**General themes from ‘Dudley Quality Outcomes for Health’ review for discussion at October 2017 locality meetings**

The following themes have been captured so far from the feedback received from practices expressing an interest in being part of the review process. In addition to these themes the CCG will be undertaking a statistical analysis of the current achievement by practices as part of the re-baselining of thresholds for next financial year. This has been collated to stimulate discussion between the GP Collaborative Steering Group and wider Members at the October 2017 locality rounds.

1. **Holistic Reviews and Care Plans**

Overall, the new framework is the right approach for the majority of patients. However it has been raised that conducting a full holistic review (a face to face consultation and production of a care plan) is not necessary for certain patient groups with stable conditions (for example, stable atrial fibrillation (low risk CHADSVASC), hypertension or asthma). The CCG recognise the need to move to a more targeted approach for intervention based on clinical need but must be clearly defined what constitutes ‘stable’ clinical parameters for each condition. It is felt that telephone consultations may be used as a second line approach as a potential alternative. The CCG recognise that if an individual’s lifestyle has been assessed, their condition is controlled and they are self-managing, then a full holistic review and care plan is not necessary.

It has also been suggested that individuals who are not in a ‘stable’ category but have been invited to a face-to-face consultation and declined, should be eligible for a telephone consultation. The CCG agreed with this suggestion, but stressed that the practice must clearly report that each person has first been invited to a face-to-face appointment.

The CCG have received several suggestions of criteria that could be used to greater target the cohort called for holistic reviews – a) age limit, b) low QRisk score with just hypertension, c) for asthmatics – could be based on the number of blue inhalers a person has ordered in one year; if this is under two then a person doesn’t need a review. With the wealth information available on EMIS this could help to formulate criteria or inform decisions about who should receive a review.

Another suggestion is whether an Mjog could be used – could a text message be sent out to patients whose conditions are well controlled asking whether they want an annual review (not to those who definitely do need a review). Then patients who have well controlled asthma, for example, would only come for a review if they would like one and reduce the pressure on practices

1. **Outcome measures**

It has been suggested that the current threshold for hypertension may be ‘too tough’ and will need to be more flexible. It is noted that people come into the practice for many reasons and it is highly likely that they may have a one-off blood pressure reading that is above the threshold: if this happens to be the last reading for that year, then that is the value that would be counted for the framework. Similarly, if a patient attends a clinic appointment in February/March then the GP may really struggle to get their blood pressure reading below the target level by April 1st. The CCG recognise this is a valid remark and will take this into consideration as part of the review process.

Comments have also been received that it is particularly difficult to meet all targets with multi-morbidity patients and in these circumstances, targets should be more flexible. For example, the difficulty of meeting HbA1c targets for patients over the age of 80 suffering from hypoglycaemic comas along with other multi-morbidities.

The CCG recognise that the targets need reviewing for multi-morbidity patients and that individualised targets need to be developed in these circumstances. However, the question of how best to define “multi-morbidity” for the purpose of this framework will need addressing.

Comments received suggest GPs are delivering care processes just to meet a target, even if they are not clinically necessary. The CCG do not want to encourage a culture of unnecessary exception reporting to meet targets and therefore indicators requiring multiple clinical parameters may need to be reviewed.

General comments have been received regardingthe move towards an outcomes based contract when a number of indicators are still around processes which need to be undertaken. The CCG recognise the current structure is a combination of both however feel this may be addressed through the financial weighting which will need to be applied to individual indicators.

1. **Maximum tolerated dosage for medications**

Currently all indicators requiring patients on maximum tolerated dosage check box is listed on both the condition specific section as well as the medication review page which is causing confusion at a practice level. Also practice nurses may not currently feel comfortable stating that a patient is optimised which may be the reason why there is generally low performance against these indicators. The CCG will need to look at a more efficient way of collecting this data or remove the need for maximum tolerate therapy.

The value of having boxes to check about medication optimisation and maximum tolerated dose was discussed. It is important medically and was raised by the medical management team initially as many patients were on different dosages of medicines when there is a dosage that all patients should be receiving regardless of age.

It has been suggested that perhaps a better way of managing the medication optimisation questions was to have reminder pop up boxes. For example, when someone is completing a HF review – a box could pop up saying ‘please ensure you have optimised the patient’s medicine’. Or alternatively, if the patient is not on the maximum dosage, the pop up box could highlight what this is.

1. **Mental health indicators**

Practices have raised concerns about the mental health indicator was appropriate and sufficient to meet the needs of CQC. It has been questioned whether QRisk2 is valid for patients of certain ages e.g. under 30, and following a recent CQC inspection and had struggled to demonstrate the number of mental health reviews that had been completed without having a clear code valid for all patients on mental health register. The CCG recognise that is a valid point and suggested that potentially another indicator specifically around mental health review more generally could be introduced and have QRisk2 as a subset indicator.

As the MCP develops the opportunities for undertaking a more joined up approach (primary and secondary care) to mental health reviews increasing the accessibility in the community and able to provide practices with support for mental health.

1. **Care home indicators**

There has been particular scrutiny regarding the care home indicators as to whether implementation has negatively impacted on the level of service provision which was undertaking as part of the Care Home LIS. The CCG recognises that this needs careful deliberation to whether CAREHOM2 in particular needs to be surrendered to look at an alternative way for delivery.

1. **Template**

There have been numerous suggestions for updating the template in the future. All recommendations will be carefully considered by the CCG as reasonable requests without further impacting on workload. One of the main limitations has been the technical capabilities within EMIS itself, which we are hoping to be rectified within the next release with an updated template release planned for next financial year. The CCG are currently exploring ways in which some of the information (specifically around the generic section) may be able to be pre-captured prior to the patient attending the appointment therefore reducing the consultation time in the future.

The dementia and LD sections of the template in particular need further detail adding.

1. **Further training**

In line with previous evaluations of the framework it has been suggested that nursing staff may need more training to support them to deliver care for multi-morbidities due to the previous condition specific focus driven by QoF.

In addition it has been recommended that all HCAs need motivational interview training/coaching which would be helpful when persuading patients to go on courses and change their behaviour – this training could help HCAs to support patients to find their motivator for change.

The CCG would support any further workforce training requirements, which can be further explored by undertaking another training needs analysis with the nursing workforce over the next couple of months.

1. **Other General comments**

The CCG have received specific comments around many of the individual indicators which will be considered as part of the review process.

A number of GP’s have questioned why there isn’t another heart failure indicator around the use of echocardiography to confirm diagnosis.

As there is a move towards replacing the 2% high risk register to focus more on frailty, the CCG will incorporate this into the existing template to make it easier for HCPs to review everything together as part of the annual holistic review process.