DH Department of Health

Developing the Quality and Outcomes Framework: Proposals for a new, independent process

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning Clinical	Estates Commissioning IM & T Finance Social Care/Partnership Working
Document purpose	Policy
Gateway reference	11510
Title	Developing the Quality and Outcomes Framework: Government response
Author	DH
Publication date	19 Mar 2009
Target audience	PCT CEs, SHA CEs, Medical Directors, Directors of PH, GPs, Communications Leads, National primary medical care bodies and voluntary organisations
Circulation list	
Description	We published a consulation on 30/10/2008, setting out proposals for how a new, NICE-led, independent process for reviewing and developing QOF indicators should work. This document provides an analysis of submissions to the consultation and sets out the Government response.
Cross reference	Developing the Quality and Outcomes Framework: Proposals for a new, independent process
Superseded documents	N/A
Action required	N/A
Timing	N/A
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For recipient use	

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Introduction

Background

1. The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme that rewards GP practices for implementing systematic improvements in quality of care for patients. It was introduced as part of the General Medical Services (GMS) contract, and virtually all GP practices take part in the QOF. Expenditure on QOF is currently just over £1 billion in England, or 15% of spend on primary medical care.

2. In the NHS Next Stage Review[1], we set out a wide-ranging strategy to support clinicians and the NHS in driving continuous quality improvements across primary and community care and in promoting healthy lives. In relation to GP services, this included supporting PCTs and practices in measuring and publishing data on quality in all its dimensions, more equitable funding for practices and promoting practice accreditation. Our proposals also included a fresh strategy for developing the QOF, including an independent and transparent process for reviewing existing indicators and prioritising potential new indicators. The proposals were informed by an external advisory board, bringing together leading GPs, other primary care professionals and representatives of other stakeholders, and based on extensive discussion with members of the public, with clinicians across the NHS and with other sectors.

3. We gave a commitment as part of the Next Stage Review that we would:

   - discuss with the National Institute for Health and Clinical Excellence (NICE) and with professional and patient groups how this new process should work;
   - explore how to give greater flexibility to PCTs to select indicators (from a national menu) that reflect local health improvement priorities.

4. In developing these proposals, we also took into account the recommendations of the National Audit Office (NAO) report on GP contract modernisation[2].

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1 High quality care for all: NHS Next Stage Review Final Report (30 June 2008) and NHS Next Stage Review: *Our vision for primary and community care* (3 July 2008)

2 NHS Pay Modernisation: New Contracts for General Practice Services in England (National Audit Office, February 2008)

Aims of the new process

5. We intend that NICE should oversee a new independent process for prioritising, developing and reviewing QOF clinical and health improvement indicators for England from 1 April 2009 as part of its role in providing guidance for the NHS based on evidence of clinical effectiveness and cost effectiveness. We proposed that the process would involve reviewing existing QOF indicators, prioritising areas for new indicators, and developing and recommending new indicators. It would be informed by open consultation with stakeholders, including patient and professional groups, and based on best available evidence of clinical and cost effectiveness.

6. In summary, NICE would manage an independent and transparent approach to produce a national menu of approved indicators made available through the NICE website from which:

   - NHS Employers (on behalf of the Department of Health) would continue to negotiate with the General Practitioner's Committee of the British Medical Association on which indicators should be applied nationally (or, with the agreement of the devolved administrations, across the UK as a whole) and what the value of those indicators should be;
   - PCTs could potentially select additional indicators that reflect local priorities using either resources specifically devolved for this purpose or other local resources.

7. We undertook to discuss with professional and patient groups how this new process should work. The aim of a public consultation was to seek views from all stakeholders with an interest in the QOF as a means to support GP practices in delivering continuous improvements in the quality of care for their patients.

The Consultation

Overview of the consultation process

8. On 30 October 2008, the Department of Health published a consultation paper, *Developing the Quality and Outcomes Framework: Proposals for a new, independent process.* This document set out the proposed principles and framework for how the new process would work in England and invited comments from professionals, patient and carer representatives, PCTs and other groups or interested individuals.

