SUPPORT TOOLS PROACTIVE CARE: PRACTICE BASED SERVICE

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CEG SUPPORT TOOLS

- Protocol
- Searches
- Template

✓Eligible search for eFI

✓Protocol (eFI)

✓Eligible search for proactive care (eFI)

✓Template to record Frailty

✓Proactive Care Register search

ELECTRONIC FRAILTY INDEX SCORE

One of the appropriate tools to identify patients with frailty is the eFI tool.

This is the tool for both GP contractual agreement as well the local enhanced service.

The difference is that the CCG have asked practices to focus using this tool for their over 75 patients.

EFI CALCULATOR PROTOCOL

eFI calculator protocol

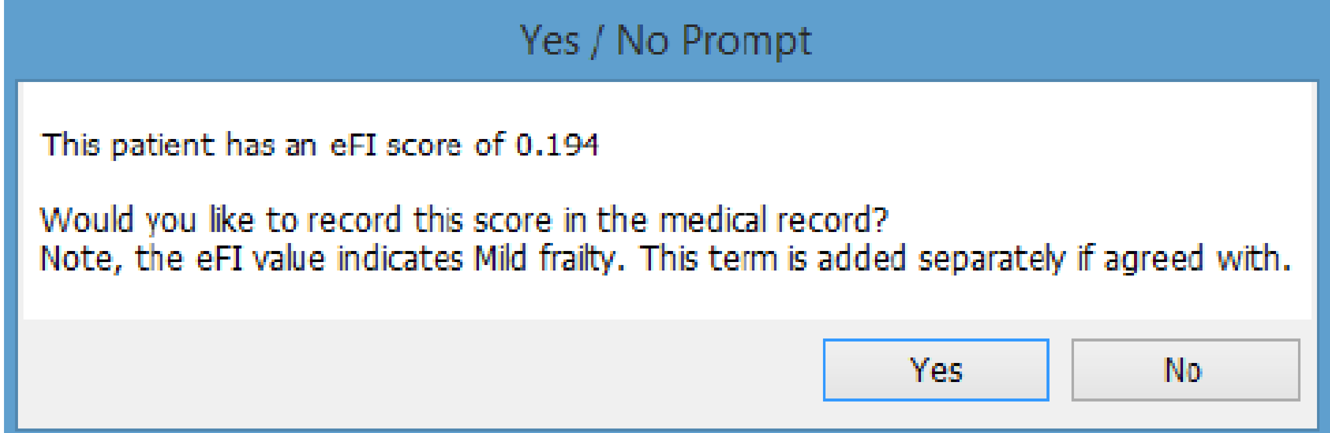
- Uses the EMIS Calculation
- Deactivate EMIS protocol

