NHS England: Report of the Review of the Quality and Outcomes Framework in England
Strategy & Innovation Directorate

Response submitted by the Royal College of Paediatrics and Child Health

August 2018

The Royal College of Paediatrics and Child Health (RCPCH) is pleased to share evidence that promotes the need for children to be included in the QOF review. RCPCH continues to learn about quality of care and variations from existing QOF data, whilst refining and further developing proposals for improvement in the QOF. We would be pleased to give further oral evidence.

The Royal College of Paediatrics and Child Health (RCPCH) is responsible for training and examining paediatricians, setting professional standards and informing research and policy. RCPCH has over 18,000 members in the UK and internationally. We work to transform child health through knowledge, research and expertise, to improve the health and wellbeing of infants, children and young people across the world.

The Case for Child Health in the QOF

The RCPCH *State of Child Health Report 2017* uncovered alarming inequalities in the health and wellbeing of children across the UK and a clear disparity with the rest of Western Europe. There are marked variations in the health and quality of care for children and young people, with significant scope for improvement. The foundations of health are laid in the early years and there is much to be gained from investment in this age group[1].

When QOFs were introduced in 2004, government had agreed that it would be discriminatory to put age limits on the indicators[2]. Including children within QOF indicators will incentivise GPs to undertake preventative and public health activities that will optimise the limited resource available to NHS services and help strengthen primary care for children. We acknowledge the current pressures in General Practice and the challenge of maintaining a predominantly aging population with multiple health needs. We also recognise the limitations of the QOF and its role in measuring processes of care rather than care outcomes. We therefore propose limited high value areas for consideration in the QOF review.

Three examples follow where the QOF can help drive improvements in child health: the first overarching area is about improving healthcare to better meet needs, the second is childhood obesity as a leading preventable cause of morbidity and mortality across the life course, and the third focuses on asthma as the most common long-term condition of childhood (see Appendix A).

[1] Chief Medical Officer (2013) Chief Medical Officer annual report 2012: Children and young people's health. Department of Health and Social Care: October 2013. Available from: https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

[2] Roland M., Guthrie B. Quality and Outcomes Framework: what have we learnt? *BMJ* 2016; 354.

Problems of Need and Healthcare

Children and young people aged 0-15 years old account for around 18.9% of the population and estimates suggest that children make up 25% of GP workloads[3]. Parents seek advice from their general practitioner on average six times per year for children under four years old[4,5,6]. As parents' preference for initial advice is their GP a primary care led model of service delivery should remain the focus but this is hindered by less than half of GPs having had an opportunity to undertake paediatric training[7,8]. Integrating services and enhancing paediatric training for GPs will help to improve children's journey through the care pathway whilst increasing the confidence of primary healthcare professionals treating children.

Since the founding of the NHS, there has been a shift in the burden of disease in childhood away from infectious diseases to more chronic, long term conditions. One in seven 11 to 15 year olds now has a long term condition or disability[9] and care for people with long term conditions in England accounts for 50% of all general practice appointments[10]. Despite the shifting patterns of need towards chronic conditions, demand for acute and urgent services continues to rise. For example, year on year the number of children presenting to the emergency department with minor ailments increases by 5%[11]. The policy response to poor outcomes and current unsustainable patterns of healthcare use promotes integrated care as close to home as possible. The *Facing the Future: Together for child health* standards – developed jointly by the RCPCH, RCGP and RCN – ensure that specialist child health expertise is available at the front end of the care pathway, strengthening the role of primary care services in order to improve outcomes for both acute and chronic conditions[12]. Moreover, investing in prevention and early intervention will ensure that children grow up to be healthy, resilient adults.

