



Proactive Care in North Kerrier

How risk information supports clinical review and
coordinated Neighbourhood care

Dr Ash Stone

GP Partner at Leatside Health Centre
North Kerrier GP Clinical Lead for Proactive Care
West ICA GP Representative for Neighbourhoods



What to expect

01

The case for change

Why act earlier?

02

Our model

How we find and support people

03

A patient journey

What this looks like in practice

04

Early impact

What we are learning



The Why

Why proactive care matters for North Kerrier



Our population is changing

More people are living longer with complex health needs, especially frail older adults.



Pressure on services is rising

Emergency admissions and crisis care are increasing and unsustainable.



People want to stay independent

Most people want to live well at home and avoid unnecessary hospital care.



Prevention leads to better outcomes

Early identification and support can prevent deterioration and improve quality of life.



Stronger together

By working across primary care, community and partner services, we can do more for our population.



Better for people and the system

Proactive care reduces crises, improves experience and ensures resources are used where they matter most.



Our goal is simple: to identify earlier, support sooner, and help people live healthier, independent lives for longer.

Delivering a Neighbourhood Health Service

The 10 Year Health Plan aims to shift towards integrated, community-based care through a neighbourhood health service model



Neighbourhood Health Centres



Integrated, Community-Based Care



Integrated Health Organizations



Multidisciplinary Teams



Neighbourhood Provider Contracts



Care Delivered Closer to Home



Population Health Management



Voluntary and Community Services



REACTIVE

PROACTIVE

THE CHALLENGE

Frailty is common, people are living longer with more complex needs, and demand on health and care services is increasing faster than we can respond.

OUR POPULATION IS AGING



70,759

registered patients across North Kerrier

15,976 people are aged 65+ (22.6% of patients)

FRAILITY IS COMMON



2,396

people have modelled moderate-severe frailty



15%

of people aged 65+ across North Kerrier

RISING DEMAND



More hospital admissions

year on year for patients with frailty and complex needs

HIGH USE OF URGENT AND UNPLANNED CARE



High proportion of admissions are potentially avoidable with earlier support

INCREASING PRESSURE ON PRIMARY CARE



GP workload is rising, with less time for proactive, personalised care

THE REACTIVE CYCLE



THE IMPACT



Worse outcomes for our patients

Loss of independence, reduced quality of life, increased mortality



High use of hospitals and emergency care

Bed days, repeated attendances, delayed discharges



Financial pressure

Frailty costs the NHS approximately **£5.8 billion** each year



Pressure on our workforce

Burnout, unsustainable workloads, less time for proactive care



Widening health inequalities

Frailty develops earlier in more deprived communities



We must shift from reactive crisis management to proactive, personalised care across North Kerrier.

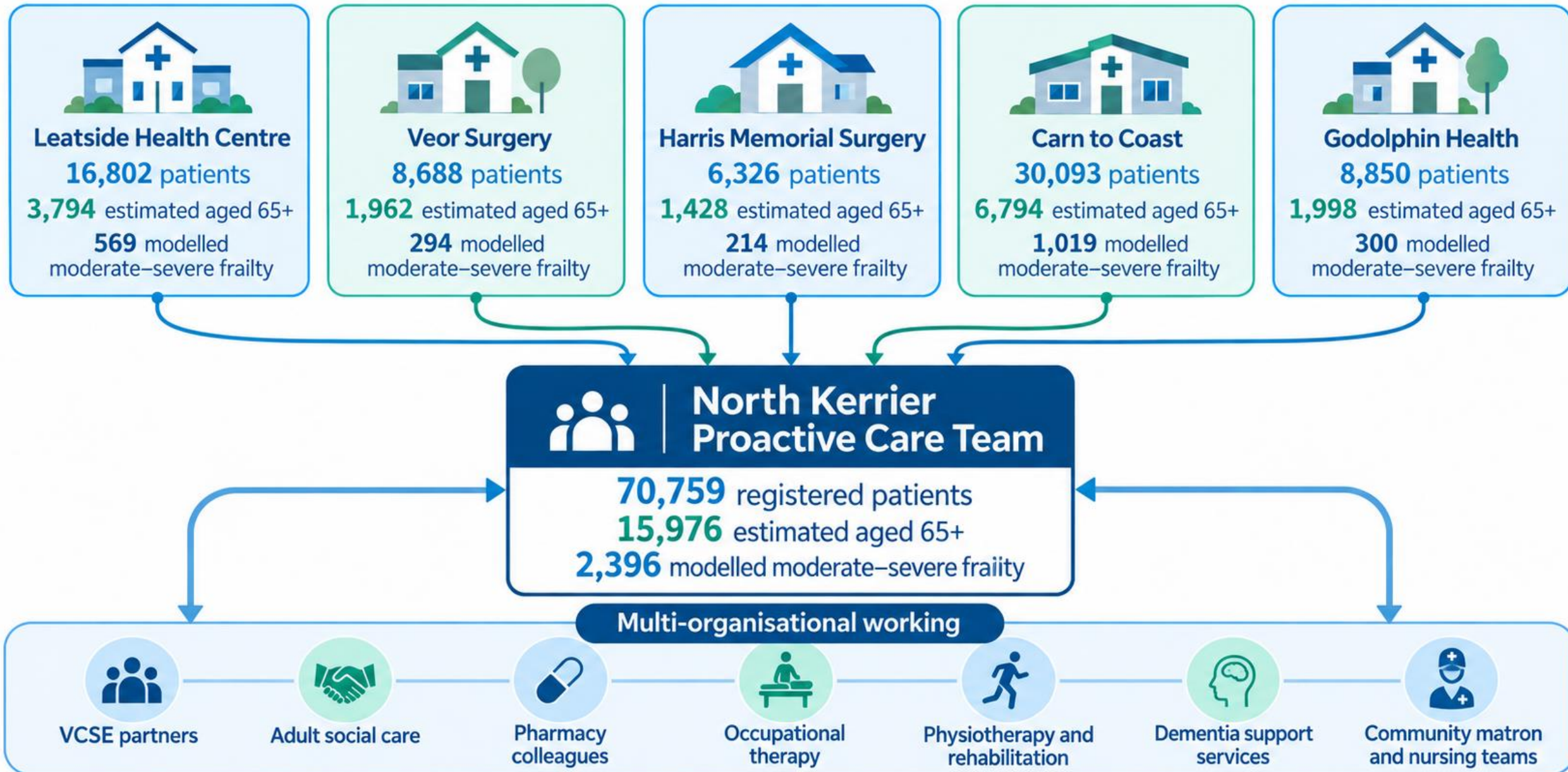


Purpose:

