NHS London

Primary Care: Identification, risk stratification and interventions for patients at an increased risk

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This document will continue to be reviewed and re-released regularly. Please email england.londoncagsupport@nhs.net to request the most recent version.

Disclaimer: The evidence regarding the impact of COVID-19 on patients and factors associated with an increased risk of the adverse impacts is rapidly emerging. This document is based on the available evidence and will be continually reviewed to ensure alignment with the emerging data. Variations to this advice may be required depending on clinical setting and individual patients which should be moderated with clinical judgement in all cases.

NHS London

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Version Control

Version	Date Agreed	Date Circulated	Amendments agreed
1	31/07/2020	04/08/2020	N/A

Upcoming release schedule and expected content

Version	Expected ciculated date	Expected updates
2	31/10/2020	Additional phase 1 condition specific risk stratification thresholds and interventions identified, amendments as a result of feedback from the system and additions areas identified through implementation

1 Background

1.1 Executive Summary

In response to the public health emergency posed by COVID-19, NHS England and NHS Improvement (London) is working to support clinicians identify patients who are at the higher risk of adverse outcomes (based on available evidence) and prioritise the allocation of existing resources to these patients.

This document sets out guidance for the identification, risk stratification and proposed progressive interventions for patients with diabetes and hypertension. **This document will be expanded in the future to cover other clinical conditions.** Clinicians are encouraged to adopt the principles detailed in this guidance as a core framework supported by clinical judgement, to manage the local needs of the populations they serve.

Prioritisation and risk stratification means that patients are offered interventions appropriate to their health, socioeconomic and demgraphic status, recognising that those at higher risk often require greater and more immediate proactive care from primary care providers.

Since the advent of COVID-19, the prioritisation of patients is critical, given the risk of health complications that arise for certain populations, and given the system resource constraints arising from significant numbers of patients with such complications.

1.2 Background

The COVID-19 pandemic has seen a disproportionately adverse impact on people from particular cohorts, according to evidence in the review by Public Health England *Beyond the data: Understanding the impact of COVID-19 on BAME groups*. The Review concluded that the impact of COVID-19 mirrored existing health inequalities particularly for black, Asian and minority ethnic (BAME) groups, further exacerbating the impact for these particular groups.

The review found that in addition to the higher risk of adverse outcomes as a result of COVID-19 amongst BAME individuals, there is evidence of a range of clinical and socio-economic factors which have also been attributed to poorer outcomes.

Further studies have demonstrated that such risk factors include:

- Health co-morbidities
- age
- gender
- level of social deprivation
- occupations and place of residence within increased risk of transmission

The evidence also highlights the complexity of the relationship between ethnicity and health, acknowledging that there are a number of factors that expose particular communities to higher risk of pandemic infection and/or of poor health outcome. Consequently, there is a need to address the higher risk factors, both for BAME population groups and other patient cohorts which have historically experienced worse health outcomes. Although these risk factors have been exacerbated by COVID-19, it is acknowledged that such health inequalities existed before the pandemic. There is now an opportunity to improve this as a legacy piece.

As the NHS begins to restore health services it must also look at preparing for and reducing the impact of any subsequent pandemic waves, in order to keep people as safe and as healthy as possible and to avoid exacerbating pressures on the health and social care system. This is particularly important and timely given that a second wave may occur concurrently with the well-characterised and anticipated winter pressures experienced across the health and social care system.

1.3 Purpose

This guidance aims to support Primary Care clinicians and managers to optimise patient contact based on identification and prioritisation of clinical risk based on health, socioeconomic and demographic factors. In addition, it seeks to support population stratification and strengthen population health management approaches, by providing tailored services and proactive interventions, particularly among population groups more at risk of the adverse impacts of COVID-19.

This guidance seeks to deliver benefits at both an individual and population level, as well as to the wider healthcare system. The advocated approach is to ensure that individuals are supported to make informed decisions together with their clinicians, that the uptake of interventions has the optimum chance of a successful outcome and that patients value the interventions, while at the same time maximising the utility of available resources. It is recognised that the interventions are those already offered to individuals, however COVID-19 provides an opportunity which may be seen as a motivator to reduce risk and optimise the chances of sucessful outcomes.

The guidance supports Primary Care to better identify and therefore respond to the higher risk population cohorts and to identify the touch points at which these populations seek and access care.

The guidance should be read alongside existing professional guidelines, standards and clinical frameworks) and the tools used in combination with clinical judgment.

