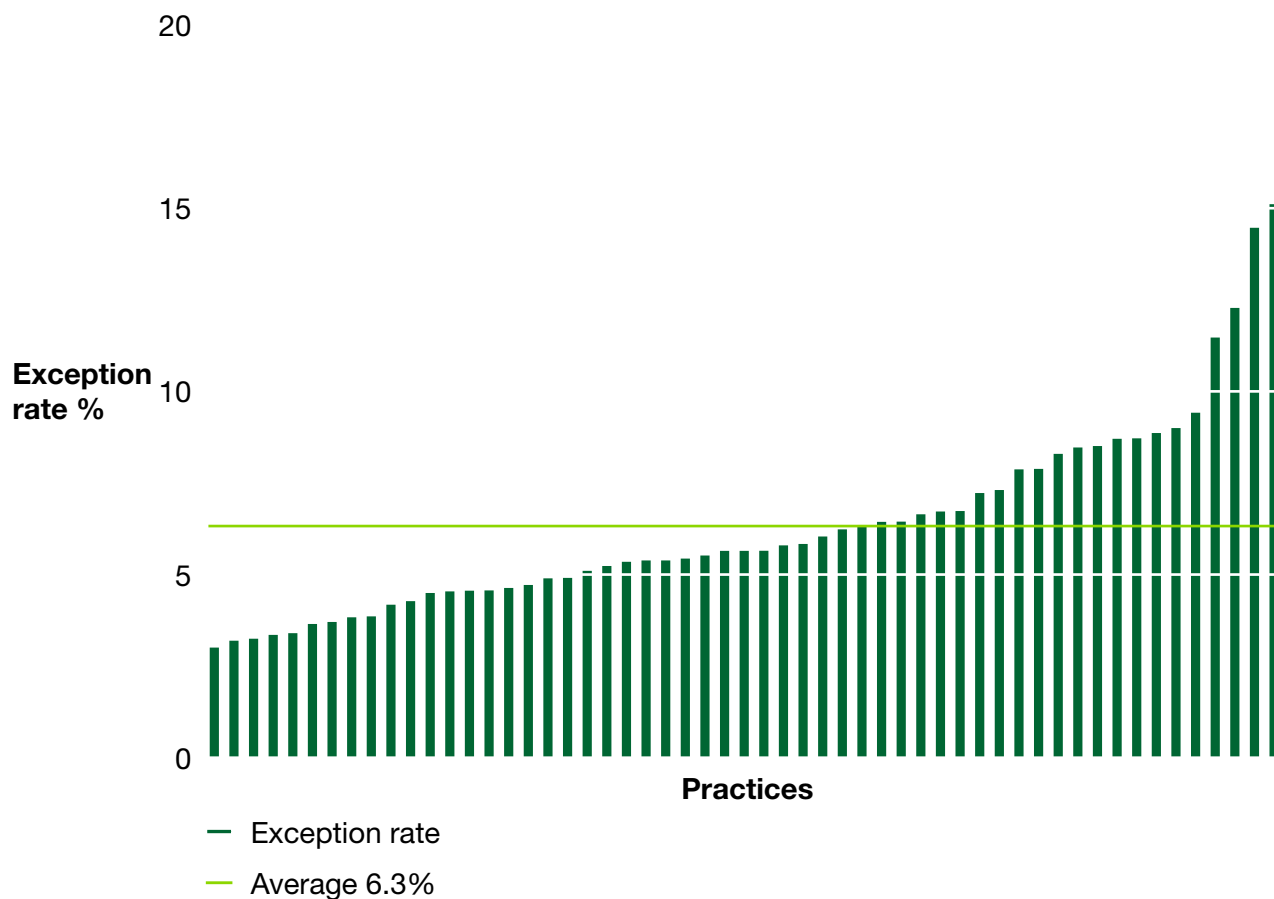
Figure 1: Overall exception rates range from 3.81 to 7.65 per cent



