

# EVALUATION OF THE SOMERSET PRACTICE QUALITY SCHEME (SPQS): PHASE 2

*A mixed methods service change evaluation of an alternative to the Quality Outcomes Framework (QOF)*

An evaluation of the SPQS pilot was conducted by the SW AHSN and the SW Peninsula CLAHRC (Collaboration for Leadership in Applied Health Research and Care) on behalf of NHS England. SPQS arose from the challenge that current GP contracting conditions do not appropriately incentivise clinical care for people with complex conditions who require person centred and coordinated care. An alternative contract was therefore established in Somerset, a key component of which was the de-incentivisation of the Quality Outcomes Framework component of the General Medical Services contract. After a preliminary evaluation of the initial SPQS (from January 2014 to July 2015), the scheme was extended into a second year. The SWAHSN and CLAHRC have now conducted a detailed mixed-methods evaluation of the SPQS scheme between April 2016 and March 2017 to explore the implementation of SPQS and any resultant changes in clinical and organizational behaviour. This report details our findings and suggests recommendations for the future implementation of SPQS.

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## Executive summary

### *The background and aims of SPQS*

- The Somerset Practice Quality Scheme (SPQS) began in June 2014, with 55 of the 75 practices in Somerset participating.
- SPQS arose because GPs, the Clinical Commissioning Group (CCG) and the Local Medical Committee (LMC) felt that the Quality and Outcomes Framework (QOF) was not incentivising the highest value clinical behaviour.
- They felt that removing the link between the incentives and clinical activity of QOF would improve the provision of Person-Centred Coordinated Care (P3C). It was also envisaged that it would enhance integration, improve sustainability and work effectively with other elements of the health and social care system.
- However, one concern was that the quality of clinical care could decline following the removal of QOF.

### *Our evaluation framework*

- We performed a comprehensive mixed-methods evaluation of SPQS using our consistent evaluation framework, including:
  - Quantitative methods:
    - A triangulation of questionnaires:
      - Patient experience (P3C-EQ)
      - Practitioner perspective (P3C-Practitioner)
      - Organisational change (P3C-OCT)
    - Analysis of admissions data
  - Qualitative methods:
    - Semi-structured interviews with practitioners
    - Observation of consultations
    - Facilitation workshops with practices

### *Key findings*

- There has been a variety of direct responses to the de-incentivisation of QOF. Some QOF-related components have remained mandatory (prevalence reporting is still required for payment), practices have retained some desirable features of QOF systems (e.g. prompts during consultation), adapted some (e.g. patient recall) and stopped using other burdensome components (e.g. exception reporting).
- The majority of practices report that these adaptations have resulted in time savings.
- **The evaluation establishes good evidence that SPQS has been successful in its stated aims, and that these time-savings from de-incentivisation of QOF have been leveraged by practices:**
  - 1) **During consultation time, engendering a more person centred approach.**
  - 2) **Reduced administrative burden for both GPs and administrators; facilitating more active engagement with other schemes aimed at the re-design of service delivery.**