However, progress in adapting to current evolving health needs, in line with policy around integration, has been patchy. RCPCH recently audited *Facing the Future: Together for child health* standards and found there to be poor integration between primary and secondary care services, with only 7.4% of acute general paediatric units linking a

---

[3] Pye S. What do winter pressures mean for paediatric care? 2018. Available from https://www.health.org.uk/blog/what-do-winter-pressures-mean-paediatric-care

[4] Action for Sick Children. First Contact Care Survey. 2013. Available from http://www.actionforsickchildren.org.uk/sites/default/files/downloads/ASC-SURVEY.pdf

[5] Royal College of Paediatrics and Child Health, Royal College of General Practitioners, College of Emergency Medicine, *et al.* To understand and improve the experience of parents and carers who need advice when a child has a fever (high temperature). 2010. Available from http://www.rcpch.ac.uk/system/files/protected/page/Fever_report_FINAL2_0.pdf

[6] Royal College of General Practitioners. RCGP Child Health Strategy 2010-2015. 2010. Available from http://www.rcgp.org.uk/child-health

[7] Maguire S., Ranmal R., Komulainen S., *et al.* Which urgent care services do febrile children use and why? *Archives of disease in childhood* 2011: archdischild210096

[8] Gerada C., Riley B., Simon C. Preparing the future GP: the case for enhanced GP training. *London: Royal College of General Practitioners* 2012.

[9] Digital N. Health and Wellbeing of 15-year-olds in England - Main findings from the What About YOUth? Survey 2014. 2015. Available from https://digital.nhs.uk/catalogue/PUB19244

[10] Lewis I., Lenehan C. Report of the children and young people's health outcomes forum. 2012. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216852/CYP-report.pdf

[11] Pharmacy Research UK. Community Pharmacy Management of Minor Illness: MINA Study. 2014. Available from https://pharmacyresearchuk.org/wp-content/uploads/2014/01/MINA-Study-Final-Report.pdf

[12] Royal College of Paediatrics and Child Health (2015) Facing the Future: Together for Child Health. Available from: https://www.rcpch.ac.uk/sites/default/files/Facing_the_Future_Together_for_Child_Health.pdf

consultant paediatrician to their local GP practice[13]. Furthermore, poor communication between secondary care providers and GPs have exacerbated workloads for primary care professionals[15] and demand for hospital services continues to rise.

Recommendations for data to improve policy and practice through the QOF

The RCPCH makes clear that an integrated approach to data collection will result in more accurate and comparable data to analyse trends and provide an essential evidence base to inform the use of resources[14]. The RCPCH *Facing the Future Audit 2017* shows evidence of poor interoperability between hospitals and primary care services. One of QOF's key successes has been in the acceleration and widespread use of electronic medical records. There are opportunities to inform quality improvement, service design and targeted service provision to local populations using data collected by QOF and a review of the impacts of perverse financial incentives might be well addressed within this piece of work.

Since paediatric patients generally make up a quarter of total general practice populations, QOF targets can often be reached without including children and young people. Consideration should be made as to how children are more accurately 'counted' in QOF targets. For example, children with cancer (CAN001), depression (MH001), epilepsy (EP001), learning disabilities (LD004) and palliative care (PC001) would benefit from primary care keeping records of local patient cohorts, improving transition of care and creating more holistic management for the child and their family.

New indicators could be used to integrate health prevention strategies into primary care assessments, such as focusing on dental health or maternal health. Thinking more upstream and applying 'making every contact count' in the paediatric and antenatal population is likely to have long-term health benefits with impact on the wider health system.

Obesity

The childhood obesity rate in the UK is not improving and for deprived groups there is evidence of further escalation. Between 2007/08 and 2016/17, the difference between obesity prevalence in the most and least deprived areas has increased from 4.5 to 6.8 percentage points for children in reception year and from 8.5 to 15 percentage points for children in year 6 in England[15]. Obesity in childhood is likely to result on obesity in adulthood and studies predict that the majority of 2 year olds today will be obese by their 35th birthday[16]. Obesity is the second highest cause of cancer in adults meaning health and social services will require a coordinated approach in tackling the effects of the rising epidemic[17].

