# Quality Indicators in British General Practice: or, the pros and cons of performance related pay!

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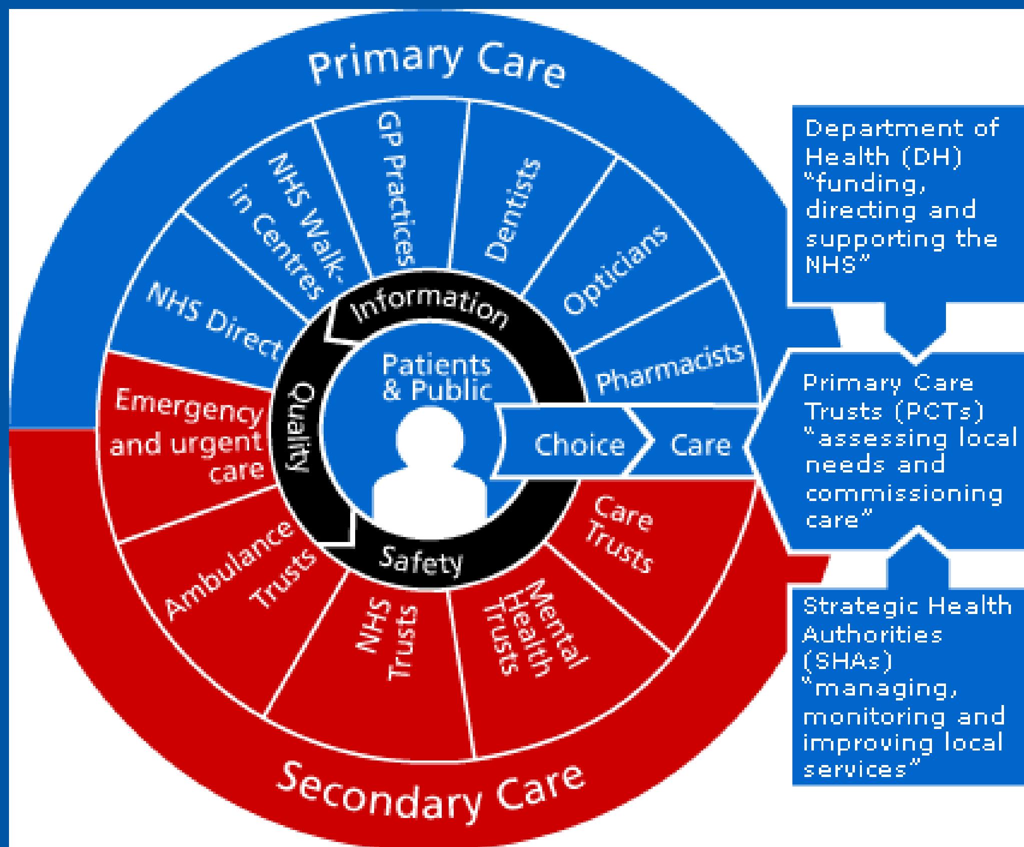
national primary care research and development centre

# Content of the presentation

- Variation in practice: the need for quality improvement in general practice
- What does research tell us about what makes a difference to quality of care
- UK government initiatives 1998-2003 – did they make a difference?
- Quality related pay 2003-2006 – intended and unintended consequences


Primary Care
GP Practices
Dentists
Opticians
Pharmacists
NHS Walk-in Centres
NHS Direct
Information
Quality
Safety
Patients & Public
Choice
Care
Emergency and urgent care
Ambulance Trusts
NHS Trusts
Mental Health Trusts
Care Trusts
Secondary Care
Department of Health (DH) "funding, directing and supporting the NHS"
Primary Care Trusts (PCTs) "assessing local needs and commissioning care"
Strategic Health Authorities (SHAs) "managing, monitoring and improving local services"

## 1980s

- Quality can’t be measured
- There’s no such thing as a bad doctor

## Good practice allowance – first suggested in the UK in 1986

The conference said “No” to a Good Practice Allowance.

Dr Wilson said that the Good Practice Allowance was political and provocative. It was prepared by a government who only listened to philosophers and trendy professors.

