digitalhealth REWIRED BIRMINGHAM 12-13 MARCH 2024

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Graphnet Transforming Care

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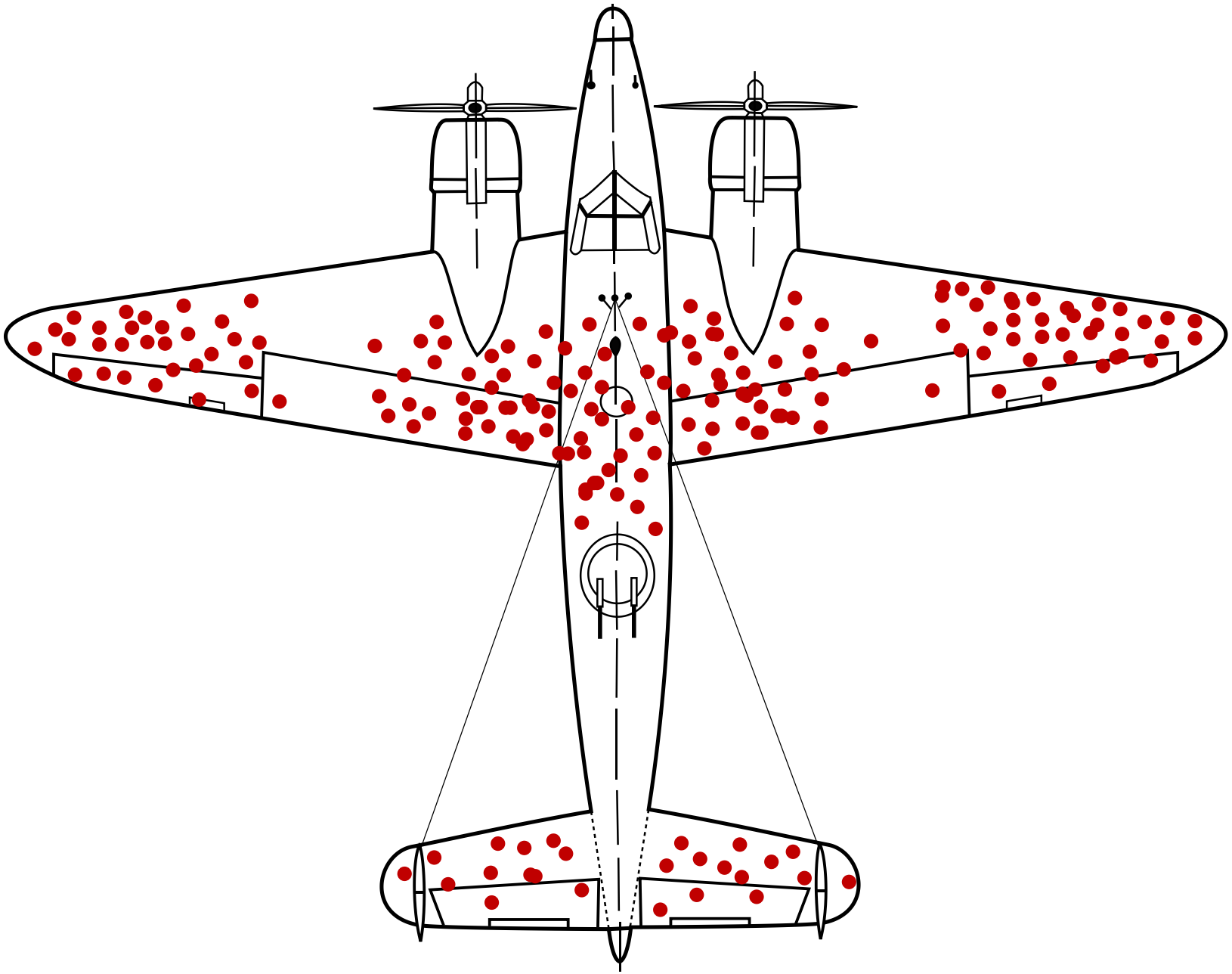
INTEGRATED CARE STAGE

Stage Sponsor: tpp

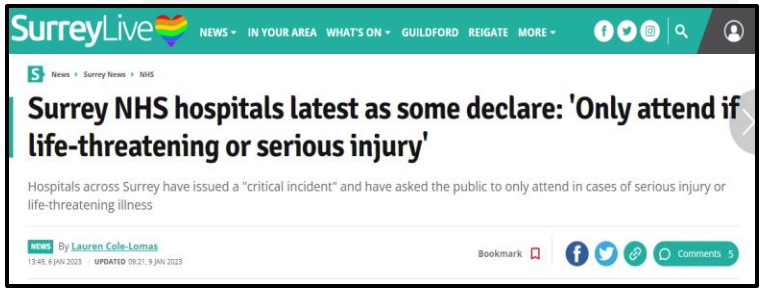


Service-based case study – Targeting Proactive Care

The challenge

SYSTEM CAPACITY

Primary care and acute services experiencing significant demand. In 2022/23, East Surrey identified over 60,000 patients who were moderate to very high users of health services.



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SURREY

The solution

IDENTIFY – Using the population health platform and Johns Hopkins risk stratification, the place-based team found the 600 patients with the highest probability of admission.

REVIEW – PCN and practice staff then searched using the same criteria, reviewing those patients to determine most appropriate course of action.