9. The consultation took place over a thirteen week period and involved five public consultation events.

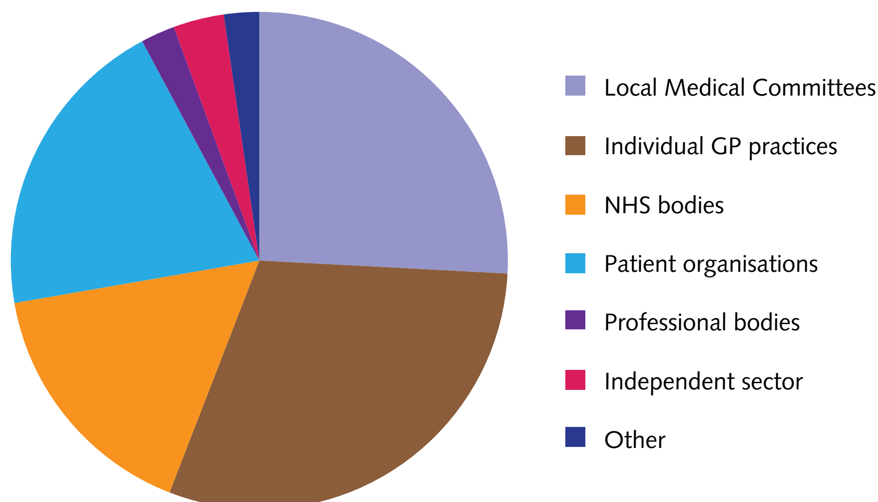
Method for the consultation

10. Copies of the consultation were made available on the Department of Health website www.dh.gov.uk/consultations and a dedicated mailbox was set up for responses and queries regarding the consultation: QOFConsultation@dh.gsi.gov.uk. Responses to the consultation could be submitted via email or in written form.

11. To support the consultation process a series of regional events were held to canvass opinions from patient groups, professionals, NHS commissioners and other stakeholders. A list of the events is at Appendix I.

Overall response to the consultation

Response by sector



12. We received 220 responses to the consultation. The overall response chart shows the ratio split between different groups. The highest number of responses came from Local Medical Committees (LMCs), with the next highest number from individual GP practices. Respondents identified as 'other' include academic institutions and responses from individuals who were not able to be identified.

13. The responses included a number of submissions from GP practices, LMCs and professional bodies in other UK countries. The submissions were broadly in line with their respective organisations in England.

14. We would like to thank all those who have given their time to respond and contribute to this consultation. A list of all respondents is at Appendix II.

Sector	Number of responses by sector	Percentage
Local Medical Committees	57	26%
Individual GP practices	66	30%
NHS bodies	36	16%
Patient organisations	44	20%
Professional bodies	5	2%
Independent sector	7	3%
Other	5	2%

The consultation events

15. The Department commissioned NHS Primary Care Contracting (NHS PCC) to carry out five open stakeholder events. NHS PCC has a track record of supporting national policy development and implementation for primary care. Over 300 participants attended these events, mainly from PCTs and from general practice. Key themes from the workshops and details of the discussions were collated by NHS PCC and have been reflected in the summary of responses below.

Responses received to each question

Q1 Do you agree with the proposed aims of the new process? If not are there any other important aspects that should be considered?

Summary of responses

16. Almost all respondents agreed that the QOF had been successful in delivering improvements in the quality of care. Respondents also agreed that it was appropriate to review indicators in a way that was transparent and evidence-based. The Royal College of General Practitioners (RCGP), the Royal College of Nursing (RCN), the Royal College of Physicians (RCP), the Family Doctor Association, all patient groups and a number of GPs welcomed the transparency of the proposed process and the opportunity to submit indicators for review. Some respondents added that it would be important for NICE to guard against being over influenced by lobbying in relation to specific areas of concern.

17. The General Practitioners Committee (GPC) of the British Medical Association, the majority of LMCs and some GPs expressed concern about whether NICE sufficiently understood primary care to lead further development of the QOF and some respondents questioned whether NICE would provide a more independent process than the current expert panel.

18. Although not within the scope of the consultation, some patient groups, a number of PCTs and the RCN commented that the NICE-led process should take steps to address high levels of exception reporting and the potential for gaming among some GP practices.

The Government's response

19. We welcome the majority view in support of a more transparent and objective process in developing the QOF.

20. We acknowledge the views expressed regarding the capacity of NICE to lead the process. We consider that NICE has been a highly effective organisation in delivering a range of clinical and public health guidance and standards, including for primary care, and is by far the best placed organisation to manage the independent process of prioritisation, consultation and appraisal of clinical effectiveness and cost effectiveness.

