Frimley Health and Care

A Population Health Management Approach to Primary Care

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Frimley Health and Care

From siloed to Integrated working

From reactive to Proactive care

Empowering our residents to stay well, get well

Improving Healthy Life Expectancy

Reducing Health Inequalities

Connected Care – Data driven, digitally enabled transformation

CONNECTED CARE

Population Health

Insight and intelligence at population and individual level supporting integrated and proactive care and evaluate the impact of interventions

System transformation approach

Integrated view of care

Shared care record (SCR) of individual's treatment and care that supports the delivery of high quality, appropriate and effective health and social care

Power of the eco-system

e.g. remote monitoring that uses all elements of Connected Care - identifying residents that can be supported at home, recordings reviewed by care teams via SCR, enabling residents to be better in control with clear evaluation of impact

Enabling self-care

Giving residents tools to manage their own health and wellbeing with support apps such as Sleepio, Healthier Together, GetUBetter

Underpinned by our objectives to integrate care around the resident, to move from reactive to proactive care and treatment and empowering our residents to better manage their own health and wellbeing

The ACG System Segmentation into Patient Needs Groups

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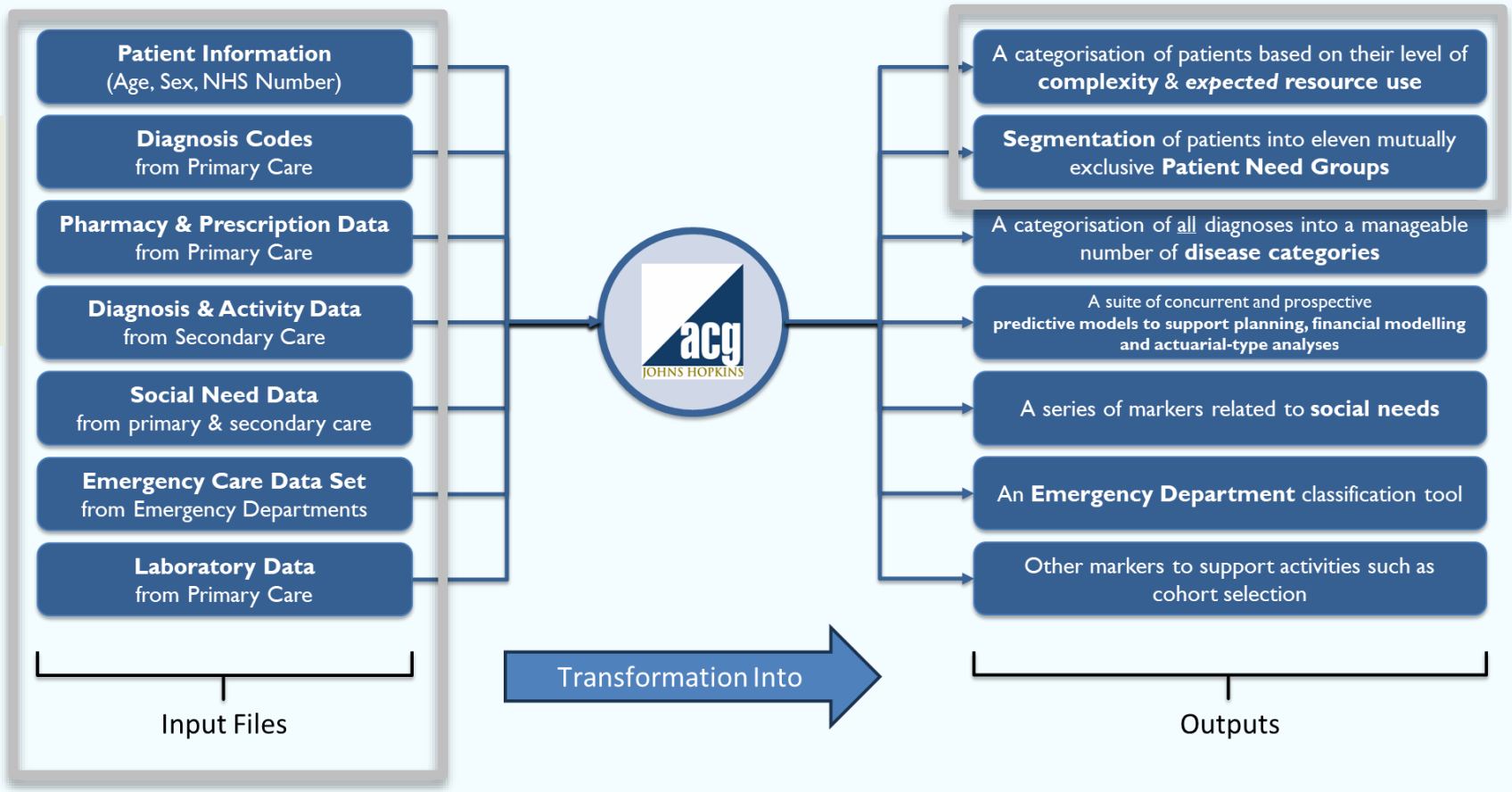
The Johns Hopkins Adjusted Clinical Groups (ACG®) System is a comprehensive population health analytics solution that transforms data (ICD/SNOMED/Read/Dm+d) that exists in primary and secondary care records into a series of meaningful patient-level and patient-centric markers.

