Frailty Best Practice Conference

NHS
Central East
Integrated Care Board

The Bridge PCN Risk Stratification Project

The Bridge
PRIMARY CARE NETWORK

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Why Risk Stratification?

The Challenges we are addressing:

- Growing Complexity of patient need
- Variation in demand and unplanned care
- Need to proactively identify people who would benefit from coordinated support
- Alignment with PCN DES/ Proactive Care/Neighborhood working

What does it mean for us at the Bridge PCN?

Our shared definition:

- Systemic use of population health data
- Identifying patients at higher risk of deterioration, hospitalization or unmet need
- Enabling targeted, proactive, and coordinated care

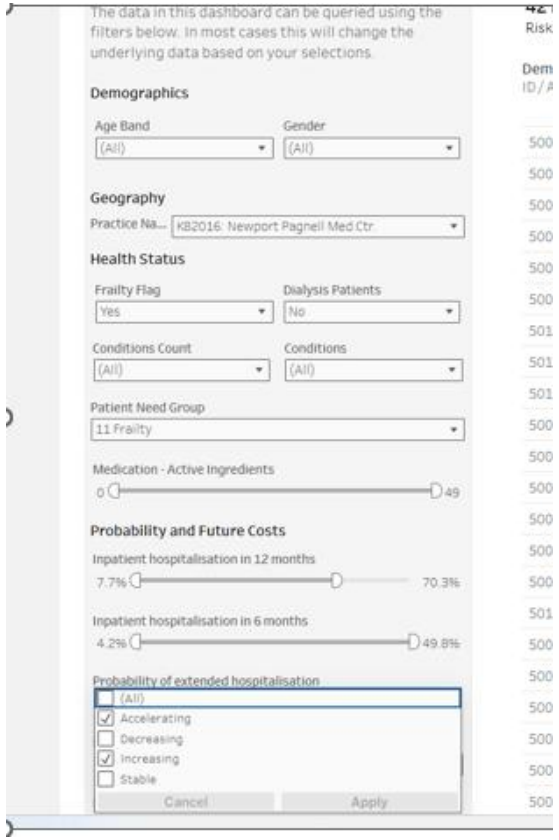
Aligns with:

- PCN DES requirements
- Proactive care and Population Health management objectives
- Development of consistent neighborhood pathways

Our Approach @Bridge PCN

How we applied the tool locally:

