HFMA response
March 2024

Response to the consultation on the role of incentives in general practice

Introduction

NHS England issued a consultation on the role of incentives in general practice, which closed on 7 March 2024.[1] This consultation asks for feedback on the quality and outcomes framework (QOF) and the investment and impact fund (IIF), which are the two main schemes at present. It is divided into three sections, asking for:

- feedback on the role and nature of incentive schemes in general practice, with a focus on the current scope of the QOF and the IIF
- comments on possible changes in scope of incentive schemes beyond clinical indicators
- input on reducing the administrative burden associated with the schemes and enhancing the clinician's experience of delivering it.

The HFMA submitted a response to the consultation on 5 March 2024. The response is based on discussions with members of the HFMA's ICB Finance Group, System Finance Special Interest Group, and Policy and Research Committee. In summary we support the use of incentives in general practice. We recommend that they should be adaptable at a local level, that they could do more to help reduce health inequalities, and that they should be simple and designed to minimise administrative burden.

Response

1. Do you agree or disagree that incentives like QOF and IIF should form part of the income for general practice?

Agree	~~Neither agree nor disagree~~	~~Disagree~~	~~Don't know~~

We support the use of financial incentives when they are designed effectively and form part of a wider strategy to improve services. As set out in our briefing, Using financial incentives to tackle health inequalities, incentives should be considered as one tool of many, not to be used in isolation

[1] NHS England, *Role of incentive schemes in general practice*, December 2023

but as part of a wider change programme.[2] They work best when they are simple, predictable, use a clear evidence base and are designed to avoid the pitfalls.

It is important that the mechanics are carefully designed and communicated to avoid perverse incentives, confusion over the objectives or excessive administrative burden. General practice is under significant pressure both operationally and financially with increased activity and costs. Reporting must be simple, income predictable and transactions minimised.

Members have told us that the incentive funding in primary care is important to support short-term pump priming to fund quality initiatives, including on health inequalities. Without the incentive funding, it is difficult for PCNs and practices to invest in these initiatives.

2. Do you agree or disagree that QOF and IIF help ensure that sufficient resources are applied to preventative and proactive care?

Agree	~~Neither agree nor disagree~~	~~Disagree~~	~~Don't know~~

We agree that preventative and proactive care are an important priority for any general practice incentive scheme, in line with the aims of the NHS long term plan. This is vital to support the financial sustainability of the NHS as the population grows and ages.

QOF and IIF include indicators on preventative and proactive care. We do not have a view on how effective they have been in directing resources, or on which indicators are the most effective.

We would stress that incentives are one tool of many, not to be used in isolation but as part of a wider change programme. They should be evaluated and reviewed regularly to assess that they are working as anticipated.

3. Would relative improvement targets be more effective than absolute targets at delivering improvements in care quality while also addressing health inequalities?

~~Yes~~	~~No~~	Don't know

Relative improvement targets may be an effective way of incentivising practices which serve different populations and therefore find it easier or more difficult to meet certain targets. We are not clear from the consultation on the format that relative improvement targets might take, but would flag two risks to consider.

Firstly, there may be a perverse incentive if the targets were based on improvement from the prior year. Practices may favour changes that result in slow progress (and repeat incentive payments) rather than a significant step-change (and one-off incentive payment).

Secondly, relative improvement targets may be perceived as more complex than absolute targets, leading to confusion over the objectives or concern over excessive administrative burden. It is important that the mechanics are carefully designed and communicated.

4. In what other ways could we use incentive schemes to address health inequalities?

To maximise the impact that incentives have on health inequalities, they could be more closely aligned to NHS England's Core20PLUS5 approach.

Currently, the QOF and the IIF touch on four of the five key clinical areas for adults (severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case finding), and two of the five key clinical areas for children and young people (asthma and diabetes). There is nothing in the incentives which specifically targets the 'Core20' most deprived population and nothing on the 'PLUS' population groups identified at a local level as facing health inequalities.

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[2] HFMA, *Using financial incentives to tackle health inequalities*, January 2024

Any incentive payment targeting the Core20 will need to be weighted towards practices that serve larger Core20 populations. Some practices will find that most of their patients fall within Core20, whereas others will have no Core20 patients at all.

Any incentive aimed at the PLUS population groups will need to be adaptable at a local level as different systems have identified different PLUS population groups.

Delivering services to a population experiencing greater health inequalities can be more complex, and we would recommend that NHS England considers incentives that target resources to reach those most in need. Existing funding streams are mainly based on '£ per PCN' or '£ per weighted head of population', but this misses health inequalities. Meanwhile, the practice of 'exceptioning' in the IIF and QOF can mean that vulnerable patients who are not engaging with medical care are excluded from the standards. Incentives could better focus on seldom-heard groups in order to give practices the resources they need to improve patient engagement and communications.