- ***Diagnoses/drugs*** recorded, last 12 months
- ***Long-term conditions*** in health record, last 5 years
- ***Hospital activity***, last 12 months



For additional information including case studies, global applications of the ACG System, bibliography and customer training resources, visit www.HopkinsACG.org.

Clinical Example: How Segments Work

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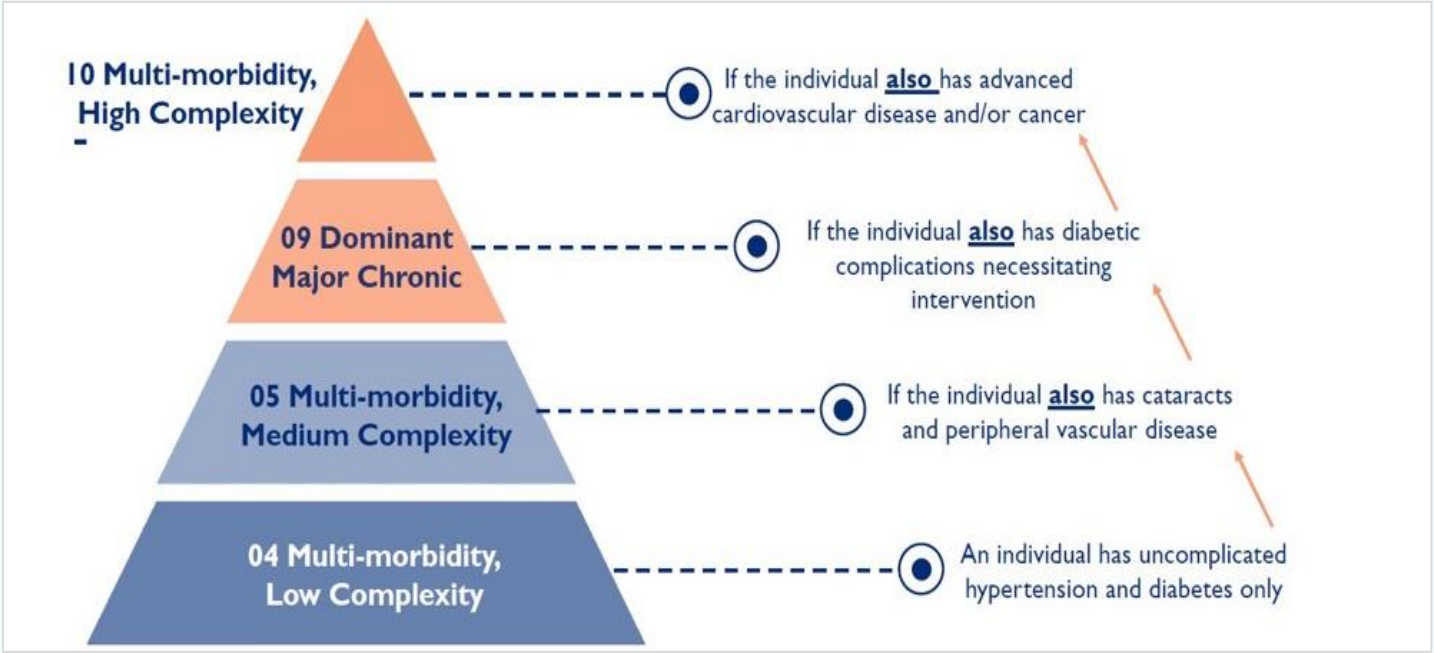
ACG System software stratifies a population by the **risk associated with their current morbidity burden + expected resource use…** The so called **"Kaiser Pyramid".**



