**CONTINUITY OF CARE COHORTS**

One Care will provide EMIS searches

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|  | **Cohort** | **Comments** | **Suggestions / Feedback** |
|  | Requiring palliative care | No current proposal - end of life register not suitable | HK - I would say continuity desirable although many cases are managed largely by palliative care/DN teams. Need for continuity perhaps more of a holistic thing than clinical need... I would feel bad as a GP subjecting a palliative care patient to poor continuity! JL - Patients coded as palliative care – should be reasonably well documented, or practices could quite quickly start using this code if they wanted to focus on this group  NM - we code palliative care or you could use one of the codes on the EOL template  DR - Should already have care package |
|  |  |  | Summary:  May not be appropriate for a cohort list. If chosen, will need specific work with each practice to identify the cohort |
|  | Frail with co-morbidities | Suggest we use the electronic frailty index (eFI) but need feedback on a suitable score ie how many deficits out of 36 | HK - Is there evidence to guide a score threshold? I don’t have too much knowledge around eFI and how it correlates to real life outcomes but in my experience, patients can often have quite high score but are still quite independent and happy with less continuity. That is not to say they wouldn’t benefit from continuity of course but I suspect the converse is also true- it only takes a single deficit to be severe to render a patient extremely vulnerable and in high need of continuity.  RB - Not sure what definition of frail as it’s so vague. You might just say multi-morbidity and leave out the word frail (it has quite a judgemental feel although with the whole “frailty agenda I guess it’s here to stay for a while  JL - eFI 0.25-0.36 and eFI >0.36 and Rockwood Score 7-9 Severe Frailty  these would be the starting points – practice can decide whether they want severe, or mod and severe  NM - possibly home visiting consultations  DR - 0.36 = X6 risk admissions - not sure numbers this might create |
|  |  |  | Summary:  eFI 0.25-0.36  Rockwood 6 Moderate Frailty or Rockwood Score 7-9 Severe Frailty  Then check numbers created |
|  | Frequent attenders | National average is 6 appointments a year so suggest use 7 and over | HK - Seems about right though in certain groups, particularly young children, there may be a high proportion of those who hit 7 appts/year with minor illnesses that often don’t need continuity. This group in particular (i.e. young families) tend to value access & convenience over continuity.  RB - This is a can of worms. Might be worth having a look at the 10 high impact modules from productive general practice. High users will be people having dressings or methadone…. need to exclude these. Then need to decide whether you go for the very high users or mid-range.  JL - Top certain %? It will depend on actual numbers of patients.  I would guess those that are coming once per month  so 12 / year  Need to set at a level where it is a manageable population size and is going to give the most value – this may be variable for each practice.  Will need to define is this GP appts, + nurse/HCA appointments or just GP,  NM - We recently looked at freqt attenders 10-20 GP consults/yr (122) 20-25 (33) >25 consults (6)  Similarly, for nursing appts >25 (less useful). Population 15900. I would go for >10  DR - Difficult with comorbidities / chronic disease clinics - but I would suggest 12 ie 1x month - again not sure what numbers this might generate |
|  |  |  | Summary:  Over 10 or over 12. GP appointments only |
|  | Poly-pharmacy | Historically 5 items or more has been used, but this seems quite low | HK - Agree, very low! I am not sure this should be used as an independent parameter. If there is Polypharmacy, they are likely to already fulfil other criteria and if not, they probably don’t need continuity?  RB - I would start with 10 as every diabetic will have 5 or more items  JL - Agree 5 Is too low – start with 10+ current issued items excluding certain dressings and appliances  NM - I would go for > 8 or even 10  DR - A pragmatic approach to identifying higher-risk polypharmacy in practice is to focus on patients at particularly high risk: for example, those receiving 10 or more regular medicines, or those receiving 4 to 9 regular medicines together with other unfavourable factors (examples include: a contraindicated drug; where there is potential for drug–drug interaction; or where medicine taking has proved a problem in the past).  <https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/polypharmacy-and-medicines-optimisation-kingsfund-nov13.pdf> |
|  |  |  | Summary:  Over 10 items |
|  | Oldest 10% of practice population | Straight-forward | RB - Not sure what this would achieve as some elderly very fit and resilient. I’m not sure this is a good rationale for prioritising or focusing care  JL - Age in itself isn’t probably the right discriminator – frailty does this better.  NM - good marker (not in a care home?) |
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|  |  |  | Summary:  Easy to calculate – practice choice whether to use |