NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Practice Quality Improvement Framework (QIF) 2024_25

For GP Practices in the following ICB sub locations:

- **Cannock Chase**
- **East Staffordshire**
- **North Staffordshire**
- **South East Staffordshire & Seisdon Peninsula**
- **Stafford and Surrounds**

Version: 18/4/24

1. Introduction

Our population priorities

The ICP strategy and Joint Forward Plan outlines how the Staffordshire and Stoke-on-Trent (SSOT) Integrated Care Partnership (ICP) will work over the next five years to improve services for our people and communities and intends to address the key physical and mental health requirements of the population, describing our collective priorities. These are aligned to the core national, regional and local strategic drivers of the NHS including the NHS Long Term Plan (LTP), the Health and Care Act and the Core20PLUS5 approach.

QIF has been developed with a number of clinical leads to support the ICP Strategy and Core20PLUS5 (a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement).

Also, as outlined in the ICBs General Practice Five Year Forward Strategy and one of the Fuller Stocktake building blocks (Prevention), QIF will also contribute to preventing ill health and tackling health inequalities by supporting improvements in the 2 biggest drivers identified with difference in avoidable mortality between most and least deprived areas of Staffordshire and Stoke-on-Trent, these are cardiovascular disease and respiratory disease. QIF will also support improvements in outcomes and quality of life for people with diabetes

QIF for 24/25 will continue to focus on the following national and local key priorities:

- Long term conditions: screening, management and quality improvement (Diabetes, AF, Hypertension, CVD)
- Palliative care (including supporting ICB End of Life programme with embedding use of ReSPECT/advanced care plans)
- Diabetes (Type 1 and Type 2 patients) - continued recovery and delivery of 8 Care Processes
- Increase identification and prevalence rate of chronic kidney disease (CKD)

Stoke-on-Trent ICB sub location has been delivering a Quality Improvement Framework (QIF) for several years, and a full independent evaluation[1] has been carried out to demonstrate the benefits of such a scheme in primary care.

2. Finance

The scheme is offered to all practices in the 5 Staffordshire ICB sub locations (North Staffordshire, East Staffordshire, Cannock Chase, Stafford and Surrounds, South East Staffordshire and Seisdon Peninsula). An extended scheme (QIF Plus) is offered to Stoke-on-Trent ICB sub location practices due to historical deprivation funding. *(50.3% of Stoke-on-Trent's population live in the most deprived 20% of communities in England compared to 10.7% of Staffordshire's population, Jan-24). In 24/25 QIF Plus scheme will be available to 12 additional practices in other parts of the ICB to recognise those practices with high proportion of their population living in the 20% most deprived communities.*

[1] https://doi.org/10.1093/fampra/cmy128

ICB Sub location:	***Cannock Chase***	***East Staffordshire***	***North Staffordshire***	***South East Staffordshire and Seisdon Peninsula***	***Stafford and Surrounds***	***Stoke On Trent***
NORMALISED WEIGHTED LIST SIZE (1/1/24)	141,853	155,362	249,534	224,913	157,892	309,434
Value of scheme per head of weighted population (phwp)	*£2.10*	*£2.10*	*£2.10*	*£2.10*	*£2.10*	*£4.00*
*QIF Budget 24/25**	£297,890	£326,261	£524,022	£472,318	£331,574	£1,237,735
Number of points	*64*	*64*	*64*	*64*	*64*	*121*

**Overall budget will be uplifted for the 12 additional practices moving onto £4.00 phwp QIF Plus scheme (£204K based on 100% achievement)*

A breakdown of points and each indicator's funding is provided in the Section 6 below:

3. Payments 2024-25

3.1 Practices will be paid **80%** of the total award for full achievement of total points (as above) in equal monthly instalments.

3.2 Once all evidence is reviewed final achievement will be calculated for the practice. Practices will then receive any outstanding money owed to them, however where a practice has received a greater payment during the year than the amount of their final achievement they will be contacted by Finance and required to pay back monies owed to the ICB in monthly instalments and, except in exceptional circumstances, over no more than a 6 month period from the date of notification.

4. Reporting requirements/ year end reconciliation - all practices

4.1 Practice consents to MLCSU Data Quality Specialist (DQS) extracting and sharing data with the ICB to enable monthly reporting requirements and reconciling practice achievement of the indicators of the framework at the due dates listed below.