Source: NHS Information Centre for Health and Social Care

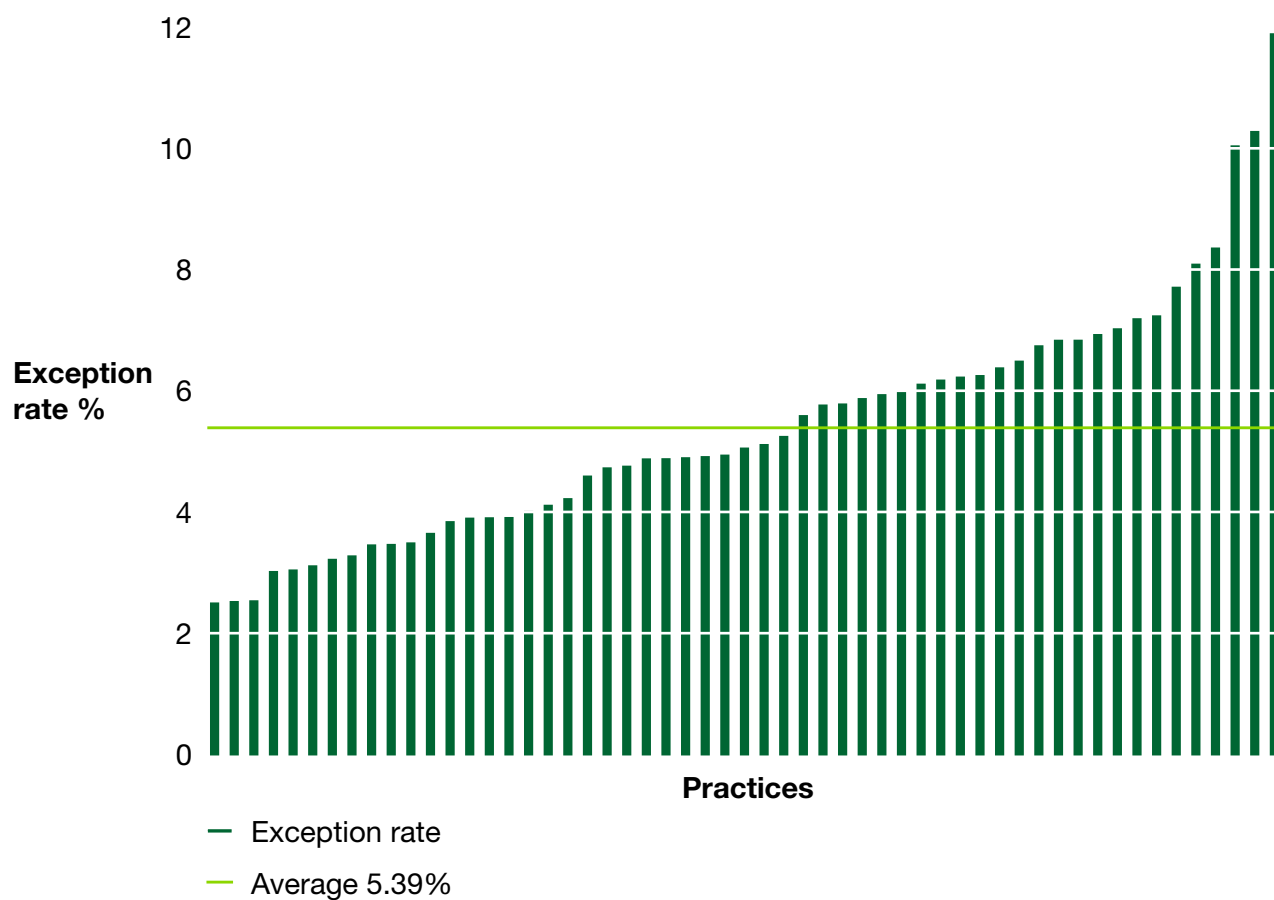
**16** Exception rates within PCTs show a greater degree of variation, as one would expect. Figure 2 shows overall exception rates by GP practice for two PCTs with an average number of practices (54/55), one in the north of England and one in the south.

