

Practice Quality Improvement Framework (QIF) 2020_21

Version: Final v2 12/10/2020

1. Introduction

Pre-Covid

1.1 One of the biggest issues for Staffordshire and Stoke-on-Trent CCGs is that services are fragmented and there is variation in terms of inequalities and outcomes for patients who live with a Long Term Condition. This is evidenced through Right Care data packs which demonstrate there is an opportunity to improve:

- The diagnosis rates for Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Coronary Heart Disease (CHD), Diabetes and Atrial Fibrillation (AF).
- The uptake of Flu vaccinations for patients with COPD, CHD and Diabetes.
- Blood pressure monitoring for patients with CHD, Hypertension, Diabetes and Peripheral Arterial Disease.
- Smoking cessation and support.
- The ongoing management of COPD patients including FEV1 tests, annual reviews and breathlessness assessments.
- The number of AF patients who are treated with anticoagulation drug therapy.
- The ongoing management of diabetes patients including monitoring of cholesterol, blood glucose, blood pressure and adherence to the NICE Nine Process of Care for Diabetes.
- Non-elective admission rates and bed days for respiratory patients.

1.2 In addition, the increasing prevalence of LTCs in the population is creating an unsustainable burden on the NHS if existing service models are continued. Staffordshire and Stoke-on-Trent CCGs spent a total of £38.4m on non-elective activity in 2017/18 relating to heart failure, diabetes and respiratory conditions. The incidence of people with one or more LTC across Staffordshire and Stoke-on-Trent is approximately 40% (based on 18/19 GP chronic condition registers) and is growing. Studies have shown that 50% of all GP appointments and 70% of days spent in hospital beds are utilised by people with one or more long term condition, posing a significant operational and financial pressure to the health and social care economy, as well as poor outcomes and experience for patients. Further benchmark data for Stoke on Trent is also shown in Appendix 1.

1.3 Stoke-on-Trent CCG 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.

Post Covid19

1.4 In March 2020 the health economy went into full lockdown as a result of the Covid19 outbreak and as a result a number of schemes due to be rolled out in Primary Care from April 2020 were put on hold.

1.5 The Quality Improvement Framework has now been reviewed and amended as an interim 2020-21 agreement for 6 months and now has a focus on-

- Winter pathway/demand
- Delivery of the Flu vaccination programme (for those aged 65 and over and those <65 in a clinical at risk group).

2. Finance

¹ <https://doi.org/10.1093/fampra/cmy128>

- 2.1. Whilst this framework has been developed as a joint scheme across the 6 Staffordshire and Stoke-on-Trent CCGs, the budgets for each CCG remain separate. However practice payments will be based on the same value per point. A reduced scheme is offered to the 5 Staffordshire CCGs' practices with the full scheme only offered to Stoke-on-Trent CCG practices.
- 2.2. Stoke-on-Trent CCG has a budget of £1.33 million FYE. Due to the Covid19 outbreak, practices have received a block funding arrangement based on the 19-20 LES/Membership agreements, therefore the funding available for the QIF for 20/21 is now a part year effect from October 2020.
- 2.3. Practices will be paid £1.60 per head of weighted list size (as at 1st Jan 2020), based on maximum achievement of 53 points for winter, as shown below.
- 2.4. The flu uptake incentive which will be paid on eligible population for the 2 main cohorts as at the end of March 2021.

| Standards | Stoke on Trent CCG Scheme | Revised Points | £0.03 Per Point |
|--------------------|---------------------------|---|-----------------|
| QIF Core Indicator | Winter Pathway/demand | 53 | £1.60 |
| Flu | Flu Incentive | Based on £1.35 eligible population (Aged 65+ and <65 in clinical at risk group) | |

- 2.5. The QIF indicator in this document will run from 1st October 2020 – 31st March 2021.

3. Payments 2020-21

3.1. Core Indicators

- 3.1.1. Practices will be paid up to 80% of the total award for full achievement of both requirements.
- 3.1.2. Once all evidence is submitted after 31st March 2021 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.

