

Barking & Dagenham Primary Care Trust

Report on the Quality and Outcomes Framework, 2004/5

1.0 Background

- 1.1 In April 2004, the new General Medical Services (nGMS) contract¹ was implemented across the United Kingdom, which brought many significant changes to the provision of primary healthcare in the country, including a greater emphasis on the quality of care. One of the main vehicles for the delivery of this is the Quality and Outcomes Framework (QOF), which is a voluntary scheme, designed to raise clinical and organisational standards, reduce morbidity and mortality, and improve the patient experience.
- 1.2 During the period 2004/5, all of the 42 primary care practices within Barking and Dagenham Primary Care Trust (PCT) participated in the QOF, and this paper summarises the PCT's QOF achievement, the costs involved in the whole process and integrating outcomes into the quality agenda and bigger picture.

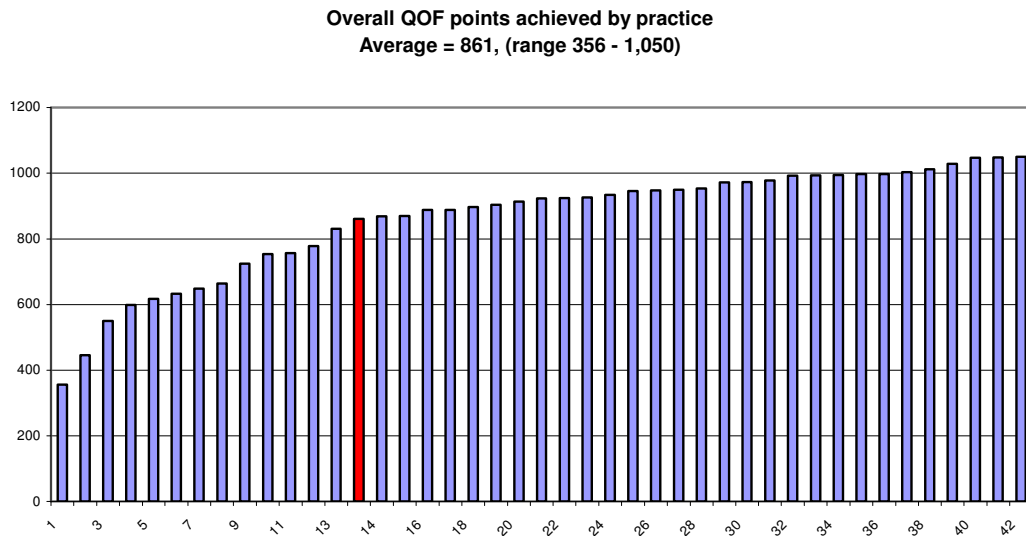
2.0 Quality and Outcome Framework: A Summary

- 2.1 The QOF is a voluntary system of standards, incentives and assessment relating mainly to the essential and additional services. Practices are assessed on the basis of their performance in four key domains. Each domain contains a range of areas described by key indicators. The four domains are:
- **Clinical:** coronary heart disease, stroke or transient ischaemic attacks, hypertension, diabetes, chronic obstructive airways disease, epilepsy, cancer, mental health, hypothyroidism and asthma.
 - **Organisational standards:** records and information about patients, education and training, practice management and medicines management.
 - **Patient experience:** use of accredited questionnaires to gain patient views and make appropriate improvements, and ten-minute consultations.
 - **Additional services (with defined quality standards):** cervical screening, child health surveillance, maternity services and contraceptive services.
- 2.2 Although the framework is well defined, it was not designed to incorporate every element of general practice. Some of the clinical domains listed above had very few indicators associated with them, and

assessment in areas such as referrals to secondary care, use of diagnostics and provision of enhanced services was excluded. Further, the QOF did not assess individual performance; it was designed to consider the practice's performance against certain indicators.