1.4 Aims and Objectives

The overall aim is to ensure that individuals across London at the higher risk of adverse health outcomes are supported to minimise their risk by providing prioritised, targeted and personalised advice based on individual levels of risk through the adoption of a pan-London approach

The objective is to develop pan-London principles to support ICSs to implement a proactive population stratification approach that is consistent across London and tailored to suit the needs and resources of each ICS. The risk thresholds are to trigger the provision of a 'menu' of available and progressive interventions appropriately identified for each risk category (High, Medium, Low).

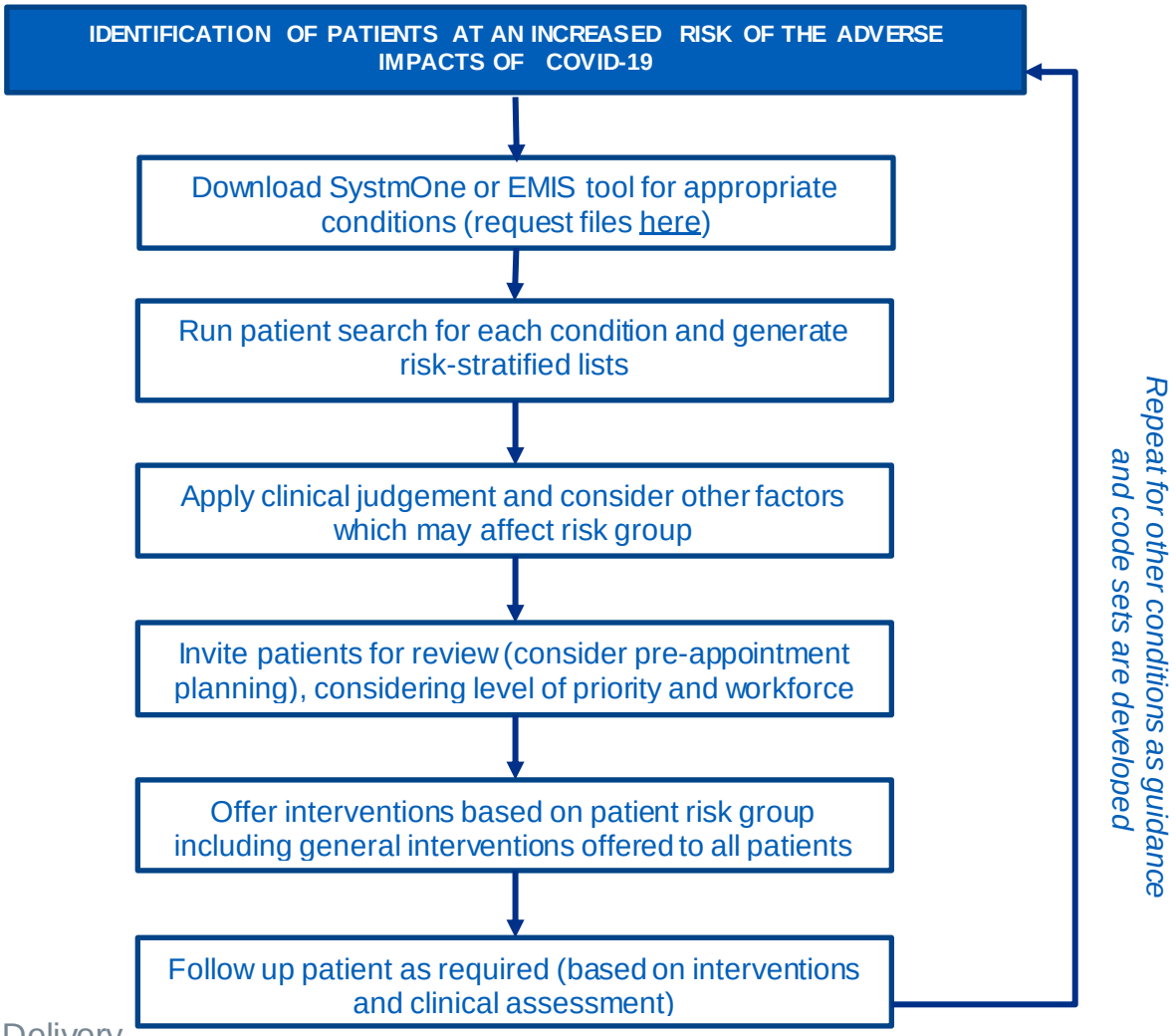
The objectives are to adopt an pan-London approach and principles that:

- Maximise the value of every encounter with healthcare professionals (make every contact count)
- Utilises existing interventions and mechanisms
- Supports best practise in the delivery of routine care;
- Supports ambitions for a single set of risk stratification criteria to be adopted across primary, community and acute teams to support MDT discussions and enhance integrated working;
- Supports an integrated, whole system approach across primary, secondary and social care as well as harnessing the opportunities within the voluntarty and community (VCSE) sector;
- Considers the impact of health inequalities and inequities on the population, supporting equity of access and actively working to engage 'seldom heard' populations;
- Improves the adoption of personalised care indluding shared decision making between clinicians and patients and improving health literacy through supported self management and Patient Activation Measures as a baseline;

- Considers workforce, resource and infection prevention and control (IPC) implications and approaches to address them including the use of new roles .