4. Requirements 2020-21

4.1. Stoke-on-Trent CCG

- 4.1.1. Practices are able to receive payment as outlined above for achievement up to a maximum of 53 points for completing the core indicator requirements for winter pathway/demand.

- 4.1.2. Practices are able to receive a payment as outlined above for achievement of Flu Uptake Rates for eligible population aged 65 years and above and <65 in a clinical at risk group.

4.2. Reporting Requirements - all practices

- 4.2.1 Practice consents to MLCSU Data Quality Specialist (DQS) extracting and sharing flu uptake data with the CCG. This will be used to provide weekly progress reports to the CCG and practices until such time as weekly data is available via ImmForm, at which time this will be the ongoing source for monitoring. DQS extracts will be used for final payment purposes if practice level data is not available on ImmForm at end of March 2021. (Microtest practices will have to provide regular data as DQS unable to extract centrally, until Immform data is available – frequency to be agreed with those practices).

4.3. Verification

- 4.3.1. All claims may be subject to post payment verification.

5. CORE INDICATORS

| 4.1 Winter Pathway/Demand Maximum 53 points (£1.60 per head of weighted population) | | | |
|--|--|--------------------------------|------------------------|
| | <p>As we move towards winter, QIF has been re-purposed to allow practices to focus their efforts on managing any potential surge in respiratory infection. It recognises the continued impact of Covid-19 on practice's productivity and increased Infection Prevention and Control requirements, providing income protection to practices, whilst allowing General Practice to concentrate on supporting our system with demand this winter.</p> <p>Covid-19 has highlighted unequal vulnerability to respiratory infection. We ask Practices to focus efforts on children and the winter respiratory pathway that has been developed, people at risk of poor health and those who experience health inequalities including those most vulnerable to harm from Covid-19; evidence suggests that this includes patients from BAME groups and those from the 20% most deprived neighbourhoods nationally (LSOAs)</p> <p>Benchmark data for Stoke on Trent (Appendix 1) shows higher respiratory related emergency admissions, IMD score, BAME population (%), lower life expectancy and higher premature mortality rates. Therefore, it is expected Stoke on Trent CCG practices will be required to support a larger cohort of patients over the winter months compared to other Staffordshire CCG/LAs which is reflected in the higher number of points for this indicator.</p> | Points 53 | Target - |

| 4.2 Increasing Flu Vaccination Uptake Rates (%) | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--------------------------------------|--|--|--------------------------------------|--|----------------------|-----------|----------------------|-----------|-------|------|-------|------|-------|-----|-------|-----|-------|-----|-------|-----|--|
| | Scheme to focus on increasing uptake rates for the following eligible cohorts:- <ul style="list-style-type: none"> - Aged 65 and over - Aged <65 in a clinical at risk group (includes all in clinical at risk groups ie. Pregnant women and Children aged 2 and 3 year old). | | £1.35 per number of eligible population per flu cohort | | | | | | | | | | | | | | | | | | | | |
| | <ol style="list-style-type: none"> 1. Practices should aim for national ambition rates however the scheme ambition rates have been set at lower rates to recognise challenges for delivery of the programme this year in line with COVID-19 i.e. an increased cohort, social distancing measures and the use of additional PPE to that which is usually required mean practices will need to carefully plan their flu clinics so they run in a time efficient and safe way. 2. Practices to ensure they have activated PharmOutcome notifications to enable patient records to be updated of vaccinations given by community pharmacists. 3. Ideally care homes would be visited early in the season. Practices could look to deliver this on a practice or PCN level basis or co-ordinate with the support of Community Pharmacists who are eligible to vaccinate both residential care/nursing home residents and staff in a single visit to increase uptake rates and offer further protection to this vulnerable group of patients. | | | | | | | | | | | | | | | | | | | | | | |
| | Targets: <table border="1"> <thead> <tr> <th colspan="2">Aged 65 and over</th><th colspan="2">Aged <65 in a clinical at risk group</th></tr> <tr> <th>Uptake Target Rate %</th><th>% Funding</th><th>Uptake Target Rate %</th><th>% Funding</th></tr> </thead> <tbody> <tr> <td>>=65%</td><td>100%</td><td>>=45%</td><td>100%</td></tr> <tr> <td>>=60%</td><td>90%</td><td>>=40%</td><td>90%</td></tr> <tr> <td>>=55%</td><td>80%</td><td>>=35%</td><td>80%</td></tr> </tbody> </table> <p>The sliding scales have been set to strike an appropriate balance between rewarding good performance, recognising increased practice costs and effort to deliver this year's programme in line with COVID-19 restrictions and ensuring that all practices are able to access some incentive funds.</p> <p>Uptake rate achievement will include those patients immunised via other providers eg. community pharmacy as reported via ImmForm.</p> | | Aged 65 and over | | Aged <65 in a clinical at risk group | | Uptake Target Rate % | % Funding | Uptake Target Rate % | % Funding | >=65% | 100% | >=45% | 100% | >=60% | 90% | >=40% | 90% | >=55% | 80% | >=35% | 80% | |
| Aged 65 and over | | Aged <65 in a clinical at risk group | | | | | | | | | | | | | | | | | | | | | |
| Uptake Target Rate % | % Funding | Uptake Target Rate % | % Funding | | | | | | | | | | | | | | | | | | | | |
| >=65% | 100% | >=45% | 100% | | | | | | | | | | | | | | | | | | | | |
| >=60% | 90% | >=40% | 90% | | | | | | | | | | | | | | | | | | | | |
| >=55% | 80% | >=35% | 80% | | | | | | | | | | | | | | | | | | | | |