- prevent deterioration
- support independence
- reduce avoidable demand

Working together for a healthier North Kerrier

Five practices. One proactive approach to support our most vulnerable patients.





Be proactive: Proactive care for older people with frailty

www.bgs.org.uk/ProactiveCare



Evidence based working

Our approach is grounded in robust evidence and proven to improve outcomes for our patients and the wider health system.



01

Systematic Identification and Risk Stratification

Early identification enables targeted intervention, decreases admissions and supports independence.



02

Comprehensive Geriatric Assessment

Decreases mortality, admissions, length of stay and care home placements.



03

Personalised Care and Support Planning

Ensures patients are active partners in care, increasing satisfaction, reduces burden, aligns care and personal goals.



04

Integrated MDT

MDT improves co-ordination, reduces duplication and improves outcomes.



05

Rapid Access to Community Based Services

Decreased admissions, promotes faster recovery and found to reduce overall cost to the NHS.

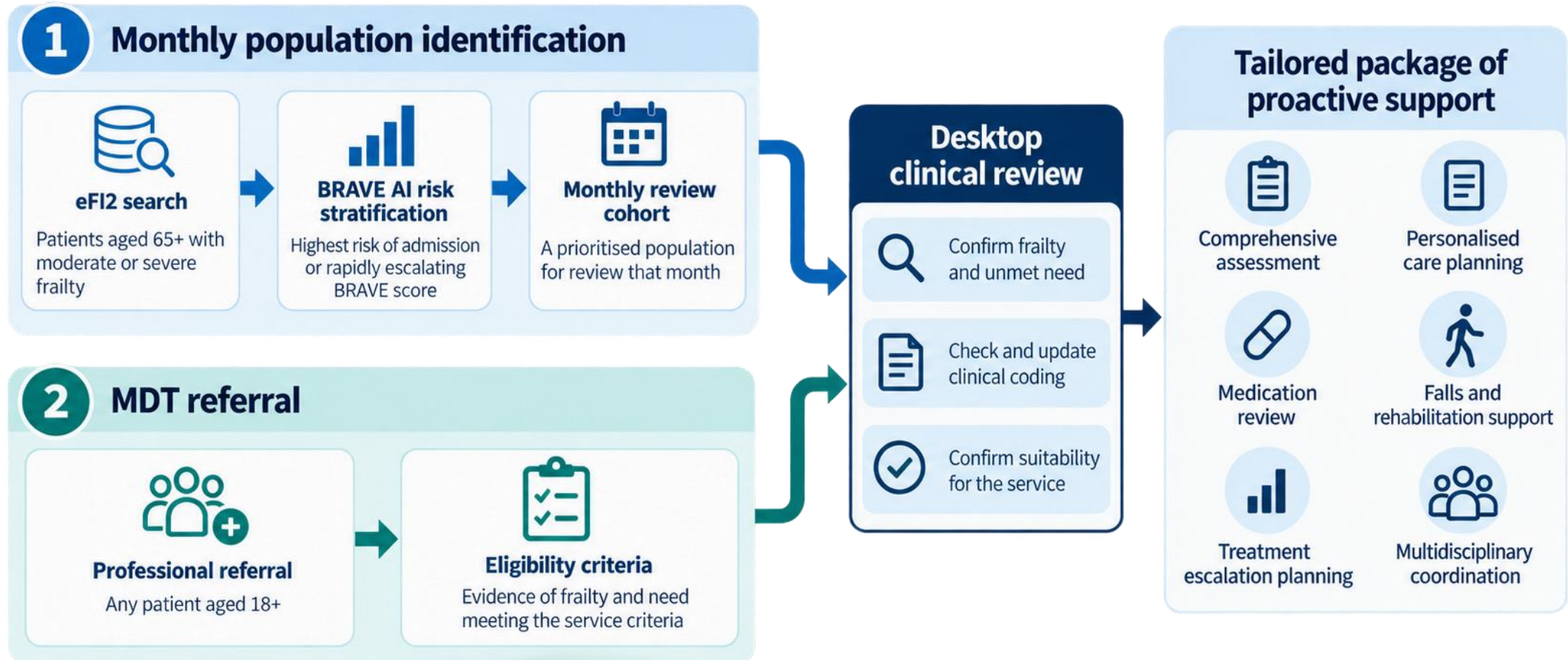


01

Systematic Identification and Risk Stratification

Routes into the Proactive Care model

Population health intelligence and professional referral identify patients who may benefit from proactive support.



Risk scores identify where to look. Clinical review determines who will benefit.

