

Practice Quality Improvement Framework (QIF) 2021_22

Final Version: 30/3/21

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 repurposed as an interim 2021-22 agreement for 6 months and to focus on the following key priorities to support restoration and recovery:-
- Improving Ethnicity coding
 - Embedding ReSPECT process and training
 - LTC Management – reviews of people in highest risk of admission (priority group 1 using UCL Partnership LTC Management risk stratification tool)

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

- 1.6 The framework will focus on winter support for general practice for the last 6 months of the year for the remaining value of the scheme. Further details will be shared on this once the impact of Covid on the financial year 21/22 is better understood.

2. Finance

- 2.1 Whilst this framework has been developed as a joint scheme across the Staffordshire and Stoke-on-Trent CCGs, the budgets for each CCG remain separate. Practice payments will be based on the same value per point. The scheme is offered to all practices in the 5 Staffordshire CCGs (North Staffordshire, East Staffordshire, Cannock Chase, Stafford and Surrounds, South East Staffordshire and Seisdon Peninsula CCGs). An extended scheme is offered to Stoke-on-Trent CCG practices due to historical deprivation funding.

	NHS Cannock Chase CCG	NHS East Staffordshire CCG	NHS North Staffordshire CCG	NHS South East Staffordshire And Seisdon Peninsula CCG	NHS Stafford And Surrounds CCG	NHS Stoke On Trent CCG
QIF Budget (12m)	£297,810	£314,069	£490,233	£449,275	£325,154	£1,243,959
Population Weighted 1/1/21	141,142	148,847	232,337	212,926	154,101	310,989
Value of scheme	£2.10	£2.10	£2.10	£2.10	£2.10	£4.00
Number of Points	70	70	70	70	70	133

Funding for 6 months of the scheme

QIF Budget (6m)	£148,905	£157,034	£245,116	£224,637	£162,577	£621,980
Value of Scheme (6m)	£1.05	£1.05	£1.05	£1.05	£1.05	£2.00
Number of points (6m)	35	35	35	35	35	67

* To be finalised based on confirmation of budget.

Stoke on Trent CCG	Points	% of scheme	£ phwp
Improve Ethnicity coding	10	15%	£0.30
Embed ReSPECT Process/Training	7	10%	£0.21
LTC Review/follow up Part 1: (Diabetes T2)	18	27%	£0.54
LTC Review/follow up Part 2: (Hypertension)	16	24%	£0.48
& LTC Review/follow up (AF)	16	24%	£0.48
	67	100%	£2.01

3. Payments 2021-22

- 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 submitted after 31st October 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. Reporting Requirements - all practices

- 4.1 Practice consents to MLCSU Data Quality Specialist (DQS) extracting and sharing data with the CCG to support reporting requirements of the framework. This will be used to provide monthly progress reports to the CCG and practices.

5. Verification

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

6. Indicators

1. Improvement in Ethnicity recording to support population health management

Comprehensive, good-quality data is essential for enabling policy-makers and health care professionals to identify the specific needs of different ethnic minority communities, respond with tailored strategies for addressing inequalities, and track the impact of these strategies.

Requirement	Target (% Point increase on practice baseline as at 3/3/21)	Points	Evidence / Data source
% of registered patients with ethnicity coded using 2011 census codes under Snomed 976571000000100.	9% points increase	6 points	CSU Data Quality team / EMIS Enterprise Reporting
	11% points increase	8 points	
	13% points increase	10 points	

CCG BASELINES 3/3/21	Current % of 2011 ethnicity recorded
Cannock Chase CCG	3.10%
Stafford and Surrounds CCG CCG	1.90%
East Staffs CCG	0.40%
South East Staffordshire and Seisdon Peninsula CCG	0.50%
North Staffs CCG	0.70%
Stoke on Trent CCG	0.80%

Practices can enable a protocol to prompt the admin team to record a code from the 2011 census (ie the non-ambiguous codes) when a patient books an appointment. Please contact your Data Quality Specialist if you need support with this.

2. Embed ReSPECT Process

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is a process that creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choice.

These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.

Patient preferences and clinical recommendations are recorded on a non-legally binding form which can be reviewed and adapted if circumstances change.

The ReSPECT process can be for anyone but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

COVID-19 Resources: Resuscitation Council UK has created a range of resources about decision making during COVID-19. [Click here to view](#)

2: Embed ReSPECT process and training		
Requirement	Points	Evidence / Data source
Practice to demonstrate all relevant staff have engaged with education and training. <i>(Training Information will need to be modified for non-clinical staff and could include in house training, further details to follow).</i>	3	Practice to provide the CCG with the number of staff that have undertaken training & education as at 30/9/2021 by 7 th October 2021. Information may also be provided by EOL Group.
Embed ReSPECT process and documentation to be used in place of Red border DNACPR forms.	4	Data to be reported to CCG via EMIS Enterprise / CSU Data Quality Team.