21. As part of the Next Stage Review, we have asked NICE to expand its responsibilities and to work with the professions and specialist associations in delivering these objectives. NICE is announcing at the same time as the publication of this response how it will work with the professions to make the new process successful. The proposed Primary Care Consideration Panel is being given the status of an independent Advisory Committee (called the Primary Care QOF Indicator Advisory Committee) whose membership will include GPs, patients/carers, commissioners, practice and community nurses, public health specialists, social care professionals, health economists and informatics specialists recruited by open competition.

22. We note the comments by some respondents regarding exception reporting. We will continue to review the evidence on variations in exception reporting and to support PCTs in working with GP practices to tackle unacceptable variations. We will ask NHS Employers to discuss with the GPC whether there are ways of improving current exception reporting arrangements.

Q2 Do you consider that the new process will help to address health inequalities? What do you consider that the impact on equality is likely to be?

Summary of responses

23. The majority of respondents agreed that it was desirable for the QOF to address inequalities of care. Respondents raised the following questions and issues about how the new process would address inequalities –

- although some respondents believed that local variation in choice of indicators could be effective in reducing inequalities, others considered that allowing too much local decision-making or giving too much of the QOF for local decision could increase inequalities;
- some respondents emphasised that it would be important not to use only cost-effectiveness criteria in prioritising new indicators, as this would make it more difficult to develop indicators that have a strong impact in improving health or healthcare for specific groups but do not have as great an aggregate impact across the wider population;
- some respondents questioned whether, taking into account the wider factors influencing health inequalities, it was likely to be effective to incentivise GP interventions aimed directly at reducing health inequalities and considered that the most effective way for QOF to continue to help tackle health inequalities was by applying indicators consistently across all socio-economic groups.

The Government's response

24. We recognise the range of views expressed about how most effectively to tackle health inequalities. Recent evidence suggests that the QOF is reducing the gap in performance between practices in areas of high and low deprivation. We consider that the phased introduction of full adjustment of QOF payments to reflect relative disease prevalence (as agreed last year with the GPC) will have a significant impact in incentivising better case-finding and further strengthening the impact in reducing health inequalities.

25. We remain committed to ensuring that existing and new indicators continue to reduce inequalities. The Primary Care QOF Indicator Advisory Committee will need to consider a number of criteria for prioritising indicators, of which cost effectiveness will be one, but not the sole approach. The criteria include whether proposed indicators promote the best possible improvement in public health and wellbeing and/or patient care, and the reduction of inequalities in health, given available resources.

26. We will also consider further whether improvements in exception reporting could contribute to addressing health inequalities and improving care for more disadvantaged communities.

Q3 Do you agree that the scope of the new process should cover clinical and health improvement indicators in the QOF excluding indicators relating to influenza vaccinations?

Summary of responses

27. The RCGP and the NHS Confederation supported this proposal. However, the majority of respondents, including the GPC, NHS Alliance and most patient groups, did not consider it appropriate that the scope of the process should be driven by the current remit of NICE. The majority of these respondents suggested that all indicators should be subject to the same review of clinical and cost effectiveness.

28. A number of patient organisations expressed concern that if the incentives for organisational quality were replaced (wholly or partly) by an accreditation scheme, the standards for accreditation should be subject to the same consultation process as the QOF indicators.

29. Some respondents understood this proposal to mean that the indicators not overseen by NICE would no longer be a part of a quality incentive scheme and expressed concern at this prospect.

The Government's response

30. We agree that the same principles of independent review and consideration of the evidence – with the aim of continuous quality improvement – should apply to all indicators and we will develop proposals to address this in consultation with stakeholders. We agree that the same principles should apply to the selection of standards used for any accreditation scheme, or to patient experience indicators, as measured through the new national GP patient survey.

31. The final choice of indicators for the QOF, however they are developed, is a matter for consultation between NHS Employers and the GPC. This includes those indicators as part of the new NICE process and those developed through other processes.

Q4 Do you agree with the proposed key elements of the new process and the proposed content of NICE advice?

Summary of responses

32. Respondents gave the following key recommendations regarding the scope of the new process:

    - It would be essential to have input from primary care professionals in all stages of the process. Remuneration arrangements for professional involvement would need to reflect this;
    - Further suggestions for representation on the Primary Care QOF Indicator Advisory Committee included representation from pharmacy, community nurses, NHS commissioners and the GPC;
    - Clarity should be provided on the evidence needed to submit suggestions for indicators and whether these will be published;
    - The business rules for indicators should be considered at an earlier stage to ensure the indicators were technically feasible.