Childhood obesity requires a multiagency approach to prevention and care. Primary care has an important role in preventing obesity, as well as its early detection and management. For example, although the National Child Measurement Programme (NCMP) collects data via school visits in reception and year 6, by the time of their first assessment at age 4, 20% of children are already overweight[18]. Since we know that early interventions, prior to starting school, can significantly change trajectories for overweight and obese children, it

---

[13] Royal College of Paediatrics and Child. Facing the Future Audit 2017. 2018. Available from www.rcpch.ac.uk/facingthefuture

[14] Royal College of Paediatrics and Child. State of Child Health. 2017. Available from https://www.rcpch.ac.uk/state-of-child-health

[15] Digital N. Statistics on Obesity, Physical Activity and Diet - England, 2018 Available from http://digital.nhs.uk/catalogue/PUB30258

[16] Ward Z.J., Long M.W., Resch S.C., *et al.* Simulation of Growth Trajectories of Childhood Obesity into Adulthood. *N Engl J Med* 2017; 377(22): 2145-2153.

[17] Berger N.A. Young Adult Cancer: Influence of the Obesity Pandemic. *Obesity* 2018; 26(4): 641-650.

[18] NHS Digital. Digital Child Health. Available from https://digital.nhs.uk/services/digital-child-health

is important to provide opportunities in primary care to develop and deliver targeted weight management education for parents and carers. So, it is imperative that growth trends are tracked more closely between birth and starting school in order to identify patients at risk of childhood obesity.

Since children aged <4 years have frequent contact with their GP, primary care is perfectly positioned to collect this early childhood weight data[19] and deliver effective early intervention.

Recommendations to improve prevention and management of childhood obesity through the QOF

We recognise the time pressures during general practice appointments, in addition to the technical challenges with embedding electronic growth charts into GP systems. However, with drastic cuts to health visiting, school nursing and public health funding, primary and secondary care must recognise their collective responsibility in addressing childhood obesity. The biggest single cut to the public health budget in 2016-17 was a £7 million reduction to services directly aimed at ICYP, such as health visiting, school nursing and childhood obesity programmes[20].

There is opportunity to use QOF indicators as a lever to accelerate implementation of electronic growth charts and BMI centile calculators in primary care. We support the exploration of IT software to collect and monitor childhood weight data in primary care, ensuring there is future potential for systems to communicate, or integrate, with the NCMP and secondary care services. There is opportunity to capture data in the electronic Personal Child Health Record (ePCHR) that would require integration with primary care IT systems. QOF has been a successful tool for improving information technology systems in general practice and would lend itself well to the national childhood obesity strategy. We accept that weight and BMI centile documentation is not the sole responsibility of GPs and support the role of allied health professionals aiding the data collection process.

We have proposed a new indicator, in which opportunistic weight and BMI centile recording on an electronic growth chart takes place for all children, with only one reading needing to be recorded over a 12-month period. The current obesity indicator (OB002) should be specifically extended to include children 2-18 years.

Asthma

The UK has one of the highest prevalence, emergency admission, and death rates for childhood asthma in Europe. There are, on average, three children with asthma in every classroom in the UK[21]. As adolescents move towards adulthood and more independent self-management, there can be challenges in maintaining good asthma control. Ensuring all primary care professionals have training in working with adolescents is essential to help them continue good disease control.

Most emergency admissions are preventable, with high-quality management and early intervention to address deterioration in symptom control.

Recommendations to improve management of children's asthma through the QOF

Creating a register of children and young people with asthma can usefully enhance understanding of national and local disease burden. This can be achieved by specifically extending the current asthma register to include children between 5-18years. Extending

[19] Hobbs F.R., Bankhead C., Mukhtar T., *et al.* Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14. *The Lancet* 2016; 387(10035): 2323-2330.

[20] Charlotte Santry. Revealed: Children's services hardest hit by public health cuts. 2016. Available from https://www.hsj.co.uk/topics/public-health/revealed-childrens-services-hardest-hit-by-public-health-cuts/7005957.article

[21] Asthma UK. Asthma facts and statistics. 2018. Available from https://www.asthma.org.uk/about/media/facts-and-statistics/

the asthma reversibility indicator (AST002) to include children aged 5-18 years will improve disease monitoring of the paediatric population.

