

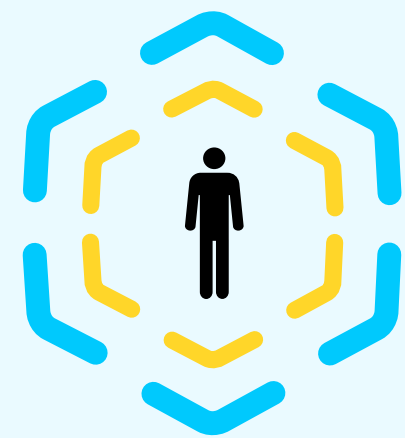


PROactive care

Personalised
Preventative
Targeted
Integrated



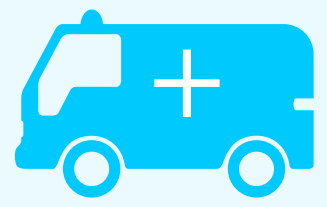
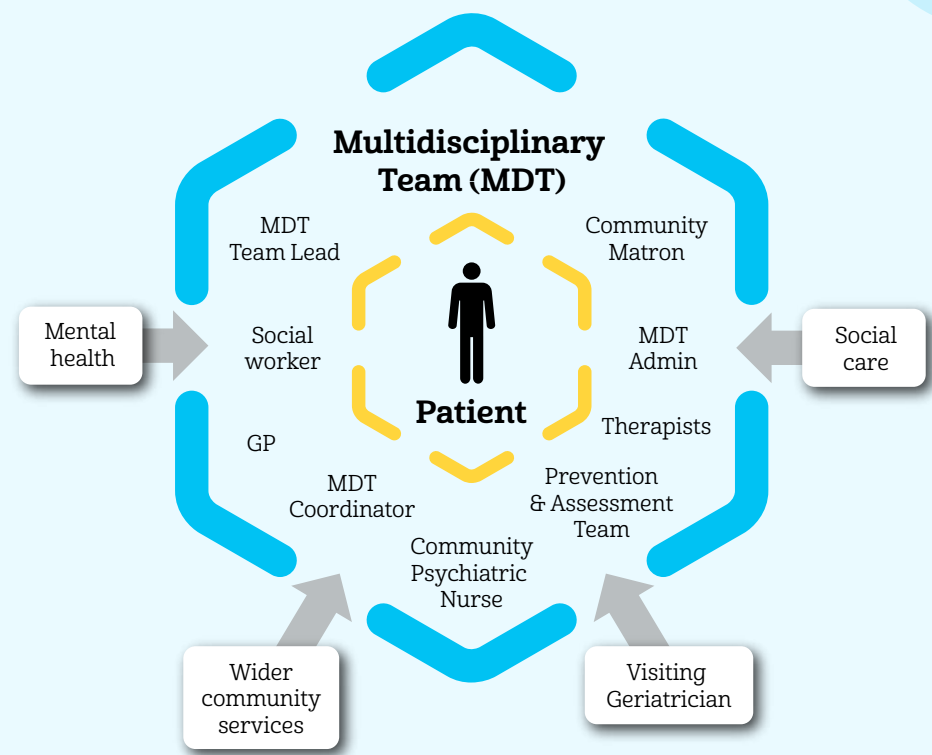
NHS Crawley Clinical Commissioning Group
NHS Horsham and Mid Sussex Clinical Commissioning Group
Sussex Community NHS Trust
Sussex Partnership NHS Foundation Trust



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

3

phases of
innovation and
transformation



Phase 1
Implementation



Phase 2
Evaluation



Phase 3
Sustainability

Outcomes promoted

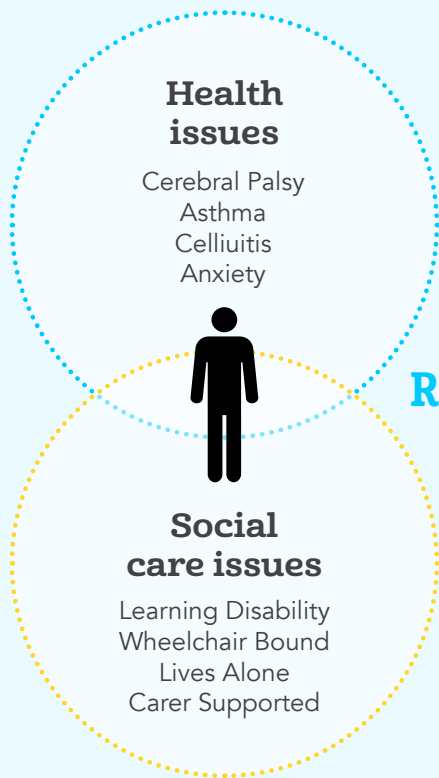
- > Improved quality of the physical and mental health, and social care for the population of Crawley, Horsham and Mid Sussex
- > Self management of long-term conditions
- > Independence
- > Reduction in unscheduled care
- > Contingency plan
- > Reduce risk of admission to acute care