The Government's response

33. NICE has recently advertised for members to join the Primary Care QOF Indicator Advisory Committee. NICE has explicitly requested that members of the Committee should include a range of experts and representatives from primary care, including GPs, patients and carers, commissioners, practice and community nurses, public health specialists and social care professionals from each of the countries taking part, health economists and information specialists.

34. The appointment of members is a matter for NICE, and it will consider any conflict of interest for appointed members. Committee members will not be appointed to act as representatives of a particular organisation, but to apply the experience and judgement from their individual backgrounds to the topics considered by the Committee. All Committee members will be entitled to receive expenses and for GP members this will include locum fees.

35. Following the publication of this document, NICE will publish an interim process guide, setting out how it will develop a menu of indicators in an open, transparent way. This will include further details on the submission of proposals from stakeholders and the interdependencies with other organisations. The interim process guide will be subject to consultation later in the year. We agree that the design of a new system provides the opportunity to ensure that informatics are considered right from the start of the prioritisation process, to improve the effectiveness of the indicators that are developed.

Q5 Do you agree with the proposed approach to reviewing existing indicators?

Summary of responses

36. Most responses from LMCs, the GPC and the majority of GPs were opposed to the principle outlined in the consultation that once activity had become embedded in general practice, QOF payments should cease. They considered that, were this to happen, established clinical interventions would no longer be resourced and staff would work on other indicators. Respondents did, however, agree that indicators should be continually reviewed for clinical effectiveness.

37. Respondents across all stakeholder groups stated that it would be critical to the process to a) clarify what criteria would be used to recommend retiring an indicator and b) continue to monitor performance against such indicators to guard against a reversal in performance. In addition, all aspects of indicators should be evaluated through piloting, in case outcome measures had unintended consequences for service delivery.

The Government's response

38. The QOF is intended to be an incentive scheme. It covers 15% of payments to GP practices and is voluntary. We recognise that QOF payments contribute to the overall NHS income of GP practices. We consider that income earned through achievement of individual QOF indicators should not, however, be regarded as linked to the specific costs of providing the interventions.

39. For example, the CHD 10 indicator rewards practices for the percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless contraindicated). We would expect that prescribing beta blockers to these patients would be part of normal care provided by an individual GP. However, there may be a good case to provide incentives to set up systems to ensure that all eligible patients in the practice receive this care and that it is recorded and audited. Once a register and call & recall system are set up and a high level of coverage is achieved, the costs of continuing to provide structured care for those patients should significantly reduce.

40. The question of what happens to resources if an existing indicator is proposed for removal is a matter for consultation with the profession through NHS Employers. However, we would not expect the QOF to be extended continuously in order to reflect the latest evidence on effective care. We would also not want to see the QOF fossilise. We would expect the QOF to evolve, with some indicators being replaced, for example, where the behaviour being measured has become part of standard practice. We therefore consider that, in making recommendations for which indicators will be most clinically effective and cost-effective, it is right to take into account how far the interventions currently incentivised by the QOF are embedded within general practice.

41. The Primary Care QOF Indicator Advisory Committee will consider and approve the criteria used to make recommendations on existing indicators. These criteria will be published in line with the transparent objectives of the process.

42. We agree the need to measure the effect on the quality of patient care where existing indicators are no longer used. We indicated as part of the Impact Assessment that we will commission an evaluation of the impact of the new process, which we would expect to look at this issue. In time, we will expect the new GP Extraction Service (GPES) being developed by the Information Centre for Health and Social Care to allow both the centre and PCTs to measure progress routinely against retired indicators.

Q6 Do you agree with the proposal to retain the principles for QOF indicators in the GMS SFE as set out in Annex C?

Q7 Do you agree with the draft criteria for prioritising new areas for indicator development attached at Annex D or do you have changes to suggest?

Summary of responses

43. There was almost universal agreement to retain the principles for QOF indicators in the GMS Statement of Financial Entitlements (SFE) among those who responded to this question.

