Author's response to reviews

Title: 'Just another incentive scheme.' A qualitative interview study of a local pay-for-performance scheme for primary care

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Author's response to reviews: see over
Response to reviews
We are grateful to all three reviewers for their helpful critiques and hope that we have responded and improved the manuscript accordingly.

Reviewer 1

Thank you for asking me to review this paper. The authors sought to investigate ‘primary care professionals’ experience of the local QOF scheme’ in one PCT which attempted to reduce health inequalities in a number of clinical domains. The research methods are well described and appropriate and the data are clearly presented. The main themes reflect the data that are presented. The detailed coding framework could be presented as an online appendix to help readers determine how these were arrived at.

We agree that the inclusion of the coding framework would be useful for readers to see in order to fully understand the analysis procedure. We have now provided this as an online appendix. Please see appendix 2.

The discussion covers the limitations of the study and relates the study findings to the broader literature on financial incentives. However, the QOF and local adaptations of it form a multicomponent complex intervention, of which financial incentives are only one component, as the authors rightly state. A systematic review of the QOF has been published.[1]

Thank you for highlighting this review by Gillam et al (Gillam SJ, Siriwandena AN, Steel N: Pay-for-performance in the United Kingdom: impact of the quality and outcomes framework: a systematic review. Ann Fam Med 2012, 10:461-468). We now cite this with corresponding changes to the Discussion. We further cite Guthrie and Morales to reinforce the point about complexity (Guthrie B, Morales DR. What happens when pay for performance stops? BMJ 2014;348:g1413.)

There is an implication that local indicators would lead to greater local ownership but this depends on how the indicators were developed. The authors should explain how these indicators were developed and discuss how indicators might be developed to increase participating practices’ sense of ownership.
As the reviewers may have realised, this manuscript is one of two; the other manuscript is a quantitative analysis of the impact of the scheme which describes the development and nature of the indicators in greater detail. In the writing of both manuscripts, we attempted to strike a balance so that either manuscript could be read in isolation whilst avoiding unnecessary duplication. Two reviewers’ comments suggest that we didn’t quite pull this off. Therefore, we have added some text to the Background of this paper outlining how the indicators were developed. For further detail on the scheme, we still cross-refer to the quantitative manuscript. We understand that there is an inherent risk in doing so – if the quantitative manuscript is rejected, we would need to substantially revise information accompanying this qualitative manuscript. If the editor prefers that we duplicated this content now, we would do so. In the meantime, we are happy to await the outcome of the quantitative submission if this will guide further decision-making.

It is also worth noting that our evaluation began after the scheme was developed and so we cannot provide much more information on the processes and discussions underpinning the development of the scheme – other than issues raised by scheme developers included in subsequent interviews and included in our overall analysis. We do further discuss how indicators might be developed to increase practices’ sense of ownership.

There is a suggestion that all local schemes are designed to reduce inequalities (P19, lines 417-420) but it seems unlikely that this applies to all local schemes.

We agree that reducing inequalities may be one of several aims and have qualified this point in the text.

The authors also argue the need for ‘future local schemes…to recognise the greater difficulties faced by practices serving more deprived populations and offer them higher rates of reward’. This is at odds with quotes from staff working on such practices and seems at odds with the findings from this paper. It would be helpful to understand why practices in more deprived areas had lower performance before suggesting that rewards need to be increased for these practices to improve performance.

Thank you for this point; it looks as if we have gone beyond the data presented in this manuscript in reaching a conclusion that ‘higher rates of reward’ would be worth considering.
Our quantitative manuscript highlights that smaller practices serving more deprived patients did less well out of the scheme financially, and we raise the suggestion about levels of remuneration there. We have therefore made a broader point here that the achievement of indicators may also depend upon the levels and types of resources already available within practices and the wider community.

Reviewer 2

Originality - While there is a large literature on the QOF (to which some of these authors have contributed), there have been few evaluations of local schemes of this nature.

