



Cannock Chase Clinical Commissioning Group
East Staffordshire Clinical Commissioning Group
North Staffordshire Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford & Surrounds Clinical Commissioning Group
Stoke on Trent Clinical Commissioning Group

Practice Quality Improvement Framework (QIF) 2022_23

STOKE ON TRENT CCG

Final Version: 30/05/21

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.

1.3 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

1.5 The Quality Improvement Framework has now been reviewed to focus on the following key priorities for 22/23 to support restoration and recovery, particularly to close the gap with QOF backlog which has been significantly impacted by Covid-19 pandemic, and to work towards returning to pre-pandemic levels:

- LTC Management – accelerated recovery and delivery of face to face reviews to close the gap with QOF backlog, with a focus on prioritising reviews of people in highest risk of admission using UCL Partnership LTC Management risk stratification tool/searches.
- Diabetes (Type 1 and Type 2 patients) - recovery and delivery of 8 Care Processes
- Pneumonia (PPV) – increase uptake of vaccination (aged 65 and over)
- Pulmonary Rehabilitation – patients to be offered referral.
- Cancer 2WW referral processes - to support embedding local referral pathways, with a particular focus on the FIT pathway & Telederm.

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.

¹ <https://doi.org/10.1093/fampra/cmz128>

	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
Weighted List Size 1/1/22	141865	150345	233026	214871	155261	310649
Value of scheme per head of weighted population (pwp)	£2.10	£2.10	£2.10	£2.10	£2.10	£4.00
QIF Budget (12 months)	£297,917	£315,725	£489,355	£451,229	£326,048	£1,242,596
Number of points	70	70	70	70	70	133

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

3. Payments 2022-23

- 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 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/ year end reconciliation - all practices

- 4.1 Practice consents to MLCSU Data Quality Specialist (DQS) extracting and sharing data with the CCG to enable 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

Long Term Conditions Reviews

The COVID-19 pandemic has displaced 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.

TABLE OF INDICATORS BELOW:

CCGs	Item:	Indicator	Outcome/Threshold	Deadline	Payment	Payment	Points
All	1	Recovery Plan - Practice to submit a recovery plan to CCG detailing accelerated recovery and delivery of face to face reviews to close the gap with QOF backlog and to return to pre-pandemic levels	(Confirmation of sign up to QIF 22/23 and brief plan to be submitted via MS Forms template supplied by CCG)	by 30th June 2022	N/A	N/A	N/A
All	2	COPD prioritise and accelerate review (priority 1 and priority 2 cohort - UCL Risk Stratification searches)	<div>>=80% of Priority 1 patients</div> <div>>=75% of Priority 1 patients</div> <div>>=70% of Priority 1 patients</div> <div>>=80% of Priority 2 patients</div> <div>>=75% of Priority 2 patients</div> <div>>=70% of Priority 2 patients</div>	<div>by 31st Oct 2022</div> <div>by 31st Dec 2022</div>	<div>25p per weighted population</div> <div>23p per weighted population</div> <div>20p per weighted population.</div> <div>25p per weighted population</div> <div>23p per weighted population</div> <div>20p per weighted population.</div>	<div>50p per weighted population (total amount available)</div>	17
All	3	Asthma prioritise and accelerate reviews (Priority 1 cohorts for both age groups: 12-16 , 17+ years)	<div>>=80% of Priority 1 patients</div> <div>>=75% of Priority 1 patients</div> <div>>=70% of Priority 1 patients</div>	by 31st Oct 2022	<div>40p per weighted population</div> <div>36p per weighted population</div> <div>30p per weighted population.</div>	40p per weighted population (total amount available)	13
All	4	Hypertension prioritise and accelerate reviews	<div>>=80% of Priority 1 patients</div> <div>>=75% of Priority 1 patients</div> <div>>=70% of Priority 1 patients</div> <div>>=80% of Priority 2a-c patients</div> <div>>=75% of Priority 2a-c patients</div> <div>>=70% of Priority 2a-c patients</div>	<div>by 31st Oct 2022</div> <div>by 31st Dec 2022</div>	<div>15p per weighted population</div> <div>13p per weighted population</div> <div>10p per weighted population.</div> <div>15p per weighted population</div> <div>13p per weighted population</div> <div>10p per weighted population.</div>	<div>30p per weighted population (total amount available)</div>	10

