

Practice Quality Improvement Framework (QIF) 2019_20

Version: Final V1.1

1. Finance

- 1.1. Whilst this has been developed as a joint scheme the budgets for each CCG remain separate and are not equivalent. However practice payments will be based on the same £ per point for both CCGs. A reduced scheme is offered to North Staffordshire practices with the full scheme only offered to Stoke-on-Trent practices to ensure that both CCGs remain within the financial envelope.
- 1.2. North Staffordshire CCG has a total budget of £215,000, and Stoke-on-Trent CCG has a substantially larger budget of £1.3 million
- 1.3. All practices will be paid £265 per clinical indicator point adjusted for actual list size against the national average list size on 1st January 2019 (8504). This will be to the maximum points of the relevant CCG, 30 for North Staffordshire and 125 for Stoke-on-Trent.
- 1.4. The QIF indicators in this document will run from 1st April 2019 – 31st March 2020.

2. Payments 2019-20

2.1. Core Indicators

- 2.1.1. For the core indicators practices will be paid 80% of their aspiration points in equal monthly instalments. For North Staffordshire practices this will be up to 80% of the total award for full achievement of 30 points. For Stoke-on-Trent practices this will be up to 80% of the total award for full achievement of 95 points.
- 2.1.2. Once all evidence is submitted after 31st March 2020 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 CCG in monthly instalments and, except in exceptional circumstances, over no more than a 6 month period from the date of notification.
- 2.1.3. For North Staffordshire practices final achievement will only take into account the core disease indicators that the practice aspired to undertake at the beginning of the year, any incidental achievement of other indicators will not be taken into account for calculation of final payment.

2.2. Exemplary Standards

- 2.2.1. In order to achieve the maximum points available, Practices in North Staffordshire are required to undertake 1(one) Exemplary Standard in addition to the selected Clinical Indicators (20 points).

- 2.2.2. Practices in Stoke on Trent are eligible to undertake 3 (three) Exemplary Standards
- 2.2.3. Practices in Stoke on Trent which aspire to undertake 3 of the exemplary standard audits/action plans will be paid 80% of the full payment in equal monthly instalments. All practices who submit their audits/action plans within the deadlines, following clinical review and any required follow up actions, will be paid the remaining 20%. Practices which do not submit satisfactory evidence, adhering to the deadlines, will be contacted by Finance and required to pay back the monies already paid for this element in a timely manner.
- 2.2.4. All exemplary standards must be completed to a satisfactory standard in order for a practice to achieve any payment. There will be no part payment for partial completion except in exceptional circumstances.
- 2.2.5. Full payment will be made if a Stoke on Trent practice did not sign up to undertake the required work for the exemplary standards (3 audits/action plans) but subsequently fulfils the requirement and submits the required work within the timescales set out in section 5.

3. Requirements 2019-20

3.1. North Staffordshire CCG

- 3.1.1. Practices are able to receive payment as outlined above for achievement up to a maximum of 30 points for completing the requirements of one exemplary standard (10 points) plus their choice of indicators, totalling another 20 points.
- 3.1.2. Indicators for choice:
- Learning Disability
 - Sepsis
 - COPD,
 - Asthma,
 - Pre-diabetes,
 - Diabetes part 1,
 - Diabetes Part 2 can only be chosen in conjunction with Diabetes Part 1
 - CKD,
 - Atrial Fibrillation,
 - Falls

Practices are only able to choose complete disease sections rather than individual indicators from separate disease sections.

3.2. Stoke CCG

- 3.2.1. Practices are eligible to undertake all clinical indicators (95 points) and 3 exemplary standards (30 points).

3.3. Reporting Requirements - all practices

- 3.3.1. Practices will be required to submit details of current achievement (%) against the relevant indicators to undertake following the end of Quarter 2, 3 and 4 using the QIF reporting tool. Data Quality Specialists will be able to assist as necessary.
- 3.3.2. The evidence for the exemplary standards will be proportionate for the practice list size.

3.4. Verification

- 3.4.1. Post payment verification visits may be undertaken in 10% of practices each year and this will involve the examination of patient records against the achievement recorded at year end (31st March 2020).
- 3.4.2. All claims may be subject to post payment verification.

