1. PROJECT INFORMATION

Project Title	Stretched QOF to incentivise improved management of Long Term Conditions – Tilbury Pilot

Project Sponsor	Ian Wake	Cabinet Member	
Project Manager		Author	Emma Sanford
Date	02/03/2017		

2. PURPOSE OF THIS PROJECT

The purpose of this project is to pilot a programme which incentivises primary care to manage long term condition patients from the point that QOF payments stop.

In doing so, we hypothesise/expect that we would observe:

1) Reduction of Non-elective hospital activity from patients with Long Term Conditions.
2) Reduction in the number of patients having a major health event that results in a new or increased need of Adult Social Care packages (eg Stroke)
3) Improvement in the health and wellbeing of our Long Term Condtion (LTC) Populations.

The project interacts with other projects being proposed in the following ways:

1) The hypertension detection business case will result in the prevalence of Hypertension increasing and so costs associated with this project would increase. We have accounted for these as much as possible in this business case.
2) The improved targeting of Health Checks business case will result in the prevalence of Hypertension, Diabetes, and CHD (coronary heart disease) increasing and so costs associated with this project would increase. We have accounted for these as much as possible in this business case.
3) The Depression screening in LTC patients business case will result in the prevalence of Depression increasing and so costs associated with this project would increase. We have looked to account for these within this business case but expect that the increased cost incurred as a result of a stretched QOF would be minimal.
4) The flu vaccination uptake business case will impact on some of the QOF indicators included here and so will result in an increase in the associated costs with this project. We need to be cautious that no additional payments are offered in that project that might result in a double payment.
5) As a result of this project General Practices will receive payment for increases in detection rates of LTCs; we need to be cautious that no other incentives are offered under any of the other projects that might result in a double payment.

3. NEEDS ASSESSMENT

QOF (Quality Outcomes Framework) currently pays Practices based on the percentage of patients who receive specific, evidence based interventions and/or treatments. However, this is capped. The value at which it is capped is dependent upon the indicator. Mostly incentivisation happens for around 70-85% of patients receiving the intervention.

Practices generally score around the level that they require for maximum payment. This either suggests that this is an "achievable" level or that Practices do not have the resources to obtain higher with no potential of funding.

The Tilbury ACO Needs Assessment identified that Long Term Condition management in Primary Care in Tilbury is in need of improvement.

The main conclusions from the needs assessment were:

- There are significant numbers of patients on the Hypertension, CHD, Stroke and Diabetes Registers with blood pressure that is uncontrolled. Programmes to address this will significantly reduce the risk of serious health events and unplanned hosp admissions.[1] [2] [3] [4]
- Control of HbA1c for patients with diabetes needs to be improved for a significant cohort of patients in Tilbury. [5]
- There is a need to increase referral of patients newly diagnosed with diabetes to structured education programmes. There is good evidence that patients who have a good understanding of their long term conditions are able to self-care more effectively and have both better outcomes and a lower usage of clinical services. [6]
- Flu vaccination uptake needs to be improved. Evidence suggests that vaccination that protects patients with LTCs against flu against can prevent serious health complications. [7]
- 2015-16 QOF performance data suggests that operational capacity to improve the clinical management of patients with diabetes within GP practices needs to be improved
- Exception rate reporting Sai Medical Centre and for COPD and CVD patients, and at Ramachandran's surgery for CVD patients is high and warrants further investigation
- Operational capacity at Dr. Mohile's Practice for CVD clinical management needs to be improved
- Implementing a stretched QOF may be highly cost effective in terms of CVD and COPD clinical management

Furthermore our Annual Public Health Report (2016) quantified the effect that low levels of management were having on emergency care for specific indicators. Some of these are used to quantify the returns on investment later.

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[1] NICE CG127. Hypertension: clinical management of primary hypertension in adults. 2011. http://publications.nice.org.uk/hypertension-cg127

[2] Collins et al. Lancet 1990; 335: 827-38

[3] PROGRESS collaborative group. Lancet. 2001: 358: 1033-41

[4] NICE 2010 menu ID NM01

[5] http://guidance.nice.org.uk/CG87 http://guidance.nice.org.uk/CG15

[6] NICE 2011 menuID:NM27

[7] https://www.gov.uk/government/publications/flu-immunisation-programme-2014-to-2015

4. EVIDENCE BASE

Spend on patients with long-term conditions accounts for over 70% of the entire NHS budget.[8]

Effective management of long term conditions is absolutely vital in order to prevent patients' health, wellbeing and independence from deteriorating and to prevent them being admitted to hospital or requiring social care packages.

