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Cite this as: *BMJ* 2023;380:p582
http://dx.doi.org/10.1136/bmj.p582

Quality improvement in primary care

Lessons from the end of QOF in Scotland

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The Quality and Outcomes Framework (QOF) pay-for-performance scheme began in the UK National Health Service in the early 2000s.[1] Under a new contract, as much as 20% of general practices' remuneration was initially tied to the achievement of performance targets. Some targets focused on the delivery of particular care (such as foot screening of patients with diabetes), whereas others tracked proxy measures for clinical outcomes (such as targets for blood pressure or diabetes control). Twenty years on it is instructive to revisit the outcomes of the scheme, and the linked paper by Morales and colleagues (doi:10.1136/bmj-2022-072098) makes use of a natural experiment to explore what happens when pay for performance ends.[2]

QOF has been evaluated extensively, and the benefits are modest at best.[3] Achievement was high from the start,[4] and, although evidence suggested the scheme led to the narrowing of some inequalities in care quality,[5] longer term evaluation was disappointing. A review 10 years after the inception of QOF found initial improvements in health outcomes for some conditions, but over time the outcomes reverted to pre-existing trends, with some evidence of adverse effects in non-incentivised conditions.[6] Other studies concluded that QOF was not associated with improvements in mortality,[7] and modelling has suggested that the scheme is not cost effective.[8]

Against this background, in 2016 the Scottish government agreed to remove QOF and add the associated funding to the core general practice contract.[9] A new quality improvement approach was implemented, with general practices grouped into clusters, working together to improve quality of care.[10] In their controlled interrupted time series analysis, Morales and colleagues explored what happened next. They found that documented performance against many QOF indicators fell significantly in practices in Scotland, compared with practices in England where QOF had not been withdrawn. The effect was most pronounced in the process indicators that required affirmation by tick box, but also in clinical indicators such as attainment of blood pressure and diabetes control targets. Reassuringly, performance against those indicators recording delivery of evidence based care, such as vaccinations, held up well.

Interpreting these findings is complex. It is not known how far the initial achievements associated with QOF represented improvements in recording behaviour rather than true quality improvement.[11] Conversely, it is not always clear whether changes in performance reported by Morales and colleagues reflect changes in care recording or changes in care quality. Furthermore, recorded blood pressures can be influenced by target thresholds, with staff tending to preferentially record readings that closely match the target.[12] It is at least plausible that the decline in performance against blood pressure targets after QOF ended may simply reflect the removal of this bias.

The new study does, however, confirm previous work showing that the withdrawal of performance targets can be associated with a reduction in documented performance.[13] This is important because most pay-for-performance schemes are modified over time—as indicators are removed and new ones added. If performance decreases whenever an indicator is removed, then the longer term value of such schemes may be limited.

More generally, Morales and colleagues' findings raise some interesting questions about what quality of care means in general practice. QOF represents a technocratic approach to quality, with indicators linked to population evidence, but it is relatively crude in terms of what can actually be measured and therefore incentivised,[3] and the scheme has been criticised for its potential impact on doctor-patient relationships.[14] The Scottish contract is positioned by those who negotiated it as a return to a more professionally led approach to quality, reducing bureaucracy and freeing up time for a more holistic approach to managing complex conditions.[10]

Recent evidence supports this approach—continuity of care is associated with benefits such as an overall reduction in mortality, reduction in hospital admissions, and reduced use of out of hours care.[15,16] Quality clusters were established in Scotland in 2018,[17] and their development was affected by the covid-19 pandemic. It is therefore too early to know whether this approach to quality improvement will bear fruit. While the drop in recorded performance may be concerning, the lack of evidence for long term effectiveness and cost effective of pay for performance in primary care suggests that there is as yet no need to panic. General practitioners in Scotland surveyed immediately after the implementation of the new contract were more satisfied with their lot than those in England.[18] How far those differences were driven by the changes to QOF is not clear, but in the midst of a recruitment and retention crisis this difference in satisfaction may warrant further exploration.

To fully understand the benefits and harms of different approaches to quality improvement, we must continue to collect all relevant data so the longer term effect of changes can be evaluated. Attention must also be paid to the delivery of quality improvement clusters in Scotland, drawing on what is known about quality improvement more generally. High quality managerial support, a systematic approach to considering performance, and the

provision of holistic and joined up care are all likely to be important.[19]

Competing interests: I have read and understood BMJ policy on declaration of interests and declare: I receive research funding from the National Institute for Health and Care Research Policy Research programme.

Provenance and peer review: Commissioned; not externally peer reviewed.

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