All Together Better

Better Health and Care for Sunderland

**20th June 2017**

# Integrated Care in Sunderland: Guide to Risk Stratification

# Table of Contents

## Background

Risk stratification is used to estimate the risk of future adverse events for individuals.

Over the last decade or so the Department of Health (DH) and the NHS have promoted risk stratification as a mechanism to: identify patients who will benefit from preventative health interventions; enable better planning of health-related services; and to decrease health-related costs (Curry et al., 2005).

If effective, risk stratification, used as part of a wider care model, can ensure that individuals at risk of an adverse event can be offered an intervention designed to reduce that risk. It can also be used as a way to identify and target appropriate proactive interventions. It can ensure that the highest-risk patients receive appropriate care for their needs (such as the input of multi-disciplinary teams)

Risk Stratification score is only a prediction and is not an exact science.

## Impactibility

The success of risk stratification depends not just on identifying those most at risk of an adverse event, but rather in **identifying those who are most at risk and most likely to respond to a given intervention – to be 'impactable'**.

- Giving priority to patients with diseases that are particularly amenable to preventative care. There are a range of methods to doing this, the most common being to focus on the subgroup of high-risk people who have one or more ambulatory care-sensitive (ACS) conditions.

- Ambulatory care sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as better self-management, disease management or case management; or lifestyle interventions. Examples include COPD, congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension. These are conditions where there is evidence to suggest that if they are managed optimally in the community then they should not result in an unplanned admission.

- Giving priority to patients with 'gaps' in their care. Such gaps are found more frequently in patients with frailty and those living in more deprived areas (the "Inverse Care Law") so targeting support at high-risk patients with a high gap score should help reduce inequalities.

**Ultimately, the aim of impactibility modelling is to identify the form of preventative care best matched to a high-risk patient's individual characteristics.**

## Risk Stratification in Sunderland

The risk stratification process aims to determine patients at risk of repeat unplanned hospital admissions utilising business and soft intelligence and professional judgement. These patients are usually frail elderly or those with multiple complex co-morbidities.

For 2017/2018 it has been determined that in Sunderland 2% of the practice population living in their own home need to be discussed at a Multi-Disciplinary Team (MDT) meeting along with all care home patients.

**Any patient that a member feels would benefit from an MDT discussion to aid the pro-active care planning of their needs can be put forward for discussion. This includes professionals from both the core membership and the extended CIT network.**

The 2% is not solely the printed list from Q Admissions, it is 2% of the registered adult patient population (living in their own home) of a practice who could most benefit from a proactive integrated approach and is determined through a variety of ways set out below. It is not about working down a list of patients, it is about identifying those who are likely to have an unplanned hospital admission.

# How to Risk Stratify

Although system tools such as Q Admissions comprise an important, but not exclusive, mechanism to facilitate case finding, local intelligence gathering has an important role in augmenting the information and in supporting the risk stratification approach.

**Risk stratification may use the EMIS Q-Admissions score, E Frailty tool, monitoring of hospital discharge list and other intelligence (including knowledge of frequent hospital attendees and high cost patients) to identify those who might be most at risk for unplanned hospital admission**.

Use of emergency alarms, ambulance call outs, A&E attendances and social care requests are also examples of valuable information and intelligence that will contribute to a population based understanding of at risk people. The team should also be open to those with primarily mental health needs or primarily social needs. **Any person can be considered if they are appropriate for discussion at an MDT.**

Linking in with other services within the CIT network will support the gathering of this information, i.e. Recovery at Home, Carers Centre etc.

Additional areas of focus include:

- Frequent Flyers – Those patients that frequently present at CHS or R@H services.
- E-Frailty tools
- High cost patients

## Frailty

The GP contract requires routine frailty identification for patients who are 65 and over. See Appendix 1 or the full NHS England Supporting routine frailty identification and frailty through the GP Contract 2017/2018

## Frequent Flyers

The CCG will arrange for a list to be sent to practices each month which highlights those patients that have frequently attended A&E / Urgent Care centres. It is important that these patients are discussed at MDT meetings to determine what care can be offered to better support the patient in the management of their health and care needs.

## Frequent Flyers – R@H

Work has been undertaken to determine the patients that frequently contact Recovery at Home services. This increased utilisation of intermediate care services could be a sign of increased need and potential impactibility. These patients will be referred for discussion at an MDT meeting to establish if a care plan can be put in place to better support the patient.

## High Cost Patients

The CCG is working to determine a list of patients and will circulate to practices once developed.

# Additional Considerations

## End of Life Care

People are approaching the end of life when they are likely to die within the next 12 months (GMC, 2010). Therefore all patients discussed in the MDT are to be considered for the surprise question 'Would you be surprised if this patient died in the next 12-months, be it months, weeks or days?' Early identification of people nearing the end of their life and inclusion on a palliative care register leads to earlier planning and better co-ordinated care.

The RGCP gold standard framework for protective identification guidance provides support for staff working with the surprise question.