4. CORE INDICATORS

Sepsis - 3 points			
	Indicator	Points	Target
Sepsis	Practice have an identified clinical sepsis lead Evidence of the whole practice undertaking sepsis training within the last twelve months (accept Blue Stream online training) Evidence of a protocol for recognition of the deteriorating patient	3	
Learning Disability – maximum 8 points			
	Indicator	Points	Target
Learning Disability	% of people aged over 14 years with a learning disability on the GP register (National average of 0.49% of overall practice population will be on the Learning Disability register)	2	0.3% of overall practice population (60%)
		4	0.36% of overall practice population (75%)

	% people with a learning disability over the age of 14 offered annual health checks.	2	60%
		4	75%
	Maximum of 8 points achievable		
COPD - 11 points			
	Indicators	Points	Target
COPD 1	<p>Audit of COPD patients with more than 1 hospital admission or A&E attendance for exacerbation in the preceding 12 months. Practices to review 1 patient per 500 population to consider the reason for admission, whether the patient had individualised written advice and if this was acted upon. The practice will be expected to reflect on the audit and develop an action plan.</p> <p>Practices will need to ensure that if they don't currently have a process to identify these patients one is developed early on in the scheme to capture such patients through the year by developing a process to code them.</p> <p>Practices would be expected to review the patients with most admissions as a priority.</p> <p>Practices with lower incidence than the required number of patients to be reviewed, can expand their audit to include a review of patients with 1 admission/attendance for exacerbation in the preceding 12 months and if necessary include patients who have exacerbated and been managed in the practice in order to achieve the required number of patients to be reviewed.</p>	3	
COPD 2	<p>Percentage of patients with COPD who have a shared management plan updated annually. This includes new plans and review/updating of an existing plan. The shared management plan should be discussed with the patient, include agreed actions and ensure a mechanism is in place to monitor patient adherence to the content of the plan. This should be completed using an agreed template. Practices must provide the patient with a copy of the updated plan and also either store a copy or include details of advice given within patient notes.</p> <p>Maximum of 7 pts achievable.</p>	2 5 7	≥80% ≥85% ≥90%
COPD 3	% of patients with COPD who have had a pneumonia vaccination in line with national guidelines.	1	≥95%

Sources

NICE Guidelines CG101 (<http://www.nice.org.uk/guidance/cg101>)

Asthma - 15 points			
	Indicators	Points	Target
Asthma 1	<p>% patients with asthma with an acute exacerbation of asthma (presenting at hospital or their own practice) who are followed up by their own GP practice within 7 working days. Practices are expected to develop an internal system to:</p> <ol style="list-style-type: none"> appropriately identify hospital letters indicating an asthma exacerbation and ensure these are acted upon within the correct time frames. The exacerbation and the hospital attendance must be coded and follow-up arranged. follow up patients who have attended the practice with an acute exacerbation <p>Follow up is defined in the most appropriate manner for the patient; it does not have to be face-to-face contact.</p> <p>Practices need to make at least 2 attempts to contact the patient. One of these should be via telephone or text if numbers are available.</p> <p>There are no exception codes for this. If a practice has not achieved the target but can evidence that patients have been contacted this can be taken into account when calculating final achievement. It is recommended that practices keep a log of patients exacerbating, attempts to contact, number of days followed up within and any reason why follow up within 7 days wasn't possible. In the event that a letter is not received within 7 days of discharge, the patient should still be followed up as appropriate and reasons noted. This will ensure that practices have the evidence available at the end of the year if they have been unable to meet the 60% target which will then be taken into consideration by the CCG. Practices would need to submit their evidence to the Primary Care Team no later than 30th April 2019.</p> <p>Maximum of 5 pts achievable.</p>	5	≥65%
Asthma 2	<p>% Asthma patients (aged 16+) with a self-management plan updated annually.</p> <p>These include new plans and review/updating of an existing plan. The management plan should be discussed with the patient, include agreed actions and ensure a mechanism is in place to monitor patient adherence to the content of the plan. This should be completed using an agreed template. Practices must</p>	5	≥80%

	provide the patient with a copy of the updated plan and also either store a copy or include details of advice given within patient notes.		
Asthma 3	<p>% Children (aged between 5 – 15 years old) with asthma who have a self-management plan updated annually.</p> <p>This includes new plans and review/updating of an existing plan. The management plan should be discussed with the patient/parent/carer (as appropriate), include agreed actions and ensure a mechanism is in place to monitor adherence. This should be completed using an agreed template. Practices must provide the patient and/or parent/carer with a copy of the updated plan and also either store a copy or include details of advice given within patient notes.</p>	5	≥60%

