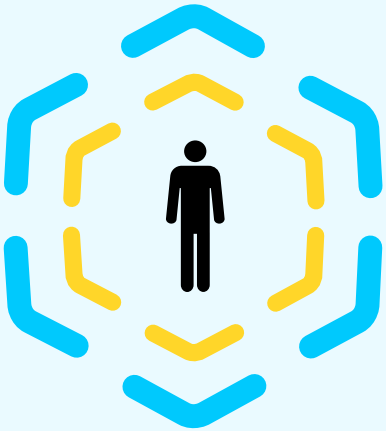
NHS

PROactive care

Personalised
Preventative
Targeted
Integrated



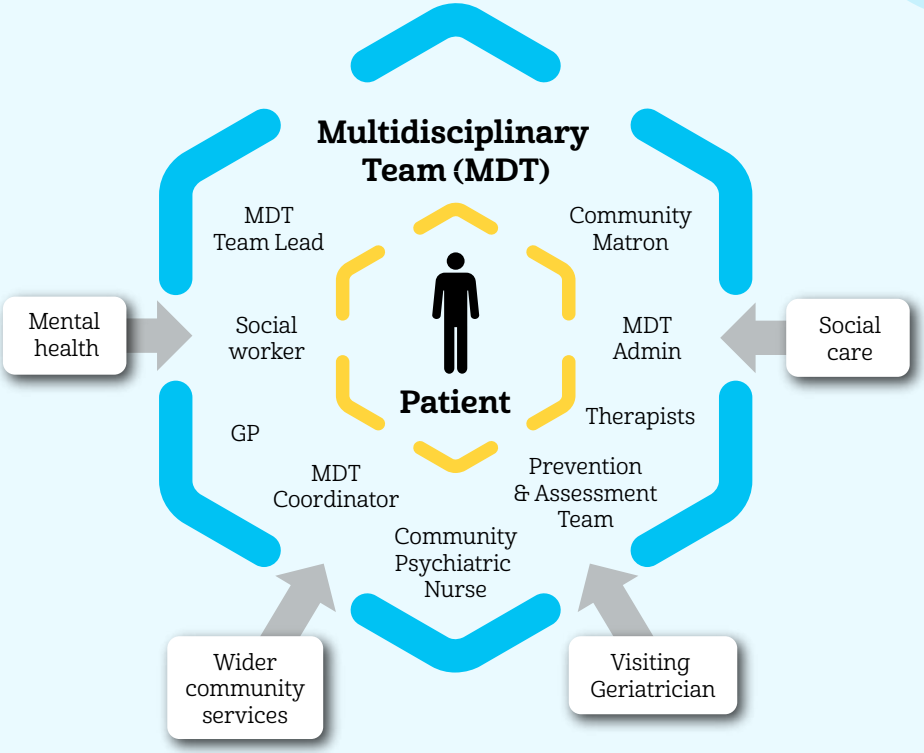
west sussex county council

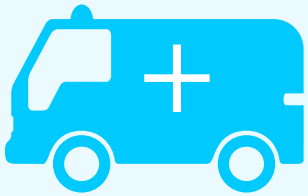
NHS Crawley Clinical Commissioning Group
NHS Horsham and Mid Sussex Clinical Commissioning Group
Sussex Community NHS Trust
Sussex Partnership NHS Foundation Trust

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

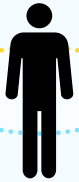
PROactive care

Case study

Illustrating proactive health and social care intervention and outcomes

Health issues

Cerebral Palsy
Asthma
Celliuitis
Anxiety



Social care issues

Learning Disability
Wheelchair Bound
Lives Alone
Carer Supported

Referral
to MDT

Health intervention

Engagement with Community Matron

Social care intervention

Carer, Patient and Family Education on managing better

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:	

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

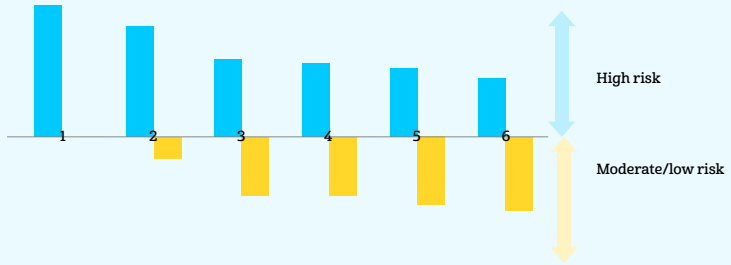
- Enhances the quality of life for clients with care and support needs
- Enhances the experience of clients with care and support needs
- Ultimately reduces the need for care and support as independence is regained

PROactive care

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%
   Therfore 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.