The management of Long Term Conditions should be done by patients with support from primary and community care services. Good management of patients' conditions by these three entities will be reflected in the Quality Outcomes Framework (QOF) – especially those which are clinical markers.

QOF records contain quality of care information on how patients who are diagnosed with diseases are treated in primary care. It was set up as an incentive system and GP practices get paid for the percentage of their "diseased population" that they offer certain tests, medication reviews and treatments for. The indicators are based on evidence of good quality care for the conditions.

There has been much debate over recent years whether QOF actually achieves good outcomes for patients in terms of reducing the risk of major events requiring hospitalisation.

However a study published in the BMJ in 2014[9] showed that nationally the introduction of QOF was in fact associated with a decrease in emergency admissions for these incentivised conditions. They also state that:

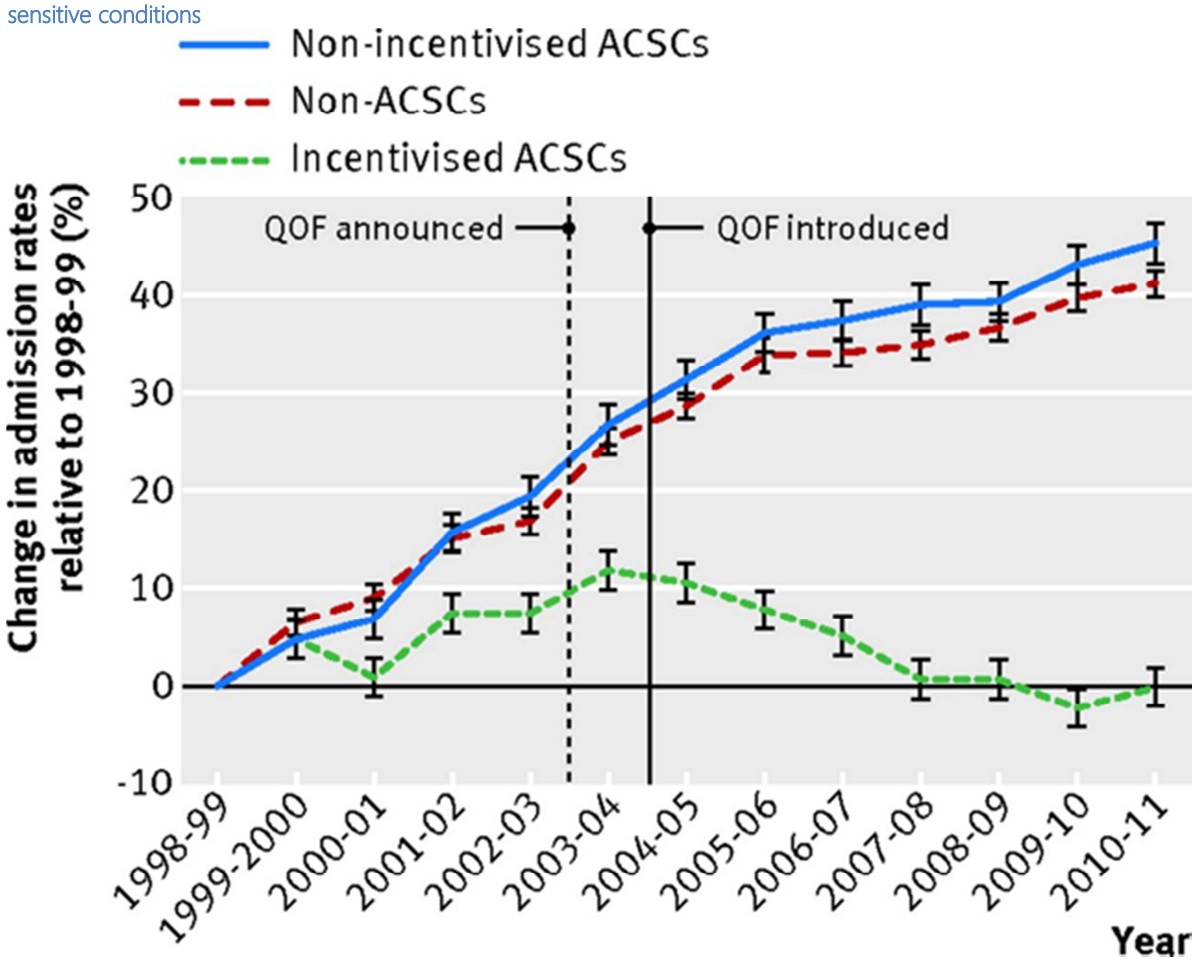
"Contemporaneous health service changes seem unlikely to have caused the sharp change in the trajectory of incentivised Ambulatory Care Sensitive Conditions (ACSC) admissions immediately after the introduction of the Quality and Outcomes Framework. The decrease seems larger than would be expected from the changes in the process measures that were incentivised, suggesting that the pay for performance scheme may have had impacts on quality of care beyond the directly incentivised activities."[i]

The chart below shows the findings from their research. It can be seen that the trend in rate of emergency admissions due to the incentivised conditions showed a reversal upon the introduction of QOF in 2004/05. By 2007/08, nationally the rates had returned to around the levels that they were in 1998/99. Whereas the rates in non-incentivised Ambulatory sensitive conditions have continued to rise.