Name

eFI - Automatically add or update eFI score plus launch - CEG Modified

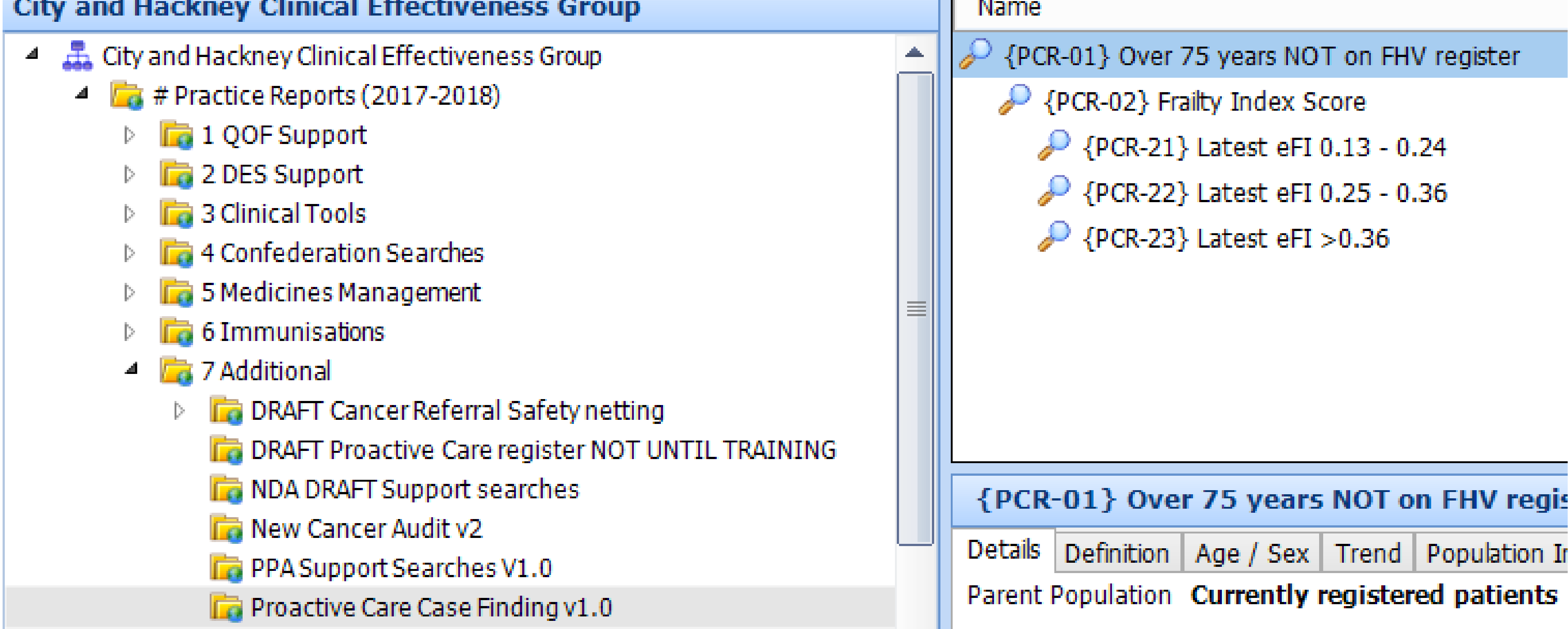
eFI - Prompt to add or update eFI score - CEG CH