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

Case study

Illustrating proactive health and social care intervention and outcomes



Referral
to MDT



Outcomes
following 3
month support
by MDT



Risk Score at referral:	90%
Risk Score at Discharge:	70%
Number of A&E attendances 2012:	9
Number of A&E attendances 2013:	0
Client confidence in managing health and social care before MDT:	
Client confidence in managing health and social care post MDT:	

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

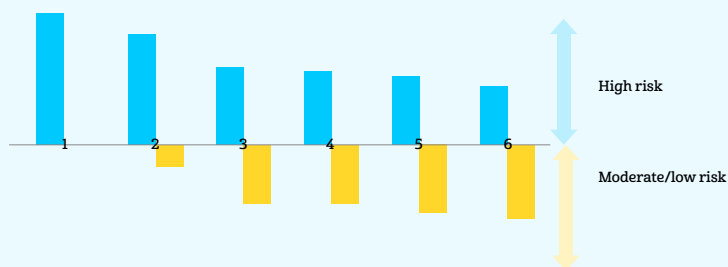
- > Enhances the quality of life for clients with care and support needs
- > Enhances the experience of clients with care and support needs
- > Ultimately reduces the need for care and support as independence is regained



Early performance and achievements

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

1. Reduction in risk of admission post MDT intervention.
Average risk at referral 76.2% Average risk at discharge 55.6%
Therefore a shift from high risk towards moderate/low risk over time.



2. 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).
3. Contingency plans uploaded onto South East Coast Ambulance service system.
4. Evidence of reduction in A&E admissions in Burgess Hill when comparing the same period 2013/14 to 2012/13.

Outcomes dependant on client variations due to demographics and long-term conditions. Qualitative data on interventions being modelled. As at December 2013.

8 OPERATIONAL MDTs

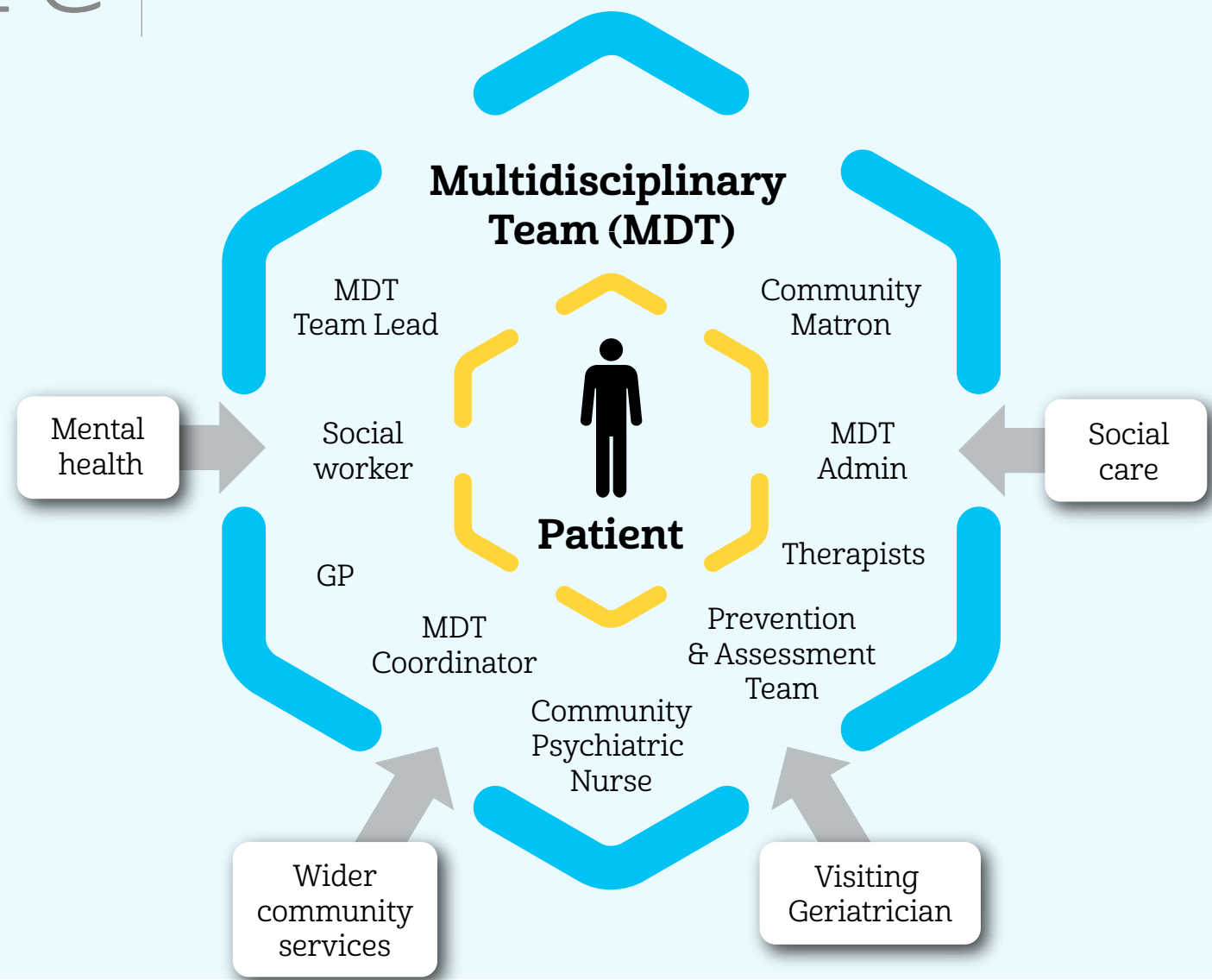
Around **400** clients currently active in the MDTs

