Financial incentives for quality improvement interventions in public healthcare systems; the NICE strategy.

Mark Minchin – Associate Director, Quality (NICE)

11th July 2024

Financial incentives; the NICE strategy

What this presentation will cover

- **Background**
  - Introduction to NICE
  - Pay for performance (P4P)
  - Benefits and limitations of P4P
- **NICE indicator development**
  - Key principles
  - Independent advisory committee
- **Practical example**
  - Validity assessments
  - Cholesterol management - secondary prevention

NICE helps practitioners and commissioners get the best care to patients, fast, while ensuring value for the taxpayer.

We do this by:

- producing useful and usable guidance for health and care practitioners
- providing rigorous, independent assessment of complex evidence for new health technologies
- developing recommendations that focus on what matters most and drive innovation into the hands of health and care practitioners
- encouraging the uptake of best practice to improve outcomes for everyone.

NICE (2024)

Financial incentives (pay for performance)

Introduction

“Pay-for-Performance (P4P) is a payment model that rewards health care providers for meeting pre-defined targets for quality indicators or efficacy parameters to increase the quality or efficacy of care”

P4P is widely used in Europe and beyond. Some questions persist about links to improved outcomes.

Mathes, T. et al. (2019) Pay for performance for hospitals. Cochrane Database Syst Rev 5 (7) 7.

Pay for performance

UK's Public Healthcare System

The UK has a government-sponsored universal healthcare system, the National Health Service (NHS). Experience from two national P4P schemes:

- Commissioning for Quality and Innovation (CQUIN)
- Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF)

- Introduced in 2004 - general practice / primary care
- NICE took over indicator development in 2009
- Annual value of QOF about £770 million[2] (€910 million)

Benefits and limitations of P4P

20 years of the QOF

Benefits

- Catalyst for computerisation and coding
- More structured care for people with LTC
- Some improvements in care
- Supported a more diverse workforce
- Influenced care across nearly all providers

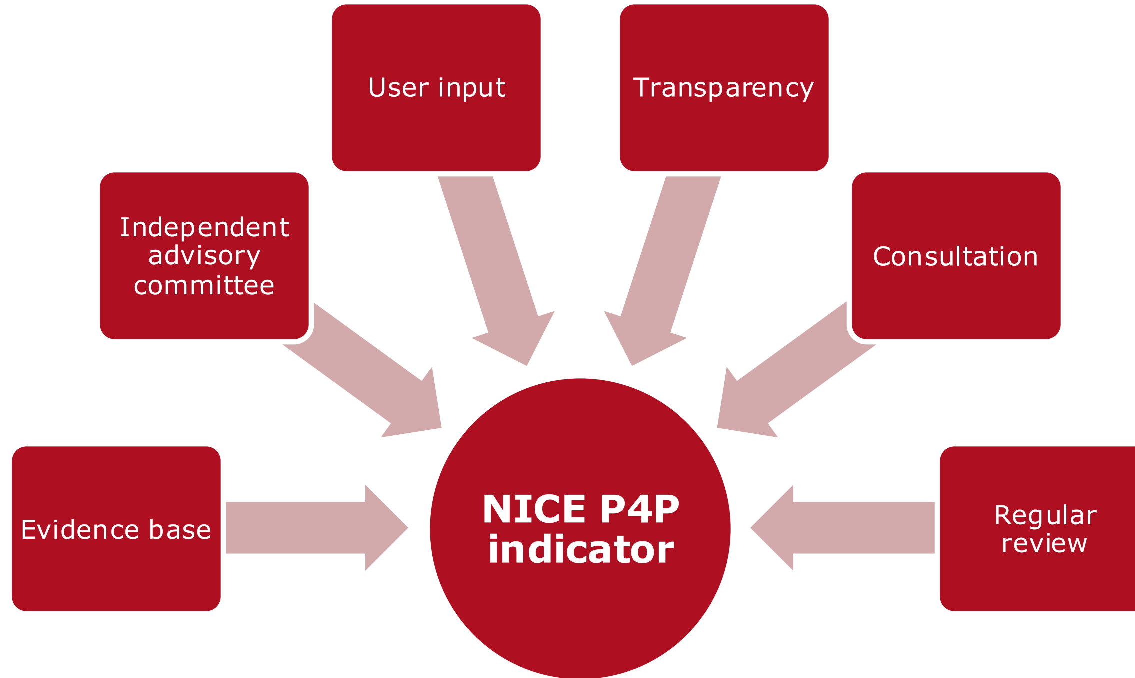
Limitations

- Focus on what can be measured
- Single disease focus
- De-professionalisation – prompts / tick box
- Lack of continuous quality improvement
- Sustainability when incentives removed

