

Improving Quality and Productivity in the NHS

Outline Agreement for the Quality and Productivity QOF indicators

1. Introduction

Detailed below is the underpinning agreement, between NHS Employers and General Practitioners Committee (GPC) of the British Medical Association (BMA), for the new one year organisational domain section in the Quality and Outcomes Framework (QOF) for improving quality and productivity in the NHS (commencing 1 April 2011 and ending 31 March 2012). This formed the basis for amending the Statement of Financial Entitlement (SFE) for 2011/12.

2. Background

NHS Employers and the GPC have agreed that GP practices should seek to improve the quality of care provided to patients and deliver productivity gains in line with the rest of the NHS. The national challenge to deliver quality and productivity savings of approximately £20bn in England over four years is well known. Similar programmes have been put in place by the three devolved administrations.

For the financial year 2011/12, NHS Employers and the GPC have agreed to focus on prescribing, emergency admissions and first outpatient referrals by GPs.

Initial discussion between NHS Employers and GPC explored the possibility of including A&E attendances but for a variety of reasons, mainly the lack of attributable data, it was agreed that this was an area that would not be pursued at this time.

The English Better Care, Better Value (BCBV) indicators produced by the NHS Institute for Innovation and Improvement for the three areas above suggest that if all GP practices were able to achieve the currently reported upper quartile performance, productivity savings of approximately £825m would be realised. For England these savings equate to approximately £86m on prescribing, £556m on emergency admissions and £183m on GP referrals. Similar estimates have been made by the devolved administrations.

The quality and productivity (QP) indicators aim to contribute to the above through the review of current practice by GPs (both within the practice and with external peers), prompted by the analysis of practice specific data that looks to understand

the reasons for and if appropriate address, outlier performance by a practice in three areas:

- Prescribing
- First Outpatient Referrals
- Emergency Admissions

These indicators are included as a new area within the organisational domain. It is acknowledged that the reasons for the outlier variation in performance may be financial, historical or organisational but the outcome of low quality services is the same: less effective patient care that has the potential to result in costly interventions down the line. It is acknowledged by all parties that high quality care can be cheaper, more effective care.

Although this agreement focuses initially on the three areas above, the emerging GP Consortia in England (particularly the Pathfinders) will want to review a wider range of services as part of their commissioning responsibilities.

These indicators also support practices to deliver care in line with agreed pathways. This agreement is for 12 months from 1 April 2011 until 31 March 2012, with the possibility of being extended to a second year if significant progress has been made at the mid year (2011/12) point.

Any extension or adaptation beyond 31 March 2012 is subject to the agreement of both NHS Employers (on behalf of the health departments) and the GPC.

The main criteria in considering whether or not to extend this activity for a second year, will centre on there being demonstrable evidence that the activities described in this outline are being undertaken by the vast majority of practices, PCO feedback and that there has been a significant improvement in the quality and cost of the areas under consideration. In reviewing progress, NHS Employers and the health departments will be looking for early evidence that the quality and productivity activity is capable of delivering significant productivity savings against an investment of approximately £100m in England. In monitoring these productivity savings in England, a number of factors will need to be taken into account including the pace of savings attributable to prescribing (given up to six months of the year will be taken up by the process of review); and changes in tariff price.

In participating in this work, practices will also be expected to work with their PCO and other GP practices in supporting the overall quality and productivity agenda in their area. Whilst there is absolute agreement that individual patients should receive clinically effective treatments, practices would need to recognise and be engaged in programmes of redesign of clinical pathways. These aim to optimise efficiency and demonstrate how they are delivering their responsibility for eliminating waste, ensuring that resources are used to the best advantage of their population and ensuring that the highest quality and outcomes are delivered in the most cost effective way.

3. Context

Within the context of a modern NHS, a good GP practice will acknowledge and respect their responsibility for making best use of public money and be willing, as both a provider of and gatekeeper to services, to make the most effective use of available resources (including skills, premises, and treatments) to deliver improvements to the population's health and social wellbeing. This is consistent with the GMC's Good Medical Practice guidance.

In this respect, a good GP practice will avoid the duplication of work through ensuring clear communication, partnership working and information sharing with relevant parts of the health service, taking into consideration patient confidentiality. They will also minimise waste in prescribing and ineffective treatments. They will engage effectively in the prevention of ill health to avoid the need for costly treatments and will manage patients proactively through the whole care pathway towards recovery, acting as conscientious gatekeepers to services.

A good GP practice will also aim to offer excellent access into the practice, and also from the practice to other services in its role as coordinator of care, facilitating access to other health and social care providers.

As part of the negotiated agreement between NHS Employers and the GPC for 2011/12, the 96.5 points for the QP indicators included the retirement of PE7 and PE8, which monitored access. As part of the agreement, NHS Employers and the GPC recognise the importance of good patient access and want to ensure that with the retirement of PE7 and PE8, there is no diminution of service to patients unless it has been agreed at a local level through discussion with patients.

Access has many dimensions; the relative importance of these will vary according to the specific needs of the registered population. These include:

- Lists being open to all without discrimination.
- Hours of opening with the ability to be seen urgently when clinically necessary, as well as the ability to book ahead.
- Continuity of care.
- Range of skills available – access to different professionals.
- A choice of modes of contact which currently includes face-to-face, phone and electronic contact but can be developed further as technology allows.
- Geographical access, enabling care as close to home as possible.

Access must be flexible enough to meet the varying needs of individuals and requires sufficient capacity to meet the population's needs. Details of access arrangements (including opening hours) should be made widely available to the population to enable patients to exercise choice.

4. Indicator Guidance

The QP indicators and supporting guidance has been published in the 2011/12 QOF Guidance on both the [NHS Employers](#) and [BMA websites](#).