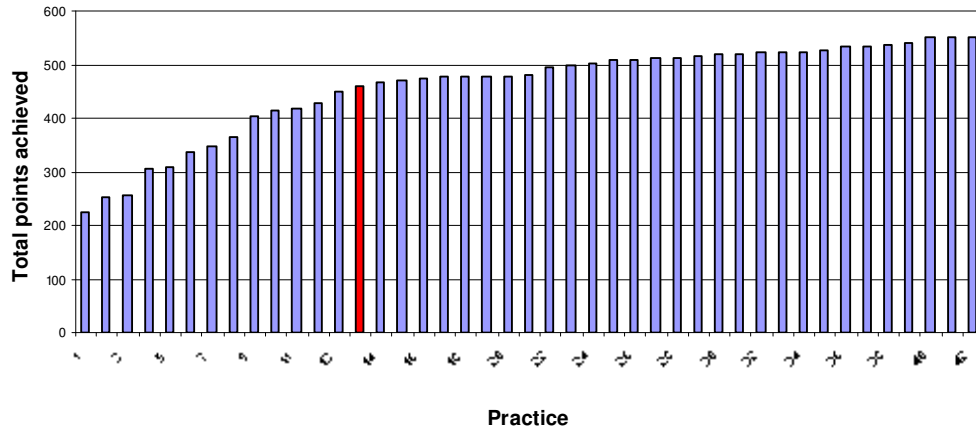
3.0 PCT performance

- 3.1 The maximum points available per practice were 1050 points; the value for each point was £77.50, which was adjusted for disease prevalence and patient list size. The PMS practices received a 168-point deduction, which was a national adjustment exercise based on the fact that these practices have had chronic disease management allowance, sustained quality allowance, and cervical cytology payments included in their baseline payments.
- 3.2 The PCT achieved a final accumulation of 36,207 points. The average practice achievement was 861 points (82% of points available); with the PMS points reduction the average practice achievement was 821 points (78% of points available). There was a wide range in the points achieved across the PCT, as shown in the graph below:-



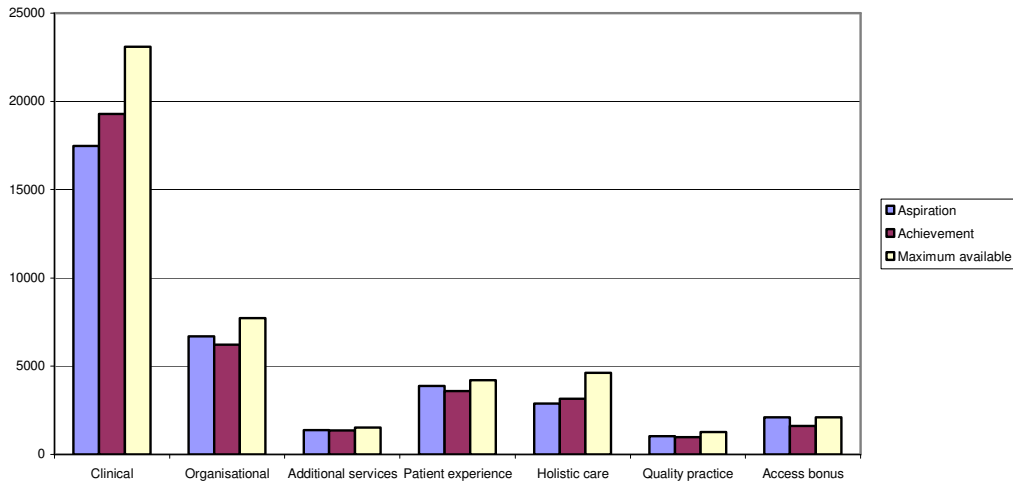
- 3.3 Practices within the PCT achieved 83% of the maximum available points in the clinical domains, with an average of 459 points achieved against a maximum of 550. The range is shown on the graph on the following page:-

QOF points achieved against clinical domains by practice
(Average 459, range 223 - 550)



3.4 Practices were required to state their aspirations for the year prior to April 2004; by the end the year, the overall achievement was 36,157 points, against an aspiration figure of 35,418, a difference of 2.1%. The graph below summarises the PCT performance against the different domains and illustrates achievement against the maximum points available:-

QOF aspiration v achievement v maximum available points



4.0 Costs

4.1 Considerable investment has been made to general practice; the total cost to the PCT for the QOF for 2004/5 was £1,797,907. If the PMS deductions are not included, this rises to £1,888,907, which is £34,287 higher than the cost predicted through the aspirations payment mechanism.

- 4.2 The PCT undertook assessment visits from October 2004 – January 2005, which involved a visit by a lay member, a GP and a senior manager. At the end of each visit, the assessment team produced a report, which was shared with the practice, the Chief Executive and PEC Chair. The total cost of these visits (and the associated training courses) was £18,770, which covered locum costs, travel claims and the honourarium fee to each lay member.
- 4.3 This does not include the costs associated with the significant demand placed on the workload of PCT officers in supporting practices, undertaking assessments and planning the process. This needs to be borne in mind for the coming year.
- 4.4 The value of quality points will increase for 2005/6 to £124.60 per point, for practice with an average list size. Based on current performance, QOF payments will rise to £2,890,570. If all practices achieved maximum points this figure would increase to £5.3m, although this is highly unlikely, it is highly probable that practices' performance will improve in comparison to last year, as they are now becoming more familiar with the details within the QOF.

5.0 Benefits of the QOF process

The QOF process has realised a number of benefits for primary care within Barking and Dagenham PCT. These include the following:-

5.1 Incentivising provision of a high quality service

The QOF process has placed an emphasis on the provision of a high quality service, and has rewarded practices that have concentrated on this important aspect of primary care provision. The process has helped the PCT to both identify and congratulate strong performing practices, and has encouraged them to share their work with others.