3. Long Term Conditions Reviews

The COVID-19 pandemic is displacing much routine primary care.

There is a risk that disruption of proactive care for people living with long-term conditions results in exacerbation and complications in these conditions. This could add further waves of demand for unscheduled care over the coming months in primary care, emergency and hospital admissions.

Covid-19 has also 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”:

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

The [UCLPartners' Proactive Care Frameworks](#) support practices and primary care networks to work differently to deliver comprehensive care to patients with long-term conditions. UCL Partners created frameworks to enable practices to risk stratify patients to prioritise clinical activity, deploy the wider workforce to reduce the workload for GPs, and maximise support for remote management and self-management.

3. Long Term Conditions – Reviews of patients at highest risk of admission				
Indicator	Requirement	Target	Points	Evidence / Data Source
LTC Management – Diabetes Type 2 (Priority 1 cohort) (All 6 CCGs)	Practice is required to prioritise those diabetes patients at highest risk of admission for review/follow-up using the UCL LTC Management tool. Practices should prioritise their BAME population, those in most deprived areas and hard to reach groups where reviews have not taken place or may have been delayed.	>=70% of Priority 1 cohort	12 points	Practice will need to complete a template (to be supplied by the CCG/CSU Data quality team via the clinical system).
	Personalised care adjustments will not be taken into account as this has been reflected in the achievement threshold:	>=80% of Priority 1 cohort	15 points	Practice will be required to confirm number of patients reviewed, describe the practice approach to the review, steps taken to manage the patient and outcome of the review.
	a. Type 2 Diabetes (aged 17+) High risk patients (Priority 1 cohort). Practice to review/follow-up patients. Remote working when clinically necessary will continue to be an acceptable way of delivering reviews.	>=90% of Priority 1 cohort	18 points (Maximum of 18 points available)	Template to be submitted to the CCG at end of September 2021.
LTC management (Part 2) SOT CCG practices only	Stoke on Trent CCG practices only:- Practice is required to prioritise those patients at highest risk of admission for review/follow-up using the UCL LTC Management tool. Practices should prioritise their BAME population, those in most deprived areas and hard to reach groups where reviews have not taken place or may have been delayed. Personalised care adjustments will not be taken into account as this has been reflected in a rate per population b. Hypertension - Priority 1 cohort (practice to move into Priority 2 cohort if necessary to achieve required number of patients)	Practice to review 7 patients for every 1,000 weighted list size	16 points	As above.

	Remote working when clinically necessary will continue to be an acceptable way of delivering reviews.			
	c. AF – Priority 1 cohort. Practice to move into Priority 2 cohort if necessary to achieve required number of patients). Remote working when clinically necessary will continue to be an acceptable way of delivering reviews.	Practice to review 7 patients for every 1,000 weighted list size	16 points	As above.

Details of UCL Partnership LTC Management tool:

The CSU Data Quality Team have further enhanced the searches provided by UCL Partners in partnership with clinicians from Staffordshire and Stoke-On-Trent CCGs. The additional child searches provided allow for easier identification of the patients at higher risk within each group including those patients who have missed previous reviews and those living in the 20% most deprived areas nationally.

The enhanced searches used as the basis of the tool are available and can be copied from the EMIS Enterprise Search and Reports tab in Population reporting to your local practice folder from the following locations:

Stoke and North Staffs Practices: *Midland & Lancashire CSU - Joint NS & SOT - LTC Management Tool

Cannock Practices: Midlands & Lancashire CSU – Data Quality – LTC Management Tool

Stafford and Surrounds Practices: Midlands & Lancashire CSU – DQT Projects – LTC Management Tool

SES & SP Practices: (SES) Midlands & Lancashire CSU – Data Quality – LTC Management Tool

East Staffs Practices: (ES) Midlands & Lancashire CSU – Data Quality – LTC Management Tool

Further information on the UCL Partners Long Term Condition management tools are available here:
<https://uclpartners.com/work/long-term-condition-management/> A video overview is also available:
<https://youtu.be/N6GExRve3dw>

(See specific conditions below)

UCLPartners/CEG Risk Stratification Tool September 2020 – Type 2 Diabetes

This search identifies all patients with Type 2 Diabetes. These patients are then stratified into priority groups based on HbA1c levels, complications, co-morbidity, social factors, and ethnicity.

This grouping will allow practices to prioritise patients for follow up and to safely phase review appointments over time. It also helps match patient care to the workforce. Patients in the high risk groups have greater degrees of complexity and are at higher risk of deterioration. In general, they will require review by a specialist diabetes nurse or pharmacist or a GP.

