Community Frailty Pathway 2018-19
Primary care Quality Premium

Scheme 4 – GP Follow up post Jean Bishop Integrated Care Centre assessment

Live scheme: 25 June 2018 – 26 April 2018

GP MDT care plan review: £23

Practices will invoice the CCG quarterly providing evidence of the number of follow ups completed using Strategic ID and the identified code against the patient's record.

Overarching aim:

To continue to support those patients who live in their own home and have received a Comprehensive Geriatric Assessment at the Jean Bishop Integrated Care Centre.

4 Community Frailty Pathway – Jean Bishop Integrated Care Centre

ACTION

1. GPs are requested to "Follow up" on the plan of every patient post Comprehensive Geriatric Assessment in the Jean Bishop ICC once instigated actions are completed (within an agreed timescale which is expected to be once during the scheme period).
2. The Follow up MDT should be undertaken as part of a structured process involving the non-clinical Care Coordinator, who will progress and chase actions and, assist in organising the meeting and involve the Clinical Care Coordinator. This should take no longer than 20 minutes as the comprehensive plan will already be in place and could be undertaken by a practice nurse in conjunction with the Care Coordinator.
3. The Clinical Care Coordinator will maintain an oversight of the patient on an ongoing basis.
4. Following this, we will require the patient's GP to periodically review the care plan with the opportunity to feed back into the ICC for advice/input, further guidance will be provided.
5. The practice will ensure the clinical system is updated with the appropriate READ/SNOMED code to allow clinicians to understand any change in the patient's condition.

NOTE - Initially the ICC will see 5 patients a day and progress to 10 in the first year. Based on 3,000 patients the cost will be approximately £69,000 (5 %+/-). There may however be instances where patients need more than one review; the scheme will only be over 10 months initially see above. There will be a separate cost for any care home reviews but potentially only 8 homes in 2018-19.

Template example:

Practice: xxxx	**Period Q1**	**Period Q2**	**Period**	**Period Q4**	**Outcomes**		
					Review details – no change	Plan updated	Consultant input refer back to ICC
Patient 1							
Patient 2							