Sources

NICE quality standard QS25 Statements 3 and 10

<http://www.nice.org.uk/guidance/qs25/chapter/Quality-statement-3-Written-personalised-action-plans>

<https://www.nice.org.uk/guidance/qs25/chapter/Quality-statement-10-Followup-in-primary-care>

Diabetes Part 1 - 15 points			
	Indicators	Points	Target
DM 1	<p>Percentage of people with diabetes who have a shared management plan updated annually, that this has been discussed with the patient, includes agreed actions and that there is a mechanism in place to monitor adherence. This should be completed using an agreed template and will include assessment of erectile dysfunction where applicable and dietary review.</p> <p>Maximum of 7 points achievable.</p>	6	≥70%
		7	≥80%
DM 2	<p>% of diabetic patients who have all of the following 8 care processes recorded in the preceding 12 months:</p> <ul style="list-style-type: none"> ○ HbA1c testing ○ Blood pressure ○ Cholesterol measurement ○ Feet examination ○ Urine albumin excretion ○ Creatinine measurement ○ Body mass index (BMI) measurement ○ Smoking status <p>Able to exception report for individual items.</p> <p>Maximum of 7 points achievable.</p>	4	≥60%
		7	≥80%

DM 3	<p>Evidence of a process being in place and followed up within GP practice to address patients not attending for retinal screening when advised of by Public Health England.</p> <p>Practices will need to provide a copy of the process and confirm that it is being followed no later than 31 March 2019.</p>	1	
Diabetes Part 2 - 5 points (Must be done in conjunction with Part 1 Diabetes)			
DM4	<p>% of women aged 17-44 years with diabetes given information and advice about pregnancy or conception or contraception (excludes women with gestational diabetes).</p> <p>Exception coding for women not suitable (including declined, hysterectomy and sterilisation).</p>	2	≥80%
DM5	% of patients with type 2 diabetes in whom the last recorded cholesterol, measured in the last 12 months, is ≤4mmol/L	3	≥50%

Sources

NICE quality standard QS6 Statements 3

<http://www.nice.org.uk/guidance/qs6/chapter/Quality-statement-3-Care-planning>

NICE guideline NG28 <http://www.nice.org.uk/guidance/ng28>

NICE guidelines NG3 <http://www.nice.org.uk/guidance/ng3>

Diabetes UK, Diabetes Health Guidelines, available at <http://www.diabetes.co.uk/diabetes-health-guidelines.html>. Accessed on 1st December 2015.

Chronic Kidney Disease (CKD) – 10 points			
	Indicator	Points	Target
CKD1	% of patients with CKD (3a-4) who have a record of an albumin: creatinine ratio (ACR) test in the preceding 12 months (excluding those not suitable who have exception codes)	2	≥80%
		4	≥90%
	Maximum of 4 points achievable.		
CKD2	% of patients with CKD who have a record of a positive ACR test (>30mg/mmol) in the preceding 12 months (latest test result) who have been prescribed an ACE inhibitor or ARB in the last 3 months (excluding those not	2	≥80%

	suitable who have exception codes)		
CKD3	% of patients with CKD where the latest BP reading (recorded in the preceding 12 months) is 140/90 or less	2	≥80%
	Maximum of 4 points achievable.	4	≥90%

NICE guideline CG182 <https://www.nice.org.uk/guidance/cg182>

Atrial Fibrillation (AF) - 4 points			
	Indicator	Points	Target
AF 1	AF detection. % of patients with CHD, CKD G3b & above, Stroke, Diabetes, Peripheral Vascular Disease or Hypertension who have a recorded pulse rhythm within the preceding 12 months. . Excluding patients with known AF.	4	≥80%
	Maximum of 4 points achievable.		