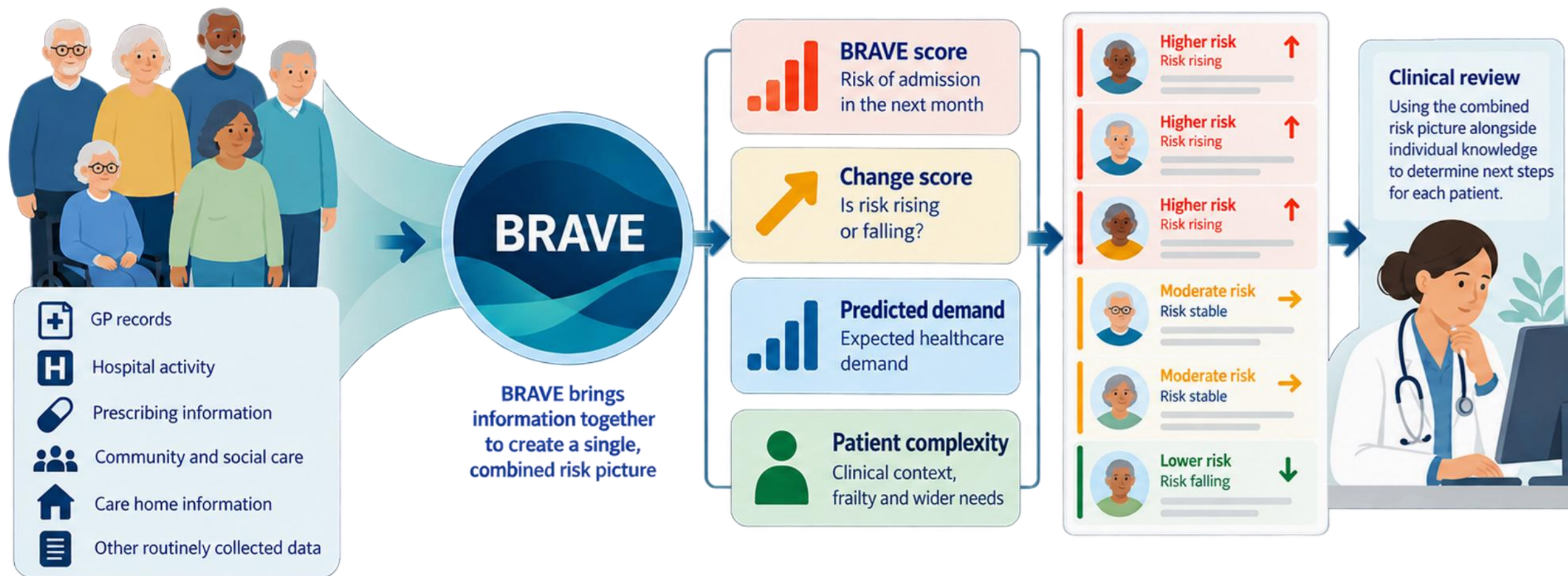
Routinely collected health and care information

BRAVE brings information together

A combined risk picture to support prioritisation

Prioritised patient list for clinical review

Clinical review

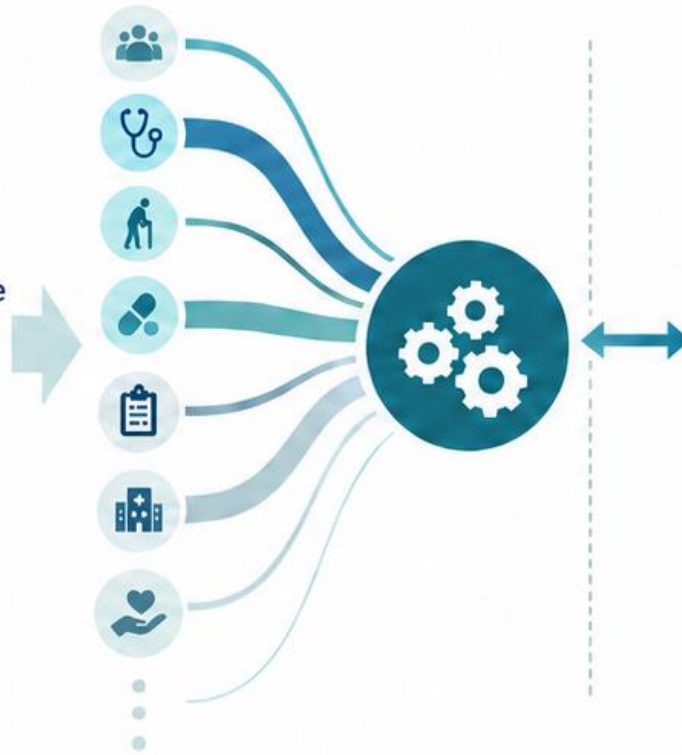


BRAVE identifies where to look. Clinical judgement determines what happens next.