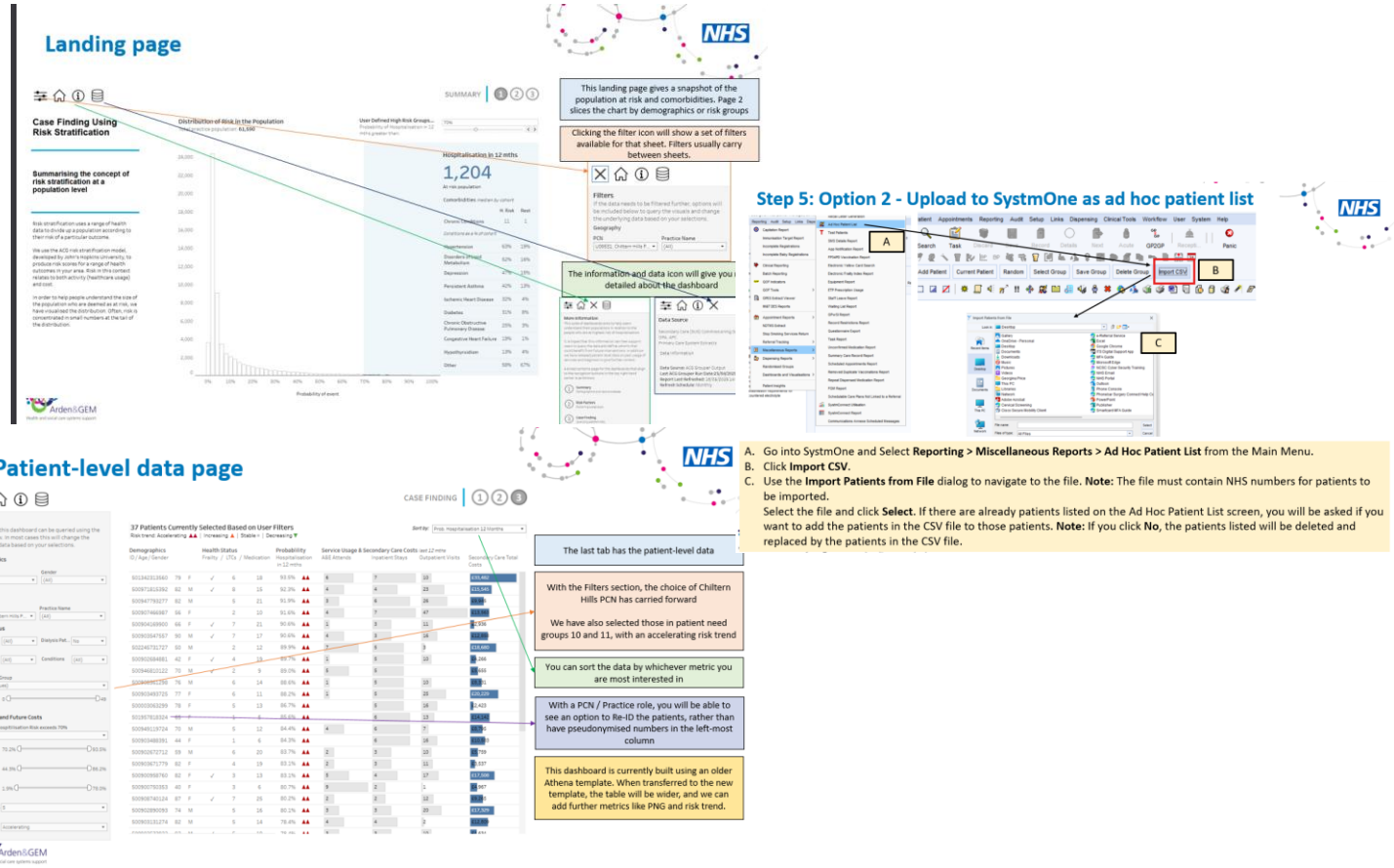
- Agreed local priority – PNG11
- Developed local SOP to have a standardized and consistent approach
- Adapted approach to fit staffing and capacity within the PCN PIT team.
- Avoided “data for data’s sake” – focused on actionable lists
- Data were reidentified on Athena, the was uploaded to SystmOne and then bulk Read Code was applied to all identified patients
- A “Risk Stratification Waiting List” was created on SystmOne to which all identified patients were added to enable ICST team review and intervention



