

What would good quality assurance look like in primary care?

Introduction

In our work at National Voices, every day we hear about ways in which primary care professionals have made a positive difference to people living with mental and physical health conditions and disability. However, we also know that the current state of play for primary care services is not working consistently - for people accessing these services or for the primary care workforce.



Figure 1: Word cloud showing workshop participants' responses to, "What does primary care mean to you?".

In 2018, when the Quality and Outcomes Framework (QOF) was last under review, many of our member charities voiced their concerns about the potential loss of QOF. For example, Diabetes UK highlighted that if the Government were to withdraw QOF indicators, there would be a high level of risk of a corresponding decline in measures of diabetes care. We know that many of our members share the same concerns for the conditions they cover.

While QOF plays an important role in incentivising quality patient care, it also generates important data on the state of patient care across conditions and communities in England. For example, many of our members have used QOF data to create a snapshot of the quality of care available to people they support, such as through the [British Heart Foundation's fact sheet](#), [Asthma + Lung UK's research on asthma prevalence by geography](#) and the [Stroke Association's resources on treating and managing atrial fibrillation](#).

In May 2023, the Government published its Primary Care Recovery Plan and committed to consult on the future of the Quality and Outcomes Framework (QOF) and Investment and Impact Fund (IIF). The Investment and Impact Fund (IIF) is an incentive scheme focused on supporting primary care networks (PCNs) to deliver high quality care to their population, and the delivery of the priority objectives articulated in the NHS Long Term Plan and in Investment and Evolution.

In November 2023, we held a roundtable session with members and people with lived experience to gain a clear picture of the perspectives of diverse groups of patients and patient charities on the future of financial incentives and quality assurance within primary care.



Figure 2: Word cloud showing workshop participants’ responses to, “What does quality mean to you?”.

Overview

National Voices’ members recognise that the current QOF system is not working well for GPs or patients. The program is failing to drive person-centred, coordinated, holistic care with people often not feeling part of their own care plan. Too often it is seen as a tick box exercise, with some patient groups reporting people aren’t even aware they have had an annual review or similar under the system.

The system is seen as unfair however, for those members who advocate for people with long-term conditions that are not part of a QOF indicator, as these patients are not receiving similar health touchpoints, especially in light of the current GP capacity pressures. Overall, despite many of our members representing conditions that are supported by QOF, people felt the

programme should be adapted to enable improvement in the quality of care for everyone.

However, without clarity on a proposed alternative, members are wary of recommending whole-scale change as they recognise that the current system does drive high patient episodes and also provides valuable data sets, such as ethnicity, which are otherwise not well recorded elsewhere.

If there was real appetite within NHS England and the Department of Health and Social Care (DHSC) for change, it was hoped a shift from micro payments to macro PCN-wide payments would enable funding to be repurposed to develop and support meaningful community prevention projects, with a real appetite to see these focused on reducing health inequalities.

Our Findings

How are current financial incentives in general practice currently working for people?

Variation in effectiveness of indicators

When QOF was first established, it was hoped that it would provide impetus for action and help people access earlier diagnosis and treatment pathways. For some conditions, such as hypertension, cholesterol control and lipid management, and diabetes mellitus, financial incentives have proven more successful as indicators include specific measurable outcomes. For example, data shows QOF has increased the number of people with diabetes accessing care pathways, which is directly linked with better clinical outcomes.

However, for other conditions, indicators do not seem as effective because the indicators either don't reflect people's needs and/or do not improve experiences of accessing care on the ground. For example, the QOF indicator for asthma fails to recognise that some diagnostic methods are not widely available, therefore the asthma register is likely to exclude people who have been unable to get a diagnosis while including others who may be misdiagnosed with asthma. There is also concern that QOF indicators lack specificity, such as those on checking asthma inhaler technique or the creation of an asthma action plan, and therefore cannot be assumed to be offering the gold standard of care.