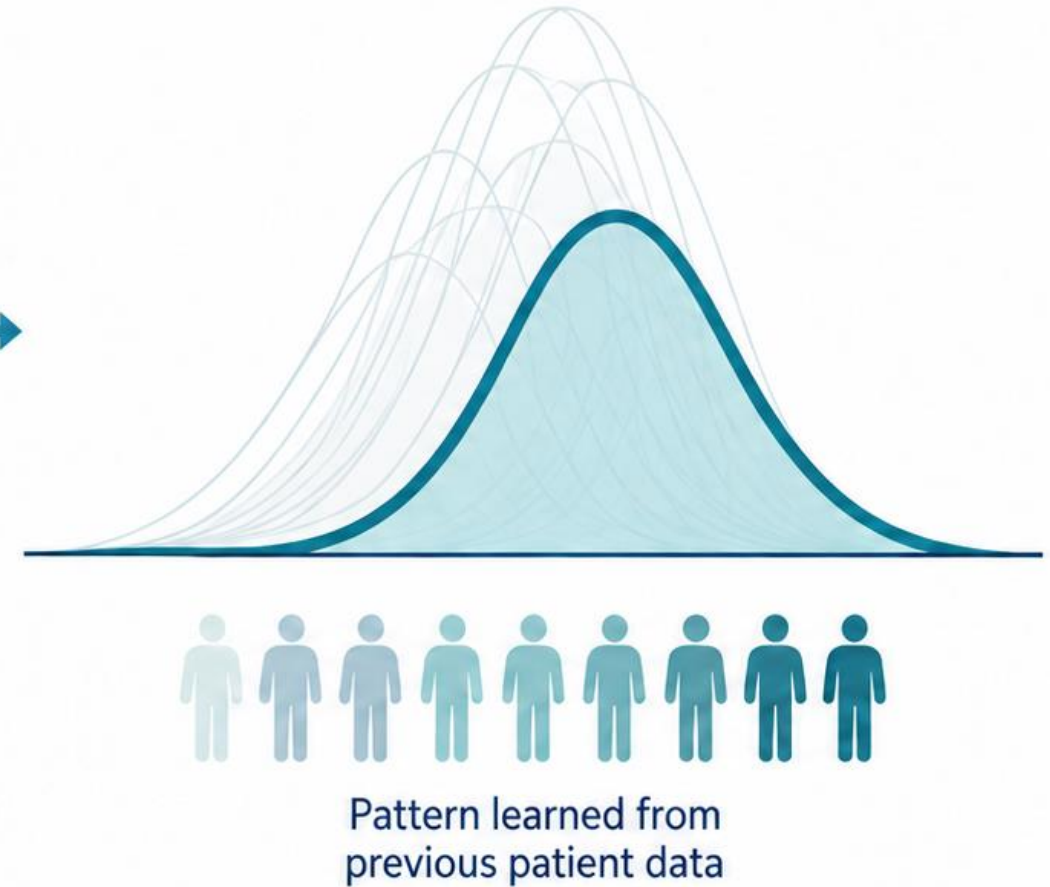
100+ patient variables



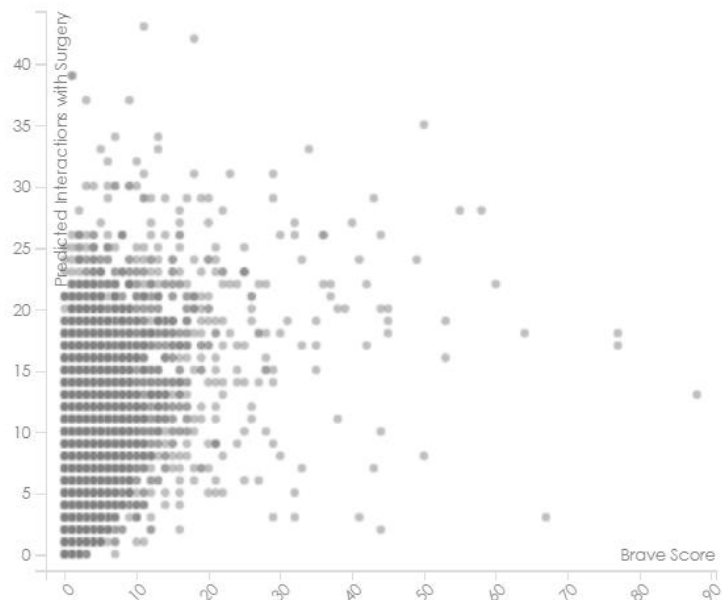
Variables are weighted and combined



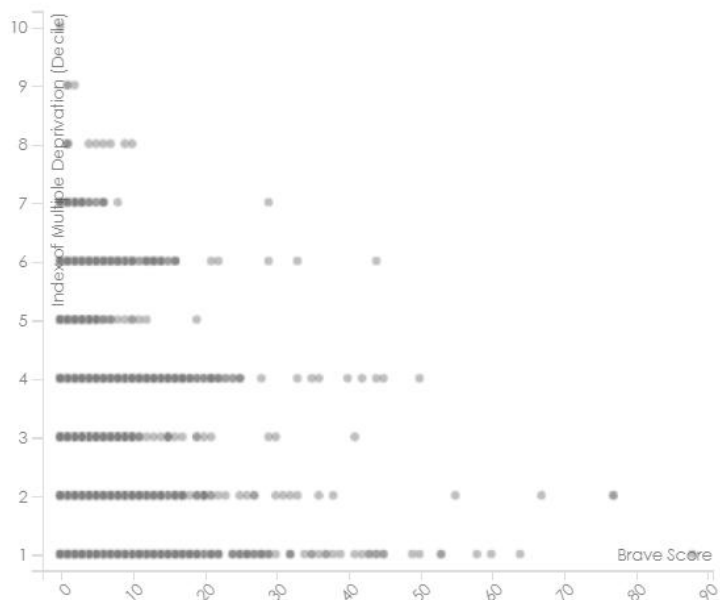
Learned pattern associated with admission