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

Low need segment (71% of population) | **Moderate need segment (19.7% of population)** | **High need (2.3%)**

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.**

Kumar Medical Centre

- **5,300 patients, 96% from an ethnic minority background, 10.5% diabetic prevalence within the practice.**
- **Optimise** streaming to ensure the right patient is seen by the right service or healthcare professional first time.
- Used at scale, **digital solutions** to efficiently manage patients where checks can be done entirely remotely.
- **Alignment of the workforce** to the complexity of the patient to avoid duplication and improve patient experience.
- **Creating capacity for change** by forward planning scheduled care appointments to deliver QOF while resources are seasonally more flexible.
- **Plan scheduled long term condition work based on complexity + risk**, enables prioritisation of patients prior to winter and optimisation of most complex patients.
- System Insights + Ardens + Segmentation + EMIS

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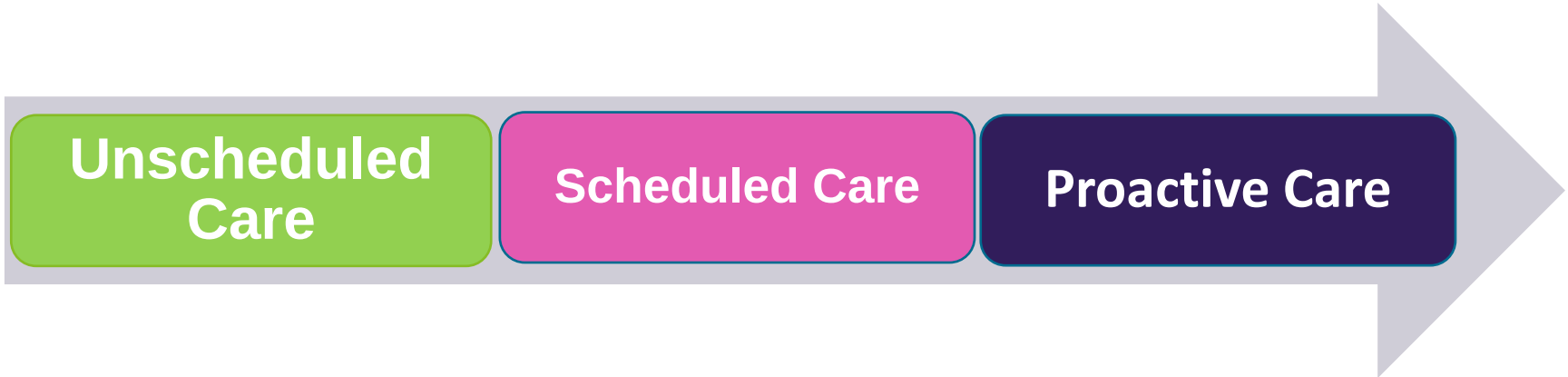
Kumar Medical Centre: AIM

- To optimise primary care access and improve continuity of care for patients by incorporating the background health of the patient (Patient Need Group) to enhance current streaming processes.

- To proactively improve the outcomes of patients on the QOF register prior to winter by reviewing the population in order of complexity using the patient need groups (PNGs) rather than date of birth.

- To release capacity and time by shifting care to left to address health inequalities.