5. To what degree, if any, do you think that ICBs should influence the nature of any incentive scheme?

~~The scheme should be entirely national~~	~~ICBs should be able to select local priority indicators from a national menu~~	~~ICBs should be able to select local priority indicators from a national menu and put additional local funding against these indicators~~	~~ICBs should be able to choose their own indicators and put local funding against these indicators~~	~~Don't know~~	Other

We would welcome flexibility for ICBs to influence the way that national incentive schemes are implemented in their local context. This is in line with the principle of subsidiarity, with decisions taken as close to local communities as possible, and at a larger scale where there are demonstrable benefits or where co-ordination across places adds value. ICBs can engage with PCNs, places and practices directly and tailor incentives according to local priorities, data and insights. This increases buy-in, with practices more likely to feel invested in incentives which are relevant to their local context.

There are examples of successful local incentive schemes in general practice, including the Bolton quality contract.[3] They however require ICBs to commit additional resources, which is challenging in the current financial climate. From recent experience working with ICB finance staff, we do not believe that many ICBs are in a position where they could put additional local funding against local indications, and so this would not be a meaningful option for them.

We would support the use of a national menu, but would also support ICBs being able to choose their own indicators and this be covered by national funding.

6. Do you agree or disagree that a PCN-level incentive scheme like IIF encourages PCN-wide efforts to improve quality?

~~Agree~~	~~Neither agree nor disagree~~	~~Disagree~~	Don't know

No comment.

[3] HFMA, *Bolton quality contract*, January 2024

7. What type of indicators, if any, within incentive schemes do you think most help to improve care quality? (Select all that apply)

~~Clinical coding~~	~~Clinical activity~~	~~Clinical outcomes~~	~~Quality improvement~~	~~Other~~	Don't know

No comment.

8. Do you think there is a role for incentives to reward practices for clinical outcomes measured at PCN or place level?

~~Yes – at place and PCN levels~~	~~Yes – at PCN level only~~	~~Yes – at place level only~~	~~No~~	None of the above	~~Don't know~~

We would support the use of incentives at a PCN or place level. For simplicity of administration and messaging, we would suggest one rather than both. PCNs are more consistently established across the country than places, and we would therefore suggest that they are the most appropriate level to work with.

Rewarding at a PCN or place level is likely to change some of the risks and behaviours, which will need to be carefully thought through and tested. In terms of financial planning, it's important that practices can predict their income, for which there needs to be good communication and transparency of reporting within the PCN or place.

9. Do you agree or disagree that there is a role for incentive schemes to focus on helping to reduce pressures on other parts of the health system?

Agree	~~Neither agree nor disagree~~	~~Disagree~~	~~Don't know~~

The theory behind the IIF is that primary care networks should benefit from 'shared savings' across the system, for instance when their work helps to reduce avoidable A&E attendances and emergency admissions. We support this principle and agree that general practice incentives can play an important role in helping to reduce pressure on other parts of the health system.

In practice, the shared savings are rarely realised as cash which can be released from urgent care, and so it is not the case of being able to move money from one place to another. With a growing and ageing population, the work that primary care does to reduce pressures on other parts of the health system is instead about minimising growth in demand. It would be helpful for NHS England to look at ways to evidence the impact of primary care in minimising growth, as this could inform decisions on how to allocate growth funding between primary care and the acute sector.

10. Do you agree or disagree that incentives should be more tailored towards quality of care for patients with multiple long-term conditions?

~~Agree~~	~~Neither agree nor disagree~~	~~Disagree~~	Don't know

No comment.

11. Do you agree or disagree that patient experience of access could be improved if included in an incentive scheme?

~~Agree~~	~~Neither agree nor disagree~~	~~Disagree~~	Don't know

No comment.

12. Do you agree or disagree that continuity of care could be improved if included in an incentive scheme?

~~Agree~~	~~Neither agree nor disagree~~	~~Disagree~~	Don't know

No comment.

13. Do you agree or disagree that patient choice could be improved if included in an incentive scheme?

~~Agree~~	~~Neither agree nor disagree~~	~~Disagree~~	Don't know

No comment.

14. Do you agree or disagree that the effectiveness of prescribing could be improved if included in an incentive scheme?

Agree	~~Neither agree nor disagree~~	~~Disagree~~	~~Don't know~~

From a financial standpoint, we support the inclusion of prescribing in general practice incentive schemes. As an example, Bolton achieved significant savings on prescribing through its inclusion in the Bolton quality contract. The outcome measures in the Bolton quality contract are:

- reduced spending on prescribing
- antibiotic items prescribed per specific therapeutic group age-sex related prescribing unit (STAR PU)
- % of antibiotics prescribed which are high-risk antibiotics.

15. If you think there are any other areas that should be considered for inclusion within an incentive scheme, please list them here.

No comment.

16. What opportunities are there to simplify and streamline any schemes for clinicians, and reduce any unnecessary administrative burden, while preserving patient care?

No comment.