2 Delivery

2.1 Overview



2.2 Identification

Developed in collaboration between UCLPartners (UCLP) and the North East London Clinical Effectiveness Group (NEL CEG), a tool based on SNOMED codes has been created to support the identification and subsequent risk stratification of patients with selected conditions.

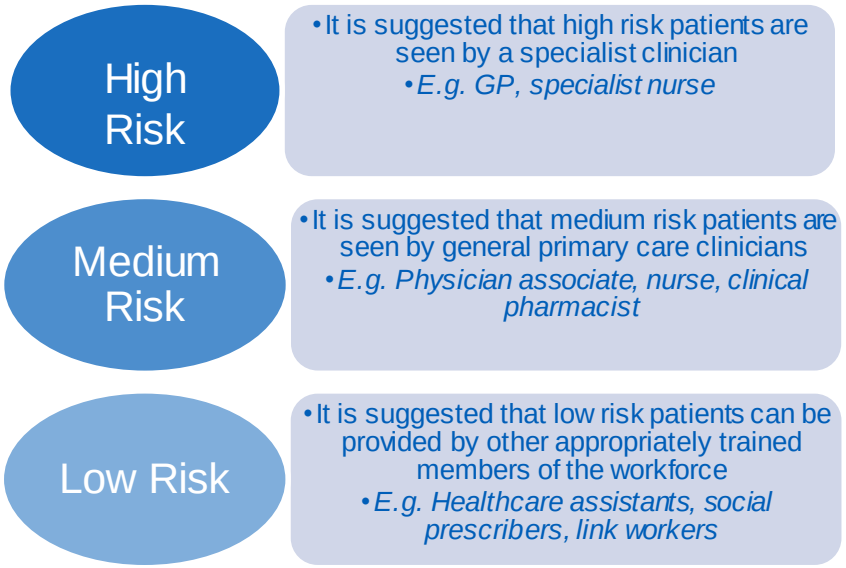
Long-Term Conditions including asthma, chronic obstructive pulmonary disease, chronic kidney disease, heart failure, Type 2 diabetes and Hypertension have been identified as being of priority within this project. For Type 2 diabetes and hypertension which have been selected as the initial conditions within phase 1, code sets which have reached clinical consensus have been developed (Appendix 1 and 2) with ongoing work being conducted on the remaining conditions in subsequent phases. These will be available for direct upload to practice systems.

The search on EMIS/SystmOne should be conducted *once* to enable clinicians to identify the appropriate patients and quantity the subsequent workload. This can be periodically reviewed to ensure that new patients are identified, but should not be done to re-stratify patients.

It is suggested that upon generation of the lists, flags are placed on the patient record to reflect that they have been identified as part of this initiative. It is also advised that patients seen as a result of this work are coded as such. Enfield Primary Care Network are currently conducting establishing SNOMED codes which will be shared upon completion.

2.3 Risk Stratification

Stratification supports Primary Care clinicians to distribute the workload by determining who is appropriate to review and provide care to the patient.



Stratification aids the subsequent phasing of proactive long-term care for patients according to clinical priority and the identification of low risk patients who may need minimal clinical input but who would benefit from systematic support for self-management, patient activation and patient education delivered by the wider workforce. Subsequent contact is important to improve activation and engagement.

Clinical thresholds are used to search for patients with either of *two priority conditions* (diabetes and hypertension) in *High, Medium and Low risk groups*. These patients are then risk stratified into *priority intervention groups* depending on other moderating factors, including co-morbidities, ethnicity and other clinical and social factors. This process is designed to allow clinical discretion and to give manageable numbers within each cohort. The criteria can be amended at a local level.

Clinicians should consider other moderating factors and apply clinical judgement when determining patient risk level.

The stratification criteria for Diabetes and Hypertension are included within the appendix (Appendix 1 and 2).