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Kumar Medical Centre: QI Approach

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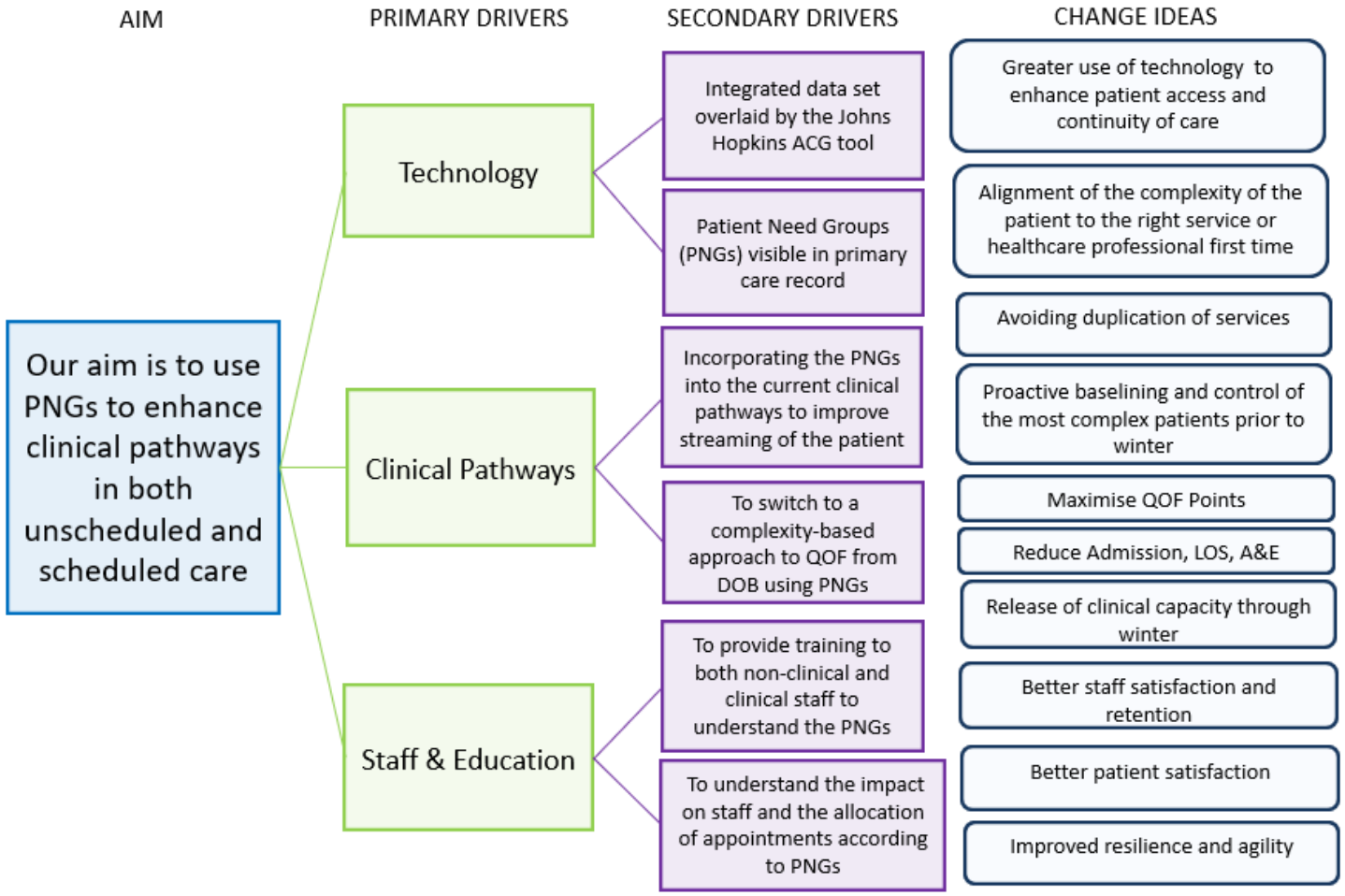
Population Health Approach to Primary Care



Getting Started

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1. Understand your population – enabled through Connected Care.

