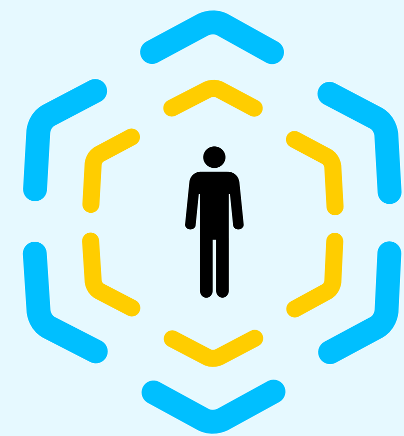
PROactive care

Personalised
Preventative
Targeted
Integrated

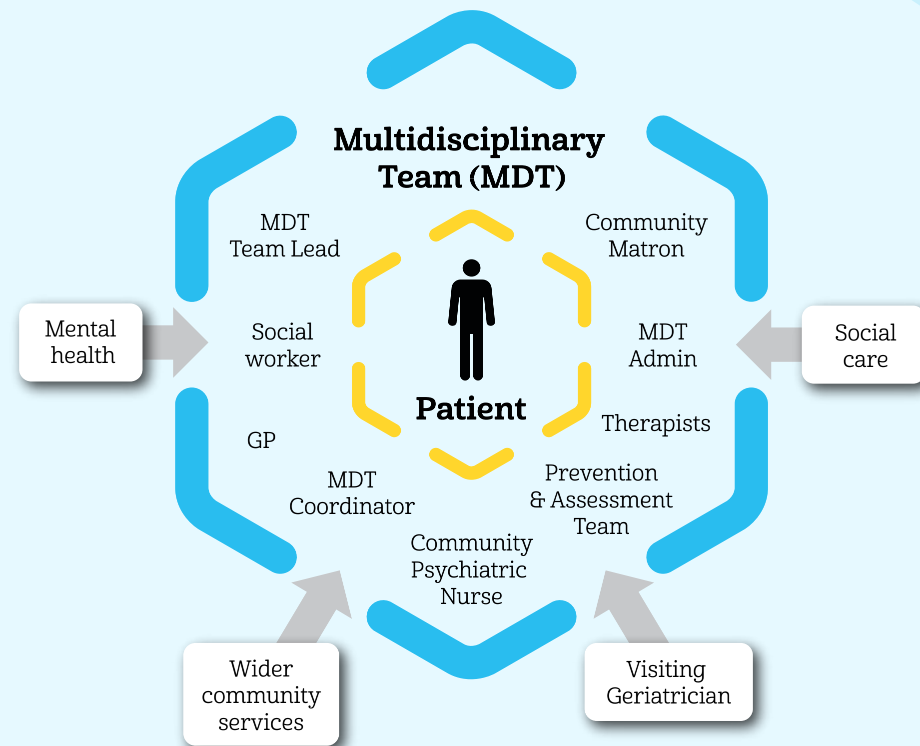
NHS Crawley Clinical Commissioning Group
NHS Horsham and Mid Sussex Clinical Commissioning Group
Sussex Community NHS Trust
Sussex Partnership NHS Foundation Trust

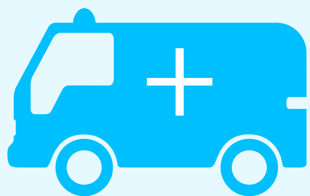


PROactive care Defined

PROactive care programme provides a patient centred approach. The approach is preventative and aims to work with the clients physical health, mental health and social care needs . The design of care is holistic and support is provided via a dedicated multidisciplinary team (MDT) wrapped around the client needs.

Clients are supported by a multitude of professionals led by a General Practitioner and supported by a Community matron, Physiotherapist, Occupational therapist, Social Worker, Community Psychiatrist Nurse, Prevention and assessment team, Geriatrician support, Team lead and administrative support. Further support from Public Health and the Voluntary sector





Key objective is to move away from episodic Reactive care that is time critical and an emergency.

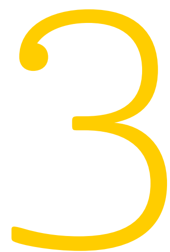
Targeted

SHIFT FROM REACTIVE CARE

Resources

Video: PROactive care in West Sussex

Video: Joined-up care: Sam's story



phases of **innovation** and **transformation**

Phase 1
Implementation

Phase 2
Evaluation

Phase 3
Sustainability

Outcomes promoted

- Improved quality of the physical and mental health, and social care for the population of Crawley, Horsham and Mid Sussex
- Self management of long-term conditions
- Independence
- Reduction in unscheduled care
- Contingency plan
- Reduce risk of admission to acute care

