NHS
Hull
Clinical Commissioning Group

Appendix 1

Community Frailty Programme
Primary Care Quality Premium

EXTENSION: Scheme 4 - Primary Care Follow-up Assessment post Comprehensive Geriatric Assessment at the Jean Bishop Integrated Care Centre

Scheme: 01st October 2019 to 31st March 2020

Overarching aim:

During 2018/2019 practices referred over 2500 patients who were proactively identified as being at risk of severe frailty into the Jean Bishop Integrated Care Centre (ICC) to receive a Comprehensive Geriatric Assessment (CGA) by a consultant-led Multi-disciplinary Team.

It has been recognised that post-CGA there is significant benefit to the patient being followed-up in the primary care setting. This continued support to the patient delivers sustainability of the clinical model that has been redesigned to ensure that patients receive an improved quality of care that is pro-active rather than re-active and ultimately reduces unnecessary attendances to hospital and GP call-outs, as well as provides a joined-up, integrated care plan for patients and their carers.

Benefits of primary care follow-up identified include:

- Providing the opportunity to monitor impacts of medications reviews
- Ensuring onward referrals have been processed and, in some cases supporting the patients and their carers following the intervention from social care and Carers Support as part of the CGA through a multi-disciplinary approach
- Ensuring that care plans are reviewed
- Enhanced patient experience

1

ACTION

- GPs/practice ACPs are requested to “Follow up” on the care plan of every patient post Comprehensive Geriatric Assessment undertaken in the Jean Bishop ICC by way of a virtual review (i.e. the review does not have to be patient facing).

- The lead clinician does not have to be a GP but must be able to make clinical decisions and make changes to medications, as required.

- The review should be undertaken approximately 3 months post Comprehensive Geriatric Assessment at the ICC.

- The practice will ensure that the patients care plan is updated with outcomes from the virtual review

- The practice will read code that a review has been undertaken - suggested code: Review of care programme approach care plan **XaJQo**

- Following this, practices will periodically review the care plan with the opportunity to feed back into the ICC for advice/input, via the ICC MDT Coordinators.

- ICC Telephone Number 01482 450101

A proposed methodology for undertaking the reviews is embedded here:

Primary Care Review Operating Model_192

Instruction referred to in Draft operating model (for completion by practice admin) is embedded here:

Accessing the ICC GP follow up template

Data collection

The following data will be collected via email submission

- Strategic ID of Patient
- Date of CGA
- Date of Virtual Review
- Name of Lead Clinician
- Outcomes – Managed by GP
- Outcomes – Referral to Community Service/s
- Outcomes – Social Care Review
- Outcomes – Referral back to ICC

- Practices will complete the embedded data capture form to provide evidence/backing data of virtual reviews undertaken

Claim summary_ICC FollowUp_1920.xlsx

Please note that the primary care reviews are for patients assessed at the ICC and exclude those who have received a CGA who reside in a care homes, as these patients will be reviewed under a different model.

Invoices should be submitted with supporting backing data to: HullCCG.Contracts@nhs.net on a quarterly basis, by 5th January 2020 and by 5th April 2020.