2.4 Interventions

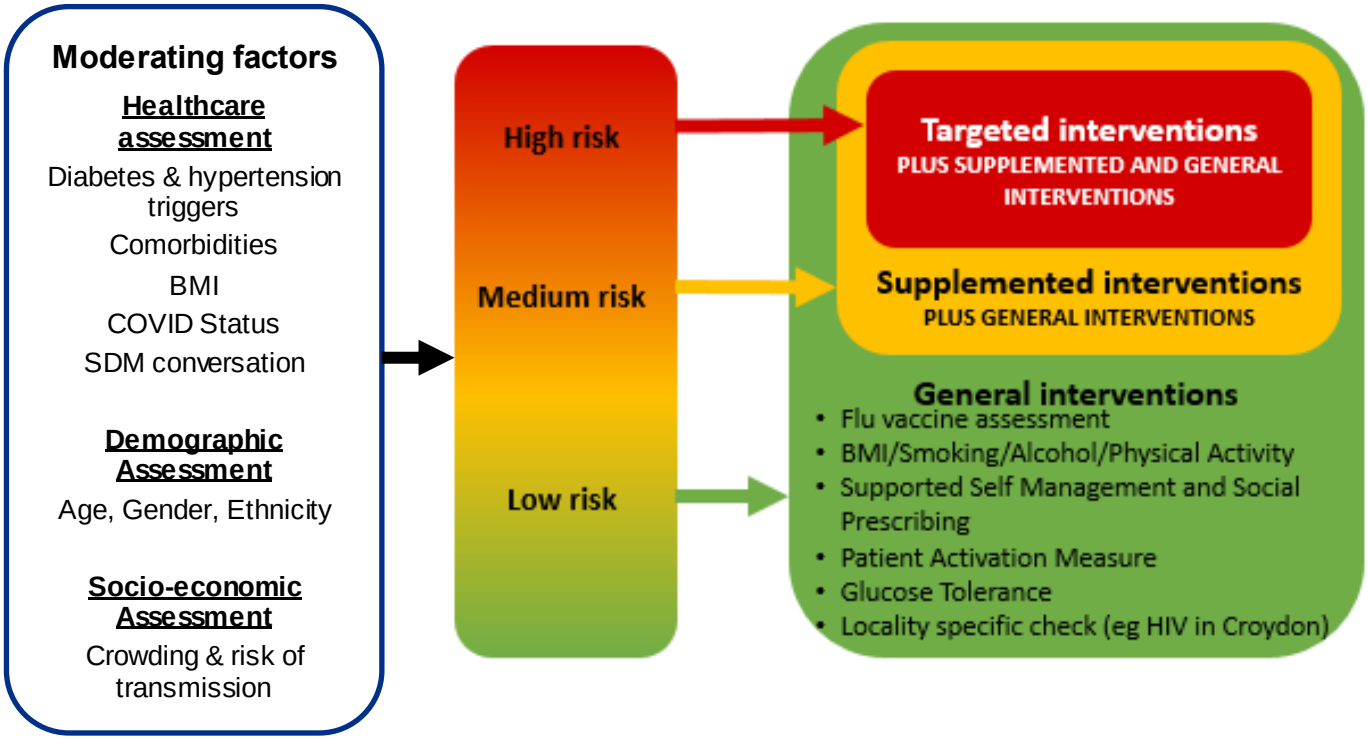


Figure 1 Risk levels associated with progressive interventions

Once practices have generated lists that stratifiy patients into risk levels and subsequent priority groups, a clinical review should take place with the patient. All patients should receive general interventions which encompass components of the NHS HealthCheck and offer information on risk factors including obesity, smoking, exercise and alcohol where appropriate.

2.5 Practices should also consider assessments and interventions that may be related to more prevalent conditions observed within localities. Further condition-specific interventions will be offered that are aligned with the risk groups. For diabetes and hypertension this is detailed in Appendix 1: Type 2 Diabetes thresholds and menu of interventions and

Appendix 2: Hypertension thresholds and menu of interventions. Clinicians should consider face to face appointments dependant on patient needs, circumstances and the interventions required rather than the level of risk.

It is recognised that these interventions and offers to the patient are not novel and patients may find COVID-19, either as a motivator or disempowering. It is therefore vital that clincians work with patients to understand the person, their preferences and their motivations to optimise the chances of sucessful outcomes and reduction of risk for the patient.

Link workers, who are trained in health coaching and motivational interviewing are instrumental in this. *Work is also being done to develop scripts specific to each condition to support other clinicians*. Our current context is unique and opportune; not only is there acute focus in the minds of citizens and clinicians on this area but additionally, we are now better equipped with non-medical evidence-based adjuntive support including link workers and social prescribing.

Social prescribing link workers work with people who have lower levels of knowledge, confidence and skills to manage their health. This includes holistic conversatons to understand what is important to them and help them to plan and achieve their goals. By supporting patients to address social barriers to health, it can impact a person's ability to address health concerns. Tools including Patient Activation Measure (PAM), which can be completed over the phone or in person, can be used to tailor interventions to indivdual needs, track a patients journey with self-management and can be used as an outcome measure. It is recommended that patients with a lower activation score who are invited for an appointment with a clinician should have a coinciding appointment where possible with a social prescribing link worker.