8 OPERATIONAL MDTs

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

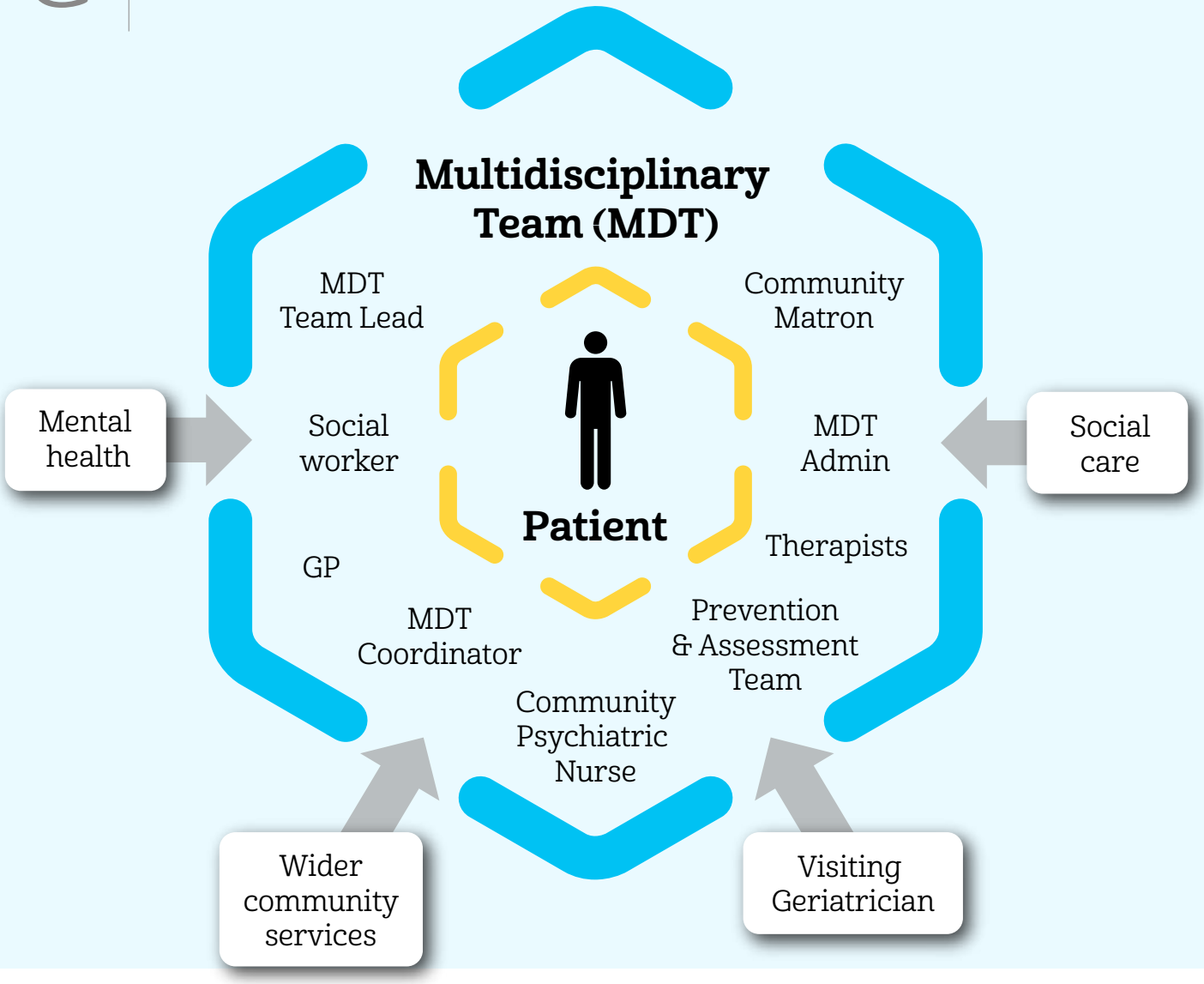
Just over **700** referrals

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

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

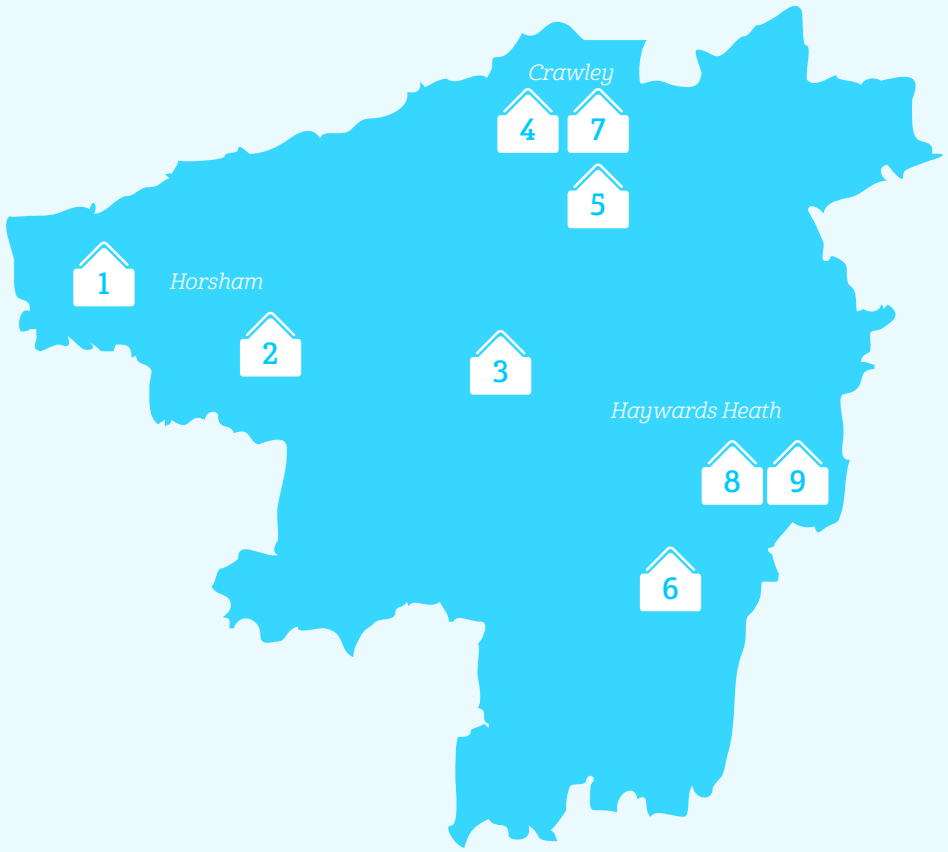
PROactive care

Model of care



PROactive care

MDT locations and affiliated practices



1 Horsham MDT Team 1

Venue: Horsham Hospital

- Courtyard Surgery
- Riverside Surgery
- Park Surgery

2 Horsham MDT Team 2

Venue: Horsham Hospital

- Holbrook Surgery
- Rudgwick Medical Centre
- Orchard Surgery
- The Village (Southwater)

3 Crawley MDT Team 1

Venue: Leacroft Medical Practice

- Ifield Medical Practice
- Langley Corner Surgery
- Gossops Green Surgery

4 Crawley MDT Team 2

Venue: Southgate Medical Group

- Woodlands Clerklands
- Coachmans Medical Practice
- Bewbush Medical Centre
- Crawley Health Centre

5 Crawley MDT Team 3

Venue: Crawley Down Health Centre

- Pound Hill Surgery
- The Glade
- Bridge Medical Centre
- Saxonbrook Medical Group

6 Mid Sussex MDT Team 1

Venue: Sidney West

- Mid Sussex Health Centre
- Park View Health
- Meadows
- Silverdale
- The Brow Medical Centre

7 Mid Sussex MDT Team 2

Venue: Crawley Down Health Centre

- Moatfield Surgery
- Judges Close
- Ship Street Surgery

8 Mid Sussex MDT Team 3

Venue: Haywards Heath Health Centre

- Ouse Valley Practice
- Cuckfield Practice
- Cowfold Surgery
- Dolphins Practice

9 Mid Sussex MDT Team 4

Venue: Haywards Heath Health Centre

- Newtons Health Centre
- Lindfield Medical Centre
- Northlands Wood Practice

PROactive care

What does it mean?

PROactive care

Appendix

Patient centred approach

Providing care that is responsive to individual patient needs. Patient need is the key value and criterion that guides all clinical or social care decisions. Central to the care is that patients and professionals work collaboratively towards a shared goal through shared knowledge that results in improved health/care outcomes.