Report from the British Medical Association
BMJ 1986; 293: 1384-6

# 1990s in the UK

A decade of quality improvement initiatives, mainly from Government

But what improves quality?

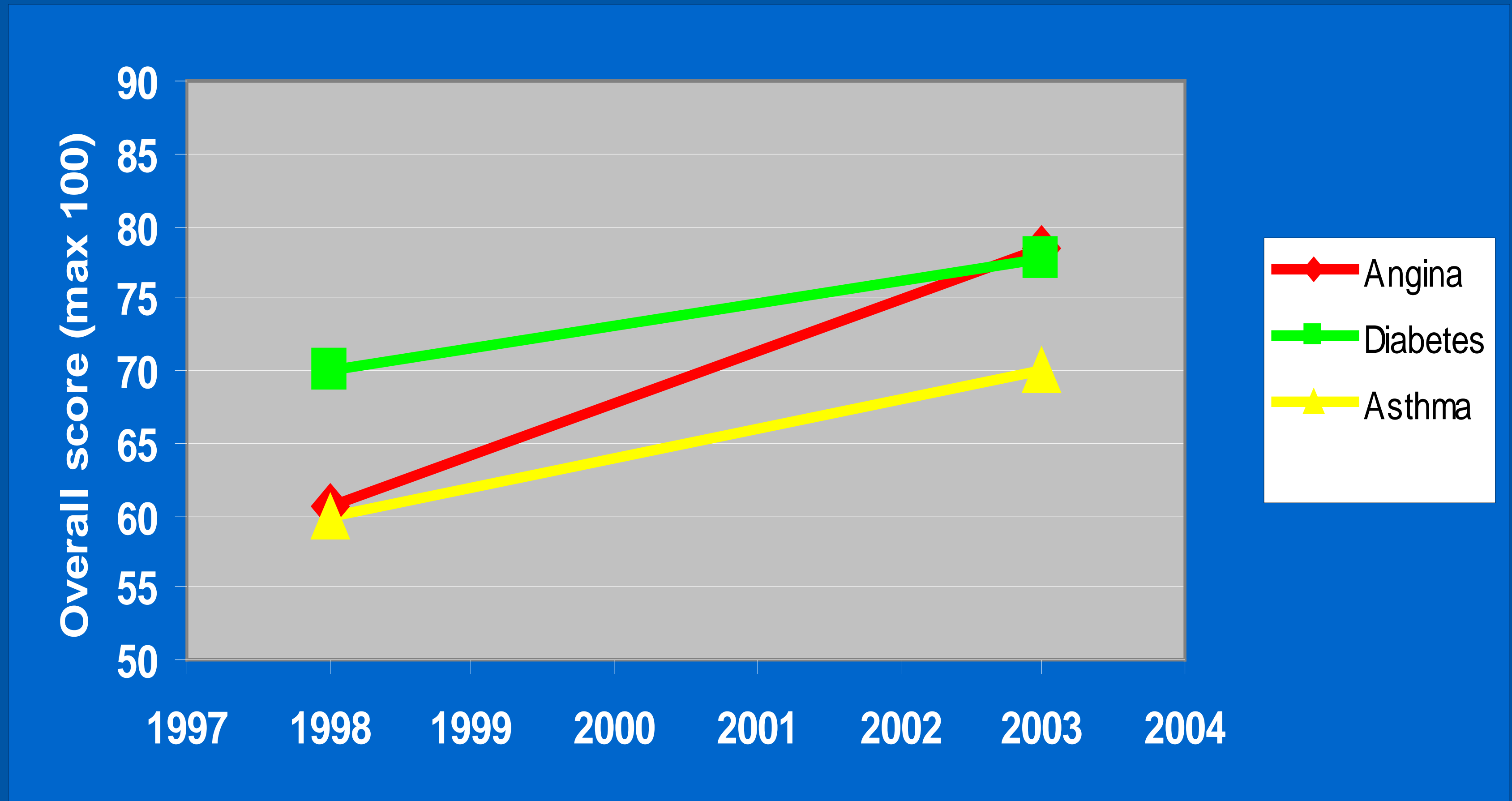
And did they work?

