Working together for better health and care

NHS Thurrock Clinical Commissioning Group

Health and Wellbeing Strategy

Action Plan 4B: Care will be organised around the individual

Vision Statement: The Health and care experience of the people of Thurrock will be improved as a result of our working effectively together.

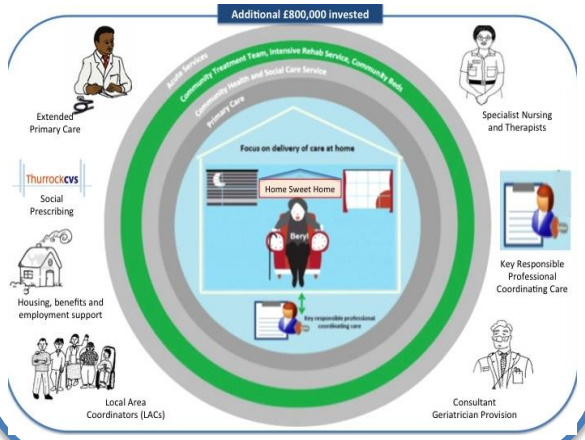
For Thurrock in Thurrock Transformation – Recap

Public Engagement

For Thurrock in Thurrock

- 4 localities + TCH Regen.

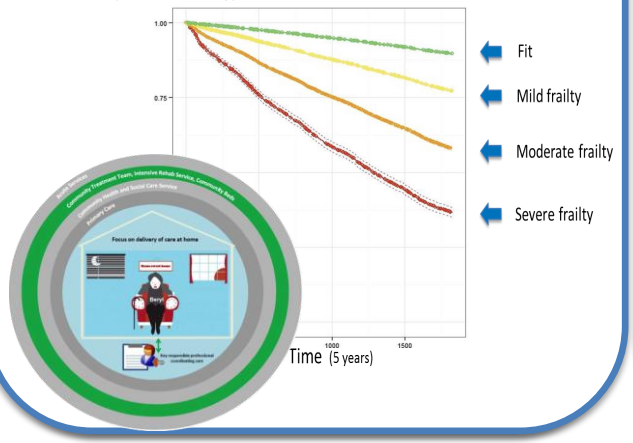
Wrapping services around our localities



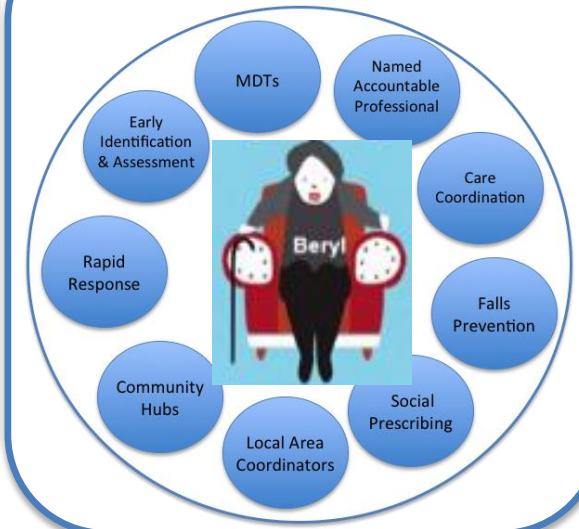
Using Risk Stratification

Supporting people like Beryl

Primary Care Electronic Frailty Index (eFI):
Survival Plots *(n=227,648; >65y)*



Enhanced Integrated Care



New Care Paradigm

TODAY	TOMORROW
'The Frail Elderly' (i.e. a label)	"An older person living with frailty" (i.e. a long-term condition)
Presentation late & in crisis (e.g. delirium, falls, immobility)	Timely identification for preventative, proactive care by supported self-management & personalised care planning
Hospital-based: episodic, disruptive & disjointed	Community-based: person-centred & co-ordinated (Health + Social + Voluntary + Mental Health)

Case Finding and Risk Stratification - NHS England Definitions

- **Case finding** is a systematic or opportunistic process that identifies individuals (e.g. people with COPD) from a larger population for a specific purpose for example, ‘Flu vaccination

