

**PCRS briefing document**

**Respiratory QOF changes for 2019/20 (and 20/21)**

Background

The latest GP contract was published on Jan 31 2019. This is a more significant GP contract than most as it reflects significant changes announced in the NHS Long term plan (LTP) in January, and provides more detail about how the 5 year contract will support delivery of the NHS LTP. It also announces important changes to QOF, how primary care networks will function, plans for additional funding of general practice and more detail about some of the new roles to be promoted in primary care networks – incl clinical pharmacist, and advanced practice physiotherapists, and physician assistants.

A review of QOF in England began in 2017 and involved major consultation with general practice and LMCs. The new GP contract represents the culmination of this review, and sets out major changes in how QOF will operate.

* QOF will migrate more towards Quality improvement (QI) and away from what has come to be perceived as a tick box, process-driven exercise for practices
* A large number of indicators are to be ‘retired’ on the basis that they are of limited value based on current evidence, or are hard to measure, or are now viewed as part of core professional responsibility. Thus 31% of current indicators are being retired (28 indicators representing 175/559 points), creating the opportunity to ‘recycle’ some of them into more clinically appropriate areas.
* The current blunt system of exception reporting will be replaced with a more precise ‘personalised care adjustment’.

Changes to respiratory QOF from April 2019:

1. One new indicator on pulmonary rehabilitation.

COPD 008 (NICE ID NM47)

The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme

2 points 40-90% payment threshold Rationale: High impact intervention for patients with COPD

1. Two COPD indicators will be retired:

COPD004 The percentage of patients with COPD with a record of FEV1 in the preceding 12 months No. points: 7 Rationale for retirement: Not required on an annual basis to guide care coupled with issues with access to annual spirometry in general practice

COPD005 The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months No. points 5 Rationale: Not in line with NICE

1. A more detailed review of the COPD and asthma indicators will be undertaken in 2019 commencing with a meeting in February 2019, and PCRS will have a seat at the table and play an active role in shaping an improved set of indicators for respiratory disease for QOF 2020/21.

In addition, a smoking indicator (SMOK 003) is to be retired on the grounds that supporting people to stop smoking is now part of core professional practice. This is very encouraging as we believe that it is the role of healthcare practitioners to treat tobacco dependency as a long term condition which starts in childhood.

PCRS response/position:

1. We welcome the move towards QOF being used as a basis for quality improvement. This will enable the collection of respiratory data in general practice to be used as a basis for investigating how the quality of care can be improved.
* However we don’t have an audit for asthma and COPD in England from which we would obtain the necessary data to reflect on what should change and how we monitor that.
1. We welcome the addition of a QOF indicator on pulmonary rehabilitation, and believe this will provide an important stimulus to local areas reviewing and expanding their provision of PR. PR is an intervention with a significant evidence base and is more cost effective than many medications.
* However, in the Wales COPD primary care audit 39.1% (32, 295) did not have MRC recorded in the last year. If practices don't improve the quality of annual reviews and pay more attention to breathlessness management then people who should be in the denominator group, suitable for PR, will still be missed and not get access to this intervention.
1. Re retirement of COPD 004: We agree with removing the requirement to undertake spirometry on all people with COPD annually because we agree that measuring FEV1 has limited value in determining the progression of COPD on its own – there is a poor correlation between lung function and severity - time released from performing this task could enable a more comprehensive and patient centred approach to the annual review.
2. Re retirement of COPD 005: We support this removal because oxygen saturations are now well-recorded (from evidence in Wales COPD primary care audit), and reflect a considerable success story for quality improvement in the last 5-10 years where pulse oximetry has shifted from being rarely used to now being business-as-usual.
3. It is disappointing that overall we have lost 12 points from respiratory indicators and only gained two with the new indicator on PR.
4. We welcome the opportunity to work with NICE to develop a better set of indicators for asthma and COPD for implementation from 2020.

References, links and quotes:

Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan 31 January 2019 <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

‘NHS England and GPC England have agreed to an ongoing programme of indicator review in key priority areas, including heart failure, asthma and COPD care in 19/20, and mental health in 2020/21 for any subsequent changes to be implemented as soon as possible.’ P23

‘We will also aim to develop and test a pipeline of further potential indicators and Quality Improvement modules for national roll-out. We would welcome additional contributions to developing new QI modules, especially from national voluntary sector organisations.’ P23

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‘The new contract framework marks some of the biggest general practice contract changes in over a decade and will be essential to deliver the ambitions set out in the NHS Long Term Plan through strong general practice services.’

‘It (the contract) will ensure general practice plays a leading role in every Primary Care Network (PCN) which will include bigger teams of health professionals working together in local communities. It will mean much closer working between networks and their Integrated Care System.’

<https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/> Accessed 4.2.19

Reviewed by PCRS policy forum 24.4.19

Approved by PCRS Executive committee 14.5.19