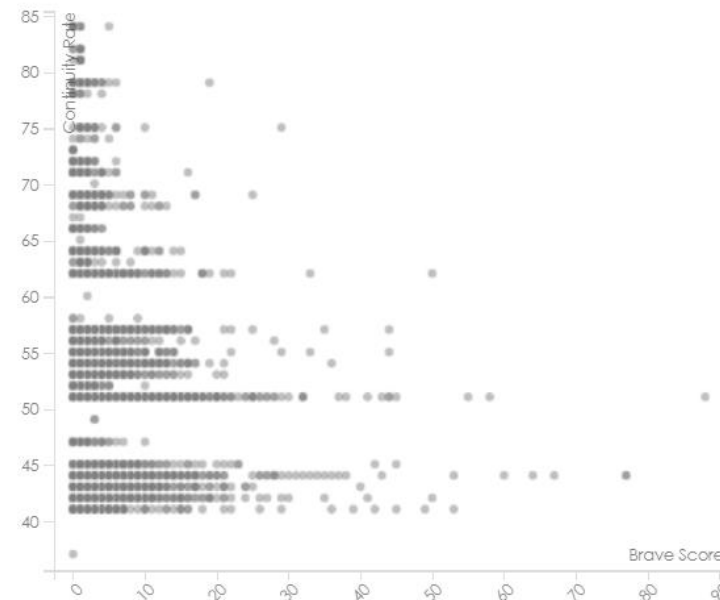
Demand Landscape



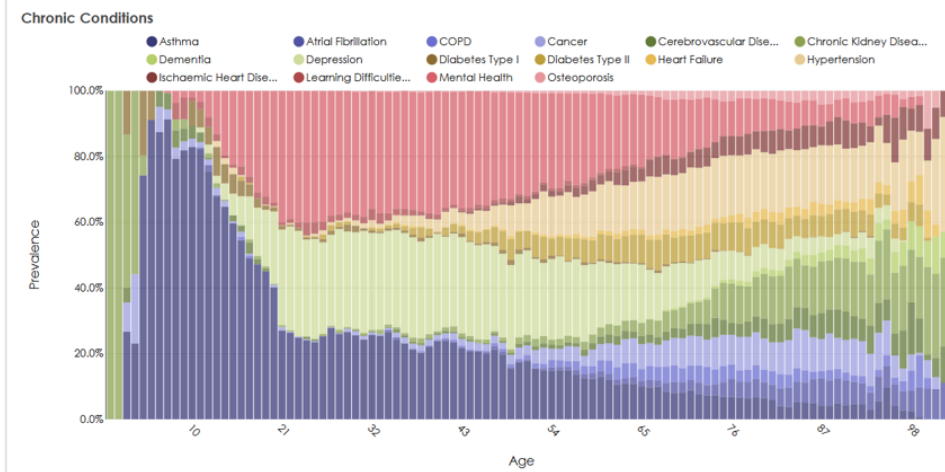
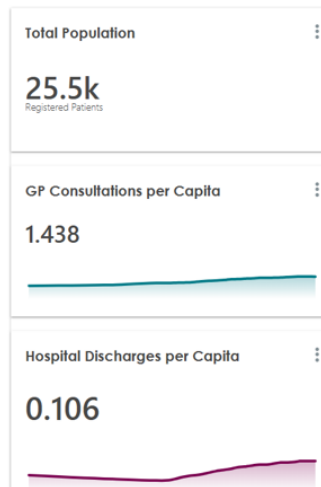
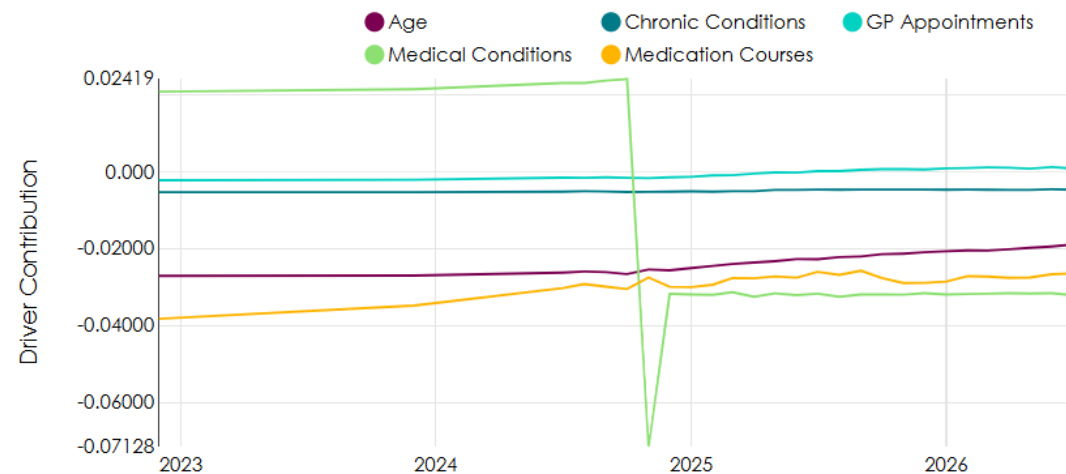
Deprivation Landscape



Care Continuity Landscape



Brave Score Drivers



North Kerrier Proactive Care Team

WORKING
TOGETHER
FOR A HEALTHIER
NORTH KERRIER

Referral criteria

EARLIER SUPPORT | SAFER CARE | STRONGER COMMUNITIES

ESSENTIAL



Aged 18 years
or over

AND

ESSENTIAL



Moderate or
severe frailty

AND

AT LEAST ONE



Multiple long-term
conditions causing
complexity



Polypharmacy —
5 or more medications



Increased or recurrent
unplanned admissions



Increasing
dependence



Not appropriate for referral



An urgent medical or social problem requiring **immediate** management to keep the patient safe

Where frailty is absent and the sole or primary issue is:



A long-term or complex condition
managed by a specialist team



Dementia or mental health concerns



Medication compliance



A social care requirement



Substance misuse



Difficulty engaging or contacting
the patient



Meets all essential criteria + at least one additional criterion



Refer to the Proactive Care Team



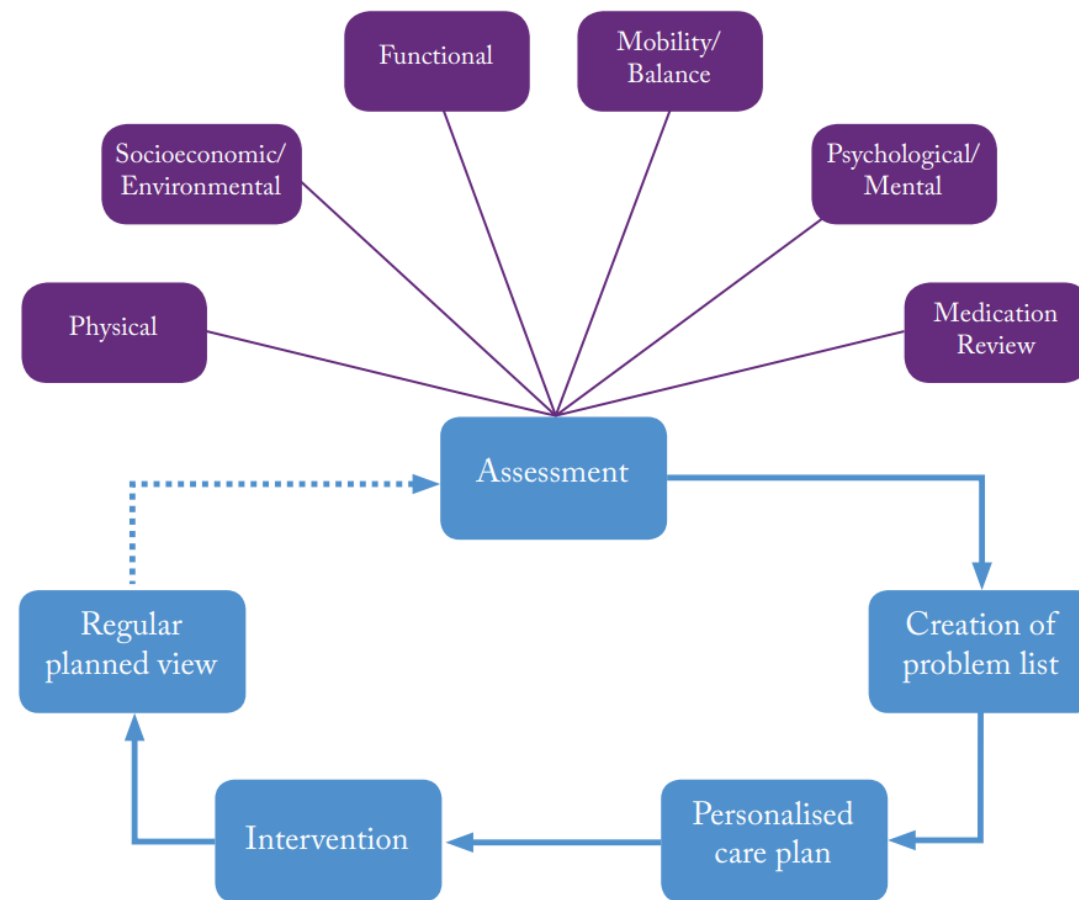
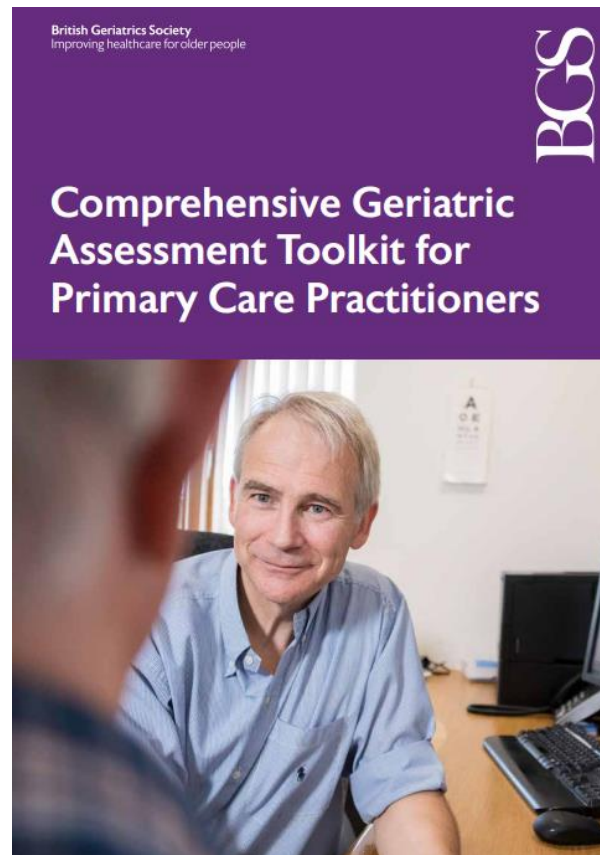
02

Comprehensive Geriatric Assessment

45

minutes

plus travel, liaising with care co-ordinators, documentation and referrals





03

Personalised Care and Support Planning

One plan built around what matters to me





04

Integrated MDT



Representatives include:



Doctor



Proactive
Care Nurse



OT



Care
Co-ordinators



Health and
Wellbeing
Practitioners



Community
Matron



Adult
Social Care



Dementia
Practitioners –
PCDP, Admiral nurse



Voluntary Care
Sector – CHWW,
Chaos, Cn4C



Pharmacist



Community
Rehabilitation
Team



Neighbourhood Dashboard

Care Co-Ordinator Dashboard

Upload Tool

Overview

Admin

Version 7 - Copyright © 2025 Dr Ashleigh Stone

Functions:

Find Patient

Clear Patient

Save Profile

Output Entries For Notes

Action Toolbar

Create Action

Mark Complete

Edit Action

Delete Action

Leatside General Practice

Pending Appointment:

Pending/Last Assessor:

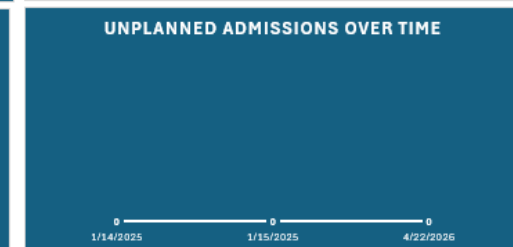
Exam Date:

PCSP Date:

Book Exam

Book PCSP

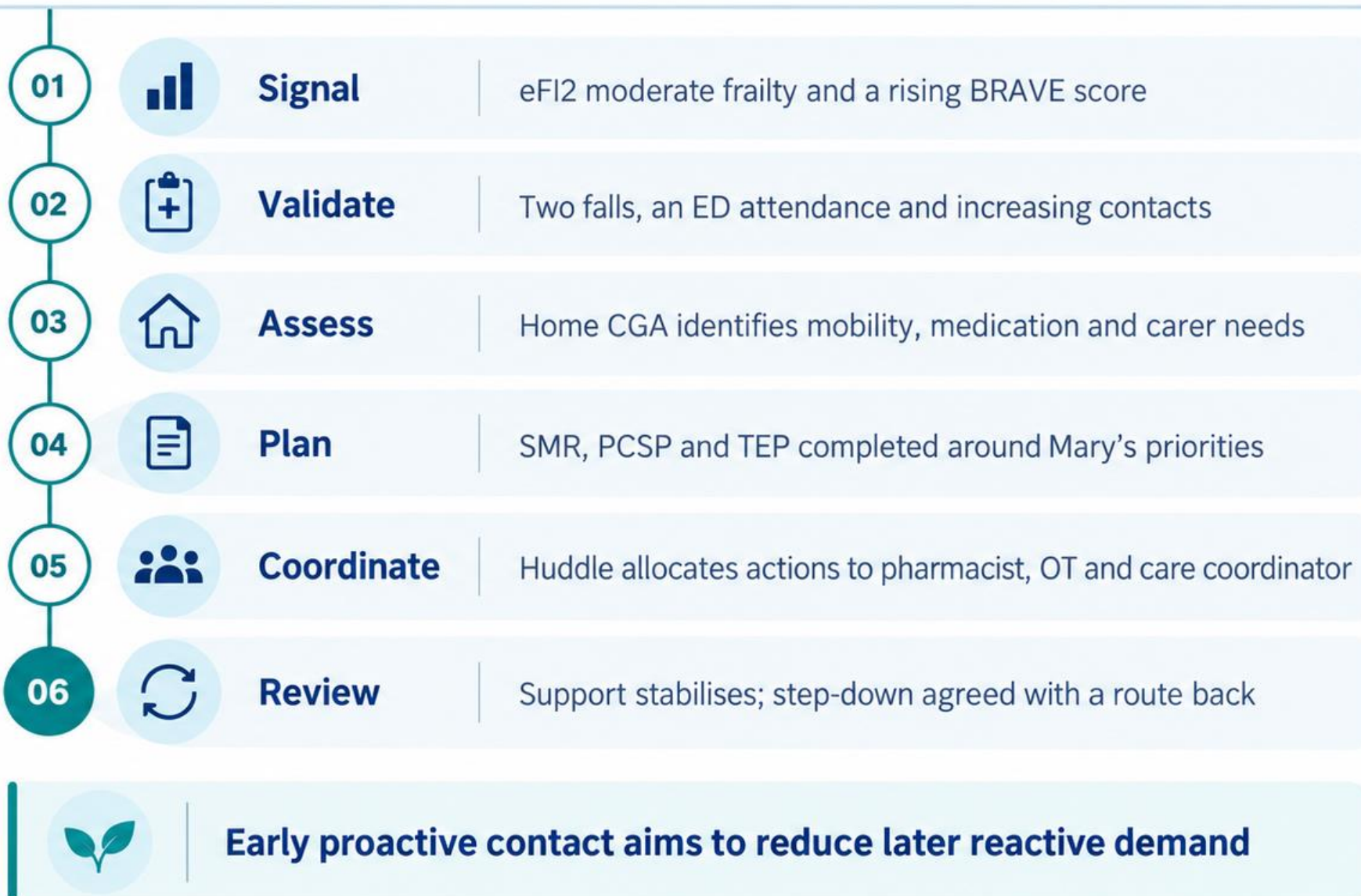
Date to Next Review At MDT:



A patient journey

Mary,
79
Lives alone

COPD, diabetes and
osteoarthritis



Patient Journey: Early Identification, Timely Intervention, Better Outcomes

A proactive, person-centred approach to preventing decline and supporting independence.



79 Year Old Male



Complexity score
59%



Index Deprivation
Score 4

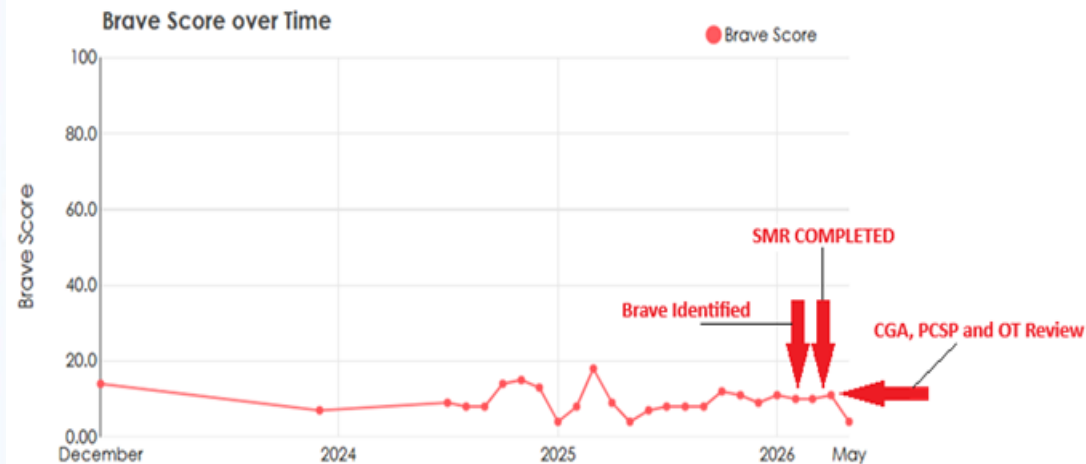


PMH - AF, CKD3,
Diastolic dysfunction



Brave Score over Time

—●— Brave Score



From October 2025 average Brave Score **10**.
Following Intervention, Brave score dropped to **4** in **May 2026** data download.



Patient Challenges

- Shoulder pain post recent fall
- Falls risk with long lie, preventing leaving house
- Catheterised, regularly blocking



Objective Challenges

- Sarcopenia
- High falls risk - Uses Rollator frame in home, 4ww outside
- Not checking blood sugars
- Mild cognitive decline



Interventions

- Treatment escalation plan created
- Advanced directives discussion
- Signposted to podiatry and retinal screening programs
- Falls - referred in house OT for review. Given falls plan
- Limit Laxative prescribing, stockpiling.
- Reiterated Hypo advice
- Memory assessment completed
- Ongoing need identified re. mobility. 2 falls in a year.
- Referred physio for shoulder pain
- Mobility assessment



Positive Outcome

Early identification and comprehensive intervention have reduced risk, improved confidence and supported independence.