# Achieving quality in practice in the 1990s

100
80
60
40
20
0

- guidelines
- audit and feedback
- opinion leaders
- prp
- education
- all of the above

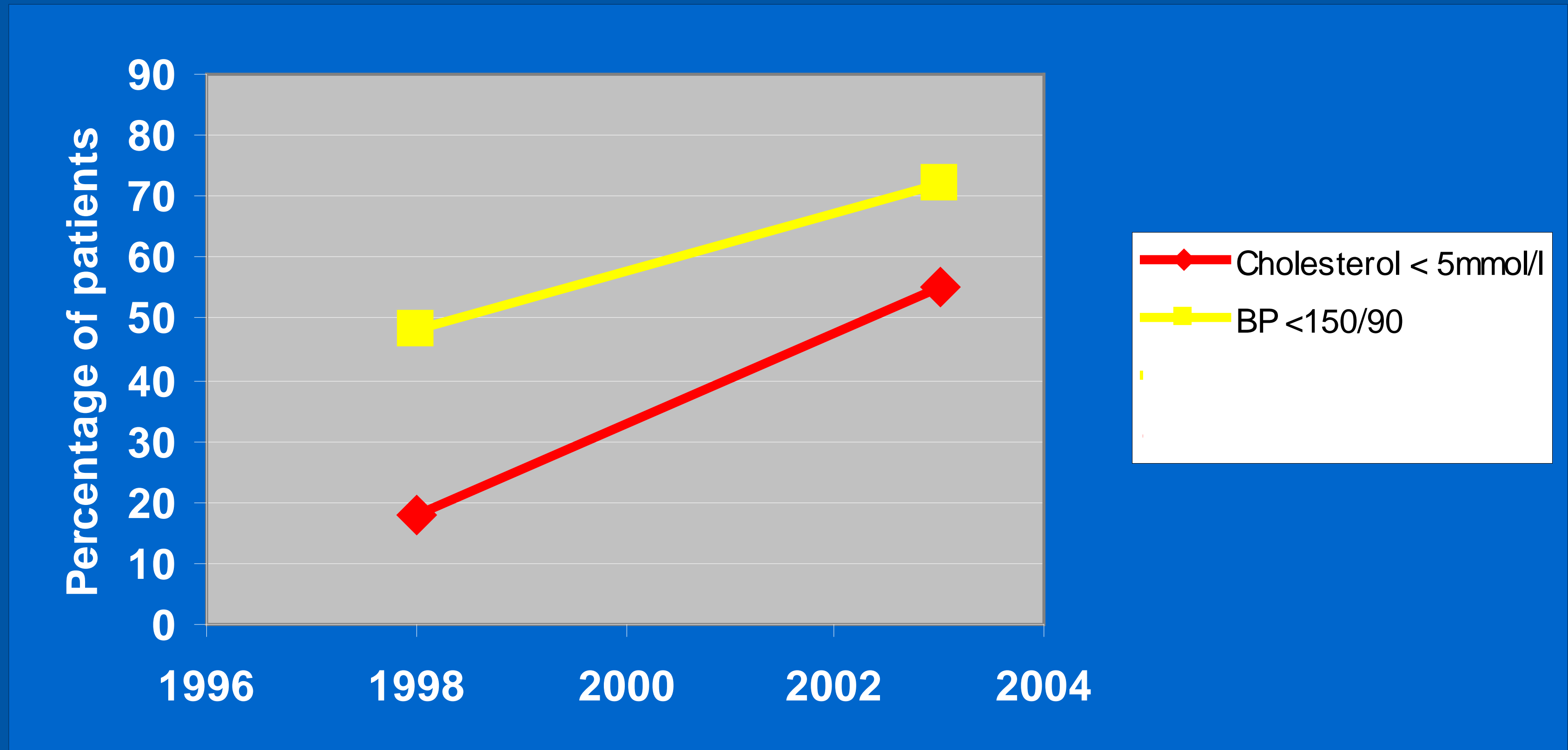
# Quality of care in the UK improved between 1998 and 2003




**Quality of care in 42 representative English practices.**

**Campbell et al. BMJ 2005; 331: 1121-1123.**

# Quality of care improved between 1998 and 2003 (patients with coronary heart disease)



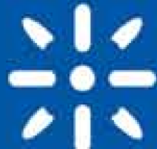

Quality of care in 42 representative English practices.
Campbell et al. BMJ 2005; 331: 1121-1123.