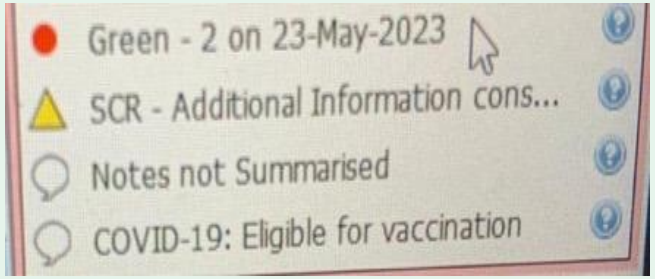
2. Get your segmentation list uploaded into EMIS

3. Engage your team in this and local ideas

4. Decide on your patient communication approach

5. Decide on your first step of change and develop your SOP around this.

What the PNG Segmentation will look like in EMIS



Box will say	Segment
Green - 1 on (date as of)	PNG 1
Green - 2 on (date as of)	PNG 2
Green - 3 on (date as of)	PNG 3
Green - 4 on (date as of)	PNG 4
Amber - 5 on (date as of)	PNG 5
Amber – on (date as of)	PNG 6
Amber – on (date as of)	PNG 7
Amber – on (date as of)	PNG 8
Amber – on (date as of)	PNG 9
Red – on (date as of)	PNG 10
Red – on (date as of)	PNG 11
Unsegmented (not enough info/ opted out)	PNG 0

Kumar Medical Centre: Unscheduled Approach

CONNECTED CARE

Creating a 'clinical currency' – a signal/marker that everyone in your practice can understand…

ALL PATIENTS
(WALK IN/ TELEPHONE/ ECONSULT)

RED FLAG SYMPTOMS
PNG 2 excluded from segmentation

Child – Rash and Fever
Children < 16
Signs of a stroke
Signs of a heart attack
Signs of difficulty in breathing
Severe Abdominal Pain
Urinary Retention – Blocked Catheter/Testicular Torsion
Abnormal Lab Results
Pregnancy
Heavy uncontrollable bleeding
Severe injuries – Head Injury /Chemical Eye Injury
Seizure /Intoxication/ Overdose
Sudden severe rapid swelling
Severe Headache/Malginant Hypertension > 180/100
Severe Back pain & weakness/numbeness/loss of bladder or bowel control
Mental health – acute condition

REFER TO ON CALL DOCTOR

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

Unscheduled
(Urgent & Routine)

Online consultation navigation and triage
Redirect to CPCS
Apps (Healthier Together App, Get U Better, Sleepio)
Same Day Service / Minor Injury Unit

Senior ANP/PA/GP navigation & triage
Same Day in- practice review if required
Maternity assessment unit
Talking therapies/MHP/CRISIS

Senior GP triage -telephone/F2F
UCR
ICT referral
Home visit – paramedic

Physio First Point Contact Service

Kumar Medical Centre: Scheduled Care QOF Approach

CONNECTED CARE

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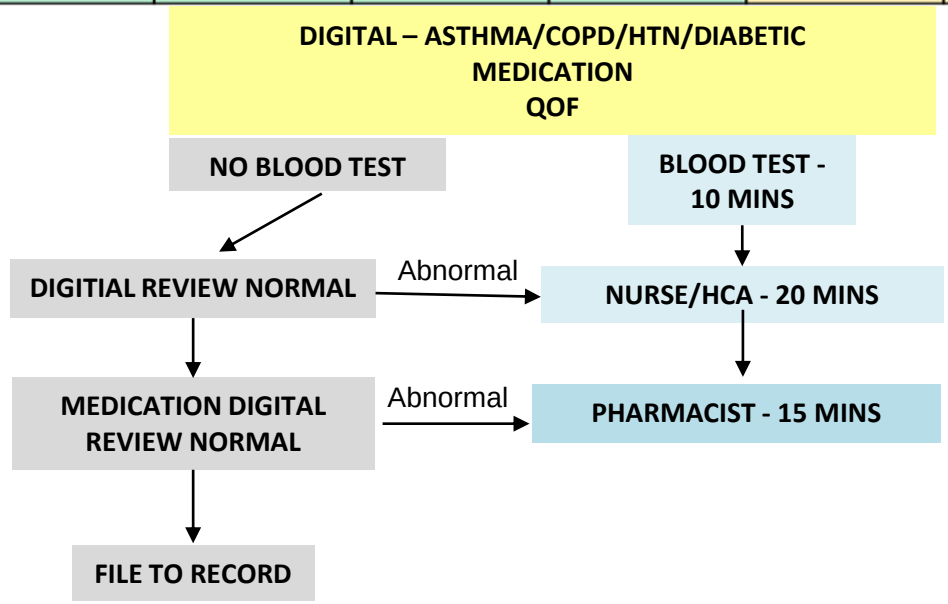