Figure 2a: **Overall exception rates at practices within two sample PCTs vary from 2.5 to 15.1 per cent: South PCT**



Source: NHS Information Centre for Health and Social Care

Figure 2b: Overall exception rates at practices within two sample PCTs vary from 2.5 to 15.1 per cent: North PCT



Source: NHS Information Centre for Health and Social Care

**17** Exception rates by indicator groups varied from 0.48 per cent (hypothyroidism) to 18.97 per cent (cardiovascular disease primary prevention). Individual indicator exception rates varied from 0.48 per cent (thyroid 02) to 37.81 per cent (heart failure 04) (Ref. 4). Tables 1 and 2 list the indicator groups and indicators respectively, with the highest exception rates for 2009/10. Apart from CHD10 (coronary heart disease), the other four indicators with the highest exception rates were new for 2009/10.

Table 1: **Indicator groups with the highest overall exception rates**

Indicator group	Exception rate 2009/10 (%)	Total number of exceptions 2009/10
Cardiovascular disease primary prevention	18.97	119,103
Heart failure	17.23	93,808
Chronic obstructive pulmonary disease (COPD)	12.65	348,939
Mental health	10.80	102,104
Epilepsy	7.82	77,806

Source: NHS Information Centre for Health and Social Care

Table 2: **Indicators with the highest exception rates**

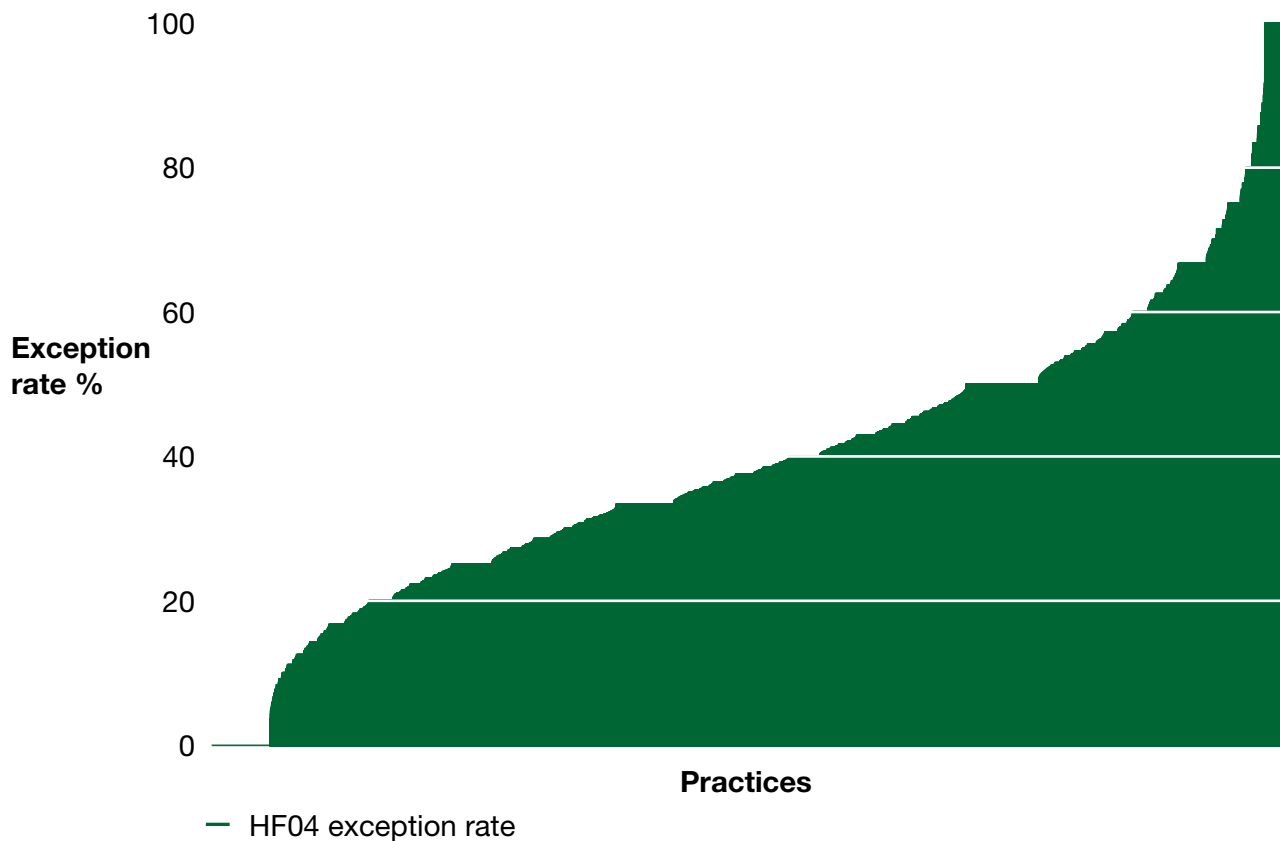
Indicator	Exception rate 2009/10 (%)	Total number of exceptions 2009/10
Heart failure 04 <sup>i</sup>	37.81	67,463
Depression 03 <sup>ii</sup>	32.69	121,649
CHD10 <sup>iii</sup>	23.67	445,679
Primary prevention 02 <sup>iv</sup>	19.94	67,672
Primary prevention 01 <sup>v</sup>	17.82	51,431