In contrast, the low risk patients in priority group 5 are likely to be at lowest risk of deterioration. Most of their care (eg support for self-management, education and support for lifestyle change) can be delivered by staff such as health care assistants, link workers and other non-clinical roles with appropriate training.

Note search results may differ from QOF searches because it includes only those patients registered on the day of the search.

High risk		Medium risk		Low risk
Priority One Hba1c >90 OR Hba1c >75 WITH any of the following: <ul style="list-style-type: none"> • BAME • Social complexity** • Severe frailty • Insulin or other injectables • Heart failure 	Priority Two Hba1c >75 OR Any Hba1c WITH any of the following: <ul style="list-style-type: none"> • Foot ulcer in last 3 years • MI or stroke/TIA in last 12 months • Community diabetes team codes • eGFR < 45 • Metabolic syndrome 	Priority Three Hba1c 58-75 WITH any of the following: <ul style="list-style-type: none"> • BAME • Mild to moderate frailty • Previous coronary heart disease or stroke/TIA >12 months previously • BP≥140/90 • Proteinuria or Albuminuria 	Priority Four Hba1c 58-75 OR Any Hba1c WITH any of the following: <ul style="list-style-type: none"> • eGFR 45-60 • BP≥140/90 • Higher risk foot disease or PAD or neuropathy • Erectile Dysfunction • Diabetic retinopathy • BMI >35 • Social complexity • Severe frailty • insulin or other injectables • Heart failure 	Priority Five All others
<small>** Social complexity includes Learning disability, homeless, housebound, alcohol or drug misuse</small>		<small>(Except patients included in Priority 1 and 2 groups)</small>	<small>(Except patients included in Priority 1, 2 or 3 groups)</small>	<small>(Except patients included in Priority 1-4 groups)</small>

UCLPartners/CEG Risk Stratification Tool September 2020 – Hypertension

This search identifies all patients with Hypertension. These patients are then stratified into priority groups based on last recorded blood pressure as well comorbidities and ethnicity.

This grouping will allow practices to prioritise patients for follow up and to safely phase review appointments over time. It also helps match patient care to the workforce. Patients with suboptimal blood pressure will need to be seen by a prescribing clinician in order to optimise their treatment.

Patients whose blood pressure is well controlled may not need clinical input, but they will need support for self-management, education about their condition and support for lifestyle change. This care can be delivered by staff such as health care assistants, link workers and other non-clinical roles with appropriate training.

Note search results may differ from QOF searches because it includes only those patients registered on the day of the search.

Priority 1	Clinic BP \geq 180/120mmHg
Priority 2	a. Clinic BP \geq 160/100mmHg b. Clinic BP \geq 140/90mmHg if BAME with CVD, CKD, diabetes, or BMI $>$ 35 c. No BP reading in 18 months
Priority 3	a. Clinic BP \geq 140/90mmHg if BAME or CVD, CKD, diabetes b. Clinic BP \geq 140/90mmHg – all other patients
Priority 4	Clinic BP $<$ 140/90mmHg (under 80 years) Clinic BP $<$ 150/90mmHg (80 years and over)

Clinic BP reading	Equivalent Home BP
BP = 180/120mmHg	BP = 170/115mmHg
BP = 160/100mmHg	BP = 150/95mmHg
BP = 150/90mmHg	BP = 145/85mmHg
BP = 140/90mmHg	BP = 135/85mmHg

UCLPartners/CEG Risk Stratification Tool January 2021 – Atrial fibrillation

This search identifies all patients with atrial fibrillation. These patients are then stratified into priority groups based on those without anti-coagulation treatment, those treated with anti-coagulation and concomitant use of antiplatelets, those on warfarin and those on DOAC anticoagulation with or without a yearly renal function.

This grouping will allow practices to prioritise patients for follow up and to safely phase review appointments over time. An initial contact with patients can be made by a Health Care Assistant, Link Worker or other team member with appropriate training in order to update the relevant clinical information and support education, self-management and lifestyle change aided by digital and other resources.

This will help save the clinician time and allow them to be more focused on the clinical interventions, while increasing the quality and quantity of personalised care for the patients. Note search results may differ from QOF searches because it includes only those patients registered on the day of the search.