When considering interventions, clinicians should also consider the accessibility of tools and where possible offer support that is free to access, culturally sensitive and available in different languages.

2.6 Interdependent Services

It is vital that the impact of interdependant services is considered, particularly where there may be an increased uptake of services with implications on resource including capacity to meet workload. Key interdepencies identified include:

- Community teams
- Existing diabetes and hypertension clinics
- Clinical networks
- Secondary care

An opportunity of particular benefit would be the involvement of secondary care to ensure that patients who are identified as high-risk patients can receive a fast-track review by specialists. Integrated virtual review clinics, which currently exist within parts of London for certain conditions, including COPD, diabetes, hypertension and heart failure are suggested as a supplementary initiative for high-risk patients in addition to existing Advice and Guidance provision. Integrated virtual review clinics are also in line with Long Term Plan ambitions for respiratory care.

2.7 Health Inequalities

Covid-19 has highlighted the long-term health inequalities and the disproportionate impact on the population. This approach helps to address health inequalities by focusing resources on those with the greatest needs. However, additional consideration needs to be given on how to improve access and reach with 'seldom heard' patients who may have higher support needs. This is likely to involve collaboration with a number of local organisations, faith communities and voluntary groups in order to facilitate channels of communication and build improved relationships.

Furthermore, considerations should be given to those who have delayed standard monitoring having made the decision to shield themselves or are fearful of nosocomial infections and are therefore at increased risk because of their unchecked chronic condition.

2.8 Evaluation

Evaluation and improvement mechanisms should be determined to ensure that learning is captured and utilised, to drive improvements and to understand the impacts and outcomes of the initiative.

Evaluation depends on intentional data capture and documentation of:

- patients highlighted for these interventions through coding or flagging
- clinical measures (starting and follow up) to support risk stratification, eg HbA1c, BMI, blood pressure
- tracking of the monitored variables such as BMI, waist circumference, PAM

2.9 Further information

2.10 Contributors to the initiative are included in

Appendix 3 – Contributors to this work.

3 Appendices

3.1 Appendix 1: Type 2 Diabetes thresholds and menu of interventions

3.1.1 Type 2 Diabetes thresholds

This search identifies all patients with T2 Diabetes. These patients are then stratified into high, medium and low risk based on clinical criteria, and then allocated for priority one or priority two follow-up depending on ethnicity and clinical and social factors. Absolute levels of HbA1c and eGFR are used for the stratification. Further work will be carried out by NEL CEG to determine if patients with deteriorating HbA1c or eGFR can be identified for prioritisation.

High Risk	
Priority 1	Hba1c >90 **OR** Hba1c >75 **AND** any of: • Black, Asian or Minority Ethnicity • Social complexity (Learning disability, homeless, housebound, alcohol or drug misuse) • Severe frailty • insulin or injectables (exenatide,liraglutide, dulaglutide, lixisenatide, semaglutide) • Heart failure
Priority 2 (excluding High Risk Priority 1)	Hba1c >75 **AND** any of: • Foot ulcer in last 3 years • MI or stroke/TIA in last 12 months • Under community diabetes team (see codes) • eGFR < 45 • Metabolic syndrome
Medium Risk	
Priority 1	Hba1c 58-75 **AND** any of • Black, Asian or Minority Ethnicity • Mild to moderate frailty • Previous coronary heart disease or stroke/TIA BEFORE 12 m. • BP≥140/90 • Proteinuria or Albuminuria

Priority 2 (Excluding Medium Risk Priority 1)	Hba1c 58-75 **AND** any of • eGFR 45-60 • Higher risk foot or PAD or neuropathy • Erectile Dysfunction ever • Diabetic retinopathy • BMI >35
Low Risk - All others excluding high and medium risk groups	