Source: NHS Information Centre for Health and Social Care

- i** The percentage of patients with a current diagnosis of heart failure due to LVD (left ventricular disease) who are currently treated with an ACE (angiotensin - converting enzyme) inhibitor or angiotensin receptor bocker, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant of, or having a contra-indication to, beta-blockers.
- ii** In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care.
- iii** The percentage of patients with CHD who are currently treated with a beta-blocker (unless a contra-indication or side-effects are recorded).
- iv** The percentage of people diagnosed with hypertension, diagnosed after 1 April 2009, who were given lifestyle advice in the last 15 months for increasing physical activity, smoking cessation, safe alcohol consumption or healthy diet.
- v** In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA [transient ischaemic attack]) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment tool.

**18** However, even within indicators with the highest exception rates, there is significant variation by GP practice. Figure 3 shows a pattern of exception rates for HF04 (an indicator on heart failure) similar to other indicators. Some practices have no exceptions. Others seem to except all, or nearly all, their relevant patients.

Figure 3: **Exception rate for HF04 by GP practice**



Source: NHS Information Centre for Health and Social Care

**19** We would expect exception rates to vary according to, say, geography, deprivation or the particular circumstances of the practice and its patients. However, we would expect PCTs to understand the reasons for high or unexpected exception rates and take suitable action to ensure patients are only exception-reported for legitimate reasons. Minimising, or eliminating, inappropriate exception-reporting of patients will help to ensure that the maximum number of patients benefit from GP services, and health outcomes and the management of long-term conditions are improved. We would also expect PCTs to test other aspects of QOF payments to ensure payments are being properly made.

## What we found

**20** We identified areas of weakness both with PCTs' and GP practices' arrangements and with the guidance in place for PCTs, GPs and GP practices. However, we also found robust arrangements at some PCTs and examples of good practice, which we encourage PCTs and GP practices to consider. Features of a good approach to monitoring QOF payments are described in paragraph 52.

**21** The issues fall within two broad areas:

- Probity – are payments made to GP practices correct and justified?
- Value for money – are PCTs getting good value from the payments they make to GP practices and are patients getting the services they should be getting?

We will also be revising guidance issued to auditors to ensure they are considering the potential impact of weak arrangements in fulfilling their responsibilities to give an opinion on PCTs' accounts.