Priority 1	Not on anti-coagulant
Priority 2	On anticoagulant & antiplatelets
Priority 3	On Warfarin (or other Vitamin K antagonists)
Priority 4	On DOAC Renal function >12m ago
Priority 5	On DOAC Renal function <12m ago

Appendix 1

Benchmarking data shows Stoke-On-Trent has 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	

Domain					
			Stoke-on-	West	
A. Overarching Indicators	Time Period	Staffordshire	Trent	Midlands	England
Life expectancy at birth-Male	2017/19	79.7	76.4	78.9	79.6
Life expectancy at birth-Female	2017/19	83.1	80.3	82.7	83.2
Healthy life expectancy at birth-Male	2016/18	63.2	57.4	61.8	63.4
Healthy life expectancy at birth-Female	2016/18	64.9	55.8	62.3	63.9
B. Wider Determinants of Health					
School readiness: percentage of children achieving a good level of development at the end of Reception (%)	2018/19	74.4	67	70.1	71.8
16-17 year olds not in education, employment or training (NEET) or whose activity is not known (%)	2019	2.9	4.6	5.3	5.5
Gap in the employment rate between those with a long-term health condition and the overall employment rate (Percentage Points)	2019/20	12.8	12.2	9.9	10.6
Gap in the employment rate between those with a learning disability and the overall employment rate (Percentage Points)	2019/20	77.4	69.5	69.7	70.6
Percentage of people aged 16-64 in employment	2019/20	79.5	73.2	73.9	76.2
Children in absolute low income families (under 16s) (%)	2018/19	12.8	25.3	18.8	15.3
Children in relative low income families (under 16s) (%)	2018/19	16.4	31.6	23.8	18.4
Homelessness - households owed a duty under the Homelessness Reduction Act (per 1,000)	2019/20	5.8	14.1	11.2	12.3
Homelessness - households in temporary accommodation (per 1,000)	2019/20	0.3	0.2	2.0	3.8
C. Health Improvement					
Low birth weight of term babies (%)	2019	2.79	4.30	3.26	2.90
Reception: Prevalence of overweight (including obesity) (%)	2019/20	26.1	27.8	24.6	23.0
Year 6: Prevalence of overweight (including obesity) (%)	2019/20	33.1	40.4	38.2	35.2
Smoking Prevalence in adults (18+) - current smokers (APS) (%)	2019	13.9	18.2	14.1	13.9
Admission episodes for alcohol-related conditions (Narrow) (per 100,000)	2018/19	814	1127	739	664
Self-reported wellbeing - people with a low satisfaction score (%)	2019/20	3.9	3.7	4.8	4.7
D. Health Protection					
TB incidence (three year average) (per 100,000)	2017/19	3.8	9.4	10.4	8.6
E. Healthcare and Premature Mortality					
Infant mortality rate (per 1,000)	2017/19	4.8	7.5	5.6	3.9
Percentage of 5 year olds with experience of visually obvious dental decay	2018/19	14.2	30.7	22.7	23.4
Under 75 mortality rate from all cardiovascular diseases (per 100,00)	2017/19	68.0	91.7	77	70.4
Under 75 mortality rate from cancer (per 100,000)	2017/19	126.3	166.5	135.0	129.2
Suicide rate (per 100,000)	2017/19	11.5	12.5	10.2	10.1

Appendix 2: Completed code of conduct for NHS Stoke-on-Trent CCG & 5 Staffordshire CCGs (from 2021/22 scheme).

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	The emphasis on preventing the deterioration of long term conditions and minimising health inequalities will realise the CCGs' commissioning priorities: admissions avoidance; mental health;

estimated benefits? How does it reflect the CCG's proposed commissioning priorities?	<p>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>
How have you involved the public in the decision to commission this service?	<p>Previously 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.</p> <p>2021/22 scheme discussed at CCG Primary Care Strategic Cell.</p>
What range of health professionals have been involved in designing the proposed service?	<p>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.</p> <p>This year's scheme has been re-purposed to focus on a reduced number of priorities due to ongoing impact of Covid-19 on primary care capacity.</p>
What range of potential providers have been involved in considering the proposals?	<p>Previously general practice providers from CCG localities have been consulted alongside public health consultants, representatives of NHS England.</p>
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)?	<p>The QIF has been submitted to the co-Chair of the H & W Board (March 2021)</p> <p>The scheme matches the NHS Outcomes Framework domains, NHS Long Term Plan, Improvement and Assessment Framework, LTC Delivery Plan and public health domain/redressing health inequalities against the contents of the QIF LIS.</p>
What are the proposals for monitoring the quality of service?	<ol style="list-style-type: none"> 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?	<p>As above; see document re anticipated outcomes</p>
Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available?	<p>Yes- the CCG has an up to date log of practices/ clinical directors/leads' conflicts of interest.</p>
Why have you chosen this procurement route?	<p>Yes – this is a revision of the previous QIF LES</p>

What additional external involvement will there be in scrutinising the proposed decisions?	Representatives of the LMC, Primary Care Commissioning Committees 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?	Previously the final QIF LIS was submitted to the CCG Governing Body after comments/scrutiny is received by the H&W Board Chair and 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 standard 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.</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 above core GP contract.</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?	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.