## 1980s

- Quality can't be measured
- There's no such thing as a bad doctor

## 2000

- Care is too variable
- Quality can be measured
- Care can be improved- the advent of EBM
- Public perceptions and disquiet
- It's expensive to provide high quality care
- "We want to be resourced and rewarded for providing high quality care"
- Political will to invest in the NHS underpinned by sustained economic growth



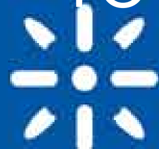
# 2003 UK pay for performance scheme "Quality and Outcomes Framework"

**25% of GPs' income relates to a complex set of initially 146 quality indicators**

- Chronic disease management (ten conditions)
- Practice organisation (five areas)
- Additional services (four areas)
- Patient experience (consultation length and patient surveys)

# Target domains and points available

| Domain | N of indicators | Points available | % of total |
|---|---|---|---|
| *(Evidence based indicators)* | | | |
| Clinical | 76 | 550 | 52% |
| Organisational | 56 | 184 | 17% |
| Patient Experience | 4 | 100 | 10% |
| Additional Services | 10 | 36 | 3% |
| | | | |
| *(Additional payment points)* | | | |
| Holistic care (clinical) | | 100 | 10% |
| Access bonus (24/48 hr access) | | 50 | 5% |
| Quality Practice (non-clinical) | | 30 | 3% |
| | | | |
| TOTAL | 146 | 1050 | 100% |



# Details of the clinical domain

| | N of indicators | Points Available | % of total |
|---|---|---|---|
| Ischaemic heart disease | 15 | 121 | 22% |
| Hypertension | 5 | 105 | 19% |
| Diabetes | 18 | 99 | 18% |
| Asthma | 7 | 72 | 13% |
| COPD | 8 | 45 | 8% |
| Mental health | 5 | 41 | 7% |
| Stroke | 10 | 31 | 6% |
| Epilepsy | 4 | 16 | 3% |
| Cancer | 2 | 12 | 2% |
| Hypothyroidism | 2 | 8 | 1% |
| Total | 76 | 550 | 100% |

**CHD 7.** The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months.

Point score: from 1 point (40%) to 7 points (90%)

**CHD 8.** The percentage of patients with coronary heart disease whose last total cholesterol (measured in the last 15 months) is 5 mmol/l or less

Point score: from 1 point (40%) to 17 points (70%)