Context – Local schemes are advocated as a means of enhancing ‘local ownership’. The study attempted to establish whether this was true and why but little detail is provided of how priorities were established and negotiated. How were the five indicators chosen, how were they ‘evidenced’, how were financial incentives agreed? The study was conducted three years ago. Some of these topic areas were subsequently covered by the QOF.

Thank you for this comment. Please see relevant response to Reviewer 1. However, we agree that there is a gap in our work as we cannot detail how the indicators were ‘evidenced’ and now acknowledge this as a limitation. We also now make a point about the local scheme priorities being later addressed within the national QOF.

Methods – These are described. Staff from 16 of 83 invited practices participated. A diverse range of personnel participated and recruitment seems to have been more haphazard than purposive.

As described in our methods, we did set out to take a systematic approach to sampling in order to achieve some diversity in local QOF achievement and practice population deprivation amongst participants. Despite further snowballing, we did find it difficult to recruit lower performing practices, which is acknowledged under study limitations. However, we consider the judgment that we recruited a diverse range of personnel (including scheme developers) as an advantage, since we sought to elicit a range of perspectives.

Five interviews were double coded; were the remainder coded by JH alone?
The remainder of the transcripts were coded by JH alone. This information has been included within the manuscript.

No particular theoretical grounding is claimed. Why were different professional groups interviewed? Were particular themes or concerns expected to emerge from different groups?

We imposed no theoretical grounding for this analysis and drew upon a thematic framework approach, with iterative refining of the codes and themes. From the outset we knew that professionals are organised differently within general practices. Different clinical and organisational members may or may not be involved in the delivery of the scheme. We therefore wanted to ensure that we captured these different ways of working and incorporate views that reflected different levels of involvement and engagement with the scheme.

Results – While there is seldom one best way of cutting the data, these themes were a little unsatisfactory given inevitable overlaps. The findings were largely unremarkable but that is easy to say after the event. Forty four transcribed interviews implies much data analysis.

Due to the nature of our research objectives, we were not striving for a conceptual framework of analysis. When coding our data, we firstly utilised deductive coding to the areas pre-specified within the topic guide, which we organised around our research questions. We have now included our coding schedule as an Appendix to help readers fully understand the analysis process, as suggested by Reviewer 1. We appreciate that some themes may appear to overlap and are not wholly distinct from one another. In particular we suspect that this is the case with ‘credibility of the indicators’ and ‘ownership’. However we judged that there were important differences between them (e.g. evidence base and localisation respectively) and they should therefore be reported separately.

Some statements were rather ambiguous. For example, did the 'limited availability of supportive resources' refer to the resources needed to manage these conditions? (Variability in access to the services needed for people with obesity or alcohol problems was one of the reasons they were originally rejected as indicators for the QOF.)

We thank you alerting us to this, we have reviewed the manuscript and also clarified this point.
Implications - The rationale for local schemes does not seem compelling. There are few causes of morbidity or mortality that are really 'local'. (Even in affluent areas, alcohol misuse is common!) The evidence base in support of national targets is going to be more rigorous given the resources at NICE's disposal to research and develop them.

We don’t disagree with this opinion. We have now highlighted the point about resources available to develop robust indicators.

Presentation – The paper is mostly clearly written but some of the phraseology was unfortunate. Did professionals really suggest that the scheme 'legitimised intrinsic motivation to improve patient outcomes'. The statement that 'even lower performing practices wished to be seen as putting patients first' implies limited understanding of what drives 'low performance'.

We're concerned that some of the phraseology appears unfortunate. In writing that the scheme 'legitimised intrinsic motivation to improve patient outcomes,' we are presenting an interpretation of what professionals reported. However, we have deleted the subsequent sentence as it over-simplifies the relationship between performance and motivation.

Conclusions – These were reasonable and add helpfully to the literature. There were no particular differences between this local and the national scheme. Local schemes could indeed be used to narrow differences in attainments between practices serving deprived and less deprived areas but this raises the age old concern about rewarding ‘failure’. The national scheme has already narrowed attainments. Research is needed to study the impact of differential financial rewards. More detail on the ‘wider range of levers to promote professional understanding’ might help policy makers.