Tick box, one-size fits all approach

We heard that financial incentive programs can feel “tick-boxy” and do not necessarily translate into people receiving better care even if their condition is covered by an indicator. One member told us this has become increasingly noticeable as primary care pressures have increased, with some practices offering the cheapest possible intervention to achieve the indicator specified, which often doesn’t deliver the care needed by an individual.

For example, Dementia UK shared that the QOF indicator can help people receive a dementia diagnosis, but that this often doesn’t translate into patients and their families receiving the follow-up care needed to help them come to terms with their life-changing diagnosis and subsequently manage the condition. Furthermore, as the health and wellbeing of the carers of people with dementia is often under strain, this in turn can have an impact on people with dementia. Incentivising carer assessments would ensure a more holistic approach to the health of the whole family.

“The small print of QOF tells us what we should be doing...but in reality that small print isn’t implemented,”

- Quote from workshop participant

QOF also adopts a one-size-fits-all approach regardless of the severity of a person’s condition. For example, one participant shared that two people with diabetes would each receive a single annual health check even if one was struggling to manage their diabetes and needed extra support, and the other was maintaining good blood glucose control. The GP practice would successfully meet the QOF criteria in each case, but the person struggling to cope would not be guaranteed extra follow-up support.

The same was heard about the asthma QOF, with people not receiving follow-up care after an annual review, even if that review flagged the need for extra support to help them manage their health.

Some members feel that QOF incentivises low hanging fruit. For example, only 70% of people with asthma on a GP practice list need to be reviewed to meet QOF criteria, but with current GP time pressures, it’s often the people facing greater social disadvantages and/or those who have more complex cases that are not reviewed.

Benefits of QOF

Yet while current financial incentive programs may need some improvements, it was widely agreed that having these methods of holding general practice to account is important. [Diabetes UK referenced its report](#) that shows routine diabetes care, such as eye and feet checks, reduces the likelihood of developing life-altering complications and early mortality, with [other research](#) demonstrating that diabetes mortality rates rise for people who have fewer routine care processes.

It was highlighted that abolishing QOF, as it has been in Scotland since 2016, has been linked to decline in quality of care.

Compared with England, [researchers found](#) a significant decrease in reported performance for 12 of the 16 quality-of-care indicators in Scotland one year after QOF was abolished and for 10 of the 16 indicators three years after QOF was abolished. We have heard from members that since 2016 referral rates and waiting lists have also soared, although it is recognised that will also be attributable to rising demand, as seen across England too.

"Unless somebody puts forward something better, we need to preserve what we have".

- Quote from workshop participant

Similarly, we heard that the condition epilepsy had been a QOF indicator which was then later removed from the framework. [Epilepsy Action reported](#) that treatment of patients with epilepsy dropped from 96% of patients (when epilepsy was a QOF indicator) to 14% (after epilepsy was removed as an indicator).

Siloed care

We heard resoundingly that financial incentive programs do not drive person-centred, coordinated, holistic care, nor do they support people in the management of multiple long-term conditions. This is because indicators cover specific conditions in silos rather than a person's overall health and wellbeing. Indeed, practices receive separate payments per condition so are not incentivised to review conditions holistically.

This lack of coordination can feel frustrating for patients and be detrimental in helping people manage multimorbidity. Asthma+Lung UK's annual [survey](#)

shows a third of respondents don't feel as though they are the receiving the care they are entitled to, yet QOF data from 2022/23 reports that 77% of practices are meeting the respiratory health indicators.

Our members reported that annual reviews are also increasingly managed virtually by administrative staff who are unable to provide personalised, specialist advice to help people live better with long-term health conditions.

Unfair focus on specific conditions

It is also clear that financial incentive programs unfairly promote the treatment of some conditions rather than working to improve quality of care for everyone.

When financial incentive programs were initially established, patients were more likely to be treated in-person by GPs or specially trained nurses. However, due to increasing financial and capacity pressures, practices are often forced to prioritise quantity over quality, and this can result in a need to prioritise conditions which are part of higher value indicators.