NICE P4P indicator development

Key principles

ESC
Cardiovascular Round Table



NICE indicator development

Independent advisory committee

Committee member	Background
Dr Ronny Cheung (chair)	General Paediatrician
Liz Cross	Advance Nurse Practitioner
Michael Bainbridge	Commissioner of Care (payer)
Prof Chris Gale	Consultant Cardiologist
Dr Chris Wilkinson	Consultant Cardiologist
Dr Paula Parvulescu	Consultant in Public Health
Prof Elena Garralda	Consultant Psychiatrist
Prof Martin Vernon	Consultant in Geriatric Medicine
Dr Ben Anderson	Director of Public health
Dr Rachel Brown	GP (family doctor)
Dr Chloë Evans	GP (family doctor)
Dr Tessa Lewis	GP (family doctor)
Dr Waqas Tahir	GP (family doctor)
Dr Victoria Welsh	GP (family doctor)
Mrs Linn Phipps	Lay member
Adrian Barker	Lay member
Prof Mieke Van Hemelrijck	Cancer epidemiology

Standing advisers

Data informatics / coding expertise

Additional expertise from guidance developers as required

Technical support and secretariat from NICE staff

Practical example – NICE indicator development and use in QOF

Lipid management secondary prevention

NICE indicator development

Criteria to appraise the validity of P4P indicators

Domain	Criteria
Importance	• Reflects a specific priority area • Relates to an area where there is known variation in practice. • Will likely lead to an improvement in outcomes. • Addresses under or over-treatment.
Evidence base	• Derived from and aligns with high quality evidence base.
Specification	• Defined components including numerator, denominator and exclusions. • Minimum population level.
Feasibility	• Repeatable and measures what it is designed to measure. • Uses existing data fields or the burden of data collection is acceptable.
Acceptability	• Performance is attributable to or within the control of the audience • Results can be used to improve practice
Risk	• Acceptable risk of unintended consequences

Modified from MacLean et al (2018) Time Out — Charting a Path for Improving Performance Measurement. *NEJM* 378 (19) 1757-1761

Practical example

Cholesterol management, secondary prevention (1)

Figure 1. Percentage of people with CVD[1], in whom the most recent cholesterol level (measured in the preceding 12 months) is non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l

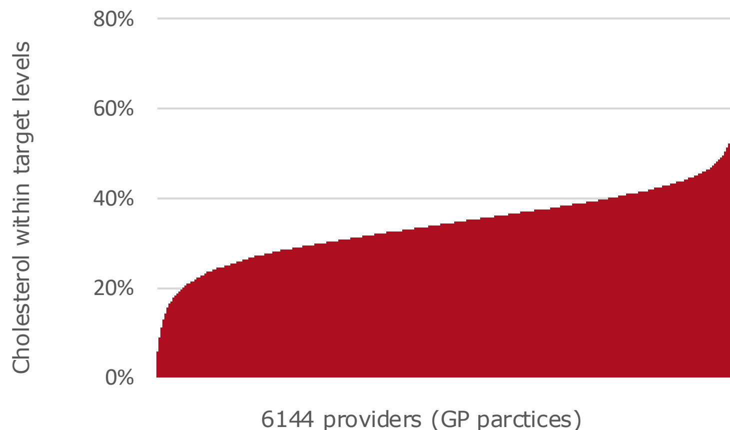
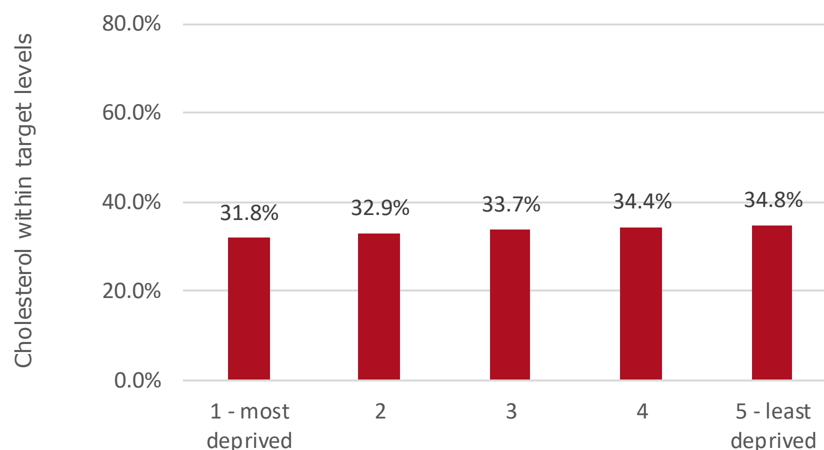


