Integrating data analytics to build a profile of over 65s in Walsall

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Commissioning Support Unit

Background

The number of people with more than one long-term condition (LTC) is rising as the population ages. This presents a challenge for healthcare providers and commissioners. Currently, LTCs and their comorbidities are not routinely analysed together to understand the full patient, cohort or pathway picture. This means patients with disease complexity are not analysed holistically in their comorbid chronic disease cohorts. Additionally, metrics used by commissioner clinical and financial leads are not always mutually understandable.

Walsall Clinical Commissioning Group (CCG) wanted to build a profile of their older person population to inform planning discussions and commissioning actions.

Action

Our Business Intelligence (BI) Team worked with the CCG using DOC, our disease origins and comorbidity tool for triangulating population health analytics. Accredited by NHS RightCare, DOC enables mutual understanding by analysing 'whole patients' with all their diseases, socioeconomic status, and demographics (health status influencers), as opposed to just costs and performance currencies which 'fragment' the person and their co- and multi-morbid LTCs.

Using DOC, evidence analysis, and input from MLCSU's Medicines Management and Optimisation (MMO) Team, we combined RightCare, Fusion48, population and contract data to create a CCG-wide picture of older people's health status, costs and outcomes.

We held two workshops in Walsall. Medical and nursing staff from primary, acute and community care, and leads from public health, commissioning and finance participated. Feedback regarding BI Team input was all positive.

Impact

Our work to build a profile of the older person population in Walsall CCG was the first time such an integrated analysis had been used to inform planning discussions and commissioning actions. This clinical analysis highlighted issues that financial analysis had failed to reveal. It led to reconfiguration of the acute setting's clinical workforce and bed base, resulting in expected savings in excess of £1million, fewer admissions and sustainable reduction in length of stay. From the strategic perspective to the local picture, the CCG and their partners could see the specific challenges facing their older populations. They gained:

- insight into older people's use of acute, mental health and community care services at a 'whole person' level
- MMO additions to the Space care home programme
- wider understanding of the evidenced effects of the innovative admission avoidance pathway
- better understanding of the multiple falls services and activity within the CCG area, revealing the acute unit had two frailty pathways and settings, creating confusion regarding patient care, payments and access.

With new insight into activity patterns, costs, healthcare status and experience of their frail cohorts, the CCG worked with partners to:

- further investigate the dual (and conflicting) frailty acute pathways, activity, costs and outcomes
- embed the START / STOPP medicine reviews' toolkit in primary and care home settings.

Impact (cont.)

Our input also informed the CCG's analysis of RightCare opportunities, RightCare delivery plan logic model and plans for 2019-20, and input into the Black Country Sustainability and Transformation Partnership Frailty Group as a key part of its reporting support.

> ***Valuable in supporting the workshops, forming the basis of discussions and helping to inform development of a set of actions to address the frailty 'gap' across Walsall, which have now been drawn up into a RightCare logic model and embedded in the CCG's three RightCare delivery plans for 19/20.***
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> **Louise Jones, Senior Commissioning Manager, Walsall CCG**