

Practice Quality Improvement Framework (QIF PLUS) 2024_25

For GP Practices in the following ICB sub location:

- ◆ **Stoke on Trent**
- ◆ **12 practices from other ICB locations**

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 (Diabetes, AF, Hypertension, CVD, Stroke Heart Failure, CHD, Asthma, COPD)
- 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)
- Prevention: Increasing uptake in Cervical Screening Rates and Pneumococcal Vaccination

Stoke-on-Trent ICB sub location has been delivering a Quality Improvement Framework (QIF) for several years, and a full independent evaluation¹ has been carried out to demonstrate the benefits of such a scheme in primary care.

2. Finance

The QIF PLUS scheme is offered to all practices in Stoke-on-Trent ICB sub location 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
<i>NORMALISED WEIGHTED LIST SIZE (1/1/24)</i>	141,853	155,362	249,534	224,913	157,892	309,434
<i>Value of scheme per head of weighted population (phwp)</i>	£2.10	£2.10	£2.10	£2.10	£2.10	£4.00
<i>QIF Budget 24/25*</i>	£297,890	£326,261	£524,022	£472,318	£331,574	£1,237,735
<i>Number of points</i>	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 income protected).	£0.25	8

£2.10 64

ADDITIONAL INDICATORS FOR QIF PLUS SCHEME:

ICB Sub area	Ref No.	Indicator heading	Detail	Thresholds	Max Funding	Points
QIF PLUS	7	Stroke	STIA014 The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less.	>65%, >70%, >75% (7p, 15p, 20p) Baseline 77.6% (Jan-24) (QOF 24/25 40-73% 3 points)	£0.20	6
QIF PLUS	8a	Cervical Screening Uptake	Proportion of women eligible for screening with adequate test has been performed in the previous 3 years and 6 months (aged 25-49)	>60% screened 15p, >70% screened 20p, >80% screened 26p Baseline: 75% (Jan-24) (QOF 24/25 threshold 45-80%, 7 points)	£0.26	8
QIF PLUS	8b	Cervical Screening Uptake	Proportion of women eligible for screening with adequate test has been performed in the previous 5 years and 6 months (aged 50-64 years)	>70% screened 8p >75% screened 10p >80% screened 13p Baseline 81.5% (Jan-24) (QOF 24/25 threshold 45-80%, 4 points)	£0.13	4
QIF PLUS	9	Heart Failure	HF007. The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses	>75%, >80%, >85% (13p, 17p, 23p) Baseline: 88.8% (QOF 22/23) (QOF 24/25 threshold 50-90% 7 points)	£0.23	7

QIF PLUS	10	Coronary Heart Disease	CHD015 - The percentage of patients aged 79 years or under, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less.	>=75%, >80%, >85% (17p, 23p, 33p) Baseline 82.83% QOF 22/23 (QOF 24/25 threshold 40-77% 12 points)	£0.33	10
QIF PLUS	11	Asthma (Children) ongoing management	Those on Asthma Register aged 6-u18's. AST007 - patients with review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan	>65%, >70%, >75% (13p, 17p, 20p) Recommendation to assess CYPs face to face, particularly when reviewing inhaler technique. Baseline 60.5% (SOT Jan-24) (QOF 24/25 threshold 45% - 70% 20 points)	£0.20	6
QIF PLUS	12	COPD Ongoing Management (COPD010)	COPD10: The percentage of patients with COPD, on the register, who have had a review in the preceding 12 months which included: A record of the number of exacerbations AND an assessment of breathlessness using the Medical Research Council dyspnoea scale. (Recommendations for COPD patients to have PPV, smoking advice, pulmonary rehab, self-management plans, treatment for co-morbidities)	>85% reviewed 25p, >88% reviewed 30p, >90% reviewed 40p (Minimum prevalence rate requirement of 2.0%). Practices to identify undiagnosed and therefore untreated COPD. Practices to increase prevalence rate to >2.0% (or maintain where prevalence rate is already higher). PCA/Exception rates not to increase or be significantly different from England average. Baseline: 86.7% QOF 22/23 PCA rate: ICB 11.5%, SoT 7.27%, England 15.5% (QOF 22/23) (QOF 24/25 thresholds: 50-90% 9 points)	£0.40	12
QIF PLUS	13	Pneumococcal Vaccination (PPV) given anytime for those aged 65 and over.	PPV (aged 65 and over) received vaccination given anytime.	>70%, >75%, >80% (10p, 12p, 15p) Baseline: 77.4% (SoT Feb-24 EMIS only) (Where practices can demonstrate approaches over and above QOF to encourage patients but not taken up offer, to submit case for consideration at year end)	£0.15	5
					£1.90	58
TOTAL					£4.00	121

APPENDIX 1 Resources / Additional information

Clinical System Search packages	<p>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)</p>
Palliative Care	<p>See guide previously provided:</p> <p>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)</p>
ReSPECT Resources & Digital programme	<p>To use within organisations and for patients to use to support their decision-making process. Also, translated versions of patient guide.</p> <p>ReSPECT Resources Resuscitation Council UK</p> <p>Guidance: DNACPR and CPR decisions Resuscitation Council UK</p> <hr/> <p>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.</p>
	<p>Do not attempt cardiopulmonary resuscitation (DNACPR) and people with a learning disability and or autism letter.</p> <p>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.</p>
ReSPECT Additional info	<p>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.</p> <p>ReSPECT printed documentation is available on request from primarycareteam@staffsstoke.icb.nhs.uk</p>
Diabetes 8 Care Processes	<p>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.</p> <p>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.</p> <p>There are some free patient resources that can be ordered or downloaded (if not already aware)</p> <p>What diabetes care to expect if you have type 2 diabetes Free diabetes information - Diabetes UK Shop</p>
Pulse Rhythm Check	<p>DQ team has activated an alert protocol that will be available for all practices to support with capturing this information.</p> <p>Free information on Pulse Check, AF, Stroke, CVD etc on the Primary Care Cardiovascular Society website: https://pccsuk.org/</p>
CKD	<p>About kidney disease Kidney Care UK Chronic kidney disease (CKD) Kidney Care UK</p>

12 ADDITIONAL PRACTICES INCLUDED IN QIF PLUS FROM OTHER ICB SUB LOCATIONS

M83718, PEEL CROFT

M83723, LOOMER MEDICAL PARTNERSHIP

M83005, HEATHCOTE STREET SURGERY

M83139, MOSS STREET SURGERY

M83073, STAPENHILL MEDICAL CENTRE

M83697, MILEHOUSE MEDICAL PRACTICE

M83113, DR KHARE'S SURGERY

M83026, CARLTON STREET SURGERY

Y00078, WINSHILL

M83637, CHADSMOOR MEDICAL PRACTICE

M83051, WETMORE ROAD SURGERY

M83010, GORDON STREET SURGERY (PENDING)

ICB Contact: Sarah Turner, Senior Primary Care Delivery Manager