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How to maximise your QOF income: End of life care

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- Indicators: 2
- Points: 37

Many GPs will remember the QP (Quality and Productivity) indicators that were briefly part of QOF a few years ago. Despite a consensus that these were not a success, some of the principles of those indicators have returned to become part of the new Quality Improvement (QI) indicators introduced from 2019/20.

The new QI indicators are more rigorously defined than the old QP indicators – an effort to make them more effective. While most of the QOF will be stable for the next five years, each of these QI indicators will run for one year only before being replaced.

For 2019/20 there are two QI indicators on the area of end of life care. Another two new QI indicators introduced this year focus on prescribing safety and are outlined separately.

Indicator 1: Continuous quality improvement activity focused on end of life care (27 points)

The practice should audit a number of deaths during the past year as a baseline audit, to identify any issues and areas for improvement – for example, the proportion that were on the palliative care register and therefore anticipated, and the proportion with care plans in place.

Palliative care tends to be poorly coded. Systematically coding these reviews, while not part of the QOF indicator, will make it easier to search records in future. These baseline audits should not involve huge numbers of patients and should not take more than a couple of hours.

Some examples of audit measures:

1. Patients identified and appearing on a 'supportive care register' (this will have a very large crossover with the QOF palliative care register).
2. Personalised care and support plans (including treatment escalation, advance directives and emergency treatment preferences including resuscitation) recorded and shared appropriately.
3. Care givers identified and supported.
4. Mechanisms for feedback.

The practice should then develop quality improvement activities and goals. These should be specific, measurable, achievable, relevant and time-bound (SMART). These can be anything that is relevant, but there are only a limited number of activities possible and for most practices these activities can be copied from the guidance.[1] They can be modified according to needs identified by the practice.

A few practices with specialist populations, such as university practices, may need to consider other objectives but these should be discussed with the CCG and be appropriately adapted from the guidance.

Examples of objectives could include increasing the amount of:

- Patients at end of life who are entered on a supportive care register. In effect this is likely to be the same as the QOF palliative care register. This can be assessed by looking at patients who have died recently and calculating how many were on the register. There is no right proportion but around 50% has been suggested as an approximate target.
- People affected by serious illness and end of life care offered timely and relevant personalised care and support plan discussions that were documented and shared electronically. There is no standard way to do this although various products are available. A standard approach will need to be agreed across local care systems.
- Family members/care-givers/next of kin contacted and offered information on dealing with grief and bereavement within a specified period. This will need a system in the practice to review death notifications as they arrive at the practice.
- Family/care-giver or patient interviews. These can be after the death of the patient to identify any aspects of care that can be improved and can be part of the bereavement contact above.

Once these have been defined the work of the indicator is in achieving the targets. In palliative care particularly this will involve all the practice team and will require awareness of policies and registers of both patients and carers. Carers in particular may be more visible to reception and administrative teams than to the clinicians. It is worth considering how these changes will be identified. This may be using coded computer records or another form of register that can be analysed at the end of the year.

NHS England has published a series of case studies on the new QI domain, including examples of the end of life indicators.[2]

Start as early in the year as you can, to allow time to complete the audit cycle before the end of the year. It will also allow time for the local meetings in the indicator below. At the end of the year there is a standard form for the practice to use to report the activity during the year. This should be around 400-500 words in length and detail the activities undertaken and their results.

Indicator 2: Participation in network activity, including at least two peer review meetings (10 points)

Usually meetings will be within the practice network. If the practice is not part of a network, arrangements will be made by the CCG. As the value of points will vary with list size, while the number of meetings does not, the payment will be bigger for larger practices.

The first meeting in the year will discuss the results of the audit within practices and the planned activities and outcomes. The second will review the outcomes at the end of the year and discuss any future activities and how benefits will be maintained. These could be combined with the two equivalent meetings for the prescribing QI indicators.

As most practices are going to be doing similar things this should not be a series of presentations but a discussion of similar findings. Tips and experiences can also be shared.

The key to these indicators is to use the published guidance and templates to analyse practice and then to concentrate on implementation. Getting the admin done as early as possible in the year will allow more time to make changes and avoid a rush later on.

These audits are also likely to be valid for appraisals so, as long as you have done the work, you could get extra value out of the audits. Sharing the audits appropriately around the practice will ensure that everybody meets the appraisal requirements.

References

1. NHS England. Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan. 31 January 2019. Annex B: QOF Quality Improvement. P79 End of life care.
2. NHS England. 2019/20 QOF: Quality Improvement Case Studies. April 2019.

Indicators in full

- *QI003: The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance. (27 points)*
- *QI004: The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings. (10 points)*

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http://preview.pulse-intelligence.co.uk/guide/how-to-maximise-your-qof-income-end-of-life-care/

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