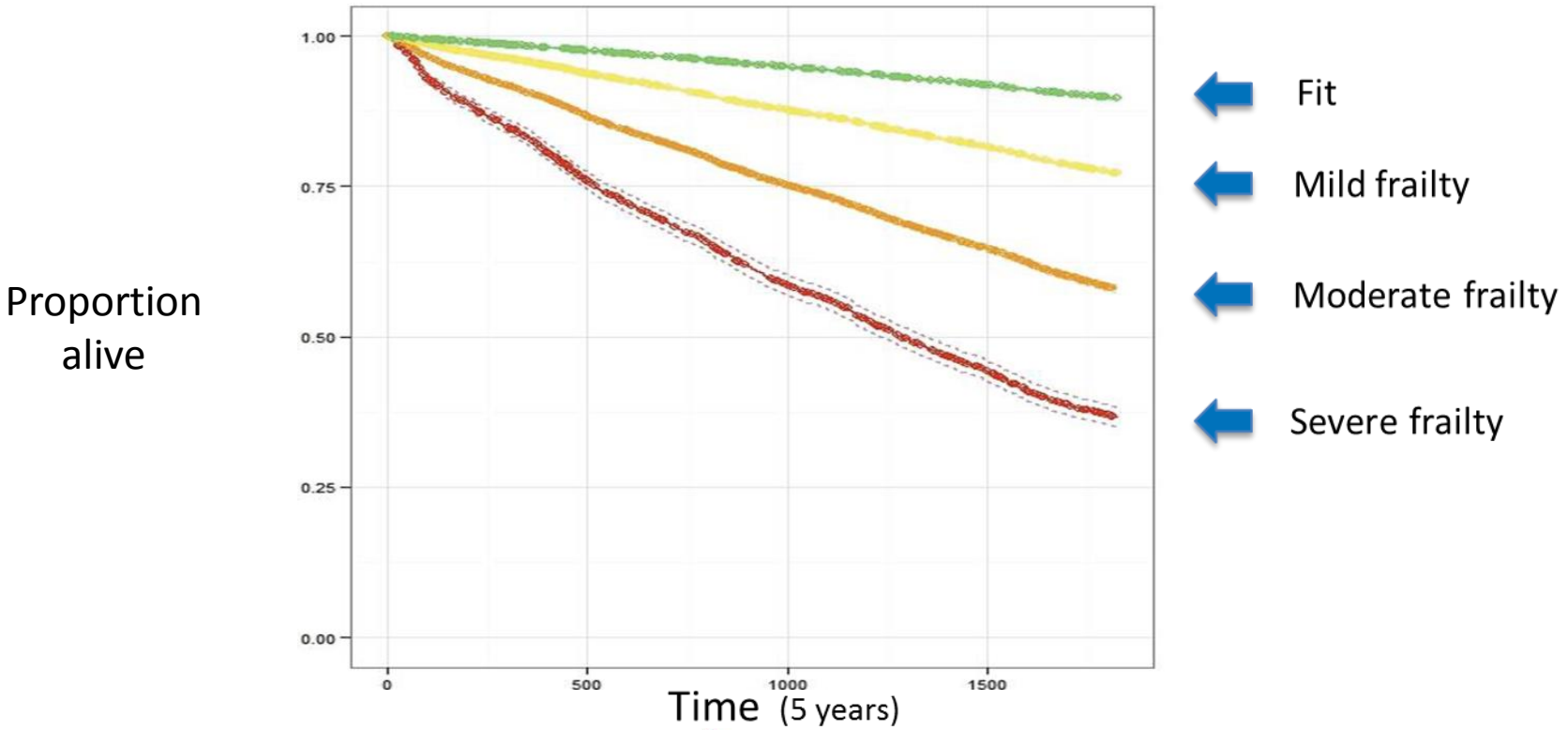
- **Risk stratification** is a systematic process that can be used for commissioning as it divides a population into different bands of risk for a specified outcome, e.g. unscheduled admission to hospital

- These concepts combine in **risk stratification for case finding,** which is a systematic process to identify sectors of the population that may benefit from additional clinical intervention, as directed by a lead clinician such as the patient’s GP.