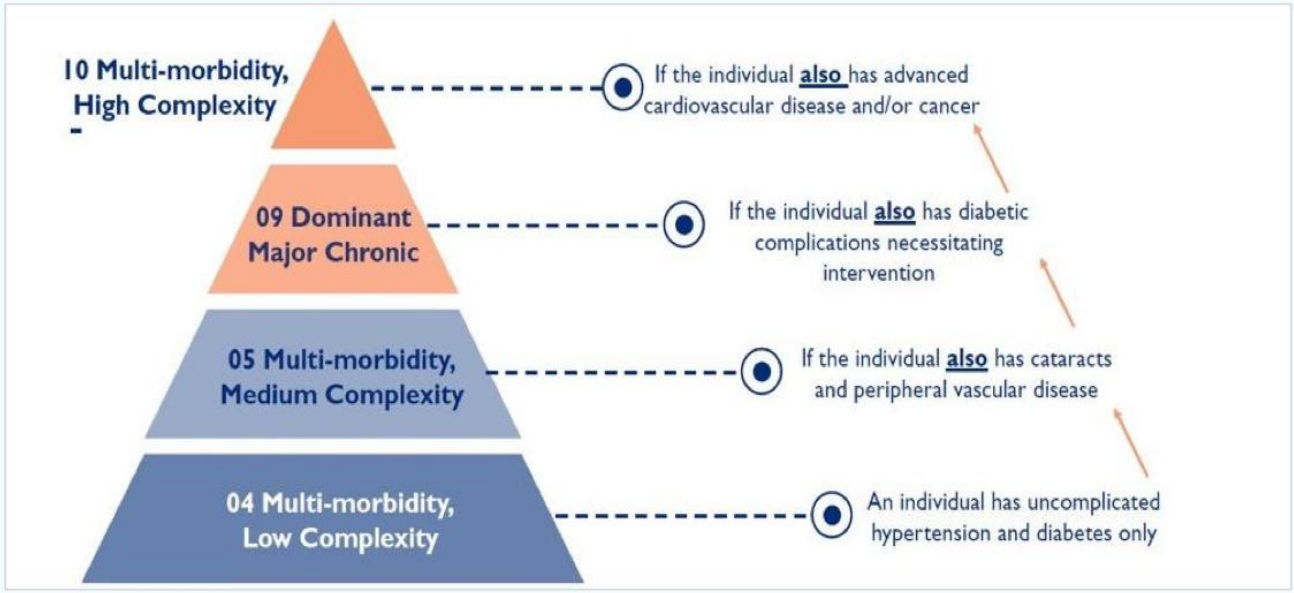
Tools and Data Used

How we identified patients:

- Athena platform to reidentify patients
- Johns Hopkins risk stratification methodology
- Risk indicators(eg: frailty, multi-morbidity, hospitalization risk)
- Data refreshed on a regular cycle



ACG System software stratifies a population by the **risk associated with their current morbidity burden + expected resource use…** The so called **"Kaiser Pyramid".**



RAG	LOW				MODERATE					HIGH	
	1	2	3	4	5	6	7	8	9	10	11
PNG	Non-User	Low Need Child	Low Need Adult	Multi-Morbidity, Low Complexity	Multi-Morbidity, Medium Complexity	Pregnancy, Low Complexity	Pregnancy, High Complexity	Dominant Psychiatric/Behavioral Condition	Dominant Major Chronic Condition	Multi-Morbidity, High Complexity	Frailty

Patient Needs Group (PNG) Segmentation Overview

Used globally for over 30 years and **calibrated for the UK population.**

Stratifies patients into clinically-relevant categories; **11 mutually exclusive and hierarchical groups, aggregated into 3 traffic light 'signals' (Red, Amber, Green)** easy to understand and apply in a clinical setting.