3.1.2 Type 2 Diabetes interventions

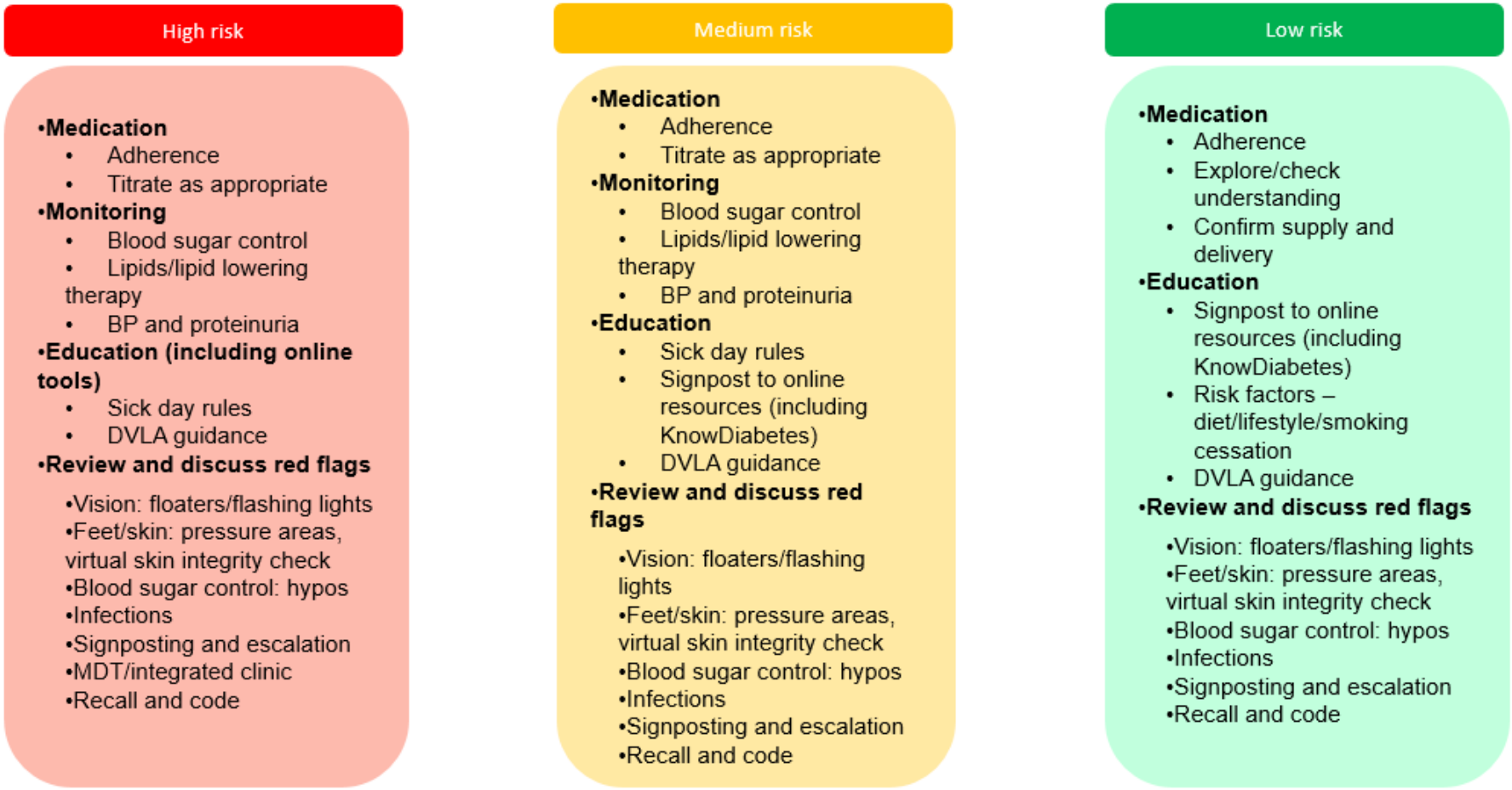


Figure 2 Initial list of suggested interventions for each risk group. Please note that this is not exhaustive and clinical judgement should be applied (adapted from UCLPartners)

3.2 Appendix 2: Hypertension thresholds and menu of interventions

3.2.1 Hypertension thresholds

The search identifies all patients with a coded diagnosis of hypertension and stratifies them into 4 priority groups based on their last recorded blood pressure. Patients from Black, Asian or Minority Ethnic communities who have cardiovascular comorbidities are prioritised for earlier follow up.

Priority 1	Last BP ≥180/120 (clinic or home equivalent)
Priority 2	Last BP ≥160/100 (clinic or home equivalent) Or last BP ≥140/100 (clinic or home equivalent) if • Black, Asian or Minority Ethnicity plus CVD comorbidities (CVD, CKD 3+, T1 or T2 Diabetes, BMI>35) Or no BP reading in last 18 months
Priority 3	Last BP ≥140/90 (clinic or home equivalent)
Priority 4	Last BP <140/90 (clinic or home equivalent) if under 80 years Last BP <150/90 (clinic or home equivalent) if over 80 years