44. Most respondents agreed with the general principles of the criteria for prioritising new areas for indicator development, but added the following key comments:

   - Most agreed that criteria 1c ("Is the topic one in which primary medical care practitioners have a significant contribution to make in terms of improving patients' health?") was the most important and should be the guiding principle;
   - Many did not consider it relevant that only indicators in NICE's current remit should be considered, nor should ideas for new indicators be dependent on the existence of current NICE guidance;
   - A number of respondents commented that whether the indicator was of "public concern" should not be of relevance;
   - The RCGP considered some criteria to be too outcome focused, which was impractical as outcomes are more difficult, expensive and time-consuming to measure.

45. Respondents also suggested that it would be important to weight the criteria more specifically.

The Government's response

46. We have revised the selection criteria for developing QOF indicators (attached at Annex A) to reflect responses to the consultation.

47. We accept that it is not appropriate to constrain artificially the prioritising of QOF indicators by limiting them to areas already covered by NICE's guidance. NICE is developing NHS Evidence as part of the implementation of the Next Stage Review, which over time will enable NICE to identify best practice information in areas not already covered by their guidance.

48. The criteria for prioritising areas for QOF necessarily focus on the evidence for outcomes – i.e. health benefits to patients. We would expect that indicators themselves should focus on delivery of direct health benefit to patients – for example measuring interventions with a direct health benefit (e.g. prescribing angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) to patients with chronic kidney disease) or achieving interim outcomes with direct

health benefit (e.g. the percentage of patients with diabetes in whom the last blood pressure is 145/85 or less).

49. We consider it reasonable that the criteria should take into account the urgency of introducing new indicators, for example if an area is of public concern.

50. Following the publication of this document, NICE will develop draft weighting criteria, which will then be considered by the Primary Care QOF Indicator Advisory Committee and published for consultation.

Q8 Do you agree with the principles proposed for assessing the cost effectiveness of QOF indicators? If not, what changes would you suggest?

Summary of responses

51. Respondents gave the following key comments on the cost effectiveness methodology:

- It was important to consider practice workload in the cost-effectiveness evidence;
- Some patient groups added that NICE would need to consider more carefully for primary care the social care costs and benefits;
- It would be important to consider the opportunity cost of excluding indicators.

52. The following key comments were made in relation to the QALY –

- Some were concerned that the QALY was flawed as an approach to measuring cost effectiveness so should not be the only determining factor;
- Some indicated that there was limited evidence on QALYs for the majority of indicators;
- The University of York suggested that if the approach should reduce inequalities, it would be important to base the QALYs on socio-demographic factors.

The Government's response

53. NICE will consider these responses in developing its analytical methodology for assessing cost effectiveness of indicators. The QALY remains an important tool because it is at present the best way of consistently measuring the health benefits of a wide range of different health-related interventions. However NICE's approach already takes account of the fact that there are important considerations that are not captured by the QALY (including equality impact). Further, the process will include an objective approach to assessing the relative value of indicators without cost effectiveness evidence but with good evidence of clinical effectiveness.

54. We will consider the impact on inequalities as part of the prioritisation process for assessing indicators.

Q9 Do you agree with the proposals for the scope of the advice that NICE would publish to inform subsequent decisions on choice of indicators, thresholds and payment levels?

Summary of responses

55. Respondents agreed with the proposals for the scope of the advice that NICE would publish. A number of organisations requested that information on rejected indicators should also be published.

The Government's response

56. We welcome the majority view in support of the scope of advice that NICE will publish to inform consultation between NHS Employers and the GPC. NICE will publish details on all proposals and piloted indicators that have been considered by the Advisory Committee, including those that have been rejected.

Q10 Do you agree with the proposals for the frequency of QOF reviews and the estimated output in terms of existing indicators reviewed and new indicators developed for the national menu?

Summary of responses

57. There was general support for the proposal to consider changes to the QOF in the longer term on a biennial basis and support from the NHS and most patient organisations on the number of indicators to be reviewed.

58. Some respondents were concerned that the result of the process would mean that 10 new indicators would be implemented a year, which would be too much for general practice to absorb. The RCGP added that to achieve 10 new indicators a year would require piloting 40 indicators, which was potentially too ambitious.

59. A number of respondents asked whether there would be the possibility to fast track certain indicators, if necessary.

The Government's response

60. We are asking NICE to review the existing clinical and health improvement indicators in the QOF over a period of four years. Therefore, initially we would expect that the two-year review cycles will need to overlap so that there are

recommendations for retirements and new indicators being made once a year. Once the existing indicators have all been reviewed there may be a case for moving to biennial recommendations.