Resources:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907149/Letter_annualflu_2020_to_2021_update.pdf

Appendix 1

Benchmarking data shows Stoke-On-Trent has higher respiratory related emergency admission rates, high Index of multiple deprivation (IMD) score and higher BAME population (%) compared to other Staffordshire CCGs/ LAs:-

| | | | | | | |
|---|--|---------------|---------------|-------------------------|----------------|----------------|
| Data Source Practice 360 | | | | | | |
| | 2019/20 | | | | | |
| Indicator | CC CCG | ES CCG | NS CCG | SES & SP CCG | SAS CCG | SoT CCG |
| Emergency admissions for children with lower respiratory tract infections (per 1,000 under 19 population) | 4.13 | 5.90 | 4.29 | 4.41 | 4.71 | 6.17 |
| Emergency asthma admissions per 100 patients on disease register | 1.12 | 2.14 | 1.92 | 1.32 | 1.30 | 2.98 |
| Emergency COPD admissions per 100 patients on disease register | 9.40 | 13.18 | 13.62 | 11.77 | 10.07 | 19.47 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Data Source : | | | | | | |
| https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019 | | | | | | |
| | CC CCG | ES CCG | NS CCG | SES & SP CCG | SAS CCG | SoT CCG |
| IMD Score | 19.2 | 18.2 | 17.5 | 15.5 | 13.5 | 33.7 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Data Source ONS 2011 Census | | | | | | |
| | ONS 2011 Ethic Group - % of local population | | | | | |
| LTLA | Asian | Black | Mixed | Other | White | |
| Cannock Chase | 1.01 | 0.29 | 0.89 | 0.08 | 97.74 | |
| East Staffordshire | 6.92 | 0.9 | 1.43 | 0.33 | 90.42 | |
| Lichfield | 1.61 | 0.48 | 1.03 | 0.12 | 96.77 | |
| Newcastle-under-Lyme | 2.84 | 0.67 | 1.2 | 0.31 | 94.99 | |
| South Staffordshire | 1.96 | 0.53 | 1.38 | 0.22 | 95.9 | |
| Stafford | 2.51 | 0.85 | 1.29 | 0.36 | 94.99 | |
| Staffordshire Moorlands | 0.52 | 0.12 | 0.62 | 0.06 | 98.68 | |
| Stoke-on-Trent | 7.41 | 1.5 | 1.8 | 0.65 | 88.64 | |
| Tamworth | 0.99 | 0.51 | 1.05 | 0.12 | 97.33 | |