## Guidance and documentation

**22** There is much guidance for PCTs and GP practices setting out the requirements of the QOF, exception reporting and undertaking visits to GP practices. Some find this useful and satisfactory. Others find it of limited value. Reasons for dissatisfaction with the guidance include concerns that it allows too much local interpretation and discretion. Others see it as guidance and therefore something that PCTs cannot impose locally. The detailed guidance on the various criteria within the clinical indicators domain contains many links to extra information, but most of this information is difficult for non-clinicians to understand, interpret or carry out. Also, as this extra material applies more widely than the QOF, it is sometimes difficult to use as guidance rather than simply more information.

**23** The national guidance has developed and improved over the years. Local material also often adds to it. However, achieving consistent interpretation and outcomes will require more specific and definitive guidance, either through revision, or in new guidance produced to support a replacement for the QOF.

**24** In relation to documentation and evidence, the best PCTs had evidence to support exceptions for a chosen indicator, including detailed reasons and notes of discussions with practices. The PCTs' assessors examined this evidence and probed further if it was not available. However, other PCTs simply allowed practices to record 'informed consent/no response' and satisfied themselves with blanket assurances that practices were following the guidance.

## Scope and purpose of practice visits

**25** Attitudes to practice visits varied. Some PCTs suggested the purpose of QOF visits was to help GP practices maximise their income. If this

involves helping GP practices by spreading good practice to improve their achievement under QOF, and ensuring that as many patients as possible benefit from the services, this is positive. However, if the aim is simply to improve QOF scores there may be no real benefits to patients. However, most PCTs found it difficult to prove a link between high QOF scores and improved outcomes for patients.

**26** Lack of independence sometimes added to lack of clarity about the scope and purpose of QOF visits. Most PCTs use GPs from within their own area as clinical assessors and, while this is understandable and practical, especially in less urban areas, it may not result in a rigorous regime. Some PCTs have let contracts for GP assessors but, even where this has taken place, PCTs have still only appointed GPs from within the PCT area.

**27** The information provided to assessors by PCTs to enable them to focus their visits effectively also varies. Sometimes we found the assessors set their own agendas and received little or no information. Good practice involved providing assessors with good quality, tailored information, including data packs, before visits. Packs could include general data about all GP practices and an individual practice report with comparisons of exception reporting against other GP practices in the PCT area and against the national average and prevalence data. Assessors could then review the indicators with high exception rates and seek explanations and evidence from the GP practices. Practice reports should be produced after each visit.

**28** At one PCT, the QOF lead reviews all exception levels for all domains and all practices in April each year, which is good practice. The PCT seeks explanations for unusually high exception levels from the practices and the assessors. If levels remain high, the PCT asks the practice to carry out an audit and follows this up in the next routine visit.

## Benchmarking

**29** Some PCTs used data and indicators to review GP practices' performance. Some included public health information, prevalence rates and locally developed indicators, as well as the data on achievement and exception rates produced by the NHS Information Centre for Health and Social Care. PCTs usually did this in more detail when comparing practices within a PCT or locality but sometimes PCTs compared their practices with others nationally.

**30** However, we also came across PCTs that carried out little or no benchmarking, either to assess practices' relative performance, or to inform QOF visits. Some PCTs were aware of GP practices within their area that were 'outliers' in terms of achievement under QOF or exception rates and had examined and understood the reasons for this: other PCTs were not. One PCT produced reports incorporating exception rates, prevalence and QOF achievement. The clinical governance group and the three locality

GP assessors use the reports to decide which GP practices require visits. At the other end of the spectrum, one PCT admitted it had carried out little in the way of benchmarking.

**31** Benchmarking information, however, may be of little help if it cannot be used for more probing. One PCT's clinical governance team benchmarked exceptions by type and used a 10 per cent tolerance to identify outliers. However, the PCT's own GP assessors were unclear about how the figures were calculated and could not reconcile them to GP practices' own data.