61. Although we expect NICE to develop up to 10 new indicators through each full review cycle, the total number of indicators included in QOF will be a matter of consultation between the GPC and NHS Employers.

62. In terms of fast tracking indicators, it would be possible to amend existing indicators and guidance in year, if new evidence emerges that shows this is required for patient safety.

Q11 Do you agree with the proposals for the transition to the new system?

Summary of responses

63. Most respondents agreed with the proposals for the transition year. A significant number (including the GPC, the NAPC and some PCTs) suggested that we should make minimal changes in the first year, as rushing the process risked credibility.

The Government's response

64. We welcome the agreement for the transition year, which NICE will set out in more detail in the interim process guide. Inevitably NICE may have limited scope to recommend new indicators for 2010/11, as it will only take over responsibility from April 2009 and will need to produce recommendations by August. The final number of indicators selected for 2010/11 will continue to be a matter for consultation between NHS Employers and the GPC and the subsequent agreement by the Government.

Q12 What are your views on the idea of reserving a proportion of nationally agreed QOF investment to enable PCT and GP practices to agree local indictors selected from a national menu of approved indicators? Do you have any other suggestions for developing local QOFs or comparable local incentive schemes?

Q13 Do you have any views on the balance between the proportion of QOF that should be determined nationally and the proportion that could be left for local decision-making?

Q14 Do you have comments on the type and degree of national IM&T support that PCTs would need for extraction of data, analysis of achievement and calculation of payments to implement local QOFs or comparable local incentive schemes?

Summary of responses

65. The proposal for local QOFs received a mixed response – both in the written submissions and in the consultation events. The GPC, the majority of LMCs, GPs, a number of patient organisations and the RCGP did not support any form of local QOFs on the basis that priorities were better agreed at national level and sufficient mechanisms were already in place to support extra incentives at local level.

66. The NHS Alliance, the NHS Confederation, the RCP, the RCN and a majority of PCTs expressed explicit support for local QOFs as a means to ensure that resources in primary care reflected the needs of their local population. Some respondents suggested that whilst local incentives could be implemented using Local Enhanced Services (rather than by a local form of the QOF), PCTs could still use evidence from the NICE process to inform the local choice of incentives.

67. Of those respondents who supported local QOFs, the majority said that no more than 5% should be available for local decision making initially, but that this could be increased over time. In terms of IT support, most respondents commented that it was important to ensure current IT requirements for the national QOF were perfected before committing resources to local incentive schemes.

The Government response

68. We recognise the breadth of views expressed in response to the question of local QOFs. It is clearly the case that the majority of indicators will be relevant at a national level. However, the Government – with the support of the NHS – believes that the local NHS should in principle have a greater say in how investment is used to the benefit of their populations. Healthcare needs and the distribution of ill health and disease burden differ across populations.

69. We recognise that arrangements to support more local investment decisions will need to develop carefully over time. This will mean also keeping under careful review the balance between investment in the national QOF and investment in locally commissioned services. The ability to use NICE approved indicators would support PCTs to improve the clinical effectiveness and cost effectiveness of the services they commission, whether this is through the Quality and Outcomes Framework or local enhanced services.

Impact on other UK countries

70. The consultation set out proposals on how the new process should work in England but we have discussed with the devolved administrations how to ensure a collaborative approach across the UK. We can now confirm that all four UK countries have agreed in principle to take part in the new NICE-led process, which will allow some flexibility to address the priorities of the different countries. NICE is now working with all the health departments on the details of the process. This will ensure that all four UK countries are fully represented and involved in the new process from start to finish, including representation on the Primary Care QOF Indicator Advisory Committee.

71. NICE is responsible for evidence based guidelines for England, Wales and Northern Ireland. There is already good collaboration between NICE and NHS Quality Improvement Scotland, which leads the use of knowledge to promote improvement in the quality of healthcare in Scotland. As outlined above, NICE is developing NHS Evidence which will enable them to identify best practice information outside NICE guidance from April 2009. It is expected that SIGN will be invited to apply for accreditation at the earliest opportunity for future consideration in the QOF process.

Next steps

72. NICE will take over the arrangements for managing the new process for indicators from April 2009 and will shortly publish on their website an interim process document setting out in detail how they would propose to manage the new process and the proposed methodology for assessing indicators.