Health Inequalities Dashboard

| Domain | Staffordshire | Stoke-on-Trent | West Midlands | England |
|--|---------------|----------------|---------------|---------|
| A. Overarching Indicators | | | | |
| Life expectancy at birth-Male | 79.7 | 76.4 | 78.9 | 79.6 |
| Life expectancy at birth-Female | 83.1 | 80.3 | 82.7 | 83.2 |
| Healthy life expectancy at birth-Male | 63.2 | 57.4 | 61.8 | 63.4 |
| Healthy life expectancy at birth-Female | 64.9 | 55.8 | 62.3 | 63.9 |
| B. Wider Determinants of Health | | | | |
| School readiness: percentage of children not achieving a good level of development | 25.6 | 33 | 29.9 | 28.2 |
| 16-17 year olds not in education, employment or training (NEET) or whose activity is not known | 2.1 | 4 | 5.3 | 5.5 |
| Gap in the employment rate between those with a long-term health condition and the overall employment rate | 10.6 | 14.5 | 11.5 | 11.5 |
| Children in low income families (all dependent children under 20) | 13 | 24 | 20.2 | 17 |
| Statutory homelessness - Eligible homeless people not in priority need | 0.3 | 1.8 | 1.1 | 0.8 |
| C. Health Improvement | | | | |
| Low birth weight of term babies | 2.8 | 3.9 | 3.3 | 2.9 |
| Reception: Prevalence of obesity (including severe obesity) | 10 | 12.5 | 10.6 | 9.7 |
| Year 6: Prevalence of obesity (including severe obesity) | 19.8 | 24.9 | 22.9 | 20.2 |
| Smoking Prevalence in adults (18+) - current smokers (APS) | 13.9 | 18.2 | 14.1 | 13.9 |
| Admission episodes for alcohol-related conditions (Narrow) | 814.1 | 1126.9 | 739.3 | 663.7 |
| Self-reported wellbeing - people with a low satisfaction score | 3.7 | 5.5 | 4.4 | 4.3 |
| D. Health Protection | | | | |
| TB incidence (three year average) | 3.6 | 10.6 | 11.3 | 9.2 |
| E. Healthcare and Premature Mortality | | | | |
| Infant mortality rate | 5 | 7.5 | 5.8 | 3.9 |
| Percentage of 5 year olds with experience of visually obvious dental decay | 14.2 | 30.7 | 22.7 | 23.4 |
| Under 75 mortality rate from all cardiovascular diseases | 69 | 96.4 | 78.4 | 71.7 |
| Under 75 mortality rate from cancer | 131.2 | 167.6 | 138.3 | 132.3 |
| Suicide rate | 10.3 | 11.4 | 9.7 | 9.6 |

Appendix 2: 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>QIF incentive for the CCG is shown in section 1.2 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> |

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|---|--|
| 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 previously discussed. 2020/21 scheme discussed at CCG Clinical Cabinet. |
| 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 has been submitted to the co-Chair of the H & W Board (Jan 2020); The LIS document matches the NHS Outcomes Framework domains, Long Term Plan, NHS Outcome Framework 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. In year reporting of all practices where indicator data available via EMIS Enterprise reporting or national published datasets. 3. League table of practices' attainment in relation to clinical targets. 4. Validation of up to 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 | The final QIF LIS submitted to the CCG Governing Body after comments/scrutiny is received by the H&W Board Chair and |

| | |
|--|-------------------|
| preserve the integrity of the decision-making process? | member practices. |
|--|-------------------|

| 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 perspectives. |

| 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 Equality Impact and Risk Stage 1 Assessment Approved (Feb 2020) |

| 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>Scheme is reviewed against national QOF requirements to avoid any 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 is 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</p> |

| | |
|--|--|
| | above core GP contract. |
| 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? | In ensure there is no inequity across CCGs it was agreed that all practices are eligible to take part in the scheme. However practice performance against core contract will be monitored and used to assess entry into the following year's scheme. |