NHS
Wolverhampton
Clinical Commissioning Group

BUSINESS CASE

Project:	QOF+ Scheme 2018/19
Project Number:	
Date:	May 2018
Project Lead:	Sarah Southall, Head of Primary Care
Project Sponsor:	Steven Marshall, Director of Strategy & Transformation
Version No:	1.0 Draft

1 Business Case History

Template Revision History

Date of this revision: 01/04/2018

Revision date	Summary of Changes	Changes marked
08/2013	Preliminary Equality Analysis added	1.1
	First issue	
12/2014	Quality Impact Analysis added	1.2
18/06/15	Document Review	1.3
02/03/16	Addition of Task and Finish Section	1.4
17/03/2017	New CCG Logo and document formatting	2.0
01/04/2018	Task and Finish section, DPIA and front sheet	3.0

Task and Finish Group Views

Task and Finish Group Views - please confirm who has been identified as the lead for each of the following areas below, and their initial comments:

Area / Team	Lead Name	Date	Initial comments from the Leads review of the Scoping Report
Clinical	Dr Reehana	16.05.18	Comments included in the QIA
Public/ Patient	Sue McKie	11.05.18	No comments received
Finance	Tony Gallagher	11.05.18	No comments received
Quality	Sally Roberts	11.05.18	No comments received
Performance	Mike Hastings	11.05.18	Can I suggest that a very simple one page is included which explains (possibly with a worked example?) how and how much practices earn points -> £££ in year one. Including the part year effect and the sliding scale (i.e. all or nothing or graduated payments based upon % attainment). This is the main question for practices and a simple explanation would help.
PMO			
Contract & Performance	Vic Middlemiss	11.05.18	No comments received
Medicines Management	Hemant Patel	11.05.18	No comments received
Equality	David King	11.05.18	No comments received
Information Governance	Peter McKenzie	11.05.18	No comments received
Legal/ Policy (Corporate Operations Manager)			
Primary Care	Steven	11.05.18	No comments received

	Marshall		
IMT / IT	Mike Hastings	11.05.18	No comments received
Business Intelligence			
Estates			

All of the sections above must be completed before the report is submitted to the relevant board. If any of these leads are not applicable please indicate why, do not leave blank.

Report Distribution

This document/report has been distributed to:

Name	Title	Date of Issue	Version
Primary Care Commissioning Committee		11.5.18	V1.0

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3 Purpose

In order to support the continued improvement and development of Primary Care the purpose of this scheme is to build on the benefits of the national Quality Outcomes Scheme (QOF).

QOF awards practices funding in response to them managing chronic disease, public health concerns and goes some way to implementing preventative measures such as regular blood pressure checks. QOF+ seeks to take this work further with a greater emphasis on local priorities & the importance of developing the prevention agenda further as follows:-

- Diabetes (pre-diabetic)
- Alcohol
- Obesity

The CCG is committed to continued investment in Primary Care as part of the implementation of the Primary Care Strategy (2016). The vision for practices as providers of healthcare in Wolverhampton is to provide 'cradle to grave prevention' ensuring patients have access to high quality care, proactively identifying those at risk of ill health.

4 Reasons

The CCG Integrated Assessment Framework (IAF) Assessment for *Diabetes* was rated as 'requires improvement' with reported prevalence higher than other comparable CCGs. Data indicates a much higher prevalence of diabetes in black and minority ethnic (BME) communities in Wolverhampton when compared with England. BME communities make up 32% of Wolverhampton CCG's population, compared with 15% BME communities in the population of England as a whole. Therefore, the scheme has been constructed with a combination of preventative and responsive indicators that seek to improve the CCGs performance in diabetes particularly in the IAF.

Alcohol mortality in Wolverhampton is worsening and remains above the England average. The number of emergency alcohol specific admissions to hospital has increased over the past decade from 493 in 2005 to 956 in 2015. A lifestyle audit commissioned by Public Health Wolverhampton in 2016 identified that alcohol increased with age, was higher in people who earned more and higher in those from a white ethnic background. The number of males being admitted to hospital for alcohol specific conditions in emergencies is more than double the number in females. This same age range of men account for most of alcohol service users whilst men aged 45 – 69 years account for the highest rate of alcohol related deaths.

The most recent JSNA identified *Obesity* as significant issue for Wolverhampton. In the region of 59% of males are either overweight or obese, compared to 52% females in Wolverhampton. Based on a lifestyle survey conducted by Public Health Wolverhampton respondents who had a black ethnic background had the highest proportion of individuals with excess weight (63%). Only half of Wolverhampton 49.9% of the population were estimated to be physically active, significantly lower compared to England 57% and the West Midlands 55%.

5 Options

The CCG are keen to introduce a focus on prevention in primary care rather than continuing to invest new money in reactive healthcare. This view has been expressed by member practices at initially in November when discussed continued with a range of General Practitioner colleagues that lead to shortlisting the areas of greater priority. There is potential to develop the scheme further beyond the 3 priorities currently included.