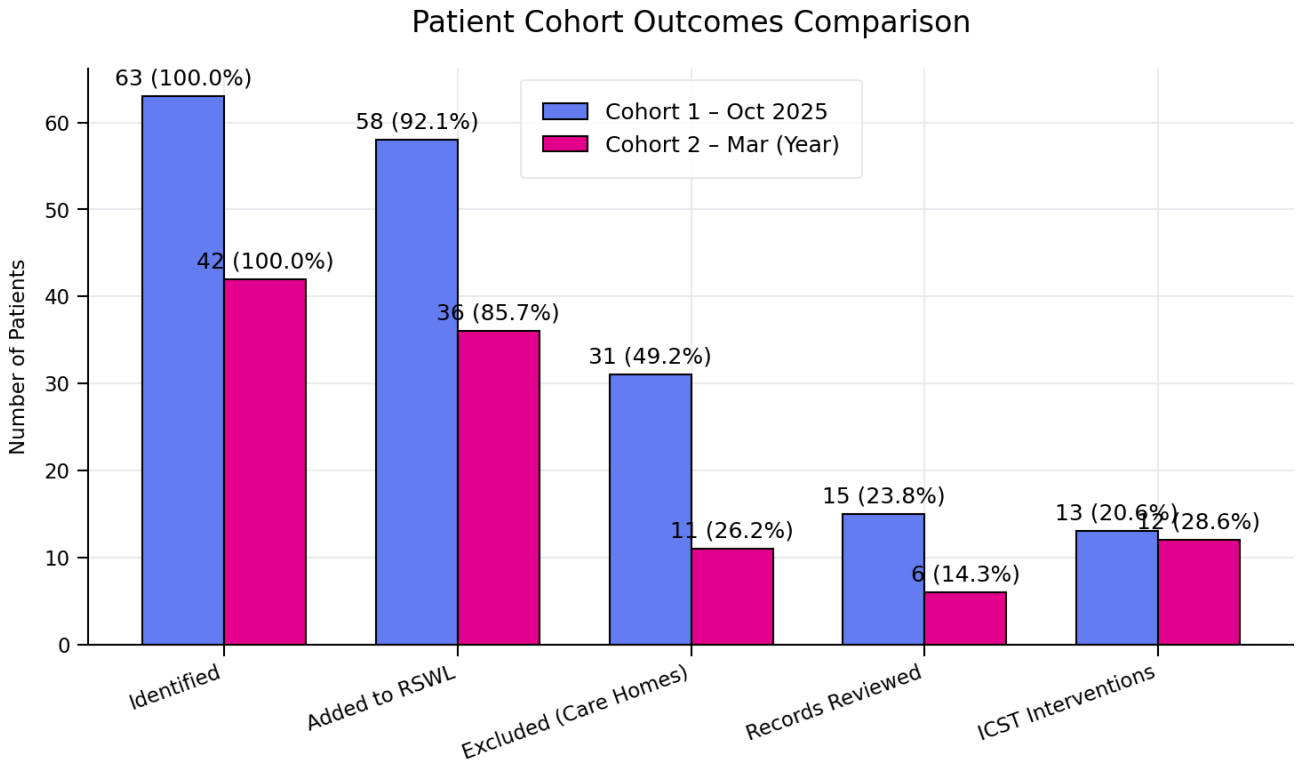
Is being used for **service development, and to define cohorts for clinical programmes targeting interventions.**

From Data to Action

What happens after identification:

- Clinical or MDT review of patients by ICST team led by Louise Rivett
- Proactive contact and care planning
- Use of existing roles - ICST team mainly and then signposting to other teams if needed like SPLW,HWBC, Social Work Assistant, OT, GPs, community matron, district nurses
- Integration with neighborhoods and proactive care pathways

Timeline & Patient Cohort



Examples of Intervention – Home Visit to review

83 year old lady with Parkinsons Disease, known to Specialist Neurology team but missed last appointment and struggling to get through to reschedule.

Recent fall causing non united fracture in shoulder – very painful, worried about falling again.

Eye sight worsening, now unable to read and watch TV causing low mood and lack of motivation.

BD private carer in place for assistance with personal care and meal preparation.

Son lives nearby and helps with shopping and appointments.

- Refer to physio for a domiciliary visit to assess shoulder and advise on management.
- Refer to Falls Team for assessment of safety walking along landing and falls prevention.
- Report low BP to GP, fluids encouraged
- Suggest son checks status of eye clinic appointment & check if due follow up for Parkinsons Disease with Neuro Team
- Refer to Social Prescriber for support with sensory loss , auditory and sight.
- Advice on optimal use of pain medication
- Add to ICST caseload and review in a few weeks

Examples of Intervention – Home Visit to review

85 year old lady with Alzheimers disease & polymyalgia rheumatica.

Checked Abtrace, diabetes and blood pressure reviews, Covid and Flu vaccinations all overdue. Has been struggling to get to surgery as housebound now.

Pain generally poorly controlled despite good concordance with pain medication.