Understanding Risk Stratification

Case finding and risk stratification - *how to understand specific sectors of a population and provide person-centred care to those most in need*

Primary Care Electronic Frailty Index (eFI):
Survival Plots *(n=227,648; >65y)*



Frailty and EOL Out of Hospital Transformation: For Thurrock in Thurrock

- **Risk Stratification:** use of the Electronic Frailty Index (eFI) promoting early identification and assessment of Severe (EOL), Moderate to Mild Frailty

- **Alignment of Multi Disciplinary Teams:** to support the outcome of risk stratification, better coordinated care and escalation planning, and alignment of Named Accountable Professional dependent on need

Care and Support Planning

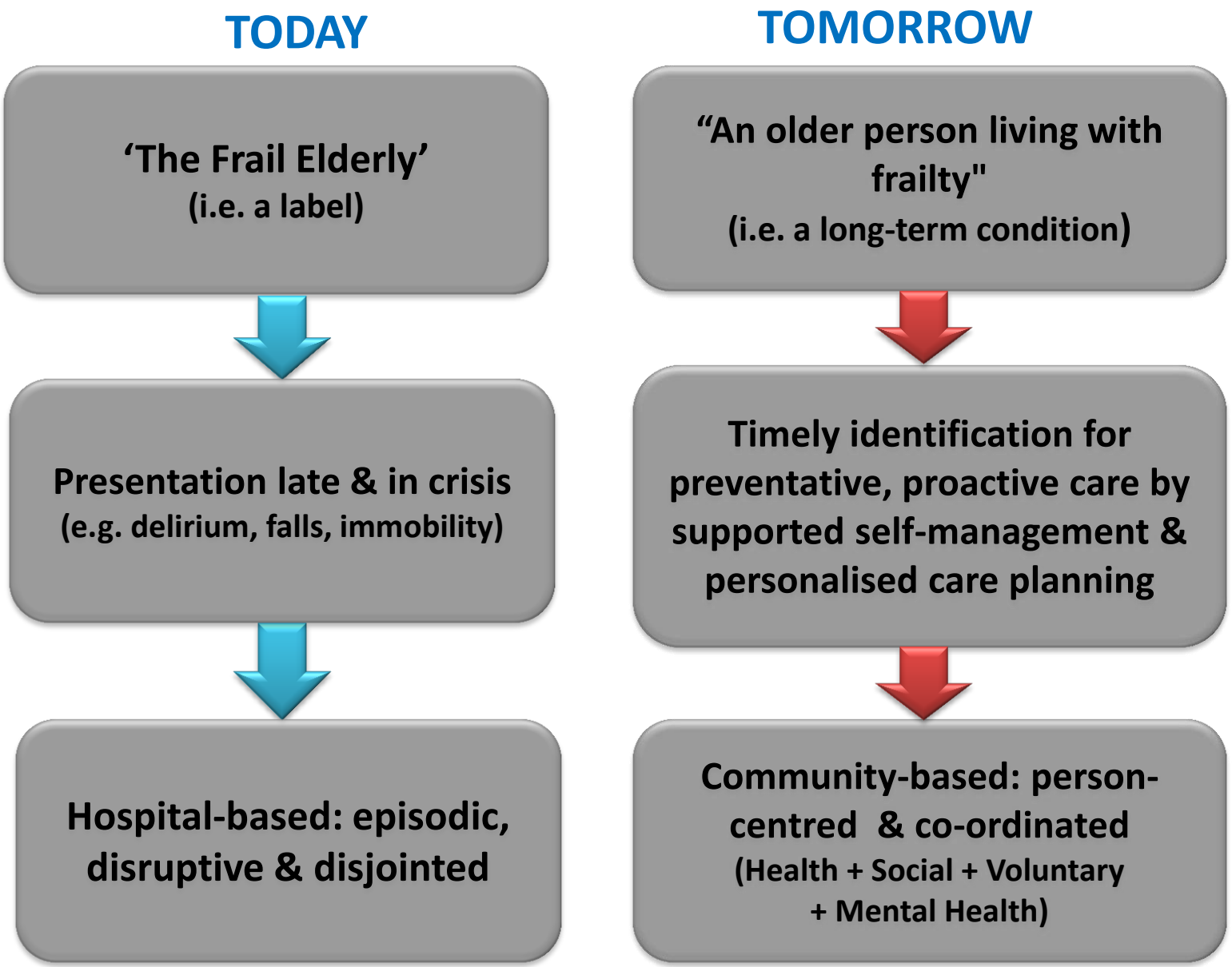
Frailty and EOL Out of Hospital Transformation: Early indications in Thurrock