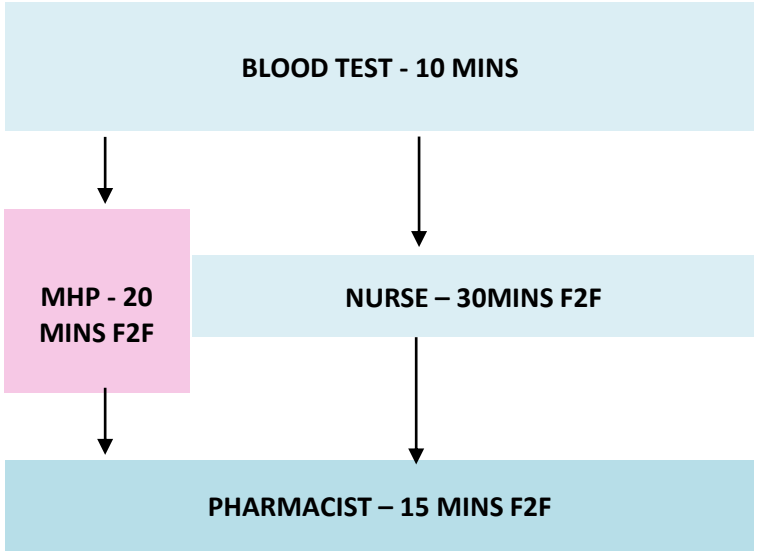

SPECIALITY – ATRIAL FIBRILLATION, CANCER, DEMENTIA, HEART FAILURE, OSTEOPOROSIS, RHEUMATOID ARTHRITIS, BABY CHECK, POST NATAL CHECKS - SPECIALIST NURSE, GP

PREVENTION: CERVICAL SMEAR/NHS CHECK UP/IMMUNISATIONS – HCA/NURSE 20 MIN
BREAST & BOWEL SCREEENING – RECALL FOR DNA
WEIGHT MANAGEMENT – DIGITAL APPLICATION
SMOKING- DIGITAL/F2F SMOKING CESSATION APPT

Kumar Medical Centre: The QOF Approach

CONNECTED CARE

	April	May	June	July	August
Target PNG Groups for F2F	PNG 9, 10 & 11	PNG 5	PNG 5	PNG 4	PNG 4
Target PNG Groups for Digital	PNG 4 & 5		PNG 9		PNG 3
Combined Face to Face	265	182	182	203	203
Combined Digital	283		39		37
Bitesize Face to Face PNG 3	107	107	107	107	107

	April	May	June	July	August
Total Face to Face Appointments Required	372	289	289	310	310
Appointments Per Day Required	19	14	14	16	16
Appointments Per Week Required	93	72	72	78	78
Appointments Per Month Required	372	289	289	310	310

slido

Please download and install the Slido app on all computers you use

Patient A
10 year, epileptic, severe learning difficulties, past pneumonia, seizure, cataract

What PNG is Patient A?

ⓘ Start presenting to display the poll results on this slide.

Frimley Health and Care

CONNECTED CARE

Results, Evaluation and Reflections

ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • WINDSOR

Kumar Medical Centre: Initial Findings July 2023

CONNECTED CARE

PNG_RAG	patient_need_group	Indicator % FY (KMC)	Indicator % FY (CCG)	Difference from System Average %
1 - Lower Need Group	**Total**	**29.8%**	**27.7%**	2.1%
	2 Low Need Child	24.4%	30.4%	-6.1%
	3 Low Need Adult	9.1%	16.2%	-7.1%
	4 MultiMorbid Low Complexity	36.1%	32.2%	3.9%
2 - Moderate Need Group	**Total**	**48.8%**	**40.2%**	8.6%
	5 MultiMorbid Med Complexity	49.6%	41.6%	8.0%
	6 Pregnancy Low Complexity	16.1%	13.6%	2.5%
	7 Pregnancy High Complexity	23.5%	22.8%	0.7%
	8 Dominant Psych Behavioral Co	47.6%	37.2%	10.4%
	9 Dominant Major Chronic Cond	48.3%	39.4%	8.9%
3 - Higher Need Group	**Total**	**54.3%**	**44.1%**	10.2%
	10 MultiMorbid High Complexity	56.0%	44.2%	11.9%
	11 Frailty	46.1%	43.7%	2.4%
Total		**44.6%**	**36.9%**	7.6%