Figure 2. Percentage of people with CVD[1] in whom the most recent cholesterol level is non-HDL <2.5mmol/l or LDL-C less than 1.8mmol/l (deprivation)



1. EMR recorded CHD, non-haemorrhagic stroke, TIA and PAD

Practical example

Cholesterol management, secondary prevention (2)

ESC Cardiovascular Round Table

Figure 3. Percentage of people with CVD[1] in whom the most recent cholesterol level is non-HDL <2.5mmol/l or LDL-C less than 1.8mmol/l (sex)

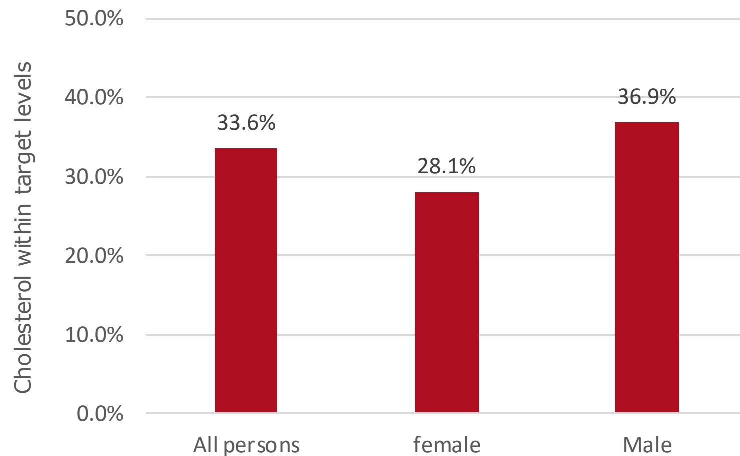
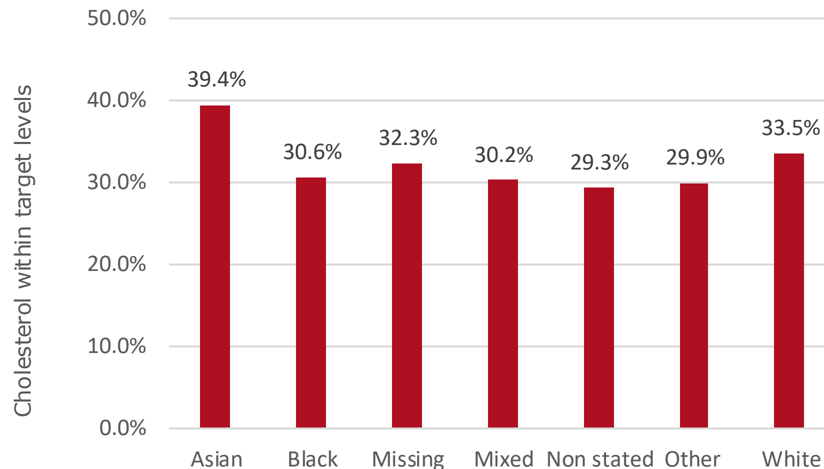


Figure 4. Percentage of people with CVD1 in whom the most recent cholesterol level is non-HDL <2.5mmol/l or LDL-C less than 1.8mmol/l (ethnicity)



EMR recorded CHD, non-haemorrhagic stroke, TIA and PAD

NICE indicator embedded in a guideline

Cardiovascular disease: risk assessment and reduction, including lipid modification

NICE guideline [NG238]   Published: 14 December 2023

As part of the December 2023 update, a new NICE indicator was developed to support quality improvement in managing cholesterol levels for people with CVD. This NICE indicator is suitable for inclusion in local and national general practice measurement frameworks, including those underpinned with financial incentives:

NM252: The percentage of patients with CVD in whom the last recorded LDL cholesterol level (measured in the preceding 12 months) is 2.0 mmol per litre or less, or last recorded non-HDL cholesterol level (measured in the preceding 12 months) is 2.6 mmol per litre or less, if LDL cholesterol is not recorded.

Included in the 2024/25 QOF with financial incentives attached, now also included in the national audit

Thanks

mark.minchin@nice.org.uk