Risk Stratification:

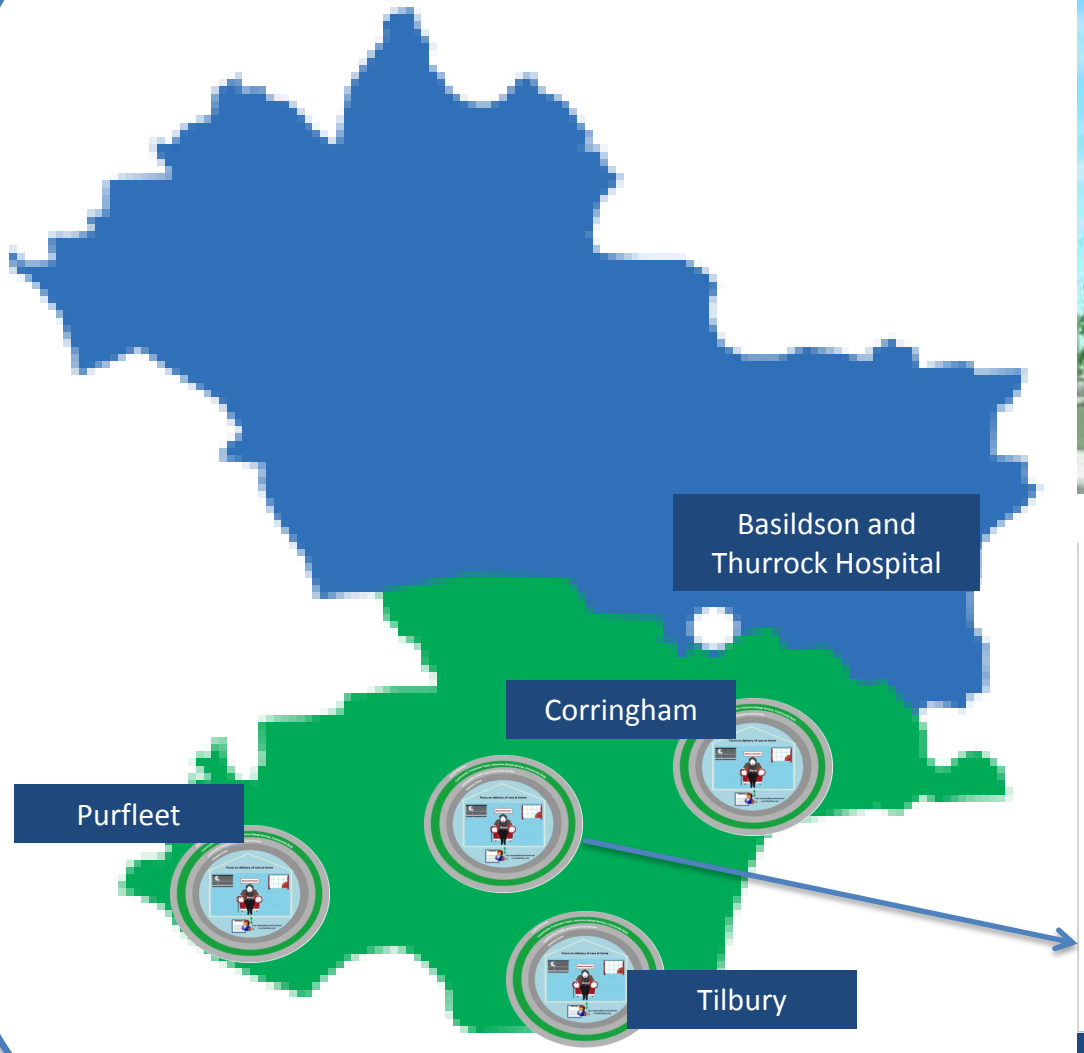
- The Electronic Frailty Index is now being used in one-third of Thurrock GP Practices to identify and assess need