eFI deficits detail CEG alert



EFI SEARCHES

eFI searches of eligible population

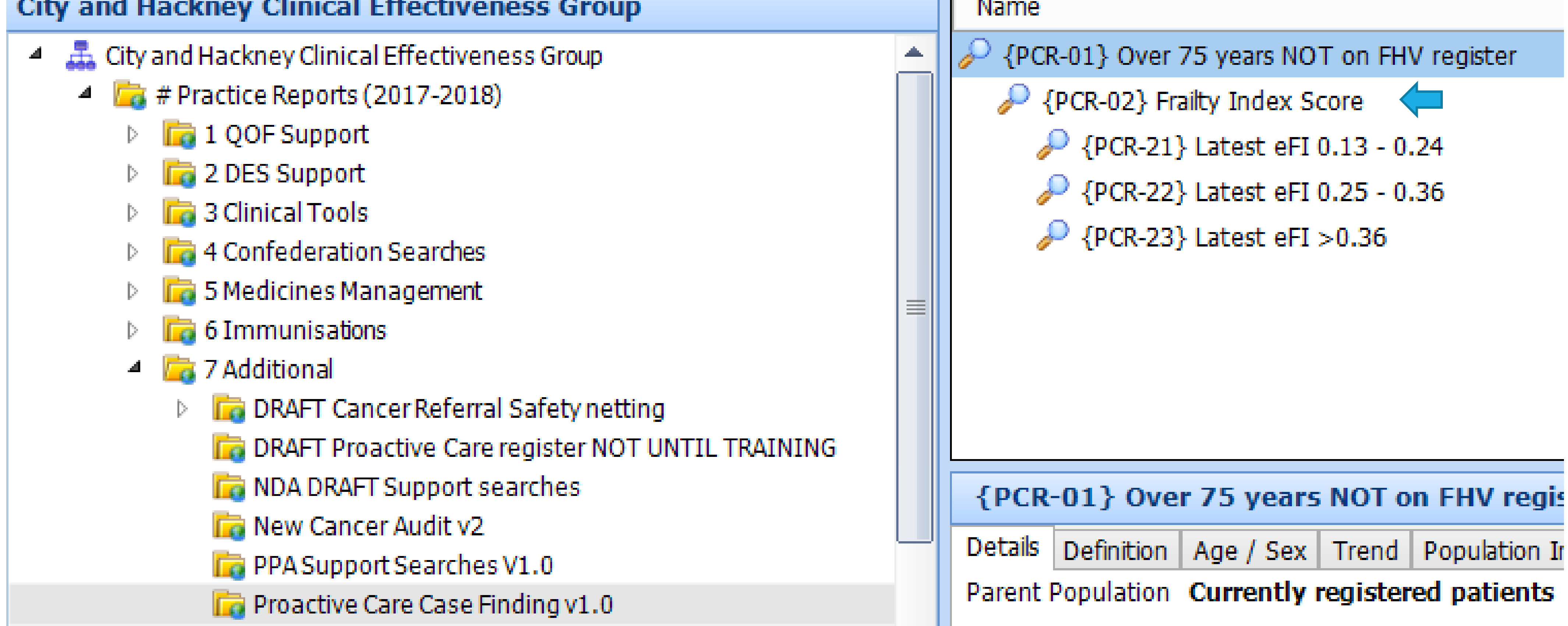


WHERE ARE WE NOW?

Name	Population Count	%	Last Run
{PCR-01} Over 75 years NOT on FHV register	7030	2%	11-Jan-2018
{PCR-02} Frailty Index Score	2457	35%	11-Jan-2018
{PCR-21} Latest eFI 0.13 - 0.24	694	28%	11-Jan-2018
{PCR-22} Latest eFI 0.25 - 0.36	1037	42%	11-Jan-2018
{PCR-23} Latest eFI >0.36	726	30%	11-Jan-2018

EFI SEARCHES

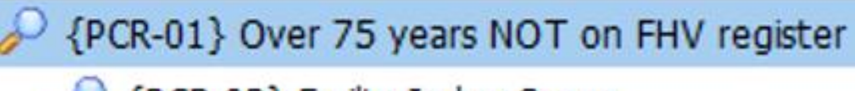
eFI searches of eligible population



REVIEW PATIENTS FRAILTY

Nominal Moderate Frailty

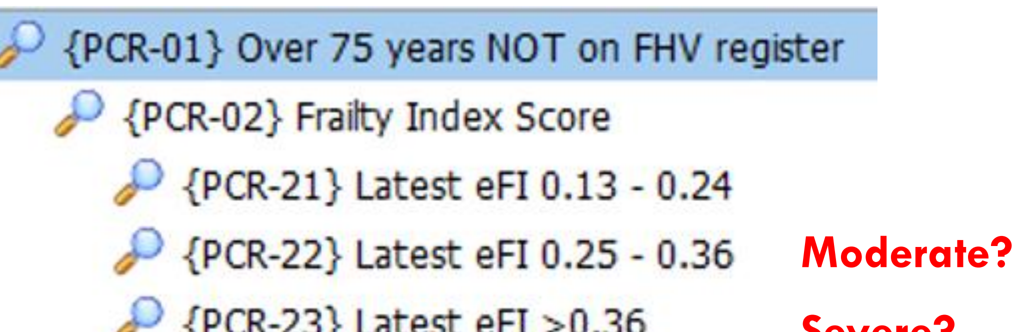
Nominal Severe Frailty



REVIEW PATIENTS FRAILTY

Nominal Medium Frailty

Nominal Severe Frailty



Moderate?