73. At this point NICE will receive all reports from the current expert panel and those in transition and will consult the newly appointed Primary Care QOF Indicator Advisory Committee at their first meeting in June 2009 on priorities for the review of existing indicators and the development of potential new indicators for 2010/2011. We expect that these will be published in the summer 2009. The process of gathering evidence for changes to the QOF in 2011/12 will also begin from 2009.

74. An external contractor will be appointed shortly, who will be responsible for the indicator development and – for 2011/12 QOF onwards – piloting new indicators.

Annex A

Selection Criteria for Prioritisation of Indicators for the Quality and Outcomes Framework

1. Is the proposed topic one in which primary medical care practitioners have a significant contribution to make in terms of improving patients' health, for example through case finding, diagnosis, referral, treatment or health promotion advice?

2. Would development of indicators promote the best possible improvement in public health and wellbeing and/or patient care, and the reduction of inequalities in health, given available resources? In particular, are one or more of the following satisfied?

   (a) Do the proposed indicators relate to one of the public health or NHS clinical priority areas, or to other health-related government priorities?

   (b) Do the proposed indicators address an area of action where introduction of evidence-based indicators in primary medical care would lead to cost effective improvements in the delivery of health care?

   (c) Are the consequences of the changed indicators on other health and social care sectors well understood? Are the costs (financial and human resources) for other sectors proportionate given the likely scale of benefit? Are they affordable and deliverable in the short term?

   And, for **public health topics**, the following.

   (d) Do the proposed indicators address an area of public health action that promotes population health or well-being, and/or relates to a significant burden of avoidable disease, disability, injury or early death in the population as a whole or in specific population sub-groups?

   And, for **clinical topics**, one of the following.

   (e) Do the proposed indicators address a condition which is associated with significant morbidity or mortality in the population as a whole or in particular subgroups?

   (f) Do the proposed indicators relate to one or more interventions or practices which could:

      i. significantly improve patients' or carers' quality of life; and/or

ii. reduce avoidable morbidity; and/or

iii. reduce avoidable premature mortality; and/or

iv. reduce inequalities in health

relative to current standard practice if used more extensively or more appropriately?

3. Would it be timely for NICE to develop indicators on the proposed topic? In particular:

   (a) Is this an area of QOF where existing indicators are coming up for review?

   (b) Would new indicators support implementation of new NICE guidance or National Service Frameworks which are in development or recently published?

   (c) Is there emerging evidence for developing new indicators with direct health benefit in areas where there are currently no indicators or where the existing indicators are not measuring direct health benefit?

   (d) Is there a degree of urgency for introducing indicators caused by factors other than those listed above, for example, [is there significant public concern], is this a new disease, or is this emerging as an important new area for public health action?

   (e) Would the indicators still be relevant and timely at the expected date of use?

Appendix I

QOF consultation events

The five QOF consultation events were held on the following dates at the locations listed below:

Date	Location	Number of Delegates
4th December 2008	London Art House, Islington, London	66
9th December 2008	Alea Conference Suite, Leeds	56
6th January 2009	Botanical Gardens, Birmingham	74
7th January 2009	Taunton Racecourse, Taunton	37
13th January 2009	Holiday Inn, Bloomsbury, London	102
Total number of delegates attending consultation events		335

Appendix II

List of respondents (organisations)

Abbott Laboratories Ltd
Age Concern and Help the Aged
Alzheimer's Society
Arthritis and Musculoskeletal Alliance (ARMA)
Arthritis Care
Association of the British Pharmaceutical Industry
Asthma UK
AstraZeneca UK
Bedfordshire and Hertfordshire LMC
Bedfordshire Health Advisory Forum
Berkshire West PCT
Birmingham East and North PCT
Birmingham LMC
Blackburn with Darwen Borough Council
Bladder and Bowel Foundation
Borders LMC
Bradford & Airedale Branch of YORLMC
Breakthrough Breast Cancer
British Association for Parenteral and Enteral Nutrition
British Geriatrics Society
British Heart Foundation
British In Vitro Diagnostics Association
British Lung Foundation
British Psychological Society
Bro Taf LMC
Motor Neurone Disease Association
Multiple Sclerosis Society
Nation Voices
National Ankylosing Spondylitis Society
National Association for Primary Care
National Centre for Young People with Epilepsy
National Council for Palliative Care
National Osteoporosis Society
National Rheumatoid Arthritis Society
Newham PCT
NHS Alliance
NHS Bedfordshire
NHS Confederation
NHS Lincolnshire
NHS Luton
NHS Norfolk
NHS Sickle Cell and Thalassaemia Screening Programme
NHS South of Tyne & Wear
NHS West Midlands
Norfolk LMC
North East Lincolnshire Care Trust Plus
North Essex LMC
North of Tyne Professional Executive Committee
North Staffordshire LMC
North Yorkshire Branch of YOR LMC