Enhanced Safety

Reduced falls and complications



Improved Function

Better mobility and daily living



Better Outcomes

Lower risk, greater independence

Early evidence of impact



36%

reduction in hospital discharges

27 fewer discharges over six months

$p = 0.003$



412

patients reviewed



132

with complete six-month follow-up



GP telephone



significant downward trend
 $p = 0.004$



Non-GP face-to-face



downward trend
 $p = 0.019$



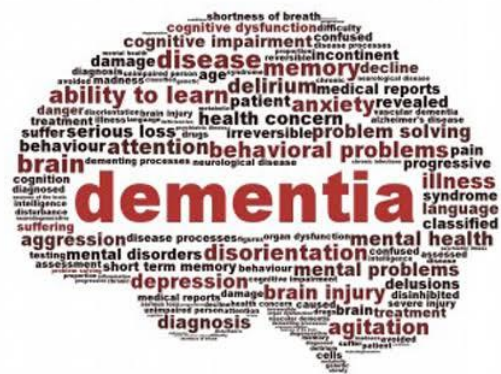
Non-GP home visits



downward trend
 $p = 0.003$



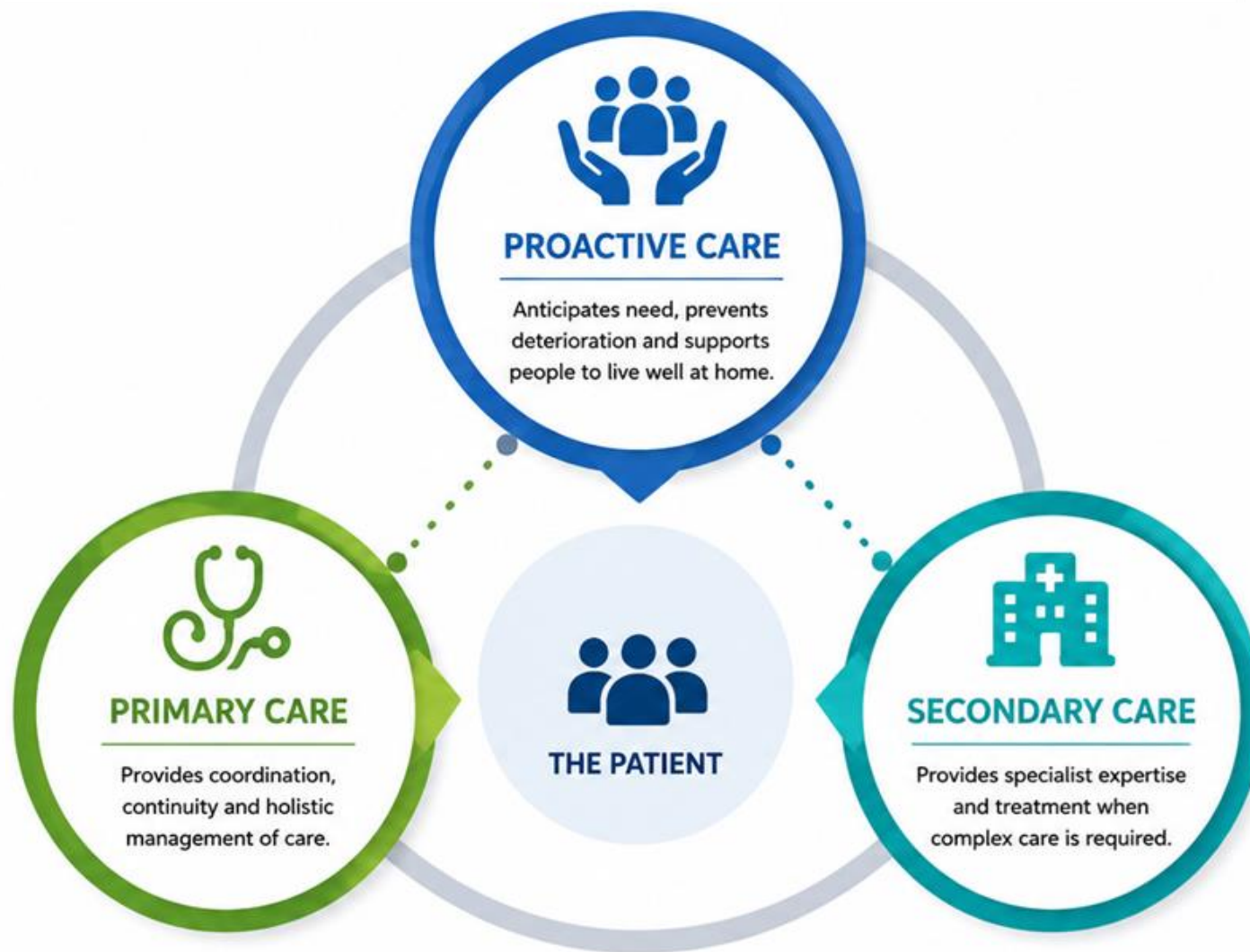
Early proactive activity increased before reactive demand began to fall

The logo for Heidi features the word "Heidi" in a blue, rounded, sans-serif font. The letter "H" is stylized with a pink dot above it.

What success looks like



System Change



Our shared goal: Right care, right person, right time – improving outcomes, experience and quality of life.



We identify
before crisis.



We assess
using Comprehensive Geriatric Assessment.



We support
using personalised care planning.



We coordinate
through MDT.



We prevent
avoidable deterioration and admission.

Thank you

Are there some questions?

Dr Ash Stone

GP Clinical Lead for Proactive Care