All	5	Recovery and delivery of Diabetes 8 care processes (targets as per National Diabetes Audit 19/20) (Type 1 Diabetes) Stepped Thresholds	>55%		by 31st Mar 2023	15p per weighted population.	15p per weighted population (total amount available)	5
						10p per weighted population.		
						5p per weighted population.		
All	6	Recovery and delivery of Diabetes 8 care processes (targets as per National Diabetes Audit 19/20) (Type 2 Diabetes) Stepped Thresholds	>55%		by 31st Mar 2023	24p per weighted population.	24p per weighted population (total amount available)	8
						16p per weighted population.		
						8p per weighted population.		
All	7	Increase pneumonia (PPV) vaccinations uptake (those 65 years and over where eligible) at any time.	>80%		by 31st Mar 2023	15p per weighted population.	15p per weighted population (total amount available)	5
						10p per weighted population.		
						5p per weighted population.		
All	8	Pulmonary rehabilitation referrals (<i>Those patients at highest risk to be prioritised for early PR referral and referrals phased throughout the year to not overwhelm service</i>)	95% offered for patients with a breathlessness score of >=3		by 31st Mar 2023	6p per weighted population	6p per weighted population (total amount available)	2
			90% offered for patients with a breathlessness score of >=3		by 31st Mar 2023	4p per weighted population		
All	9	Cancer 2WW referral processes - to support embedding local referral pathways, with a particular focus on the FIT pathway & Telederm	Funding to support FIT, Teledermatology,		Direct payment in anticipation of work required.	30p per weighted population	30p per weighted population (total amount available)	10

SOT CCG	10	Stroke / TIA* – prioritise and accelerate reviews for QOF elements STIA007, STIA010, STI011	Part 1: >=80% STIA007 The percentage of patients with a stroke shown to be non haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti platelet agent, or an anti coagulant is being taken	by 31st Mar 2023	20p per weighted population.	50p per weighted population (total amount available)	17
			>=75% STIA007		18p per weighted population.		
			>=70% STIA007		15p per weighted population.		
			Part 2: >80% STIA010 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		15p per weighted population.		
			>=75% STIA010		13p per weighted population.		
			>=70% STIA010		10p per weighted population.		
			Part 3: >80% STIA011 The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less		15p per weighted population.		
			>=75% STIA011		13p per weighted population.		
			>=70% STIA011		10p per weighted population.		
			>=80% of all priority groups		34p per weighted population		
SOT CCG	11	AF – prioritise and accelerate reviews	>=80% of all priority groups	by 31st Dec 2022	34p per weighted population	34p per weighted	11

			>=75% of all priority groups		>=70% of all priority groups	30p per weighted population 25p per weighted population	population (total amount payable)	
SOT CCG	12	HF* – prioritise and accelerate reviews	HF007	by 31st Mar 2023	>=80% of QOF HF007 >=75% of QOF HF007 >=70% of QOF HF007	22p per weighted population 18p per weighted population. 15p per weighted population.	22p per weighted population (total amount payable)	7
SOT CCG	13	Cholesterol Primary prevention (No pre-existing CVD) Priority 1 UCL search One of: • QRISK ≥20% • CKD • Type 1 Diabetes AND • Not on statin	80% of priority 1 cohort Issued with a statin or offered and patient declined this year. 75% of priority 1 cohort Issued with a statin or offered and patient declined this year. 70% of priority 1 cohort Issued with a statin or offered and patient declined this year.	by 31st Dec 2022		60p per weighted population 50p per weighted population 40p per weighted population	60p per weighted population (total amount payable)	20
SOT CCG	14	Cholesterol - Secondary prevention (Pre-existing CVD) Priority 1 UCL search Not on statin therapy	80% of priority 1 cohort Issued with a statin or offered and patient declined this year 75% of priority 1 cohort Issued with a statin or offered and patient declined this year. 70% of priority 1 cohort Issued with a statin or offered and patient declined this year.	by 31st Dec 2022		24p per weighted population 20p per weighted population. 16p per weighted population	24p per weighted population (total amount available)	8

Priority cohorts based on UCL baselines as at 31/3/22.

* QOF as at achievement date

Important information: Personalised care adjustments will not be taken into account as this has been reflected in the achievement thresholds.

30/5/22 - Asthma threshold payments updated to 40p/36p/30p

Details of Support searches (UCL Partnership LTC Management tool):

The supporting UCL searches used as the basis of the tool and to identify priority cohorts are available and the folder of searches can be found in Population Reporting from the Enterprise tab (bottom left), here you will see the 'CCG - Enhanced Services (ES & LES)' folder and within it the 'MLCSU QIF 2022-23 [v1.3] (Alpha NOT FINAL)' folder. To use the suite of searches simply copy this search folder to a folder of your choice in your practice tab.

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>

Added 30/5/22 - The UCL resources below specify the criteria for each priority group.

Hypertension: https://s31836.pcdn.co/wp-content/uploads/UCLPartners-Search-Tool-%E2%80%93-Hypertension_2021August.pdf

Asthma: [Guide-to-the-UCLPartners-Asthma-Search-tool.pdf \(pcdn.co\)](#)

COPD: [UCLPartners-CEG-Risk-Stratification-Tool-September-2021-COPD .pdf \(pcdn.co\)](#)

Cholesterol: [Microsoft Word - UCLPartners Search Tool Cholesterol \(pcdn.co\)](#)

AF: [UCLPartners-Search-Tool---Atrial-Fibrillation Sep-2021.pdf \(pcdn.co\)](#)