Bromley LMC
Bromley PCT
Calderdale LMC
Cambridgeshire LMC
Cancer Research UK
Centre for Health Economics, University of York
Cheshire LMC
Chronic Pain Policy Coalition
Cleveland LMC
Consortium of LMCs (Coastal, Central Lancashire, Cumbria, East Lancashire)
Cornwall and Isles of Scilly LMC
Deafblind UK
Derbyshire LMC
Devon LMC
Diabetes UK
Dudley PCT
East & North Hertfordshire and West Hertfordshire PCTs
East of England SHA
Epilepsy Action
Family Doctor Association
Family Planning Association
Fife LMC
Gateshead and South Tyneside LMC
General Practice Airways Group
Glasgow LMC
Gloucestershire LMC
GPC
GPC Northern Ireland
GPC Wales
GPC West Midlands
Northamptonshire LMC
Northern Lincolnshire & East Yorkshire LMC
Northern LMC, Northern Ireland
Northumberland LMC
Northumberland, Tyne & Wear and Durham GPC
Nottinghamshire LMC
Pfizer
Plymouth Teaching PCT
RCGP Scotland
Roche Products Ltd
Rotherham PCT
Royal College of General Practitioners
Royal College of Nursing
Royal College of Physicians
Royal National Institute of Blind People
Salford and Trafford LMC
Sandwell LMC
Sanofi-aventis
Sense
Sheffield Health and Social Care NHS Foundation Trust
Sheffield LMC
SignHealth
Solihull LMC
South Central SHA
South Essex LMC
South Staffordshire LMC
Southampton City PCT
Southern LMC, Northern Ireland
Suffolk LMC
Sunderland LMC

Grampian LMC
Gwent LMC
Halton and St Helens PCT
Hampshire PCT
Heart UK
Infant and Dietetic Foods Association
Joint Epilepsy Council
Kent LMC
Kidney Research UK
Leeds LMC
Leicestershire County and Rutland PCT
Londonwide LMCs
Macmillan Cancer Support
Manchester LMC
Medway PCT
Merck Sharp & Dohme Ltd
Mid Mersey LMC
Morgannwg LMC
Surrey and Sussex LMCs
Target PAD
The King's Fund
The Primary Care Cardiovascular Society
The Princess Royal Trust for Carers
The Queen's Nursing Institute
The Stroke Association
UK National Obesity Forum
UK National Screening Committee
University of Oxford, Department of Primary Health Care
Walsall LMC
Wessex LMCs
West Pennine LMC
Wigan LMC
Wirral PCT
Wolverhampton LMC
Worcestershire LMC

List of respondents (individuals)

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H Beerstecher
Dr S Bradley
Dr M Breach
Dr P Cawston
Dr S Chambers
Dr T Chesworth
D Clifford
Dr M Cohen
D Colvin
Dr A N Crawford & Partners
Dr J Davies
Dr P Davies
S McGraw
Dr D Mackenzie
Dr N McLoughlin
Dr H McNeil
I Moon
Dr G Morrow
Dr J Nugent
Dr D Outram
Dr G Phillips
Dr G Place
Dr T S Platts
Dr G Pohl
Dr V Rawcliffe
Dr S Riddell

Dr R Denning
Dr P Edney
Dr U Freudenstein
P Ganesh
Dr A Green
Dr C Hall
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B J Harris
A Hartley
Dr D C Hartley
Dr C Hatton
Dr K Hawthorne
P Horton
Dr G Jamie
Dr D Jeffrey
Dr C Jones
Dr D Keeley
Dr N Kerfoot
Dr L Kersh
Dr H Lupton
Dr J M McAtear
Dr A Macdonald
Dr G Macfarlane
Dr J Rivers
Dr K Saunders
Dr P Sambale
H Saunders
Dr R Sharpe/ S Rutland
Dr D Simpson
Dr S Smith
R Stark
M Steiner
Dr M J Tayler
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294200 1p Mar 09
Produced by COI for the Department of Health
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