Asthma reviews (AST003) should be specifically extended for children aged 5-18 years. Alternative methods of engaging with asthma reviews, including phone reviews, self-management check-ins or nurse-led clinics should be explored by GP services.

In conjunction with local registers (AST001) and asthma review registers (AST003), at-risk children in local populations will be more easily identified. Targeting interventions to at-risk communities is a key recommendation from the National Asthma Death Review[22]. This information can be shared within clinical networks and secondary care providers to better tailor interventions to poorly controlled, or at-risk children.

One method of achieving these goals could involve counting children <18 years separately in registers; current QOF points could be divided up between patients <18 years and >18years based on proportionate national burden of disease. For example, the asthma register QOF (AST001) is worth 4 points. Around 20% of all patients in England with asthma are children[23]. Therefore, 4 points can be divided proportionally to national prevalence. Registers for patients aged 5-18 years would be allocated 1 point, and those for patients >18years, 3 points.

Conclusion

RCPCH welcomes this opportunity for improving the QOF and harnessing its potential to improve the quality of care for infants, children, and young people. Our recommendations are designed to support changes that would be of high value and impact from improving outcomes. We look forward to continuing to work in partnership with NHSE and other Royal Colleges on improving children's health.

[22] Royal College of Physicians. Why asthma still kills. The National Review of Asthma Deaths (NRAD). 2014. Available from https://www.asthma.org.uk/globalassets/campaigns/nrad-full-report.pdf

[23] Asthma UK. Asthma facts and statistics. 2018. Available from https://www.asthma.org.uk/about/media/facts-and-statistics/

Appendix A

	QOF	Proposal for extension/addition and rationale
Clinical indicators		
ASTHMA	AST001. The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	**Specify register is to include children aged between 5 years and 18 years** The register can used to better understand the burden of disease and local and national levels, supporting development of targeted improvement interventions to at-risk communities.
	AST002. The ***percentage of patients aged 8 or over with asthma*** (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis *NICE 2015 menu ID: NM101*	**Reassess the lower age reference to include children aged 5-8 years.** Current care pathways (NICE and BTS/SIGN) recognize the difficulty in diagnosing asthma in children under 5 years but agree on management of CYP aged 5 years and over. The QOF should be amended to reflect this.
	AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions *NICE 2011 menu ID: NM23*	**Extend register to measure the percentage of patients aged 5-18years with asthma, on the register, who have had a structured asthma review in the previous 12 months. Asthma assessment should take place as per BTS/SIGN guidelines.** At-risk paediatric asthma patients often do not engage with routine follow-up appointments. This indicator aims to better identify these cohorts in local areas. This can be used to support development of targeted improvement interventions for at-risk communities. A high achievement should be set for the indicator to more accurately identify true at-risk cohorts. Alternative methods of follow-up, including phone reviews or self-management led check-ins can be included as having achieved follow-up.

		The review should be developed in conjunction with wider primary care networks and local secondary care providers, promoting integration and alignment of care pathways. BTS guidelines suggest that symptom scores for children are best assessed with Children's Asthma Control Test (4-11years) and Asthma Control Questionnaire (over 5years), rather than adult RCP questions.
Public health domains		
	Opportunistically record weight and BMI centile on electronic growth charts at least yearly for all patients 2-18yrs who present for an appointment,	This intervention ties in to national attempts to promote development and use of electronic growth charts with integrated BMI centile calculator. The indicator denominator is of all children and young people 2-18 years. There is recognition that most children seen by GPs are <4 years. Early intervention of raised BMI prior to first National Child Measurement Programme (aged 4/5 years) can assist in delivering early nutritional education for families.
OBESITY	OB002: The contractor established and maintains a register of patients aged ***18years or over*** with a BMI>/= 30 in the preceding 12 months	**Specify register is to include children aged 2-18 years. Weight recording to be converted to a BMI centile measurement using BMI calculator.** The register can used to better understand the burden of disease and local and national levels, supporting development of targeted improvement interventions to at-risk communities.