PNG 4 and 5: Remote Health Checks completed digitally

PNG 8,9,10: F2F Health Checks prioritised for this group

Kumar Medical Centre: Results – September 2023

HbA1c control: High need group

PNG_RAG	2022/23	2023/24
1 - Lower Need Group	59.1 %	57.3 %
2 - Moderate Need Group	78.6 %	74.9 %
3 - Higher Need Group	81.8 %	89.5 %

- +8% more patients now below 75
- +5% more patients controlled below 58

Total QoF Achievement

QoF	Sept 22	Sept 23
% of Achievement	67.60%	**90.55%**

For the first time (in my career) I feel I have all the tools I need to effectively schedule patient appointments; ensuring the most appropriately skilled healthcare professional is matched to a patients needs...
...Staff morale is up and we're feeling more able to cope with surges in demand.

Becky Deol, Receptionist at KMC.

- Able to baseline and stabilise more red complex patients earlier in the year.
- Use of digital/remote consultations released capacity for more complex patients F2F.
- Optimally using workforce capacity; senior clinicians seeing more complexity and avoiding duplication of appointments.
- Releasing capacity for seasonal flu vaccinations and improving urgent care access to support winter pressures.
- Improved overall staff and wellbeing- staff, and no rush at the end QOF year.
- Able to review workforce needs when have vacancies to suit the maturing practice model.

Kumar Medical Centre: Findings + Milestones Jan 2024

CONNECTED CARE

Practice Analysis January 2024

Summary on practice	Care Related Encounters per 1K	Proportion of Care encounter for adults	Encounters (+65)	F2F Green	Tel Green	F2F Ambers	Tel Ambers	F2F Red	Tel Red	QOF
Slough vs Practice	↑ historically	↓ lower historically	↑ historically	↓ lower	↓ lower	↑ historically	↑ historically	↑ historically	↓ historically	Achieved earlier in year
Practice vs Practice YTD	↓ 13.7 %	↓ 1.1%	Same	↓ 4.5%	↓ 3.8 %	↑1.7%	↑3.0	↑0.1 %	↑0.1 %	↑1.9%
Practice prospective	PNG effect - reduced duplication	No effect on wider system pressures	No effect on wider system pressures	PNG effect	PNG effect	PNG effect	PNG effect	Status quo - remote monitoring	Status quo -remote monitoring	PNG effect

Summary on wider system	A&E attendance per 1K	Admissions per 1 K	Total Bed days per 1 K
Slough vs Practice	↓ lower historically	↓ lower historically	↓ lower historically
Practice vs Practice YTD	↓ 10.6 %	↓ 33.6%	↓ 31.4 %
Practice prospective	PNG effect	PNG effect	PNG effect

Recent exploratory data generated by the System Insights Analysts compares practice activities vs Slough place and vs practice/itself over the previous year.

*****

Practice prospective captures the Lead GP (Dr Priya Kumar) interpretation of the changes seen/ the cause of change.

Segmentation Primary Care Framework

CONNECTED CARE

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Scheduled	Digital invitations to QOF Nurse/HCA/PCN Pharmacist/ARRS Led QOF Paeds QOF SMRs - Pharmacist				Pre-natal Health Optimisation QoF prioritisation for LD and SMI SMRs – Senior Pharmacist DMARDs				Senior Nurse/GP lead QOF prioritisation based on risk prior to winter SMRs reviews by senior pharmacists		
Proactive	NHS health check ups (PNG 1 &3) Immunisations Health Promotion/Weight Management Quit Smoking Cancer screening NHS login /Social Prescribing				Identifying non-attenders for QoF Immunisations Prediabetes /Health Promotion /Weight Management /Quit Smoking Cancer screening Pre-conception advice NHS login /Social Prescribing				Remote Monitoring Secondary Care MDTs ICT/ Post admission home visit Health Promotion/smoking/ weight management /cancer screening/Imms NHS login/Social Prescribing		

Frimley Health and Care

It’s all about the people

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