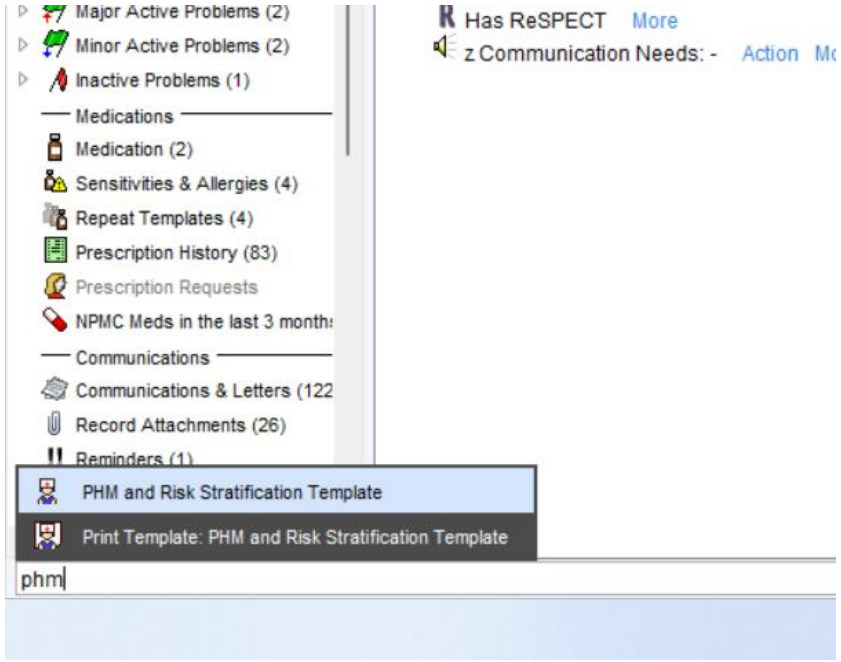
BD care in place. Husband also supporting.

Unable to do own BP measurements.

- Register as housebound.
- Request pain medication review.
- Refer to DN for LTC review, bloods, BP check and Covid/Flu vaccinations.
- Refer to ICST SWA for carer conversation for husband and signpost to carer support.

PHM Risk Stratification Template

- Use for ease and streamlining of documenting the review.
- Personalised Care & Support Plan (PCSP) gives access to required templates for holistic assessment.
- Can use Frailty ‘5M’s’ for PNG 11 cohort as alternative (can be found within the PCSP) .
- Complete the questionnaire on the management tab to ensure episode is captured for future reporting.



What were the outcomes?

- Seamless assessments, using existing templates so a risk stratification review is no different from every other ‘holistic’ review that we do.

- A few additional assessments but general feeling is that these patients would be coming onto our caseloads further down the line, so getting to them earlier.

- Hard to quantify the benefits of the reviews, but anecdotal evidence supports:
  - Reducing falls with identification of low BP, declining mobility and lack of appropriate equipment in homes.
  - Proactive addressing of low mood, lack of motivation to seek health related help and maintain independence.
  - Earlier identification of carers in need of support, preventing carer crisis and hospital admissions as a result of carer breakdown.
  - Earlier identification of care and support needs not currently being addressed.

Patient Feedback

- Feedback from patients has been positive, some have declined a home visit but all happy to have been contacted.
    - ‘I’m glad you contacted me as been trying to manage by myself and didn’t know the support was available’.
    - ‘Better late than never!’
    - ‘I’ve been struggling to support my wife with her care needs and it is good to know about support for carers out there’.

Challenges, Mitigation & Key Takeaways

What we have learned:

- Data volume - required prioritisation
- Manual process in place for project mapping and documentation
- Importance of clear local SOPs

Key Takeaways:

- Risk stratification gives us a systemic, equitable starting point
- The real value comes from what we do after the data
- Sound foundation for proactive, neighbourhood-based care

Next Steps

Where we are heading:

- Continue working with frailty group using risk stratification tool
- Embed into routine workflow, MDTs – not a one-off project
- Continue evaluation and learning
- Strengthen links to neighbourhood pathways