



BRITISH GERIATRICS SOCIETY
SPECIALIST MEDICAL SOCIETY FOR HEALTH IN OLD AGE

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Patron: H.R.H. The Prince of Wales

Submission by the British Geriatrics Society to the Department of Health on:

**DEVELOPING THE QUALITY AND OUTCOMES FRAMEWORK: PROPOSALS FOR A NEW,
INDEPENDENT PROCESS**

The Society is delighted to be given the opportunity to contribute to this debate.

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

Yes – transparency in accepting new proposed topics for inclusion in QOF, and robust evaluation is correct.

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?

Yes – there is emerging evidence that QOF has had impact on reducing health inequalities. Further progress probably depends upon redefining the standards, and introducing new measures.

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 vaccination? This scope would cover indicators in the Clinical Domain of the QOF (apart from CHD 12, STROKE 10, DM 18, COPD 8), indicators in the Additional Services Domain and the following indicators in the QOF Organisational Domain: Records 11, 17 and 23.

We agree that domains such as CHD, stroke, diabetes and COPD are crucial, but I am unclear from what I have read here why these should be excluded from the new rigorous review of QOF standards. Surely the standards for these diseases need to evolve as with everything else. The QoF has ignored many of the conditions suffered by the frail elderly and some of those conditions, falls, continence, have been turned down; given prevalence and impact, this is unacceptable. There is reference to 88 new indicators being considered (point 47, page 18), but the reference given is no more than a footnote, so the source of these 88 indicators is obscure.

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

Yes

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

Yes – but we wonder if this needs to be open to local adjustment of the standards e.g. if the standard is set at 75%, but locally all practices are achieving 80%, is it possible to raise the bar locally?

Q6: Do you agree with the proposal to retain the principles for QOF indicators in the General Medical Services Statement of Financial Entitlements set out in Annex C?

Yes

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?

Yes this is satisfactory as long as the breadth of criteria is retained, and new areas are not chosen solely on the basis of cost-effectiveness, but also in terms of quality of care and avoidable morbidity. Cost-effective judgements alone can disadvantage interventions aimed at improved quality of life for older people. The British Geriatrics Society is

keen to see more indicators reflecting the important needs of frail older people, whose health costs are so large, and is keen to be engaged in the selection or proposal of topics.

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

We have some concern about basing cost-effectiveness decisions in very old people around QALY, as this concept has much less face validity to older people and specialists in the care of older people. However, this is of less importance if the criteria for agreeing a new area for inclusion is not purely on cost grounds (Question 7)

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?

Yes

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?

Yes – regular review is critical for the system to continue delivering any real benefit to the NHS.

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

Yes

Additional comment

Local flexibility is considered very important. It would be nice to see a proposal that a certain percentage of the QOF money should be determined by the local PCT. Our specialty is interested, for example, in the standards of medical care in nursing homes, and would welcome the development of QOF standards in this area. However, not every PCT would see this area as a priority for investment in their locality.

Professor Graham Mulley

President

For and on behalf of British Geriatrics Society

2nd February 2009

The British Geriatrics Society

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,500 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, nurses, allied health professionals, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.

Geriatric Medicine

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.