Thank you. We have highlighted that there is a growing and increasingly robust evidence base for interventions to change professional practice.
In summary, the authors are to be commended for perseverance and this study presumably complements their quantitative analysis. With minor alterations, I should be inclined to publish this paper.

Reviewer 3

This is a very interesting paper which deals with a ‘local’ Pay for Performance initiative. The paper does not explicitly state the research question(s) of interest. I think that doing so would enable a much more focused discussion of findings.

As it stands the results section lists various things that have been gleaned from interviews as part of a process of gathering experiences. I think that this dilutes the paper’s message. Additionally, I’m not entirely clear what that message is. For example, the paper highlights problems in terms of limited support services (p8) which may undermine credibility of indicators. Is this only an issue for local P4P or does it apply to national QOF? If it applies to both, to what extent is this an important finding for our understanding of the differences between local & national P4P schemes? But the extent to which the various elements of the results section are important depends on the question(s) being addressed.

We appreciate these comments. Together with the comments of the other two referees, we think that they have provided enough ‘grit’ to help us rearrange the narrative of what we did and why we did it, as well as refine our research question.

Our story is that our quantitative analysis of gaps in achievement between practices serving less and more deprived patients found rather mixed if disappointing results compared with similar analyses of the national QOF. Our parallel qualitative study explored primary care professionals’ experience of the local QOF, including perceptions of the scheme this local QOF scheme, and indicators, likely mechanisms of influence on practice, and perceived benefits and harms. We asked whether professionals’ experience of the local QOF did differ from that of the national QOF in relation to the goal of reducing inequalities.

We hope that this framing will make it easier for readers to understand our findings. We later demonstrate that there appeared to be no particularly ‘special’ sense of ownership of the scheme (compared with the literature reporting experiences of the national QOF) and that implementation of certain targets was difficult because they partly relied upon factors outside of practices’ control.
Is the paper asking whether a local P4P scheme can overcome problems identified in the literature related to national P4P schemes? If so, it would be useful to know something about how this local scheme was developed and whether it was intended to overcome some of the difficulties previously identified (it would be helpful to know this anyway, even if this is not the question).

We refer to our above responses.

The paper states that at face value local schemes offer advantages by for example, promoting ownership. Our recent evaluation of CQUIN, a national P4P initiative which centred on locally negotiated indicators (Kristensen, McDonald, Sutton JHSRP 2013) found that although the intention (following Darzi) was that local clinicians should contribute to clinical topic area & related indicator selection, in practice this did not happen. So that the 'local' nature of the scheme was very different from that which policy makers had intended. Therefore, it seems likely that if local schemes are to promote ownership, then mechanisms must be created to engender such ownership. Merely calling something local seems unlikely to do this.

Thank you for bringing this work to our attention. We absolutely agree that it is consistent with our own findings and have commented upon this now in the Discussion.

If local scheme developers in Bradford & Airedale intended this initiative to overcome problems related to national QOF, then it is hard to see (from what is presented in the paper) how this was supposed to happen. Were scheme developers simply naive (a ‘then a miracle occurs’ approach to scheme development) or were there important processes/scheme details explicitly intended to address to anticipated problems?

We agree with this point that the scheme was implemented based on a hopeful set of assumptions. That said, we give our (former) PCT collaborator full credit for inviting our scrutiny. We have added a more general point about assumptions inherent in many quality improvement initiatives to the Discussion.
I think that some discussion of what constitutes a local scheme & the mechanisms intended to produce particular outcomes (i.e. ownership, clinician behaviour change) combined with explicit research questions would strengthen the paper a great deal.

We have added some further points for policy-makers, as suggested by other reviewers, to the Discussion. We could not mount a convincing argument for ways to enhance engagement and effects of local pay-for-performance and have placed more emphasis on reminding readers that there is a wider evidence base on improving practice.