# Reported achievement, Year 1

Median: 83.5%

IQR: 78.4% - 87.0%

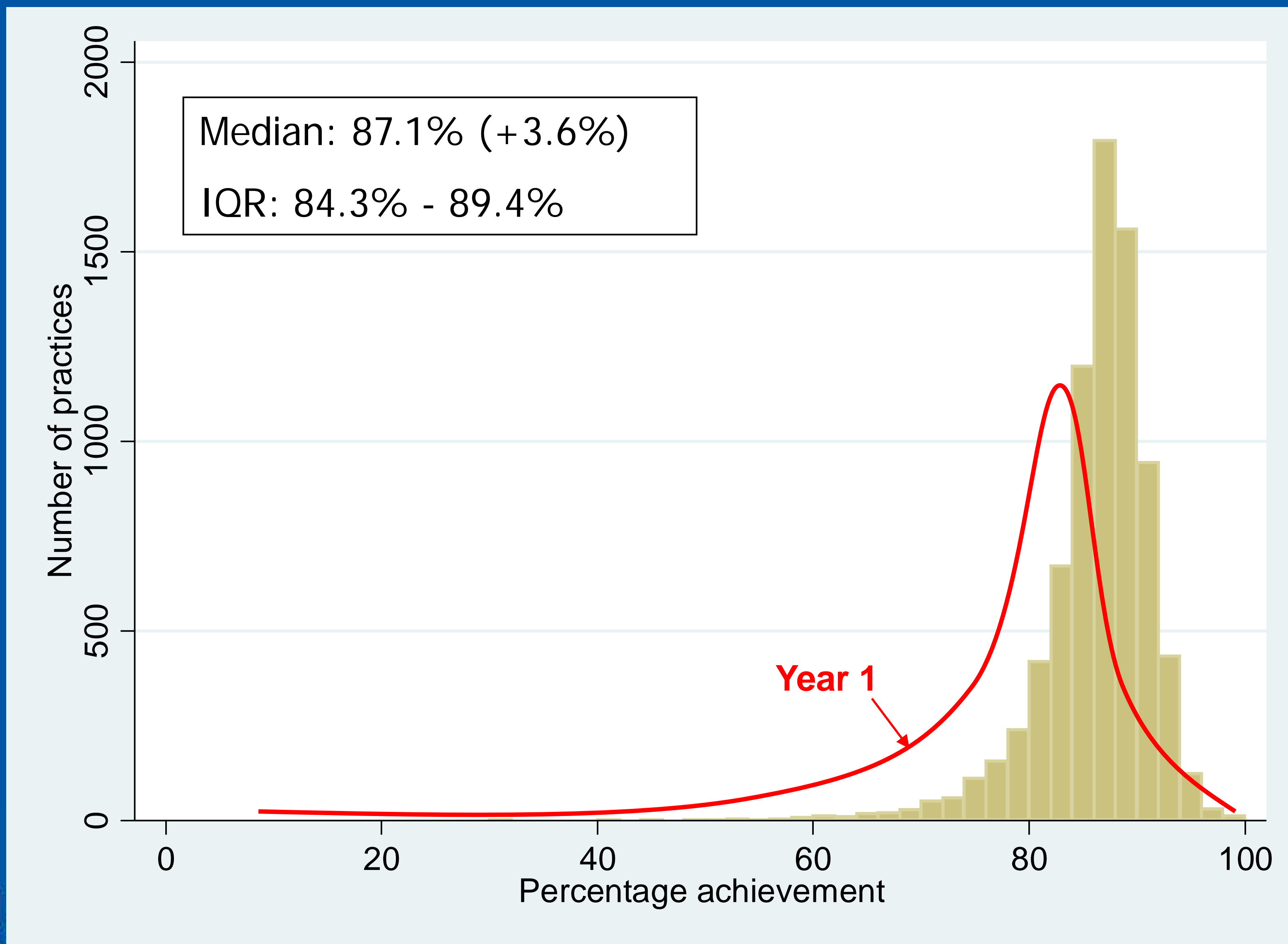
Number of practices

0
500
1000
1500
2000

0 20 40 60 80 100

Percentage achievement

# Reported achievement, Year 2



# Target domains and points 2006-8

| Domain | N of indicators | Points available | % of total |
|---|---|---|---|
| *(Evidence based indicators)* | | | |
| Clinical | 80 | 655 | 65% |
| Organisational | 43 | 181 | 18% |
| Patient Experience | 4 | 108 | 11% |
| Additional Services | 8 | 36 | 4% |
| *(Additional payment points)* | | | |
| Holistic care (clinical) | | 20 | 2% |
| TOTAL | | 1000 | 100% |

# QOF changes in 2006

**166 points change: 137 in clinical areas**

| | N of indicators | Points Available |
|---|---|---|
| **Depression** | **2** | **33** |
| **Atrial Fibrillation** | **3** | **30** |
| **CKD** | **4** | **27** |
| **Dementia** | **2** | **20** |
| **Obesity** | **1** | **8** |
| **Palliative care** | **2** | **6** |
| **Learning Disability** | **1** | **4** |
| **Ethnicity recording** | **1** | **1** |

PULSE-i
Informing
Supporting
Championing

QOF depression screening tools 'next to useless'