**32** Our auditors found that some PCTs had concerns about GP practices exception-reporting all patients because of where they lived: for example in nursing homes or hostels. Given that exception reporting is about the clinical condition of patients, not their location, this seems hard to justify. PCTs need to be clear whether they support GP practices exception-reporting in this way and, if not, take action.

## Assessor quality and training

**33** Some PCTs experienced difficulties getting assessors. This has sometimes been the reason, or at least one reason, for carrying out less frequent QOF visits. Most PCTs have a small team of clinical assessors many of whom have been assessors for some years. Some PCTs accept it has proved difficult to recruit new clinical and lay assessors and some PCTs do not routinely use lay assessors in their QOF teams. Lay assessors add an important user perspective and may be seen as being more independent than the GP assessors, so a balanced team is preferable.

**34** One reason for the difficulties in recruiting clinical assessors may be that the role involves checking up on, and potentially being critical of, local colleagues. Using assessors from outside the area may help to overcome this.

**35** The training provided is usually satisfactory, although basic. However, one PCT visited described its own training for assessors as 'not very robust or consistent'. The PCT also had concerns about the consistency with which QOF guidance was used and interpreted.

**36** One GP assessor described the PCT's direction and training for GP assessors on how to focus their visits and improve awareness and understanding about the purpose of the QOF visits as being 'lacking'.

**37** We did identify some good practice. One PCT is introducing an appraisal system for its GP assessors, while another now requires assessors to sign annual job descriptions which is a useful way of creating a shared understanding of the nature and purpose of the role.

## Frequency and resourcing of QOF visits

**38** Some PCTs do not carry out annual QOF visits to GP practices and although PCTs can carry out visits only every three years, some do not meet this standard. We found one PCT that had, for several years, only carried out visits to practices that had asked for them.

**39** Good risk assessment can help PCTs decide their programme of visits. This is important where PCTs carry out visits every three years rather than yearly. Good PCTs will consider a range of information and examine key indicators and then set their programme accordingly. We found PCTs where there was no risk assessment of individual practices to inform either the timing or the focus of the visit.

**40** Moving from annual to three-yearly visits was sometimes based on an assessment of overall risk but sometimes was due to the availability of assessors and the cost of carrying out visits.

**41** One PCT only visited 15 per cent of practices each year, although they are now moving back to an annual visit to every practice. Another had a rolling programme that had led to less than 50 per cent of practices being visited in a three-year period. These are not only examples of non-compliance with guidance but they also represent missed opportunities.

**42** Some PCTs have been able to resource annual visits to all GP practices. This included one PCT with over 100 GP practices that had a team of 20 assessors, including 11 GP assessors.

**43** QOF visits represent a significant commitment for PCTs, both in time and money, and they may not regard this as well-spent. Even a robust system for checking payments is unlikely to result in significant financial savings from claw back of overpayments. PCTs should not approach their assurance process with this goal uppermost in their minds. The purpose of the QOF is to improve health outcomes for patients and ensure patients get the treatments, tests and procedures they need to improve health outcomes and reduce inequalities. PCTs need to use QOF visits as an important lever for achieving this.

## Reporting and following up visits

**44** We came across some cases where little or nothing had been done to follow up findings, or issues identified in QOF visits. Sometimes, assessors had asked for more information but appeared to have been satisfied with letters thanking the PCT for raising the issue and assuring the PCT that the practice took QOF seriously.

**45** Sometimes there was no evidence to show that issues identified had been followed up or that challenges made to GP practices, for example around exception reporting, had been resolved.

**46** Some PCTs produced detailed visit reports with action plans and followed these up in return or later visits. We found one PCT that had a GP practice that had exception-reported patients who did not attend for reviews after writing to them three times. However, as many of the patients concerned did not have English as their first language, the PCT was not prepared to accept that the GP practice had done all it could as it had written to them in English.