Perverse incentives

People with lived experience of certain conditions, such as diabetes and respiratory conditions, shared they were more likely to receive health checks and care for conditions covered by QOF indicators even if they didn't need it, rather than being able to access care for needs that more directly impacted their quality of life, but which were not covered by indicators.

This left individuals feeling like the system was working for itself and not focused on their needs, which subsequently reduced the value and trust people placed in their primary care team. It also demonstrates that QOF can generate perverse care incentives which wastes precious resource and can have negative impact on patients. If incentives were repurposed or focused on improving people's general quality of life, over condition-specific mandated actions, people could be better supported to manage their health.

Another issue members highlighted was around only 40-90% of criteria needed to achieve QOF indicators 'well'. This is quite broad and encourages practices to provide lower quality care as the financial result would be the same regardless.

How could the use of current financial incentives be improved?

Preventative approach

Current indicators can feel too specific, focused solely on particular conditions and diagnosis. Members and people with lived experience both agreed that more importance must be given to ensuring everyone has access to personalised and holistic care. This should include access to timely diagnosis and treatment for all, along with being supported to manage their health and wellbeing in a way that works for them and their personal situation.

"Patient voice is missing [from data],"

- Quote from workshop participant

Many practices and PCNs have introduced initiatives to promote health and wellbeing such as walking groups and healthy cooking groups, often organised by social prescribers. These are demonstrating success in their local communities and is proving an excellent way to build prevention initiatives into primary care.

For example, in Fylde Coast, part of the Lancashire and South Cumbria Integrated Care System (ICS), [three GP practices](#) have come together to work with a social prescriber link worker to offer people access to walking groups to improve their health and combat loneliness.

If financial incentive indicators could support the importance of developing similar preventative care innovations, funding could be channelled into spreading best practice such as the Fylde Coast example across the country.

Local need

Some members expressed an interest in indicators becoming more flexible and responsive to local need rather than being standardised nationally. For example, by monitoring the rate of hospitalisations and use of urgent and emergency care, QOF could then focus on conditions which are most prevalent across an ICS or Place.

This could include appropriate preventative measures and proactively addressing self-management of these conditions in primary care to ensure

people don't reach crisis point with consequential unplanned hospital admissions. However, others recognised this would likely increase the postcode lottery of care for conditions, with people receiving better care dependent on whether the area they live in prioritised their health condition.

Collaboration

There also needs to be greater allowance for collaborative working across Places which the current system of incentives per practice prevents. One participant shared an example from Bradford where special interest GPs provide specialist care and support for people with certain conditions. This has been well received locally as people can receive more expert, personalised care as well as being signposted to relevant services.

Members agreed that if contracting could be flexible and support collaborative commissioning, multiple practices in one Place could share resources and ensure their patients are able to access specialist care. Examples offered including patients from a small group of practices access to a specialist asthma nurse at one practice and a specialist allergy nurse at another. However, we recognise this could widen health inequalities and would have to be carefully implemented to ensure that those who are less able to travel (due to travel costs, caring responsibilities or disabilities), and/or are digital excluded, do not miss out on specialist care.

Data collection

There should also be scope to use national surveys and audits to identify what is working well and what could be improved. Making sure the General Practice Patient Survey and condition-specific national audits are used to support targeted quality improvement can be useful to identify areas for improvement across a PCN.

Recognising the value that QOF adds in terms of collecting rich data, one member suggested that audits and national surveys can be used to continue to hold practices to account on quality outcomes, which in turn can then free up QOF funding to be invested in macro-level projects such as health inequalities transformation projects.

Utilising VCSE organisations

"Working more proactively with specialist groups...contacting charities and grassroots have value and benefits because they're community connectors and trusted messengers and well as passing on health care messages."

- Quote from workshop participant

Voluntary, Community and Social Enterprise (VCSE) organisations often hold a wealth of specialist insights and data which, in conjunction with national NHSE data, could be vital in helping improve people's experience of care and ensure financial incentive indicators are either appropriately reflecting people's needs or can be safely repurposed without a drop in quality.