6 Benefits Expected

There are 19 indicators within the scheme that will be measured via GP clinical systems that will form the basis for reviewing the effectiveness of the scheme. The scheme seeks to achieve the improved outcomes (10 Investment Appraisal) but recognise that benefits of the improved outcomes may not be realised for some time and may not be evident until subsequent year of the scheme 2019 and beyond. Therefore, continued investment and development are also considered beneficial in achieving improved outcomes for the population of Wolverhampton.

7 Risks

Risks that are foreseen with deployment of the scheme are as follows:-

There is a risk of practices experiencing difficulty implementing the scheme if support isn't available from the CCG. Ongoing support will be available from the Primary Care & IM&T Team during the implementation and monitoring of this scheme.

Risk of practices not signing up to the scheme due to the amount of additional work attached to the scheme. Practice Groups will be encouraged to deliver components of the scheme at scale via their hubs where reasonably possible in order to keep costs down and avoid replication.

Risk of practices not achieving the thresholds defined in the scheme due to the numbers of patients they are required to work with. A preparatory scheme has been in place to enable practices to identify patients pertaining to each priority in readiness for commencing intervention(s).

Risk of practices reaching partial achievement if they have not undertaken the preparatory work funded in 2017/18. There are xx practices who have not participated fully in the preparatory work for the scheme.

Risk of variation if searches to identify at risk patients are not pre-defined in clinical systems. The IM&T Facilitators will have searches set up in clinical systems in readiness for practices commencing this work.
All risks will be factored into the communication to practices when launching the scheme and on an ongoing basis whilst monitoring activity & uptake.

8 Cost

The total annual investment for the scheme in year 1 is £1.2 million, funded from with Primary Care budgets and as part of the continued commitment to invest in Primary Care in Wolverhampton.

The scheme provides a breakdown confirming the value of the scheme to each of the CCGs 42 member practices, should they achieve all points attached to the thresholds for each of the 19 indicators.

There is potential for a combination of full and partial achievement, individual performance will be monitored at practice and group level at quarterly intervals.

9 Timescales

Member practices were engaged in discussions about what the priorities should be for this investment concluding with a shortlist of suggested areas. There was an overwhelming desire for more preventative work to take place in order to avert disease and effects on long term health.

An external review being commissioned by the CCG, this took place January/February 2018 and included scoping work coupled with a review of evidence at national level to determine the evidence base for interventions pertaining to the three priority areas.

In March the first draft of the scheme was shared for initial consideration with clinicians across primary care including Group Leads, Clinical Reference Group and LMC Following a period of development of the scheme with clinical engagement from a number of forums

10 Investment Appraisal

The return on invest for the priorities that have been identified is based on interventions identified in the evidence review. This draws on a range of data sources and has been applied to population estimates. In this section of the

business case the following indicative cost savings for each priority should be recognised:-

	Diabetes	**Alcohol**	**Obesity**
Outcome	Better glycaemic control at 12 months, assuming 10% the population with diabetes could lead to a 5% reduction in A&E Attendances and 6% reduction in hospital admissions & day cases reducing costs by £7,000 per year.	Assuming 20% of the population reduced their alcohol consumption would lead to a 14% reduction in alcohol related health conditions & a reduction in 10% of A&E attendances resulting in costs being reduced by £250,000 per year for secondary care.	Obesity identification, brief advice leading to weight loss leading to reduced demand on general practitioners. Assuming 10% of obese adults was estimated cost savings to primary & secondary care were £37,000 per year.
Saving	For every £1 spent on the intervention there would be a saving of £0.33.	For every £1 spend on the intervention there will be a saving of £2.83	For every £1 spend on the intervention there will be a £0.96

The outcomes for all 3 priorities identify effective & cost effective interventions that will benefit primary and secondary care settings. Some of the interventions within the scheme require primary care to work in partnership with a range of community & commercial providers. Providing brief advice and intervention is a theme that cuts across all 3 priorities therefore economies of scale at the point of delivery will be encouraged at practice group level in order to avoid replication of costs with set up and ongoing provision.

Investment has been apportioned based on practice list size, page 43 of scheme confirms the potential amount each practice may be paid for undertaking this activity in order for longer term savings and improved outcomes to be realised.

11 Equality – Appraisal

A full equality analysis has been undertaken and can be found in Appendix 1. This was approved in April by the respective lead. A number of components of the impact assessment will be a live document and forms the basis for ongoing monitoring of the scheme.

12 Quality Impact Analysis (QIA)

A quality impact analysis has been duly completed and approved by the relevant lead, this took place in April 2018 (Appendix 2).

13 Data Privacy Impact Assessment (DPIA)

A data privacy impact assessment has been undertaken and considered by the relevant lead, this took place in May 2018 (Appendix 3).

Enclosures: Appendix 1 Equality Analysis
Appendix 2 Quality Impact Assessment
Appendix 3 Data Privacy Impact Assessment
Appendix 4 QOF+ Scheme 2018/19
Appendix 5 Frequently Asked Questions

SLS/QOF+-BC/MAY18/V1.0