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Does personalised care mean worse QOF outcomes?

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I'm a GP at a busy practice in North-East England and, like all, we are feeling the strain of increasing patient access as well as reducing practice income. We want to provide high-quality, person-centred care for our patients with long term conditions – this has always been a priority for us. However, achieving high quality and outcomes framework (QOF) points is vital for the finance of the practice.

Are these two aspirations mutually exclusive or is it possible that using the Year of Care approach to personalised care and support planning (PSCP) will help us to get those ever more elusive QOF points?

We implemented the Year of Care approach to PCSP for people with single and multiple long term conditions around 7 years ago. When we first moved to this approach, we gathered data showing that it was saving us both time (clinical and administrative) and money, knowing that it saved time and streamlined care for patients too. This approach is now firmly embedded in our practice systems and our patients expect it.

How does PCSP work for us?

We recall people in their birthday month for an annual information gathering appointment where, using an EMIS template, we make sure the tests and tasks needed for all their long term conditions are done at once. We then share relevant results with the person together with an explanation, the previous year's results, agenda setting prompts and space to write what's important to them. At a PCSP conversation appointment a week or two later we allocate sufficient time to discuss all their long term conditions, focussing on what is important to them at that time. This appointment will be with a practice nurse, advanced nurse practitioner or GP depending on their clinical history and results; we always strive for continuity.

So, why is this important in terms of QOF?

The conditions with points attached in the QOF clinical indicators for 2025/26 are coronary heart disease, stroke/ TIA, diabetes mellitus, atrial fibrillation, heart failure, COPD, dementia, mental health, asthma, non-diabetic hyperglycaemia, hypertension and lipids. The first seven of these are included in our recall system for PCSP.

If patients with any of those conditions also have any of the other five conditions these would be addressed at the same time alongside any non-QOF conditions as part of the Year of Care, PCSP approach.

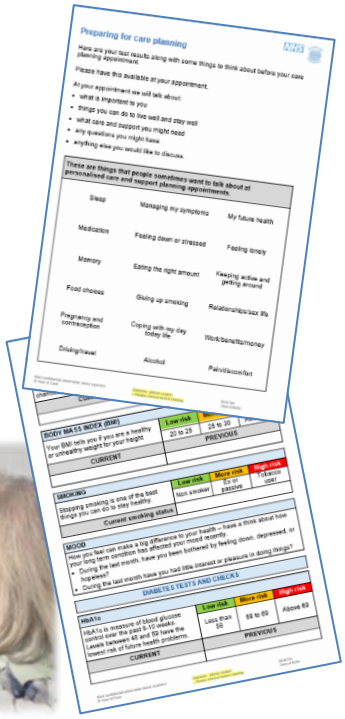
As an example, at the end of the 2024/25 year we had full QOF clinical domain points for our patient population of 14,000 (barring childhood vaccinations which showed a slight decrease like many practices in this area). Our exception reporting rate is low since we note how people prefer to be contacted, reaching out by telephone if they are not responding to invites, thereby extending the personalised approach beyond appointments to our recall system. Additionally, because of PCSP our eight care process achievement in the 2023/24 National Diabetes Audit was 81% for people with type 2 diabetes (national average 62%).

How did our approach help achieve QOF points?

Moving to a single longer appointment for information gathering means all the tests/tasks needed for QOF can be gathered, and duplication of work is reduced (i.e. a person might have type 2 diabetes and a previous stroke – most of the information needed is the same). By sharing results with the patient afterwards there is the opportunity for them to let us know anything that has been missed *("I did have my retinal screening last April," "Here are my home BP readings"*). It also encourages people to come to their second appointment for a PCSP conversation to discuss what's important to them as well as reviewing medication, goal setting and action planning for the year ahead.

So, what's next?

We are using more emails and texts for initial contact and working on results letters that are easy to send and read electronically. We are also using text questionnaires to routinely gather home BPs and Asthma Control Test/MRC scores. These measures should all continue to support the achievement of QOF targets while ensuring the person remains at the centre and is supported to actively manage their own health and wellbeing.



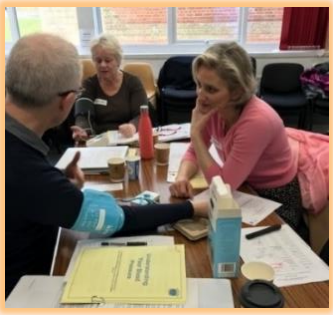
What about hypertension?

HEaT
Hypertension Education and Treatment

Hypertension affects 25–30% of the population and is a key risk factor for cardiovascular disease, a leading cause of morbidity, disability, mortality and health inequalities.

One of the key areas of focus for QOF 2025/26 is preventing and managing CVD and its risk factors including hypertension. However, it is often beyond the capacity of practices to offer PCSP to people with hypertension as a single long term condition.

To overcome this and provide meaningful support to people newly diagnosed with hypertension Year of Care has developed a pilot patient education programme called HEaT (Hypertension Education and Treatment). At its heart is the engagement of individuals newly diagnosed with hypertension, linked to self-monitoring and self-management.



How can YOC support collection of QOF points?

Systemising long term condition surveillance

The Year of Care process separates the biomedical tasks, tests and assessments from the PCSP conversation enabling a structured method of QOF data collection with space for a separate, holistic and meaningful conversation.

The role of the healthcare assistant is vital as they support people to understand and engage in the PCSP process during the information gathering appointment, whilst also gathering data to meet QOF targets.

It is therefore extremely important to support health care assistants with training and mentorship as their role and skills can dramatically impact the person and the process.

"I would try to do as much as I could but now, we are more structured, and I know what I have got to do. I think it is more beneficial for patients and for us"
HCA Newcastle

"We've just finished our QOF year having performed well. For once we weren't doing the last-minute dash for numbers which I think is thanks to the YoC process." **GP**

The role of the patient in achieving QOF targets

Practices gain their QOF points when patients attend appointments and reach clinical targets. This is more likely to happen when patients understand the PCSP process and its benefits, and have a better understanding of their own health, including routine results. "Preparation" supports people to review and prepare for their PCSP conversation. This enables people to understand their health, ask questions, raise concerns, and ultimately self-manage their own health, which in turn gives the best chance of improved outcomes.

"Each time I get a greater understanding of my condition and…how I can go about maintaining and improving it" **Person with long term conditions**