[8] Thurrock Annual Public Health Report 2016

[9] M J Harisson, M Dusheiko, M Sutton, H, Gravelle, T Doran, M Roland; Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions: controlled longitudinal study, *BMJ* 2014; 349:g6423

Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions



This project would test the Hypothesis that to further incentivise the same conditions would lead to further reductions in activity. This is a scientifically plausible hypothesis.

A programme in sommerset showed that removing QOF and designing a system where GP's are payed for the total of what they do had positive impacts on patient care. We would expect to see similar results.[10]

[10] http://www.swahsn.com/wp-content/uploads/2016/06/Evaluation-of-the-Somerset-Practice-Quality-Scheme-July-2015.pdf

5. DELIVERY PLAN AND KEY MILESTONES

Key Milestones (Key events indicating progress)	To be reached by (date)	Who is responsible for meeting the Milestone?
Introduction of Mede Analytics. This will enable us to establish baseline rates of activity and monitor progress against these over the period of the pilot for evaluation and consideration of further roll-out.	Current Target data to start Primary care sign up. November 2017. Expect to take 4-6 weeks providing all Tilbury practices are enthusiastic.	Emma Sanford
Publication of offer to practices, including details of any caps to be applied and any support available to help achieve, payment frequency, expectations from practices.	January 2018	Emma Sanford
Sign up from practices	Mid-Late February2018	Emma Sanford / Monica Scrobotovici
Project initiation	March 2018	Monica Scrobotovici
Monitoring	Monthly	Monica Scrobotovici
Evaluation	September 2018 and March 2019	Emma Sanford / Monica Scrobotovici

6. FINANCIALS: Costs, Resources, Cashable Benefits, Cost Avoidance, Return on Investment

Resources

In order for monitoring arrangements, evaluation and calculating payments this project would be easier to run if practices in Tilbury agreed to sign up to provide data through the Mede Analytics software.

Using this software we can also support practices to achieve the maximum payments they can by providing reports which identify the patients for whom interventions are not currently offered.

Potential Costs

We have generated a Stretched QOF modelling tool which allows calculation of the maximum payment that would be available to each practice for each of the QOF indicators in the domains listed below.

The table below shows the maximum expected cost of all of the indicators for the Tilbury area in total.

	Cost to achieve 100% on All indicators based on current detection rates	Proposed Increase in Detection Rates	Cost to achieve 100% on All indicators based increased detection rates	Proposed Increase in Detection Rates	Cost to achieve 100% on All indicators based increased detection rates
Hyp	£4,635.14	10%	£5,274.62	20%	£5,914.09
CHD	£1,471.00	5%	£1,638.00	10%	£1,806.00
AF	£3,815.43	0%	£3,815.43	0%	£3,815.43
HF	£4,786.00	0%	£4,786.00	0%	£4,786.00
PAD	£311.35	0%	£311.35	0%	£311.35
STIA	£1,981.50	0%	£1,981.50	0%	£1,981.50
DM	£10,800.40	5%	£11,180.98	10%	£11,450.63
COPD	£5,735.28	0%	£5,735.28	0%	£5,735.28
Asthma	£10,366.64	0%	£10,366.64	0%	£10,366.64
Dementia	£13,902.99	0%	£13,902.99	0%	£13,902.99
Mental Health	£2,455.66	0%	£2,455.66	0%	£2,455.66
Depression	£1,908.25	0%	£1,908.25	0%	£1,908.25
Oesteoporosis	£1,752.31	0%	£1,752.31	0%	£1,752.31
Rhumatoid Arthritis	£583.89	0%	£583.89	0%	£583.89
Total	£64,505.84		£65,692.90		£66,770.02

Cashable benefits

Practices may receive cashable benefits. However this is dependent upon their costs of delivery.