5. Verification

5.1 All claims may be subject to post payment verification.

6. Indicators

Covid-19 shone a light on inequalities and highlighted the urgent need to strengthen action to prevent and manage ill health in ethnic minority communities. A cross-government strategy for reducing health inequalities, and the wider socio-economic and structural inequalities that drive them, should be an urgent priority. "The health of people from ethnic minority groups in England":

Practices are therefore asked to strengthen action in ethnic minority communities and Core20Plus5 approach when delivering QIF to reduce health inequalities.

https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england

Core20PLUS5

Note: Deadline for all indicators: 31st March 2025.

ICB Sub area	Ref No.	Indicator heading	Detail	Thresholds	Max Funding	Points
All	**1a**	**Increase Palliative Care Prevalence Rate**	Increase palliative care prevalence. (practices should be aiming for prevalence rate above 1%).	Stepped threshold and weighted payment: >0.5% prevalence rate 8p, >0.75% prevalence rate 15p Baseline: 0.71% prevalence rate (Jan-24) QOF 24/25 3 points	£0.15	5
All	**1b**	**Increase use of ReSPECT documentation**	% of people who have died during 24/25 with ReSPECT documentation in place at time of death. (Practices are also asked to improve depth of coding eg. preferred place of death, actual place of death).	% of people that have died during 24/25 had Respect documentation in place. **a. Where Palliative Care prevalence rate >=0.75% (as at 31/3/25):** >30% of patients with Respect Documentation 15p, >38% of patients with Respect Documentation 20p, >45% of patients with Respect Documentation 26p or **b. Where Palliative Care prevalence rate between 0.5% and <0.75% (as at 31/3/25):** >30% of patients with Respect Documentation 10p, >38% of patients with Respect Documentation 15p, >45% of patients with Respect Documentation 20p Baseline: 43.8% of people on Palliative Care register have ReSPECT in place (Jan 24). 2023/24 (11 months EMIS practices) % of deaths with ReSPECT in place: 36.1% (lowest quartile 26.2%, interquartile 34.3%, highest quartile 42.4%)	£0.26	8
All	**2a**	**Delivery of Diabetes 8 Care Processes (Type 1)**	Achievement of 8 Care processes (People with Type 1 Diabetes) (Practices are asked to aim to prioritise those not seen in 23/24)	Stepped thresholds: >35% achievement of 8 care processes 10p, >40% achievement of 8 care processes 13p, >45% achievement of 8 care processes 17p	£0.17	5

All	**2b**	**Delivery of Diabetes 8 Care Processes (Type 2 & unknown type)**	Achievement of 8 Care processes (People with Type 2 & unknown type Diabetes) (Practices are asked to aim to prioritise those not seen in 23/24)	Stepped & weighted thresholds: >40% achievement of 8 care processes 17p, >45% achievement of 8 care processes 23p, >50% achievement of 8 care processes 33p	£0.33	10
All	**3**	**Pulse Rhythm check to support AF screening (Aged 65+)**	Pulse Rhythm check recorded for those aged 65+ without AF. (Any deviation from normal pulse rate for the patient should be reported and investigated)	Stepped & weighted thresholds: >40% recorded 20p, >50% recorded 25p, >70% recorded 34p	£0.34	10
All	**4**	**Hypertension ongoing management**	**HYP008**. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	Stepped thresholds: >65% achieved 22p, >72% achieved 25p, >78% achieved 30p Baseline >68% (Jan-24) **PCA/Exception rates** not to increase or be significantly different from ICB (10.9%) or England average (10.61%) QOF 22/23) (QOF 24/25 thresholds 40-77% 14 points)	£0.30	9
All	**5**	**Cholesterol control and ongoing management**	**CHOL002**. Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, or Stroke/TIA Register, who have a recording of non-HDL cholesterol in the preceding 12 months that is lower than 2.5 mmol/L, or where non-HDL cholesterol is not recorded a recording of LDL cholesterol in the preceding 12 months that is lower than 1.8 mmol/L.	Stepped thresholds: >30% achieved 10p, >35% achieved 20p, >40% achieved 30p Baseline: CHOL002 38.5% (Mar-24 EMIS practices) (QOF 24/25 CHOL004 thresholds 20-35% 16 points). (QOF 23/24 CHOL002 thresholds 20-35% 16 points) **Note:** Indicator will change to CHOL004 when revised Business Rules published and DQ team will revise QIF search package. (Stepped thresholds and value to remain the same) CHOL004. Percentage of patients on the QOF Coronary Heart Disease (CHD), Peripheral Arterial Disease (PAD), or Stroke/ Transient Ischaemic Attack (TIA) Register, who have a recording of LDL (Low-density Lipoprotein) cholesterol in the preceding 12 months that is 2.0 mmol/L or lower or where LDL cholesterol is not recorded a recording of non-HDL (High-density Lipoprotein)	£0.30	9