- Use of the Electronic Frailty Index to identify and assess need with one Thurrock practice has highlighted that 25% of the people identified as living with frailty were not already known to the health and social care system - potential A&E attends/admits if left unidentified and unmanaged.

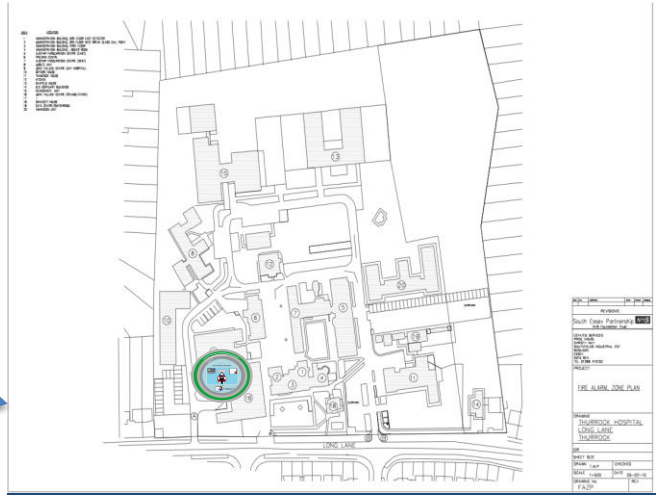
New Care Paradigm for older people and frailty