Source

NICE guidelines CG180

<http://www.nice.org.uk/guidance/cg180/chapter/1-Recommendations#diagnosis-and-assessment>

Pre-diabetes – Maximum 11 points			
	Indicator	Points	Target
Pre-diabetes 3	The practice maintains their impaired glucose regulation register (pre-diabetic) (FBG 6.1-6.9mmol/l or HbA1c 42-47 mmol/mol as defined by WHO 20016 & 2011)	3	
	The CCG expects the register to be at least 2% of the practice population 16+. Where this is not the case, in order to achieve the 5 points, the practice will be expected to provide evidence to show that they have increased their register by 10% during the year (from the baseline recorded on 31 March 2018).		
	The CCG may validate this further where judged that practice prevalence is an outlier.		
Pre-diabetes 3a	% of patients on the impaired glucose regulation register who have had all of the following undertaken in the preceding 12 months	2*	≥ 75%
	- HbA1c or FBG	5*	≥85%
	- Blood pressure	8*	≥90%
	- Weight		
	- BMI		
	- Lifestyle education for risk of diabetes (dietary and physical activity)		
	Maximum of 11 points achievable.		

	* Where a practice register is <2% of the practice population 16+ (by 31 March 2010) they will only be eligible to achieve half of the points available for this indicator (≥65% = 2pts; ≥85% = 3.5pts; ≥90% = 5pts)		
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Source

NICE guidelines PH38 <http://www.nice.org.uk/guidance/ph38/chapter/1-Recommendations>

Public Health England calculates that the expected prevalence of non-diabetic hyperglycaemia in the registered population over 16 years of age for North Staffordshire CCG is 11.7% and for Stoke-on-Trent CCG is 11%.

(<https://www.gov.uk/government/publications/nhs-diabetes-prevention-programme-non-diabetic-hyperglycaemia>).

Falls - 5 points			
	Indicator	Points	Target
Falls1	% of patients aged 65 – 74 (inclusive) with MS, Parkinsons, history of stroke or muscle wasting (e.g. Motor Neurone disease) who have been assessed for the likelihood of falls via CCG Falls assessment tool and pulse rhythm recorded for the patient in the preceding 12 months.	3	>50%
		5	>60%
	Maximum of 5 points achievable		

GRASP COPD - 8 points			
	Indicator	Points	Target
GRASP	Use of the GRASP tool to identify patients who may have a missing diagnosis code for COPD by reviewing patients with a COPD monitoring code ever, patients prescribed LAMA in L12M, patients prescribed carbocisteine in L12M, patients prescribed inhaled steroids in L12M but no asthma Dx and patients with >9 antibiotics prescribed in L3Y but no asthma Dx. A template will be provided to practices to complete to show the outcomes from the use of the tool.	8	

5 Exemplary Standards

Practices can choose from the following exemplary standard audits, outcomes and action plans in order to obtain a maximum of 10 points per standard:

North Staffordshire and Stoke on Trent

- Patient Education
- Health Literacy Friendly*
- LTC newly diagnosed care

North Staffordshire only

- Hypertension 1
- Hypertension 2
- End of Life
- Suicide Prevention Review & Action Plan

Stoke on Trent only

- Suicide Prevention 2

Completed audits, outcomes and action plans must be submitted no later than 31 March 2020.

*Practices who choose Health Literacy Friendly will need to have completed the Public Health training in advance of compiling the action plan.

The quality of the audit reports will be assessed by a small group of primary care peer staff to ensure that a minimum standard is reached.

North Staffordshire and Stoke on Trent Exemplary Standards

Patient Education

Practices will setup a new education and support network for one of the conditions below, in conjunction with their PPG, with a focus on prevention, self-help and empowerment. This could be a Facebook group, face-to-face or combination. An information event must be held with ongoing support including clinical input at least monthly. The group should be based on one of the following conditions and have a minimum of 20 members for practices with <5000 patients or 30 members for practices with ≥5000 (or at least the potential to have that number of members from each practice):

- Impaired glucose regulation (pre-diabetes)
- loneliness
- healthy pregnancy
- epilepsy

Groups of practices may approach this together on a local geographical basis, however each practice must provide evidence that:

- the PPG of their practice has been continually

	<p>involved,</p> <ul style="list-style-type: none"> - there has been continued involvement of the practice key champion or nominated deputy on a regular basis, - the practice has provided clinical input on a pro-rata basis.
<p>Health Literacy Friendly</p> <p><i>1 member of the practice should undertake the Public Health training in advance of undertaking this standard. Please note these will be held in venues across Stoke on Trent only due to funding sources.</i></p>	<p>Practices will work to improve their health literacy environment. Practices will choose one of the following areas of health literacy and undertake an audit and action plan to work towards best practice in Health Literacy using the becoming a Health Literacy Friendly Organisation handbook as a guide:</p> <ul style="list-style-type: none"> • General Communication and Speaking to people • Written Information: Style, Design and Print • Arriving, entering, getting around and signs • Staff training and policies
LTC newly diagnosed care	<p>Audit of newly diagnosed patients (between 01 April 2017 and 31 March 2018) with a long term condition (LTC) to ensure that:</p> <ul style="list-style-type: none"> - they have been given self-care advice - relevant lifestyle changes have been discussed - mental wellbeing has been considered including IAPT referral or self-referral advice as appropriate - a Patient centred care plan has been agreed where appropriate - appropriate diagnostic tests have been completed - medication has been reviewed within the last 12 months - the patient has been requesting and collecting repeat prescriptions where relevant - patient was offered an annual review of their condition within the last 12 months - patient was offered structured education as appropriate (Diabetes, Pulmonary Rehabilitation) - referrals to acute or community specialist were undertaken as agreed with the patient <p>A summary of findings will be reported and an action plan developed to address any issues that arise from the audit.</p> <p>LTCs included in this exemplary standard are: Asthma, Chronic fatigue syndrome/ myalgic encephalomyelitis (or encephalopathy), Chronic Heart Failure, CKD (G3a-G5), COPD, Dementia, Depression (lasting for 12m+), Diabetes, Epilepsy, Multiple Sclerosis, Parkinson's Disease, Rheumatoid Arthritis.</p> <p>Practices may include/exclude children from the audit as they see fit.</p> <p>NICE guideline NG5 https://www.nice.org.uk/guidance/ng5 and all NICE disease specific guidelines and quality standards.</p>

North Staffs only- Exemplary Standards	
Hypertension 1	<p>Audit of patients with ≥ 150 systolic and/or ≥ 100 diastolic blood pressure who are not on the practices hypertension register, with associated action plan</p> <p>Practices with a list size < 7500 will review 50 patients and practices with a list size ≥ 7500 will review 100 patients.</p>
Hypertension 2	<p>Audit practice records to identify individuals with poor control of high BP - focus first on people under 85 years old with BP above 140/90 mmHg who are not on a 3 drug combination</p> <p>Practices with a list size < 5000 will review 20 patients and practices with a list size ≥ 5000 will review 30 patients.</p>
End of Life	<p>Produce a report using the template provided to demonstrate that at least half (50%) of your 1% of patient population (expected to be on your palliative care register) are being recorded and coded red, amber (yellow) and green on the practice palliative care register in accordance with the Gold Standard Framework. Where a practice is unable to demonstrate that 50% of the register is colour coded, they will be expected to develop an action plan to improve this.</p>
Suicide Prevention Review & Action Plan	<p>Practices will undertake a review of patient deaths from suicide, or patients who have attempted suicide, over the past five years. Practices will undertake a significant event review and detail the learning from the review and subsequent actions for the practice. Practices with < 5000 patients review 3 events and practices with ≥ 5000 patients review 5.</p> <p>Where a practice has less than 2 relevant suicides or attempted near misses they will not be eligible for this indicator.</p>

Stoke on Trent only - Exemplary Standards

Suicide Prevention 2	<p>Practices must:</p> <ul style="list-style-type: none"> i) Appoint a nominated lead for suicide prevention, who must attend training and cascade learning and best practice to the wider team ii) Develop and implement a practice protocol, or review current protocol, for monitoring patient engagement in treatment following presentation with a mental health problem. iii) Develop and implement a practice protocol, or review current protocol, for the assessment and management of suicide risk, taking account of NICE guidance. This should include a proactive approach to the identification of suicide risk in vulnerable patient groups (patients with LTCs, a previous history of mental health problems; alcohol or drug dependence; tiredness or sleep disturbance; bereavement; financial difficulties; relationship breakdown; with a pattern of increasing attendance). iv) Undertake a serious event audit of all deliberate self-harm incidents/suicide attempts within one week of notification of discharge from hospital. Where a patient regularly self-harms the practice should contact the primary care team to discuss whether they need to continue to undertake SEAs for that particular patient. Where a practice has multiple patients from a mental health home/hospital who regularly fall into this category the practice should contact the primary care team to discuss a ceiling to the number of SEAs needed to fulfil the exemplary standard. http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/significant-event-audit.aspx
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Appendix 1: Completed code of conduct for NHS Stoke on Trent CCG

To be used when commissioning services from GP practices, including provider consortia, or organisations in which GPs have a financial interest.