3.2.2 Hypertension interventions

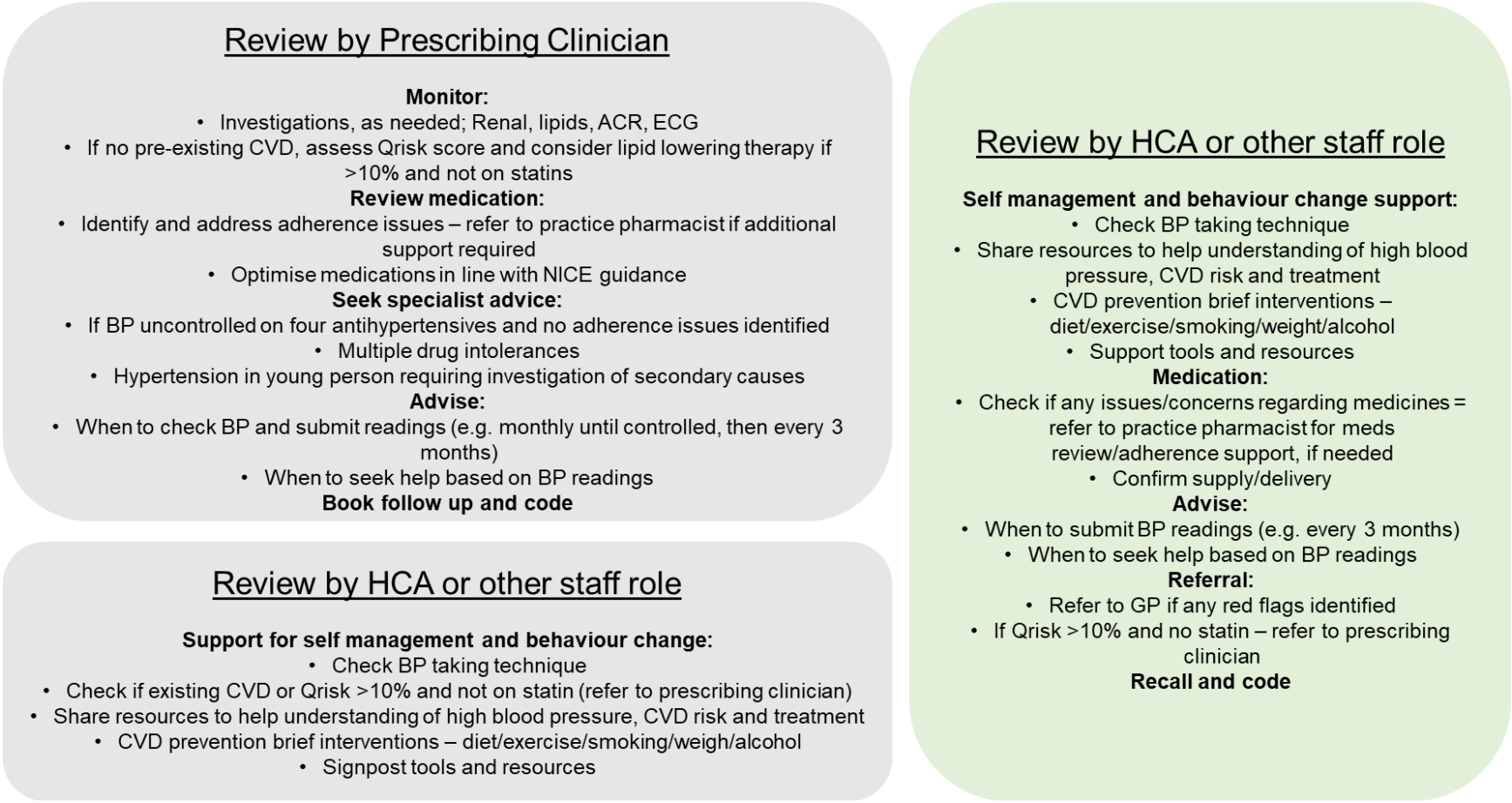


Figure 3 Initial list of suggested interventions for each risk group. Please note that this is not exhaustive and clinical judgement should be applied (adapted from UCLPartners)