For Thurrock in Thurrock … Locality based services

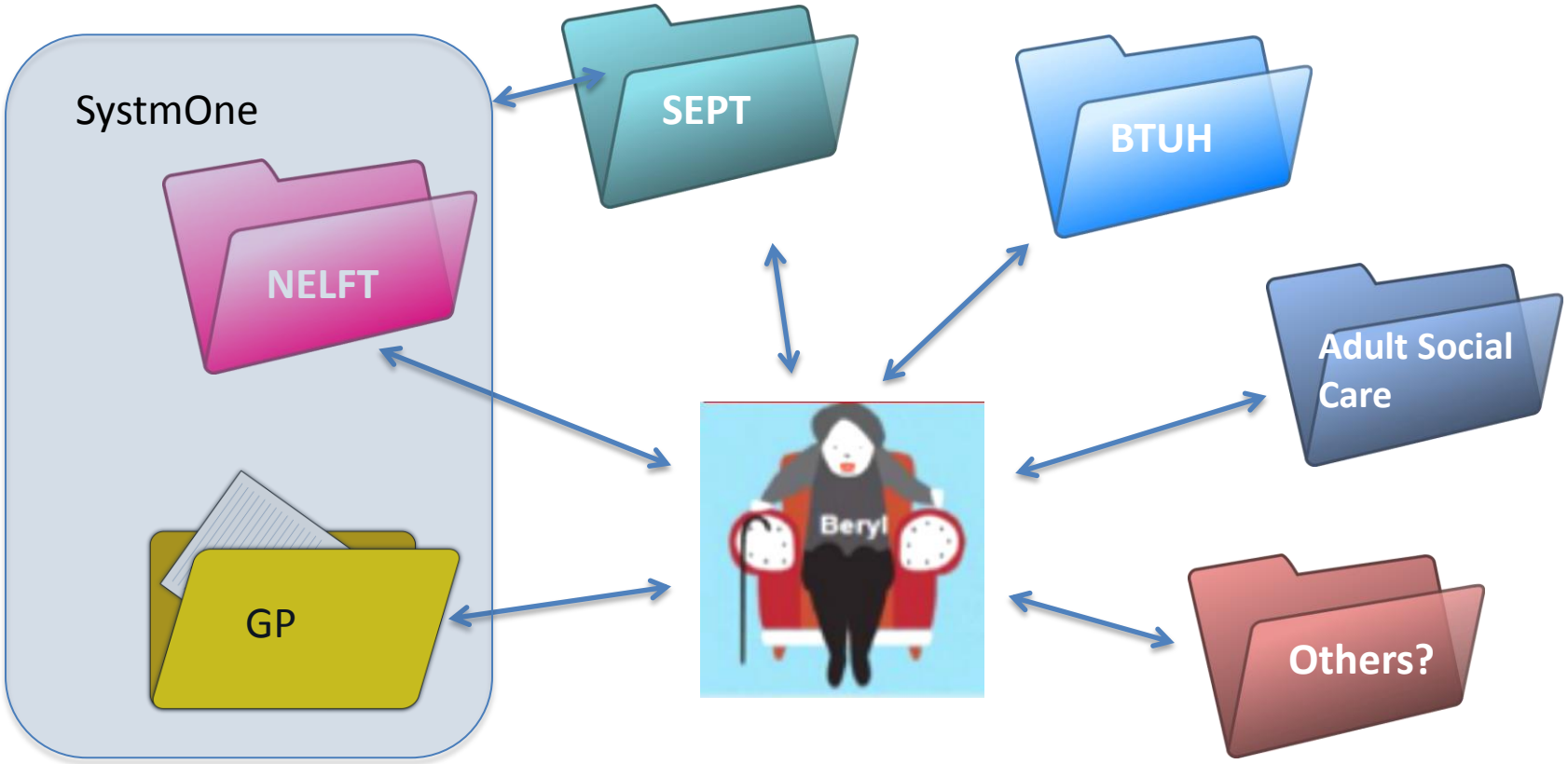


21st Century Healthy Living Centers



Thurrock Community Hospital

Key barrier to this vision: Data Integration



Implications of not integrating health and social care data

Repeatedly gives the same information to different people

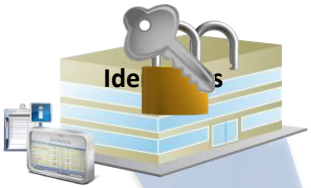
Care is reactive not proactive

Cared for by different people who don't have all the information they need

Care is not holistic or person-centred

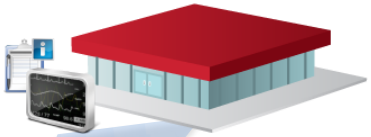
Waits for care

Gets "stuck in the system"

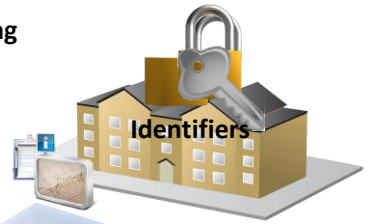


Mental Health

Social Care



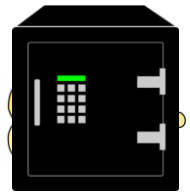
Commissioning



Primary Care

Acute Hospital

Rich Linked Data Set



Trusted 3rd Party Key Vault

Overnight updates

Pseudo-anonymised

From my perspective the data allows the identification of individuals who have characteristics that mean they might benefit more from specific interventions. Although this can be done with the type of tool within a GP system, by using multiple provider data this can be enhanced e.g social care current and previous input, community care plans, ambulance call outs

From a commissioner point of view it allows creating new ways of aligning data which then allows greater understanding along a care pathway e.g. how often do our diabetic patients access hospital care and community service. That way we can create richer cohort data and understand how costs can be attributed to groups of patients. It allows development of services to meet specific needs. That aim being to focus on cohorts deemed at "rising risk" and wrap services around or provide specific interventions to try and avoid move into a high risk cohort. It than allows tracking by population whether you are achieving changes. **Dr. Jane Moss, West Essex CCG**

Next Steps

Final amendments to service specification