## Patient Activation Measures (PAM)

Evidence shows that people who have the knowledge, skills and confidence to manage their own health wellbeing experience better health outcomes. Yet the ability of people to successfully manage their long term conditions (LTCs) better can vary considerably from person to person. So it is important that we understand people's ability to do that. The Patient Activation Measure (PAM) is a tool which enables this by capturing how engaged and confident someone is in taking care of their health. This can be described as their activation level.

The PAM tool is a questionnaire completed by the patient to determine their 'activation level' from 1 to 4. By finding out someone's activation level, professionals can get an idea, not only of how much support someone might need to look after themselves better, but also how to tailor that support better to fit with that persons need depending on their level of activation. One size health care does not fit all, for example, those with very low activation level may be easily overwhelmed by a conversation about their condition and how to manage it. Understanding a patient's activation level can support the way in which health and social care staff interact with patients.

Work is underway in Sunderland to pilot / roll out the PAM and training will be provided to many staff directly involved. However awareness of this area can improve understanding of not only patient participation in their own health and care but also on the impactibility of plans put in place by MDTs.

# Appendix 1

## 1. Why focus on Frailty?

Sunderland needs to prepare for a dramatic increase in frail elderly patients with multiple long term conditions as demographics shift over the next 10-20 years.
Increasingly we will need to manage these vulnerable complex patients in their own home, promoting self-help and resilience to avoiding admission where possible, and facilitating timely discharge to avoid bed blocking in order to achieve a financially sustainable health economy.

## 1. What is Frailty?

Frailty is a distinctive state related to the ageing process, as multiple body systems gradually lose their in-built reserves (physical and psychological).
This means the person is vulnerable to sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication.

A person therefore typically presents in crisis with the 'classic' frailty syndromes of delirium, sudden immobility or a fall (and subsequent unsafe walking).

It should be noted that Frailty is:

- A long term condition, and not an inevitable part of aging
- Common (25-50% of people over 80 years)
- Progressive (5 to 15 years)
- Episodic deteriorations (delirium; falls; immobility)
- Has preventable components
    - The degree of frailty of an individual is not static; it naturally varies over time and can be made better and worse.
- Varies in its severity
- Potential to impact on quality of life
- Expensive

## 2. Why is frailty important?

- Older people living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health (e.g. infection, new medication, fall, constipation or urine retention).
- Frailty might not be apparent unless actively sought.
- Many people with multiple long-term conditions will also have frailty which may be overlooked if the focus is on disease based long-term conditions such as diabetes or heart failure.
- Other people whose only long term condition is frailty, may not be known to primary care or the local authority until crisis (i.e. they become immobile, bed bound, or delirious as a result of an apparently minor illness)
- Requires an MDT goal orientated person centred approach rather than a pure medical model. There is evidence that in individuals with frailty, a person-centred, goal-orientated comprehensive approach reduces poor outcomes and may reduce hospital admission.
- Many living with frailty will have multiple long term conditions and so frailty lies beyond the comfort zone of guideline based medicine.

- Despite this we do not routinely identify patients with frailty, 'diagnose it' or routinely code it. We therefore are not systematically looking to address modifiable risk factors and are not engaged in preventative work. Rather, we risk focusing on disease based approaches missing a proactive person centred approach.
- If we did aim to identify and help those living with frailty, there is great potential to make them less dependent, less immobile, less fearful and less confused – and, in turn, less reliant on care.

### 3. Risk Stratification: Reasons to look at frailty:

Much of the below comes directly from Fit for Frailty Part 2 BGS 2015, a helpful document to aid in understanding frailty.
Frailty acute syndromes that present as crisis often leading to admission

- **Falls** (legs give way/found on floor) – most likely reason for admission from coalfields care home project
- **Immobility** (off legs/stuck on toilet)
- **Delirium** (acute, acute on chronic)
- **Incontinence** (new onset or worsening urinary or faecal incontinence)
- **Susceptibility to side effects of medication**

There is a risk of significant harm to patients with frailty if health interventions are planned for them in the absence of recognition of their frailty.

Frailty is a long term condition and the NHS Outcomes Framework in England requires improved management of long term conditions.

Transforming Primary Care policy (NHS England 2014 and the DOH) calls for safe personalized and proactive out of hospital care for those with complex needs and aims to drive up quality for older people.

The Care Act (2014) requires a preventative approach to the management of older people.

Five Year forward View indicated that NHS will provide more support for frail older people living in care homes and that "primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex on-going needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients".

**Summary**:

- Frailty is the increasing challenge we will be facing in the future.
- Will enable us to focus resources on a cohort that will benefit from coordinated care with SS and Recovery at Home.
- Enable pathways to be developed that deal with problems we commonly encounter causing admission, prolonged IP stay and delayed discharge.
- Shape our workforce, IT and infrastructure & partnership working in a way that supports care to this challenging and complex group placing us in a good position to deal with future demands on the health economy.
- Put the resource of integrated teams to help those who are most likely to be most vulnerable in our community and use most health and social resource.
- Enable outcomes and measures to be focused and specific