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**Primary Care Respiratory Society position on 2019 review of**

**Quality and Outcomes Framework for asthma and COPD**

Background

Since the Quality and Outcomes Framework (QOF) was introduced, PCRS has engaged with the process of developing and shaping the respiratory indicators. The process of development has varied over the years, and is currently run by NICE, which develops indicators which are put forward to the negotiating committees for inclusion in the GMS contract in each of the four nations each year.

In 2018 NICE undertook a major overhaul of the diabetes indicators, and these new indicators were introduced in April 2019. They announced at the start of 2019 in a report on the GP contract[[1]](#footnote-1) which followed the NHS long term plan, that the next therapy areas to review would be asthma, COPD and heart failure. PCRS has a seat at the table for the discussions on asthma and COPD indicators, as does AsthmaUK and BLF.

This paper was prepared for the first review meeting led by NICE on February 13,2019 and was shared in advance with various stakeholders attending. It sets out what we believe were the important considerations at the start of the review process.

Principles for improving asthma and COPD QOF:

1. QOF could serve a useful role in highlighting and promoting key quality improvement opportunities for asthma and COPD.
2. We are pleased to see some joined up thinking between the NHS Long term plan[[2]](#footnote-2) and GP Contract – e.g. new QOF indicator on pulmonary rehabilitation (PR) for 2019/20. We find it disappointing to see that overall there are fewer points for asthma and COPD QOF at a time when respiratory disease is supposed to be an NHS priority (lost 10 points (net) overall for asthma and COPD between 2018/19 and 2019/20).
3. We are keen that any revisions to QOF build on and are developed in the knowledge of other work that has been done by RCP audit group on National Asthma and COPD Audit Programme (NACAP) and COPD audit before that (importantly); NHS RightCare pathways and Focus packs, and work of Asthma UK, British Lung Foundation, British Thoracic Society, and Primary Care Respiratory Society (PCRS).
4. QOF should be aligned with latest thinking on best practice care in line with national and international guidelines. (e.g. We support the removal of COPD 004 as it is no longer recommended to measure FEV1 annually.)
5. Many QOF indicators measure process and PCRS has always promoted the development of QOF away from process and more towards outcomes. Other disease areas have more outcome focused indicators than respiratory – e.g. target for optimum blood pressure for hypertension So we would like to suggest indicators such as - overall fewer exacerbations and fewer symptoms, a decrease in avoidable A&E attendances, and hospitalisations for COPD and asthma. We know from the National COPD audit for example, that recording of exacerbations is very poor, yet it is increasingly important as a tool to differentiate patient types and guide appropriate treatment.
6. PCRS has promoted the adoption of indicators with a sound evidence base for many years, but sometimes these have not been adopted due to implementation issues, which has been disappointing e.g. self management plans in asthma. We would support a blended approach to measuring indicators such as self management plans and inhaler technique that uses PROMs and PREMs, as these indicators depend on how the intervention is provided, not just whether it is provided
7. Those involved in the review process being led by NICE should be aware that there may be patients with asthma and COPD who are eligible to be considered in the practice lists for asthma and COPD, but who are not currently included. It is as important to have mechanisms to identify these and get them included as it is to minimise exception reporting of patients who are on practice lists.
8. We support the move towards using QOF as a quality improvement tool (QI) and would like to see the asthma and COPD indicators reinforcing this approach. We would like to see QOF build on work done by NACAP/COPD audit. Compared to Welsh QOF, for example, NACAP shows a much bleaker picture of the quality of respiratory care in primary care. E.g. in the most recent Wales COPD primary care audit[[3]](#footnote-3) 39.1% (32, 295) did not have MRC recorded in the last year. However the level of achievement of MRC scores recorded for QOF appeared to be much higher than this as reported in the first Welsh COPD audit[[4]](#footnote-4). We believe that the audit asks the right questions and looks for meaningful Read/SNOMED codes.

We would recommend a QI approach for asthma and COPD to reflect the QI areas for this year – e.g. under prescribing safety – QI initiative in prescribing of short acting bronchodilators (SABAs) in asthma and on reducing use of (inappropriate) inhaled steroids in COPD.

1. QOF should seek to reinforce high quality coding in respiratory disease. It should extract data based on key codes in the GP computer system reflecting the quality of care rather than require additional QOF-specific codes. We believe that some rationalising of respiratory codes will be helpful between now and April 2020, and that NICE should follow the work NACAP has done to specify appropriate codes for data extraction.
2. Some stratification of the asthma and COPD populations may be possible. E.g. Asthma by age, and both asthma and COPD by severity, or by e.g. history of hospital admissions.
3. The impact of current smoking in respiratory conditions is significant, and therefore treating tobacco dependency in respiratory patients has very specific benefits. SMOK 003 has been retired on the grounds that it is now considered part of core professional practice. (‘The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy’). While at one level, this is positive, it is also important that healthcare professionals in primary care consider treating patients with tobacco dependency as a priority area for their attention. There are still QI opportunities for TD that could be introduced in exchange for some dated tobacco QOF areas.
4. We believe that there should be an indicator specifically about treating tobacco dependency in people with COPD. Including a specific indicator on treating tobacco dependency in COPD would give a clear message to healthcare professionals that treating tobacco dependency is their responsibility – using the most effective method, which is support with medication. Inclusion of such an indicator will also give a clear signal to CCGs that a policy of prohibiting the prescribing of evidence based medication is unacceptable, and runs counter to national public health policy and the need to address inequalities, and the NHS Long term plan.

References:

2019/20 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF) Guidance for GMS contract 2019/20 in England April 2019 BMA/NHSE <https://www.england.nhs.uk/wp-content/uploads/2019/03/1920-gms-contract-qof-guidance.pdf>

Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan 31 January 2019 BMA/ NHSE. <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf> This is the report on the GP contract published in the wake of the NHS Long term plan for England. It sets out longer term plans for QOF too.

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1. Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf> January 2019 Accessed 11.2.19 [↑](#footnote-ref-1)
2. NHS Long term plan <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf> January 2019 Accessed 11.2.19 [↑](#footnote-ref-2)
3. Planning for every breath - Primary care audit (Wales) 2015-17 Second report from National primary care audit of COPD in Wales December 2017 <https://www.rcplondon.ac.uk/projects/outputs/primary-care-audit-wales-2015-17-planning-every-breath> Accessed 11.2.19 [↑](#footnote-ref-3)
4. Primary care: time to take a breath. First report from National primary care audit of COPD in Wales October 2016 ‘The MRC breathlessness score results are at odds with the QOF declarations for annual

review where MRC breathlessness score should be recorded: 91.1% (QOF COPD003) versus

58.2% from extracted data.’ P33 [↑](#footnote-ref-4)