CKD fad is a triumph of fashion over sense

CKD targets drive mass overuse of ACE drugs

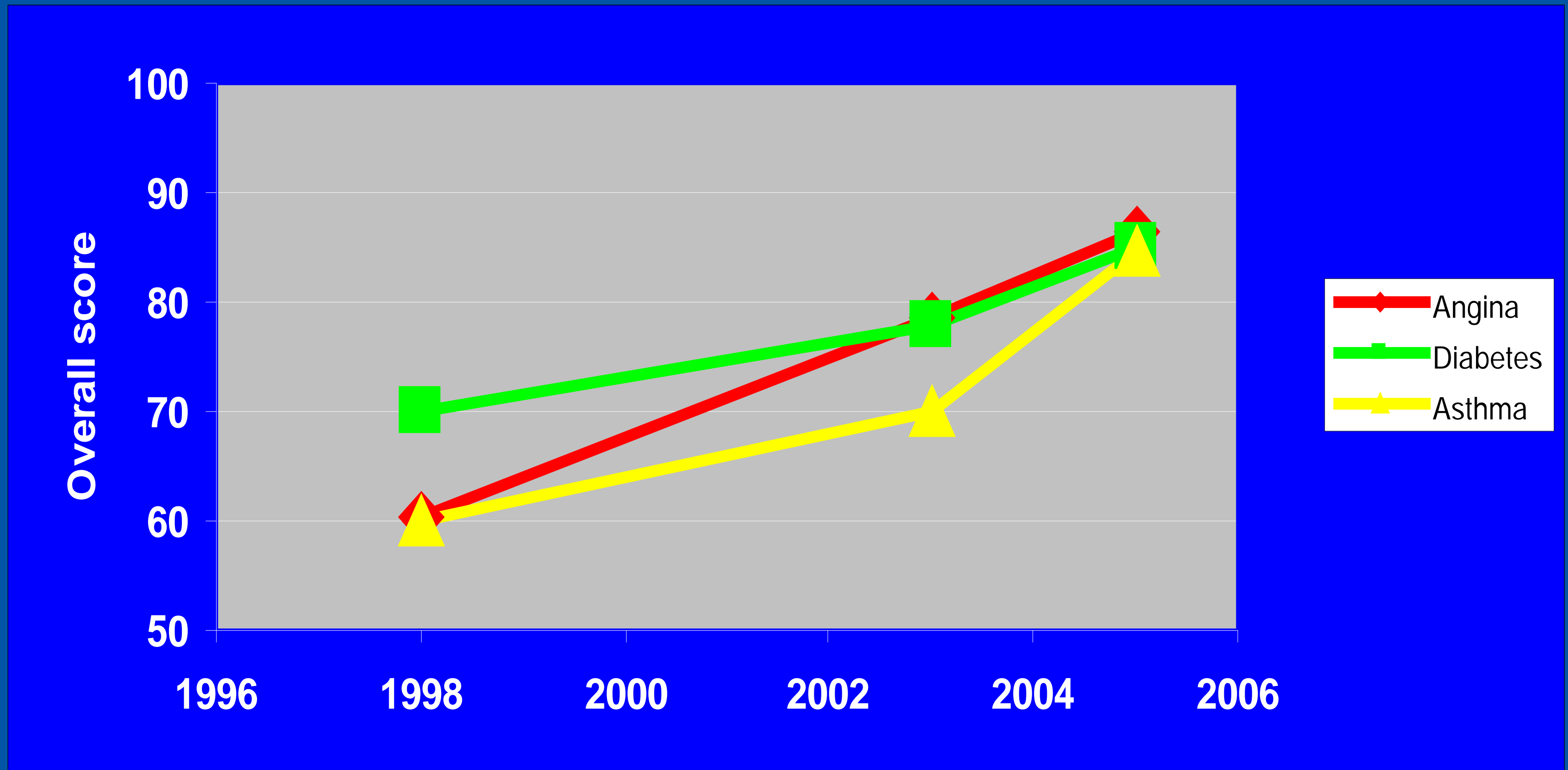
Depression and CKD targets hit income

**What are the effects of this type of financial incentive likely to be?**

# What might the effects be?

- Improved care
- Increased computerization / admin. costs
- Fragmentation, less holistic approach
- Un-incentivized areas get worse care
- Gaming or misrepresentation
- Change in professional values

# Quality of care improved further between 2003 and 2005, following the introduction of financial incentives




**2005 data extends the time series in 42 representative practices reported by Campbell et al. BMJ 2005; 331: 1121-1123.**

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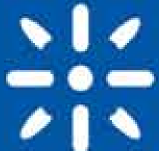

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# Less holistic approach?