Just over **700** referrals

180

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

Model of care

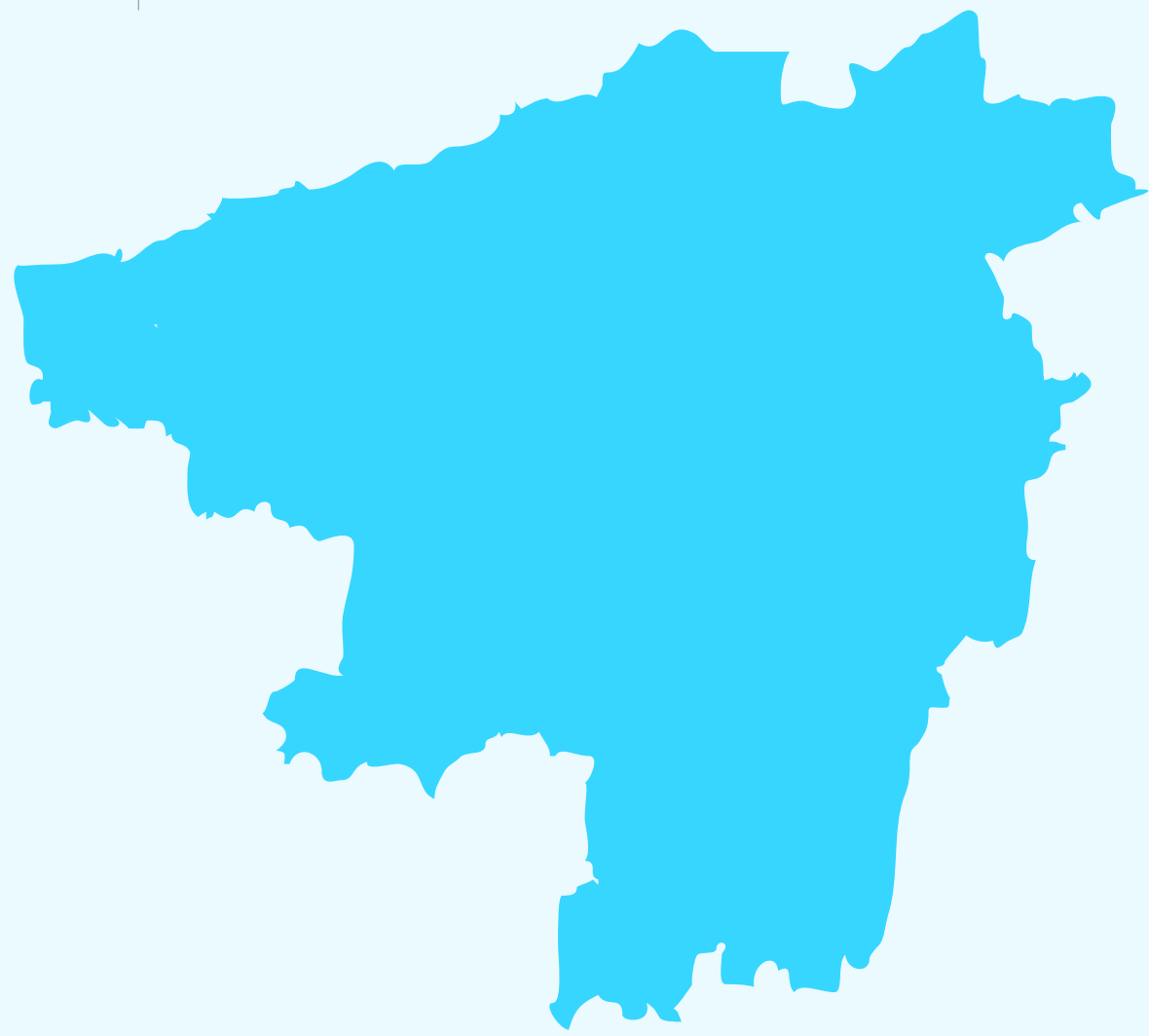




one
two
three
four
five
six
seven
eight



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

Mental health

Independent living

Dedicated team

Contingency plan

Voluntary sector support

Seamless care

Health and social care

Positive experience