Service: Quality Improvement Framework (QIF) Local Improvement Scheme	
Question	Comment/Evidence
Questions for all three procurement routes	
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities?	<p>The emphasis on preventing the deterioration of long term conditions and minimising health inequalities will realise the CCG's commissioning priorities: admissions avoidance; mental health; community services; elderly care; strengthening primary care capacity and capability – in particular the first and fifth priorities.</p> <p>The QIF incentives equal £1.3 million per year. The series of QIF evaluations for each year demonstrate value for money in terms of quality improvements. Future evaluation will note changes in numbers of hospital admissions per practice.</p>
How have you involved the public in the decision to commission this service?	The Community Health Voice (CHV) and lay members of PCT and CCG have been involved in the evolution of QIF since its inception in 2009. CHV participated in the recent consultation about refining the QIF LIS; the patient congress was represented at the Northern Staffordshire Primary Care Delivery Group where the draft QIF was discussed.
What range of health professionals have been involved in designing the proposed service?	Since the inception of QIF, GPs, practice nurses and practice managers, and public health consultants have continually critiqued the design and delivery of the QIF service; and redesign and

	improvements have been made as a result.
What range of potential providers have been involved in considering the proposals?	General practice providers from CCG localities have been consulted alongside public health consultants, representatives of NHS England.
How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint Health and Wellbeing strategy (or strategies)?	The QIF LIS will be submitted to the Chair of the H &W Board; The LIS document matches the NHS Outcomes Framework domains and public health domain/redressing health inequalities against the contents of the QIF LIS.
What are the proposals for monitoring the quality of service?	1. End of Year Assessment of all practices. 2. League table of practices' attainment in relation to clinical targets. 3. Validation of 10% of practices' claims.
What systems will there be to monitor and publish data on referral patterns?	As above; see document re anticipated outcomes
Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available?	Yes- the CCG has an up to date log of practices/ clinical directors/leads' conflicts of interest
Why have you chosen this procurement route?	Yes – this is a revision of the previous QIF LES
What additional external involvement will there be in scrutinising the proposed decisions?	Representatives of public health, the LMC, the NHS England will continue to provide oversight of the QIF programme and the end of year practices' assessment.
How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process?	The final QIF LIS will be submitted to the CCG Governing Body after comments/scrutiny are received by the H&W Board Chair.

Additional question for AQP or single tender (for services where national tariffs do not apply)

How have you determined a fair price for the service?	Yes- the amount paid for the exemplary practice and clinical targets was set in 2008 and has been critiqued and revised since then to take account of NHS England views, the LMC and CCG
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Additional question for AQP only (where GP practices are likely to be qualified providers)	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	N/A

Additional questions for single tenders from GP providers	
What steps have been taken to demonstrate that there are no other providers that could deliver this service?	None of those involved in the development of the scheme and engagement around it, could see how any other provider than a GP can deliver this service as all components are focused on the patient's personal medical history and conditions in individualised ways; and the provider supplies a continuous health pathway for each patient for their various health conditions.
In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	<p>The focus on provision of structured individualised management plans and proactive follow up of exacerbations for the most significant local long term conditions is over and above core contractual work in general practice and complements the work of the CCG Local Improvement Scheme (LIS). Some of the indicators in the scheme may overlap slightly with the CCG Local Improvement Scheme (LIS) for individual patients. However there is no direct duplication of activity for the targeted patient populations covered by this scheme therefore practices are not receiving double payment.</p> <p>There is currently no overlap with QOF; however this will be reviewed when 2018-19 QOF targets</p>

	<p>are finalised to ensure that there continues to be no duplication. The requirements for self-management plans go above and beyond the scope of an annual review required under the QOF.</p> <p>Those consulted (including primary care/NHS England who are responsible for managing the core contract with GP providers on behalf of the Clinical Commissioning Group) were all content that QIF exemplary standards and clinical aspirational targets were over and above core GP contract.</p> <p>There are obvious new areas such as health literacy that are outside the core contract.</p>
<p>What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?</p>	<p>In ensure there is no inequity across Northern Staffordshire it was agreed that all practices are eligible to take part on the scheme. However practice performance against core contract will be monitored and used to assess entry into the following years scheme.</p>