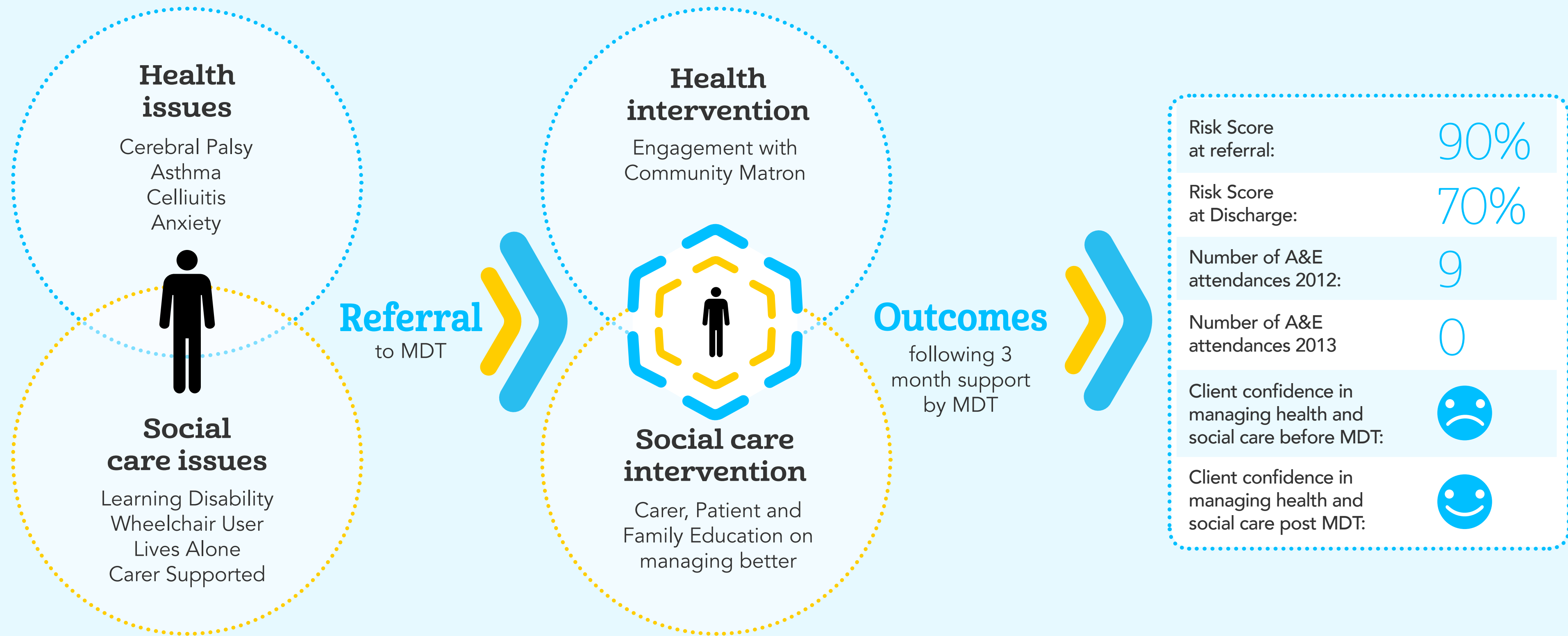
Model of care

1. A case management approach using risk profiling
2. Clients selected for referral have 65% and higher risk of admission to acute care in the next 12 months or frequent fliers
3. Emphasis on those with chronic and long term conditions
4. Clinically led by a GP from the outset
5. Primary and Community Care led
6. Single access to multi-disciplinary team
7. Care provided by nine Multidisciplinary teams In North Sussex, each supporting an enrolled population size of between 30,000 and 50,000
8. Co location of professionals
9. 12 weeks or more support via personalised pack ages of care
10. Monitor and review client for expected outcomes

PROactive care

Case study

Illustrating proactive health and social care intervention and outcomes



PROactive care

Benefits and outcomes

Key benefits of proactive care in a multidisciplinary setting

1. Identifies a cohort of patients suitable for early intervention
2. Ring fences time and resources
3. Prevents parallel care for multiple health co morbidities and social care needs
4. Improved and continuous communication between professionals in MDT
5. Care needs designed specific to the client and maximise independence
6. Results in a shift from emergency to planned care

View the latest performance data for proactive care in our CCG areas.

Contribution to positive outcomes

Health outcomes

- Enhances the quality of life for clients with long term conditions
- Enhances the experience of care
- Helps clients to manage their conditions in an informed and supported manner

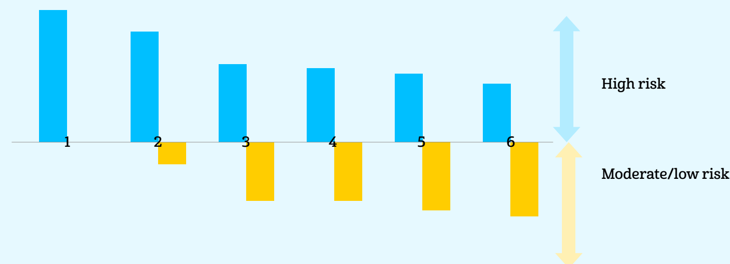
Social care outcomes

- Enhances the quality of life for clients with care and support needs
- Enhances the experience of clients with care and support needs
- Ultimately reduces the need for care and support as independence is regained

Performance and acheivements 2013/14

Early indications for patients with 65% and higher risk of admission demonstrates:

1. Reduction in risk of admission post MDT intervention.
   A shift from high risk towards moderate/low risk over time.



2. Net reduction in risk by 8% for discharged cohort (2013/14) referred in the high risk group
3. Those towns with established MDTs from phase 1, showing an observable reduction in non-elective activities for the same period 2013/14 compared to 2012/13 (Horsham and Crawley).
4. Contingency plans uploaded onto South Coast Ambulance Service, results in a conveyance rate of 30% to A&E compared to a conveyance rate of 70% for those patients without contingency plans.
5. Self Care and management understood better by patients when supported by MDTs.

Outcomes dependant on client variations due to demographics and long-term conditions. Qualitative data on interventions being modelled.

Just over
1200
referrals

clients discharged after at least **3 month** intervention/support from MDTs

PROactive care

Model of care

Multidisciplinary Team (MDT)

MDT Team Lead

Community Matron

Social worker

MDT Admin

Patient

GP

Therapists

MDT Coordinator

Prevention & Assessment Team

Community Psychiatric Nurse

Mental health

Social care

Wider community services

Visiting Geriatrician

MDT locations and affiliated practices

What does it mean?

Single access point
Partnership working
Outcome focused
Early identification of needs
Collaborative working
Assistive technologies
Physical health
Preventative
Integrated care
Prioritise
Person centred
Empowered Patient
Voluntary sector support
Mental health
Independent living
Dedicated team
Contingency plan
Seamless care
Health and social care
Positive experience