For example, Prostate Cancer UK has developed [resources](#) to support colleagues in primary care settings in England; [Epilepsy Action](#) has developed a guide to primary care commissioning in epilepsy; and, as part of the National Cancer Diagnosis Audit, [Cancer Research UK](#) supported GPs to use local data to understand what the opportunities for quality improvement are and offered free, tailored support for their quality improvement activities.

However, many of the smaller grass roots charities or small equalities focused charities do not have the capacity to do this work, either due to finances, resource or skills. As such the VCSE sector must be supported with funding to provide this service with PCNs/ICSs able to recognise and fill necessary data gaps, especially around protected characteristics.

How could we use current and future financial incentives to maintain focus on preventative and proactive care and tackle health inequalities?

Focus on health inequalities

The NHS is facing growing concerns around health inequalities, with the gap between healthy life expectancy of those living in the least and most deprived areas acting as a stark marker of the inequalities faced in England. [Statistically](#), women living in the most deprived areas are likely to live 19.7 years less than those in the least deprived. For men, the same gap is 18.4 years.

A refreshed QOF that has the goal of reducing health inequalities would be highly welcome and align with the pressing need recognised by NHS England and DHSC to manage growing demand.

However, we heard that QOF currently incentivises time intensive micro-tasks, which can actually hinder GPs from tackling entrenched issues such as health inequalities and/or the preventative approach outlined above through tactics such as improving multi-disciplinary teamwork and identifying and addressing grass root community needs.

Consider communities

It is impossible to tackle longstanding health inequalities without considering people and communities holistically. Patient experience is a vital measure of the quality of services, but it is not currently sufficiently represented in financial incentive indicators. While QOF and IIF data may show practices are performing well, people's experiences on the ground are far different.

Too often, quality of services continue to improve for people who already have good experience of care, while those who are marginalised or excluded continue to face challenges in accessing care and support that works for them, including those who are living with complex multimorbidity and/or experiencing inequalities.

People accessing primary care should understand the full support offer available to them, so they are empowered to access care and support in a way that works best for them. As part of this, greater education and communication about QOF, including how best to prepare for an annual review and what to expect afterwards, will ensure patients and primary care staff are working as a cohesive team focused on what is important to the individual.

"For many patients, they don't know what QOF is or why it happens to them by GPs. There's different aspects we need to bear in mind when considering patient experience and quite often we don't communicate why we're doing it in the first place."

- Quote from workshop participant

Access needs such as ensuring translators are available and the Accessible Information Standard is being met are essential basics that mustn't be missed.

Better health inequalities data collection needed

Data collected as part of financial incentive programs, such as QOF and IIF, is an essential source of information. Nationally, there is a data gap in understanding ethnicity and there is significant variation across the country in how ethnicity data is recorded.

We heard of examples where basic data recording mistakes are being made. One participant shared how they witnessed admin staff at one practice they visited recording patients as being of “Islamic” ethnic origin, while another participant said a practice did not record ethnicity data as front of house staff did not want to ask people their ethnicity and cause offense. It is clear that more information and training is required to make sure this data is being collected consistently and accurately across all practices.

Diabetes UK shared that particularly for diabetes, QOF has been useful in recording data around the number of people with the condition and the demographics of people receiving care and support. This is also helpful in identifying where certain groups in the local community may not be accessing care and highlight the need for alternative methods of support (e.g. social prescribing link workers to reach out to particular groups and encourage uptake of primary care services).

Similar indicators that are focused on health inequalities are not being used accurately, for example incentives to ensure people with learning disabilities receive health checks. One participant shared an example where people were being identified as having a learning disability, resulting in financial reward via QOF for an annual review, even if the impairment is so mild a referral to a specialist care team finds little impact of the referenced disability. Such evidence raises concerns over the impact this would have on the patient and the way they view their own identity.

The current investment by NHS England in training care navigators in GP practices could be one way of ensuring people are aware of their care rights under any new or refreshed QOF model as well as addressing concerns around inaccurate data recording.