				cholesterol in the preceding 12 months that is 2.6 mmol/L or lower		
All	**6**	**Increase identification of Chronic Kidney Disease (CKD)**	**CKD005**. Increase identification of patients aged 18 or over with CKD classification of categories G3a to G5 with coded diagnosis to increase prevalence rate.	Stepped threshold: >4.5% prevalence rate 15p, >5.0% prevalence rate 20p, >5.5% prevalence rate 25p Baseline Prevalence rate 22/23 4.28% QOF 24/25 (CKD005 6 points protected).	£0.25	8
					£2.10	**64**

APPENDIX 1 Resources / Additional information

Clinical System Search packages	See briefing email from DQ Team and Specifications and reporting tools for each clinical system are on GP365 GP365 - QIF 24_25 - All Documents (sharepoint.com)
Palliative Care	**See guide previously provided:** Link to guidelines for practitioners in General Practice: Palliative & End of Life Care Identification and ReSPECT: GP365 - ID ReSPECT Guidelines.pdf - All Documents (sharepoint.com)
ReSPECT Resources **&** **Digital programme**	To use within organisations and for patients to use to support their decision-making process. Also, translated versions of patient guide. ReSPECT Resources | Resuscitation Council UK Guidance: DNACPR and CPR decisions | Resuscitation Council UK
	We are now working to digitalise the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form within the Shared Care Record, One Health and Care. Currently piloting with 12 GP practices and County hospital. Clinical Safety sign off imminent and training pilot users for go live date due 21st May. We would ask practices to support rollout of the future digital programme.
	Do not attempt cardiopulmonary resuscitation (DNACPR) and people with a learning disability and or autism letter. The attached letter highlights the importance of implementing the Universal principles for advanced care planning and ensuring that DNACPR decisions for people with a learning disability and autistic people are appropriate, are made on an individual basis and that conversations are reasonably adjusted. The analysis by Kings College London of the deaths of people with a learning disability in 2021 indicates that there were still a significant percentage of cases where good practice in DNACPR decision making was not demonstrated. Please note your Community LD nurse specialist/facilitator can also provide advice and support.
ReSPECT Additional info	MPFT will continue to support Primary Care and deliver the Respect sessions facilitated via the Staffordshire Training Hub. Dates will be advertised via the Staffordshire Training Hub bulletin and website. ReSPECT printed documentation is available on request from primarycareteam@staffsstoke.icb.nhs.uk
Diabetes 8 Care Processes	The community teams are going to encourage patients to attend primary care for the 8 care processes. When the 8 care processes are completed at the Acute Trust for type 1 patients we are looking to share a process and form by Wolverhampton that captures this information that can then be sent back to primary care to record. UHNM are looking to adapt this form to provide the information to avoid patients having the tests repeated. A review of the individual 8 care processes shows lower completion for the Urine Albumin and Foot Surveillance, a focus on these processes could increase achievement of all 8 care processes. There are some free patient resources that can be ordered or downloaded (if not already aware) What diabetes care to expect if you have type 2 diabetes | Free diabetes information - Diabetes UK Shop
Pulse Rhythm Check	DQ team has activated an alert protocol that will be available for all practices to support with capturing this information. Free information on Pulse Check, AF, Stroke, CVD etc on the Primary Care Cardiovascular Society website: https://pccsuk.org/
CKD	About kidney disease | Kidney Care UK Chronic kidney disease (CKD) | Kidney Care UK

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