**47** Some PCTs also take action on the basis of their findings, including reducing payments where GP practices have been unable to evidence compliance, or withholding payments until the practice produced satisfactory evidence.

**48** We found wide variation in reporting to PCT Boards on achievement under QOF or the outcome of QOF visits. These ranged from PCTs that provide no information to their Boards, to others that provided good quality reports annually to both their Professional Executive Committee and Board covering all key areas.

## Conclusion

**49** The approach to all aspects of managing and monitoring the QOF varied significantly in the PCTs reviewed. Some have sound arrangements. Others do not. There is, however, no evidence to suggest any systematic 'gaming' by GP practices to improve their scores and so increase the payments they receive by over-reporting exceptions.

**50** Greater consistency of approach would provide better assurance that QOF payments were being properly made. It could also bring benefits for patients. Data on exception reporting suggests that the QOF does not benefit as many patients as it could. Some may not be receiving the treatment and care they need.

**51** We set out below the features that we consider characterise good practice in managing and monitoring QOF payments.

### Features of a good approach to monitoring QOF payments

**52** Good arrangements for managing and monitoring the QOF include:

- Annual QOF visits to GP practices, or every practice being visited at least once every three years based on a robust and systematic risk assessment involving the use of benchmarking, both local and national, including achievement, exception rates and prevalence rates.
- Job descriptions should be used to create a shared understanding of the assessor role and there should be an appraisal system for assessors.
- QOF visits carried out by appropriately trained GP and lay assessors (but preferably not local GPs) that:
  - focus on high-risk areas;
  - challenge GPs;

- examine evidence; and
- report and follow up findings (including suspending or reducing payments where evidence is not provided to support payments).
- Regular checking of QOF claims.
- Scrutinising 'block exceptions' whereby, for example, all registered patients in nursing homes or hostels are excepted from reporting. This practice is likely to lead to inequality in terms of access to services and treatments, and outcomes.
- Linking QOF visits to pre-payment verification (PPV) work and ensuring the quality of the 5 per cent random check process.
- Identifying high exception rates and seeking supported explanations.
- Monitoring changes in the pattern of QOF scores and exception rates.
- Using information on the local population's health needs and on the clinical areas where exceptions are taking place, to ensure the QOF is maximising the contribution to improving health.
- Producing good quality visit reports and ensuring findings are followed up.
- Reporting annually to the Board on QOF scores and the outcome of benchmarking and visits, including summarising the impact on patients as well as any financial consequences.

## What about the future?

**53** At present it is uncertain how the QOF will operate and be monitored if the changes proposed in the White Paper *Equity and Excellence: Liberating the NHS* take place. The consultation document *Commissioning for Patients* proposes that the QOF should be reformed 'to focus more on health outcomes... and to provide incentives for continuous improvements in quality of care' (Ref. 5). The NHS Commissioning Board will need to think about its overall strategy. But it will be able to deliver a consistent, rigorous approach to monitoring payments: taking forward the approach adopted by the best PCTs and scrutinising payments in a more systematic way than has been done to date.

**54** *Commissioning for Patients* suggests that GP consortia might manage some aspects of primary medical services contracts. There may therefore be a role for them in relation to QOF but this will need careful management if conflicts of interest are to be avoided.

## References

- 1 *Delivering Investment in General Practice – Implementing the New GMS Contract*, Department of Health, December 2003.
- 2 *Quality and Outcomes Framework Achievement Data 2009/10*, The NHS Information Centre for Health and Social Care, October 2010
- 3 *Quality and Outcomes Framework Guidance for GMS Contract 2009/10*, Department of Health, March 2009.
- 4 *Quality and Outcomes Framework Exception Data*, The NHS Information Centre for Health and Social Care, October 2010.
- 5 *Liberating the NHS: Commissioning for Patients – Consultation on Proposals*, Department of Health, July 2010.

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