Exception reporting

Currently, practices are able to label people as ‘exceptions’ in their QOF reporting. In 2019 exception reporting was renamed as [‘personalised care adjustments’](#), but the two are very similar in practice. This is done to allow practices to pursue quality improvement but not be financially penalised where circumstances are beyond the control of the practice. For example,

these can include patients who do not attend appointments or circumstances where a medication cannot be prescribed due to a contraindication or side-effect. By labelling these as exceptions the practice can still receive QOF funding even if the intended incentivised outcome was not achieved.

However, we are hearing that it is often the most marginalised that already struggle to access services that are likely to be recorded as an exception, or those people living with complex multimorbidity. As part of their investigations, the Care Quality Commission (CQC) can review a practice's exception rates and discuss ways to reduce these, but this is not consistently implemented. However, it has been [reported](#) that the CQC has stopped using QOF data to assess practices because it is 'not reliable' and 'many months out of date'.

Members agreed that there needs to be more focus on analysing exception rates to identify which access barriers may exist on a local level and to identify particular community groups who would benefit from targeted support (e.g. social prescribing link workers in a local community centre or place of worship).

Amending indicators to encourage practices to minimise exception reporting and to review reporting where it is used, could have a significant impact on helping to make primary care is accessible for all, as well as prevent bad practice in some cases.

Health inequality indicators

We heard that when the IIF/DES framework was first established it was hoped that the coverage of health inequalities as an indicator would set a foundation for future years to build on and develop more detailed, specific indicators to help tackle health inequalities. However, the IIF/DES prevention and tackling health inequalities indicators have changed minimally over the past few years (aside from including mention of the COVID-19 pandemic).

Recently, NHS England have adopted the 'Core20PLUS5' approach to reduce health inequalities at both national and system level. The approach defines five key clinical areas requiring accelerated improvement – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, hypertension case-finding and optimal management and lipid optimal management. Each ICS is then expected to target the most deprived 20% of the national population that need these services. It can then locally identify 'PLUS' population groups at greatest risk of exclusion, such as those from Gypsy and Traveller communities or isolated elderly people and add them to the population outreach work.

Some members suggested the IIF indicators should have tracked to embed Core20PLUS5 financial incentive indicators, and the QOF refresh presents a similar opportunity. This would provide a more cohesive approach to tackling health inequalities nationally across different parts of the health system.

Recommendations

We urge the consultation to form just the first engagement of a QOF review. The VCSE sector and people with lived experience are able to add vital support around operational changes such as qualitative measurement, communication needs and a refocus on health inequalities.

With that said we have developed eight clear recommendations:

1. For a primary care system focused on prevention, DHSC must ensure fair access for all long-term conditions with QOF enabling everyone with a long-term health condition to receive a high-quality annual review.
2. DHSC must instruct NHS England to split QOF payments into two tranches to ensure meaningful follow-up to the concerns and needs raised by patients in the review, whether this be additional diagnosis and treatment, or support to better self-manage.
3. We urge DHSC to capture the experiential impact of QOF on patients. As it currently stands, QOF financial payments focus on quantitative measures which do not reflect the value that QOF is intended to offer to patients.
4. DHSC, working with NHS England, should pilot a more radical way of using QOF funding across select ICSs to support real prevention initiatives, especially those with a focus on health inequalities. This pilot should also include how to reutilise alternative data sets to ensure quality improvement is maintained.
5. To ensure patient trust and their ability to self-manage are maximised, NHS England must ensure all annual reviews are holistic, focusing on all multimorbidity, where present alongside the patients wants, needs and concerns.

6. ICSs, supported by NHS England, should improve communications on what an annual review will include, alongside how a patient might want to prepare. This will ensure people accessing primary care are empowered to access care and support in a way that works best for them and understand the full support offer available to them.
7. ICSs, supported by NHS England, should ensure additional communication needs are recognised and planned for advance so the obligations under the Accessible Information Standard are met alongside additional needs such as translators.
8. ICSs, supported by the CQC if appropriate, must ensure exception reporting is minimised, and analysed when it does happen, to ensure bad practice is weeded out and community need is identified.

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