Key features of patient/ person centred care are

- Care is designed for the "whole person"
- Support and empowerment is through co ordinated care that is accessible from a single referral.
- Tailored communication, encouragement and incentivisation enables better engagement from the patient/client.

Preventative

Care that focuses on disease or health maintenance.

The intervention prevents a deterioration in the condition, disease or social care needs and avert a crisis.

Innovation

The innovation with the programme is application of a solution that targets a selected segment of the population with need for proactive care. The technical solution is Risk stratification. The Predictive risk stratification model is based on the King's Fund Combined Predictive Model, which combines Practice and hospital data to provide a risk score for patient's being admitted to hospital over the next 12 months.

Contingency plan

A contingency plan is devised for each patient/client. This provides specific information on the patients condition and during times of crisis, the plan allows the direction of emergency or urgent services as appropriate. This is uploaded on the South East Coast Ambulance Service information systems (IBIS) and regulates ambulance conveyances.

PROactive care | Appendix

Risk profiling

Risk profiling provides an opportunity available to commissioners and providers as illustrated by the Kaiser Permanente triangle (see diagram to left in the high risk group highlighted red) to better manage people in the system, and is based on levels of complexity of care.

The objective of risk stratification linked to the proactive care programme is a patient centred approach to achieve a shift in the direction indicated by the arrow, such that the health / social care needs of the person are managed in a manner to prevent it becoming an emergency and time critical.