Severe?

FRAILTY PAGE IN LTC REVIEW TEMPLATE

Template Runner

Pages «

- Main Page
- Lab Results
- Depression
- Frailty

eFI

The electronic Frailty Index is derived from a range of 36 deficits.
Higher scores indicate increasing frailty.
The score is calculated from existing local (not shared) electronic health care record data.
Click **calculate** to record the score:

eFI Score [ ] Calculate 01-Dec-2017 **0.222**

eFI ranges	Notes
Mild frailty - eFI score **>0.12** and **≤0.24**	At risk of decompensation if concurrent illness
Moderate frailty - eFI score **>0.24** and **≤0.36** Severe frailty - eFI score **>0.36**	Higher scores indicate increasing frailty and vulnerability that may require early support and intervention

Further informaton
NHS England - Toolkit for supporting older people
Bristish Geriatric Society - Fit for Frailty

The eFI score is reproduced by permission of University of Leeds.
This product was developed by University of Leeds in collaboration with The Phoenix Partnership (TPP) using the ResearchOne database.

Mild/moderate/severe frailty [ ] No previous entry

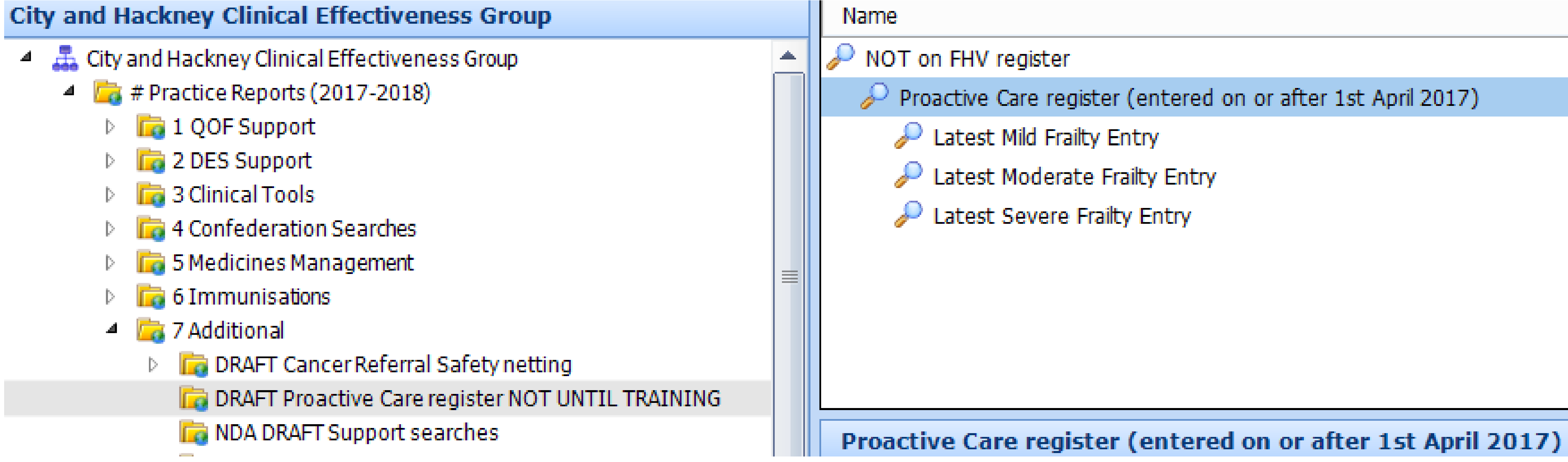
☐ Medication review 21-Sep-2016

MODERATE / SEVERE FRAILTY

Add to Proactive Care Register: Practice based (8CZ0)

PROACTIVE CARE REGISTER

Proactive Care searches



PROACTIVE CARE TEMPLATE

SMITH, John (Mr)