Cost avoidance

	Min additional cases treated	Maximum additional cases treated	Assumptions for range	Outcomes	Returns estimated	Potential Savings
The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	893	1170	Excluding exception reporting and no detection increase to including exception reporting and 10% increase in detection	18-23 strokes avoided over 3 years	NHS - Stroke Avoidance Adult Social Care - Stroke Avoidance	£65,082 to £85,270 £75,387 to £98,771
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	48	85	Excluding or Including exceptions	62 - 110 strokes avoided over 3 years	NHS - Stroke Avoidance Adult Social Care - Stroke Avoidance	£227,385 to £402,662 £263,390 to £466,420
In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB	2	9	Excluding or Including exceptions	2.2 - 7.6 fewer non-elective admissions for CHD/HF over 3 years	NHS - admission avoidance	£10,058 to £45,263
Total Measurable Returns					NHS Adult Social Care **Total**	£302,525 to £533,195 £338,777 to £565,191 £641,302 to £1,098,386

We can calculate potential outcomes and returns for three of the QOF indicators by using the Long Term Condition models produced for the 2016 APHR. These are detailed above. We predict that implementing a Stretched QOF will save the Health and Social care system at least £640K based on only three QOF indicators to avoid CVD events. We are unfortunately unable to estimate this further for other conditions and indicators but it is logical to assume that additional saving.

Note: additional savings related to other conditions would be expected in addition, however we

do not have sufficient data to model these currently. The pilot could be seen as a tool to collect this data and true returns on investment could be calculated upon evaluation.

8a. NON FINANCIAL BENEFITS

Benefit Description	Measure to track realisation of benefit	Benefit realisation timescales:
Reduction in Hospital Care for LTC patients	For each LTC – produce Mede report that tells us rate of Admissions that our diagnosed cohort have.	We would expect to see a benefit within 6 months
Reduction in rate of strokes from patients on a register	Produce a report in Mede which tells us rates of strokes in diagnosed patients	We would expect to see a benefit within 3 years (maybe sooner)
Reduction in ASC new/increased packages due to a major health event	Produce a Mede report which tells us the rate of new/increased packages within 2 months of a major health event in diagnosed patients	We would expect to see a benefit within 3 years (maybe sooner)
Improved feeling of health and wellbeing in patients	GP satisfaction survey – provided that we improve response rates	1 year

8b. POTENTIAL DIS-BENEFITS

Dis-benefit description	Measure to track realisation of dis-benefit	Dis-benefit realisation timescales and mitigation
Costs could increase if LTC prevalent population increases over and above what is expected	Continual monitoring so that we can have monthly estimates of expected costs	We believe that we have over-estimated the potential for this increase.

9. KEY RISKS TO PROJECT DELIVERY

Risk Type, Risk Level and Risk Description	Risk Mitigation	Who will monitor this Risk?
Data not being released to Mede by PC, CC, and Adult Social Care		Emma Sanford / Ian Wake
DAAG application		Jane Marley
Capacity to deliver	Increasing capacity under other programmes	Ian Wake
NHS England have commited to review QOF next year. We believe that it will be a 1% uplift across the indicators so we would need to account for a similar uplift in the stretched QOF.	We should assume that the cost going forward would be 1% higher. This would still result in a high return on investment.	Emma Sanford

9. KEY ASSUMPTIONS AND CONSTRAINTS

ASSUMPTIONS

Assumption	What happens if assumption is no longer correct	Who will monitor the assumption
For every 3 patients with AF with a CHADs 2 score of more than 2 1 stroke avoided over 3 years	Returns would be less	
For every 5 patients with hypertension under control a reduction of 1 stroke	Returns would be less	
GPs will have capacity	We would not have a cost or a return and patient care would not improve. Increasing capacity is key to making this work. See workforce skills mix business case.	

CONSTRAINTS

Constraint	What happens if the Constraint is no longer correct?	Who will monitor this Constraint?

9. DEPENDENCIES

Inbound: This project is dependent on the delivery of these projects/activities

Project/Activity	What is the dependency?	Who will monitor the dependency?

Outbound: Other projects or activities will not deliver if this project fails to deliver

Project/Activity	What is the dependency?	Who will monitor the dependency?
Hypertension detection	Ethical grounds – don't screen if you can't treat	Emma Sanford / Monica Scrobotovici
Depression screening	Ethical grounds – don't screen if you can't treat	Emma Sanford / Funmi Worrell
Health Checks	Ethical grounds – don't screen if you can't treat	Emma Sanford / Maria Payne/ Fiath/ Andrea

10. GOVERNANCE ARRANGEMENTS

ACO project team to determine.

11. APPENDICIES

[i] M J Harisson, M Dusheiko, M Sutton, H, Gravelle, T Doran, M Roland; Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions: controlled longitudinal study, *BMJ* 2014; 349:g6423