- The SPQS contract specifically states that person-centred coordinated approaches will be facilitated by involvement of some practices in the “Test and Learn” pilots in South Somerset (Symphony), Taunton and the Mendips (Frome hub). SPQS has also enabled greater involvement with a patchwork of other P3C-related schemes in Somerset, including Health Connections Mendip (HCM) and Village Agents.
- It is difficult to disentangle the benefits of SPQS with these other schemes, as in many respects they represent the various local implementations of SPQS.
- **Nonetheless, our measure of organisational change for P3C (P3C-OCT) reveals a significant increase in P3C related activity across Somerset during the period of the evaluation in 2016-2017. This longitudinal analysis of P3C activity (from a consistent group of Somerset practices) provides the most robust quantitative evidence of service redesign during the SPQS scheme.**
- **This is confirmed by our in-depth qualitative evidence, where semi-structured interviews and observations of consultations provide a rich contextualisation for the barriers and facilitators of service redesign. This includes successes such as changes to GP appointment structure, increased Multidisciplinary Team Meetings (MDTs) and employment of healthcare professionals such as Health Coaches (HCs) and Health and Wellbeing Coordinators (HWBCs). These findings also highlight various implementational nuances, such as the criticism that “hub” services are perceived to be drawing resources away from rural areas, ongoing issues of incompatible IT systems, difficulties engaging with specific services (particularly social services and mental health) and that tools such as the Patient Activation Measure (PAM) may have more utility for HCs/HWBCs than for General Practitioners.**
- **Comparison of patient experiences (P3C-EQ) and practitioner perspective (P3C-practitioner) to a control group of South-West (non-Somerset) QOF practices revealed similar results.**
- An unavoidable shortcoming of this element of the evaluation is that the **control group represents a self-selected sample of practices that are likely to represent engaged, active practices**, which was compared against the mandatory completion of these instruments for all SPQS practices. Therefore, **the similar results can be cautiously interpreted as a positive reflection of the aggregate performance of SPQS practices.**
- The growth in **Acute MI Emergency Admissions** from SPQS Practices is seen when looking at England data and to a certain extent Somerset data but not so in Kernow, NEW Devon and South Devon and Torbay
- The growth in **Diabetes admissions** is primarily in the Respiratory, Urinary Tract and Immunology HRG Chapters. The growth in these chapters can also be seen in the regional data (Kernow, NEW Devon, South Devon and Torbay) and all England data.
- Analysis of QOF data to assess quality of care is no longer possible, as de-incentivisation has consequently resulted in significant variation in how activity is recorded.
- Similar to our first SPQS evaluation, we again found that there was a genuine passion and commitment to improving Person Centred and Coordinated Care (P3C), including stronger federation-level agreements and informal networks, increased multidisciplinary team working, reallocation of resources for health care assistants, nurses and others, and changes to structure and timings of GP appointments.

### *Discussion and future recommendations*

- **This evaluation establishes reasonable evidence (from both qualitative and quantitative methods) that the removal of QOF incentivisation has been a successful system lever for service redesign aimed at the delivery of greater P3C. This has been achieved via several mechanisms including reallocation of time and resources in addition to boosting the capacity and passion for innovative approaches. SPQS has therefore been largely successful in its stated aims.**
- As with the previous evaluation, coordination across teams and sectors requires further support and would be facilitated by addressing issues related to functional integration, information sharing and local agreements.
- One dis-benefit of the scheme is the lack of data for ensuring quality of care. One of the major benefits of QOF has been the consistent recording of clinical activity, the subsequent large increase in available data, with benefits for research, evaluation and healthcare management. **It is not currently clear how schemes that de-incentivise QOF will ensure quality of care. As SPQS continues into future years, this dis-benefit is liable to confound stakeholders by the persistent challenge of assuring that quality is being maintained across all Somerset practices.**
- **We would recommend that future incarnations of the SPQS scheme aim to address this shortcoming in a manner that combines the benefits of SPQS (greater freedom, time and efficiency) whilst retaining assurances to healthcare managers that a basic quality of care is being maintained across all practices.** Such assurances would also have to be concurrent with evolved notions of quality, where UK healthcare policy puts an increasing emphasis on person-centredness over the processes and indicators of QOF.
- **One recommendation is to use GP contact data as a generalised measure of continuity. At present GP data is an anomaly within the system, whereby service providers only grant access to this data in an ad-hoc manner. Access to this data could be made mandatory. It could be utilised to measure: (a) which patients are having consultations (b) when they are having consultations and (c) how long the consultations are. This could offer some assurances to service providers that appropriate care was being delivered, whilst retaining some of the key benefits of SPQS (e.g. efficiency; trust in clinicians to manage consultation time appropriately without “tick-box” exercise).**
- We also recognised the demand for an efficient recall system for patients with long-term conditions and multimorbidity. This could include in-built data capture to record duration and frequency of contact with services, and should be co-designed with GPs, managers, information specialists and researchers.
- A further suggestion would be to embed a consistent evaluation framework to measure the delivery and quality of person centred care. This could be assessed via patient and practitioner experiences of care, in addition to tools such as PAM and several carefully selected measures describing person centred processes (e.g. goals elicited, care planning consultations).