Born **01-Jan-1940 (78y)** Gender **Male**
NHS No. **Unknown**

Template Runner

Pages «

- Housebound - Proactive Care
- e Frailty Index
- QAdmissions Page
- Proactive Care -Practice based
- Carer's Details
- Social Prescribing
- Depression/Anxiety Screening
- Dementia Screening/Assessment

Proactive Care register

Practice based Proactive Care Service

The aim of the service is to provide more personalised support to patients most at risk of unplanned admission, readmission, and A&E attendances to help them better manage their health. In order to achieve this, under this service practices will be required to;
Identify patients who are at high risk of avoidable unplanned admissions (and who do not meet the threshold for FHV) and proactively case manage these patients.

Create a register using teh eFI score and the CSU's Stratification tool.

Add these patients to the Proactive Care register using the following prompt:

- [ ] Provision of proactive care — No previous entry
- [ ] Proactive care ended — No previous entry

Care planning - CMC

Each patient in the Proactice care register to undertake a minimum of 2 face to face appointments per annum with each patient on the register. Review the care plan at each appointment. The appointment can take place wherever is most appropriate.

Care planning should include holistic care needs, taking into account social factors as well as clinical (eg. the GP Practice should link with Connect Hackney and the work on social isolation where applicable)

Record Care plan done on CMC and Reviewed in the year. If a CMC care plan already exists, review this twice in the year.

Connect Hackney

- [ ] **Coordinated support plan — No previous entry
- [ ] **Review of admission avoidance care plan — No previous entry
- [ ] **Admission avoidance care plan declined — No previous entry

Social Prescribing (see also Social Prescribing Page)

Provide practical and emotional support to individuals, couples and families who are frequently presenting to A&E or have presented with psychosocial or low to moderate mental health difficulties.
Refer to A&E Well Family Service, using the form available:
Social Prescribing Referral Form CH CEG.

AE Well Family Service web link

Named Accountable GP

A named accountable GP will have overall accountability, and will be responsible for ensuring that the creation of the care plan and review of the care plan takes place, and the appointment of a care co-ordinator if different to the named accountable GP

- [ ] Informing patient of named accountable general practitioner — *Text* Named GP is: — No previous entry
- [ ] Care co-ordinator — *Text* Name & role — No previous entry

New Section 4

- [ ] Multidisciplinary review — No previous entry

Cancel

HOW DOES THIS FIT WITH GP CONTRACT – ROUTINE FRAILTY IDENTIFICATION AND FRAILTY CARE 2017/18

From July 2017 practices have a contractual agreement to use an appropriate evidence based tool e.g. eFI to identify patients over the age of 65 who may be living with moderate or severe frailty.

For those confirmed though clinical judgement with severe frailty practices are expected to:

- Do a clinical review providing an annual medication review
- Where clinically appropriate discuss if patient has fallen in last 12m
- If patient does not already have an enriched Summary Care Record the practice will promote this seeking informed patient consent to activate (EMIS User Winter 2017 issue 81)
- THERE IS NO TARGET LEVEL FOR PAYMENT

HOW IS CEG SUPPORTING THE NHS E FRAILTY CONTRACT?

CEG Protocol:

Adds eFI score is for patients aged 65 yrs and over

CEG Template:

The LTC CEG template contains a Frailty page

Searches:

Eligible population searches of patients with nominally Severe Frailty and those coded with Severe Frailty

SUMMARY

Import and trigger the CEG protocol

Use the CEG 75 years search to:

- Identify target/eligible patients for eFI score

The protocol activates when loading a patient record

- Add eFI Score to all patients in 75y+ list

Use the Moderate/Severe frailty CEG searches to:

- Review patients Frailty and code moderate or severe
- Code Proactive Care (Register)

ANY QUESTIONS?

RSS Feeds:

Presentation

FactFile9, see GPC bulletin link
http://www.cityandhackneygpconfederation.org.uk/cm-uploads/hac01/ckfinder/files/FactFile%209%20eFI%20score.pdf