**"The profession has essentially been bribed to implement a population based disease management program that often conflicts with the individual patient centered ethos of general practice…it comes dangerously close to medicine by numbers and threatens the basis of general practice."**

**Lipman T. Br *J Gen Pract* 2005; 55: 396.**

THE QOF IS HARMFUL TO PATIENTS

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# Exception reporting for clinical indicators

- Patient refused
- Not clinically appropriate
- Newly diagnosed or recently registered
- Already on maximum doses of medication

# Exception reporting rates

Overall median 5.55%

444 practices (4.5%) had overall exception rates higher than 10%

n=8105 practices in England

Standardised overall weighted truncated exceptions

25
20
15
10
5
0

-1 0 1 2 3 4

Standardised percentage of the population who belong to an ethnic minority

# What might the effects be?

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- Fragmentation, less holistic approach
- Un-incentivized areas get worse care
- Gaming or misrepresentation
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**“We developed this zero tolerance of blood pressure. No-one is allowed to say ‘It’s a little bit up, leave it’ …. it’s not acceptable.”**

**Senior GP**

**Roland M, Campbell S, Bailey N, Whalley D, Sibbald B. *Primary Health Care Research and Development* 2006; 7: 70-78**

“They (the GPs) forget we’re actually nurses. You’ve not stopped all day because you have had ill patients. And then they come in and tell you that you are 1% down on a target.”

**Practice Nurse**

**"I enjoy being given the autonomy to manage the different diseases…. because we are actually meeting targets, patient care has definitely improved."**

**Practice Nurse**

**“It will not provide the care for the whole person. It doesn’t allow that I have sat in this chair for over twenty years and I know my patients really well. It doesn’t allow for that. You can’t count that…and you can’t count the caring element.”**

**Senior GP**

# Trends in Job Satisfaction

Mean overall satisfaction

7
6
5
4
3
2
1

5.23
4.26
4.67
3.95
4.62
5.24

1986 1988 1990 1992 1994 1996 1998 2000 2002 2004 2006

Survey year

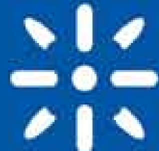
# Lessons for others?

- Incentives in the UK appear to have improved the quality of patient care; avoided inappropriate treatment through exception reporting and improved GP job satisfaction
- Good quality baseline data are important
- Indicators that go beyond national guidelines need careful piloting and educational support
- IT infrastructure is essential
- The financial costs have been substantial, reflecting reward and resource and may have been too much?

"An initiative to improve the quality of primary care that is then boldest such proposal on this scale ever attempted in the world…with one mighty leap, the NHS has vaulted over anything being attempted in the Untied States, the previous leader in quality improvement initiatives."

Shekelle P. *BMJ* 2004;326:457-8.

Thanks for listening!



# Could P4P increase health inequalities?

- Practices in deprived areas may be financially disadvantaged
  - Lower rates of achievement
  - Reduced financial reward for same level of achievement
- Patients in deprived areas may not benefit
  - More likely to be exception reported
  - Less likely to be registered

**“The greatest challenge facing contemporary medicine is for it to retain or regain its humanity- its centre- without losing its essential foundation in science…to find a middle way.”**

**James Willis. The Paradox of Progress. 1994.**

# Patient and public involvement 2006

27%
25%
13%
15%
10%
5%
3%
1%
1%

- National societies
- Patient groups
- Pharmaceutical companies
- Individuals
- PCOs
- NICE
- Networks
- RCGP
- Healthcare Commission