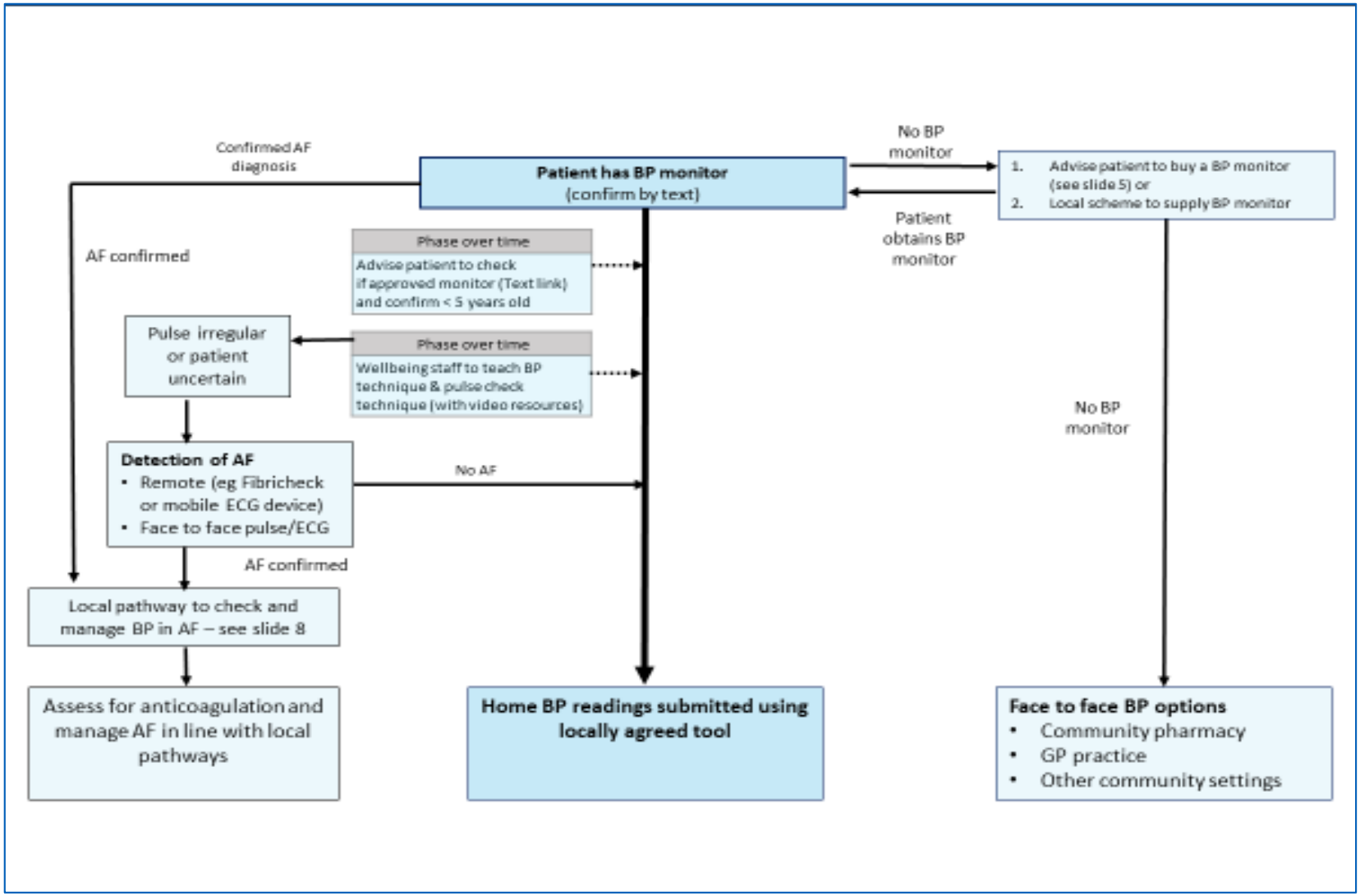


Figure 4 Suggested pathway for home blood pressure monitoring

3.3 Appendix 3 – Contributors to this work

Forename	Surname	Org	Role
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Hélène	Brown	NHS England & NHS Improvement (London)	Medical Director for System Improvement and Professional Standards
Heather	MacFarlane	CQC, NHS England & NHS Improvement (London)	Clinical Fellow, Covid Response team
Joe	Fraser	NHS England & NHS Improvement (London)	Clinical Network Senior Programme Manager, Maternity & Personalised Care
Jagan	John	Chair BD CCG (East London Health Partnerships)	Co-Chair and GP
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Mike	Gill	London Clinical Senate	Chair
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Malti	Varshney	NHS England & NHS Improvement (London)	Project Lead, Deputy Director, Clinical Network and Senate
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Stephen	Thomas	NHS England & NHS Improvement (London) & GStT	Clinical Director London Diabetes Clinical Network

Forename	Surname	Org	Role
Steve	Tolan	NHS England & NHS Improvement	London AHP Lead
Tim	Windsor-Shaw	NHS England & NHS Improvement (London)	Project team
Vince	Mak	Imperial College Healthcare NHS Foundation Trust	Consultant for respiratory integrated care Clinical Director for London Respiratory Network
Zara	Brookes	NHS England & NHS Improvement (London)	Project team