Of this cohort…

80+	75%	20%	81 (13%)	Of which, most..
Mostly aged over 80	Have moderate to severe frailty	Reside in a care home	Are current smokers	Are living in greater deprivation

- An average of 3.1 ED attendances and 87 contacts with GP services per patient over 12 months
- Most common comorbidities included hypertension, CKD, heart disease, AF and diabetes
- Of the over 65s in one PCN, 42% were previously unknown to Anticipatory Care services

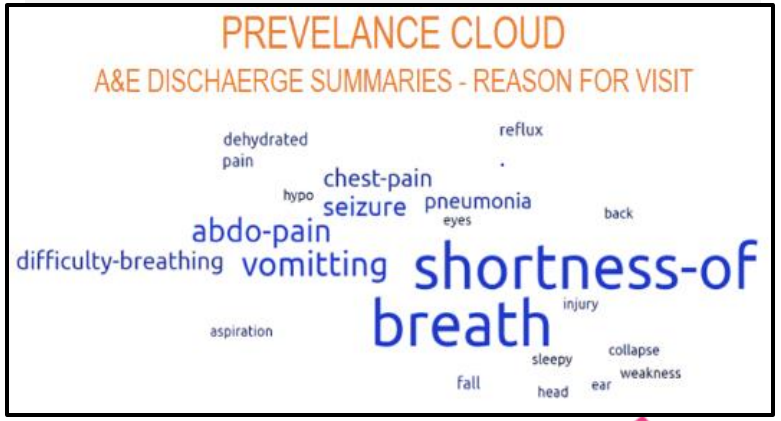
Impact & Benefits

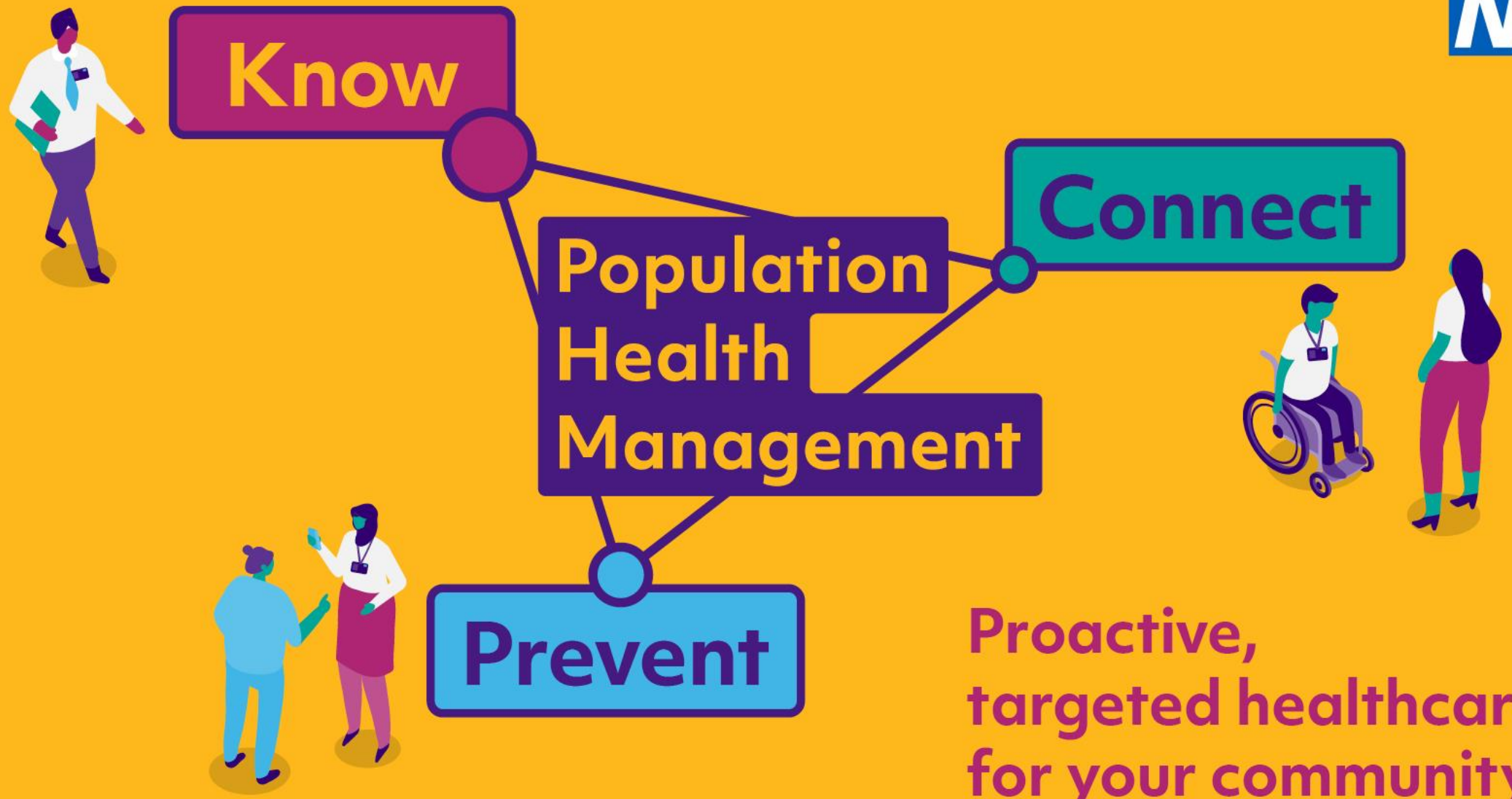
MORE EFFECTIVE USE OF RESOURCES:

The system saw a 50% increase in referrals to PCN frailty hubs – from 130 in June to over 200 in September – targeting those most in need as a priority

Initial impact measures (comparing 2022/23 with 2019/20) showed reductions in:

- A&E attendances for over 65s
- Attendance/admission conversion rate
- Non elective admissions





NHS

Proactive, targeted healthcare for your community

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