5.2 Improving relationships between the PCT and practices

The reviews carried out were both summative and formative, in that they performed a verification and an inspection function, as well as a forward-looking, quality improvement role. As a consequence, the review represented a significant opportunity for the PCT to establish robust supportive links with practices and form part of an ongoing process of dialogue and engagement.

5.3 Meeting targets

The framework has had a key role in supporting the PCT in the achievement of a number of national targets in areas such as chronic disease management (CHD, Diabetes, COPD) and cancer. It also rewarded practices that had managed to achieve the 24/48 hour access target without making use of the walk in centre service.

5.4 Service re-design

The QOF has been a major incentive for practices to update their IT systems and ensuring that templates are in place and accurate coding occurs. It has acted as a catalyst for role re-design and practice staff have had their roles revised to maximise the opportunities of the QOF and reflect the changes of the new GMS contract.

5.5 Model practices

Based on the evidence that the PCT collected during its assessment visits, and the data collected on QMAS, it has been possible to identify the characteristics of a strong performing practice. These are:-

- All the practice staff are IT literate, and use the practice system to its full potential
- The clinical staff use their computers during consultation
- The practice regularly monitor progress against QOF
- The practice nurse is highly involved in the management of patients suffering with long term conditions
- The practice has a well informed and well developed practice manager, who is given a high degree of freedom in exercising his/her duties.
- The practice operate as a team, recognising and responding to each other's strengths
- The practice does not focus on specific clinical domains.
- The practice has invested its aspiration payments in the practice, to improve its score at the end of the year.

5.6 Provision of detailed information

The data held on QMAS, which is provided by individual practice system, contains information that previously has not been readily accessible across the PCT. This includes information on disease register size, as well as the % of patients meeting certain national targets. The information is aggregated, and is therefore anonymised; it provides the PCT with a strong data to assist in future planning and service delivery.

6.0 Issues for Consideration

There are several areas that need to be considered in relation to the above:-

6.1 QOF as an indicator of primary care performance

The QOF represents only one measure of certain clinical and organisational targets within practices and is not a full reflection on the whole performance of practices within primary care. Other issues, such as admission, prescribing and mortality rates, as well as patient satisfaction, should also be considered to obtain a broader overview of each practice and its performance relative to others in the PCT.

The PCT is developing a contract monitoring review process which will run in parallel to the QOF review process, to consider other aspects of the contract with each practice.

6.2 Associated costs

Whilst the PCT has made provision in its LDP for the likely additional costs associated with QOF claims for 2006/7, no consideration has been given to the opportunity costs associated with the amount of time that senior managers spent on the review process.

6.3 Process for 2005/6

Given the positive responses from practices to the assessment process, the PCT is keen to repeat this during 2005/6. Given changes to the PCT structure, there is likely to be some gaps in the availability of senior managers to honour this commitment, and the Board is asked to note and agree to support the QOF lead in addressing this issue.

6.4 Future support to practices

The QOF process for 2004/5 identified a number of training needs for a significant number of practices across the PCT. Some of these were clinical issues (e.g. the use of spirometry), and others were organisational (e.g. the purpose of staff appraisal). The PCT will identify these and support practices by providing appropriate training. Similarly, practices that have achieved high points could be used as quality benchmarks with examples of good practice that facilitated achievement shared to practices that performed at a lower level.

6.5 Use of QMAS data to support the public health agenda

As discussed above (5.6), QMAS has released a significant amount of information across the PCT that was previously difficult to collate. This data will be used to support the PCT's public health agenda associated with reducing health inequalities. One of the most interesting data items is that of the PCT's prevalence for the ten clinical domains, in comparison to the national average. With the exception of diabetes and mental health, the prevalence for other conditions such as CHD and COPD is lower than the national average, which is somewhat surprising,

given the higher mortality rates that have been identified. The PEC will be considering the possible reasons for this in the near future.

6.6 Local QOF indicators

Along with most PCTs across the country, Barking and Dagenham decided not to explore the development of local QOF indicators during the first two years of the process. However, the PCT may wish to explore further, local indicators to incentivise practices to meet the associated with National Standards, Local Action, e.g. the recording of Body Mass Index for patients, or to encourage other evidence based practices with a view to improving the quality of life of the practices' patients. Given that this will have resource implications, this will be considered by the LDP Steering Group in the first instance.

6.7 Freedom of Information Act

Information from QOF will also be made available to the public on the PCT's website, in accordance with the Freedom of Information Act 2000, to promote the high achievement made by local practices.

7.0 Recommendations

The Board is asked to:

- Note the considerable achievement of practices in exceeding their aspirations and the costs involved.
- Provide the Primary Care and Community Services with the support required to the development of the QOF process in future years.

Graham Blowes
Head of Corporate and Primary Care Performance
June 2005

1. Department of Health. Delivering Investment in General Practice. 2003 Available at www.doh.gov.uk/gmscontract/implementation