NHS England

Proactive Care

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Aims and overview

- What is Proactive Care (Anticipatory Care) ?
- How does it link with housing?

Summary of Proactive Care (1/2)

1. What is Proactive Care ?

- Creating culture change: "**moving from reactive, single disease-based fragmented care to proactive joined-up** care, personalised to the individual."
- For a specific sub-set of individuals-Multiple long-term conditions (MLTC), including frailty
- Delivered through multi-disciplinary teams in local communities.

2. What public commitments have we made to Proactive Care (PC) and why?

Proactive Care (PC) is one of the **NHS Long-Term Plan commitments** to supporting **individuals to age well**. It is one of a number of complementary Community Care models supported nationally to enable more individuals to be **supported at home and remain independent** and optimist well being

3. What is the primary aim of implementing Proactive Care?

To optimise the health and wellbeing of people and communities, by intervening earlier, proactively, and more holistically, whilst the person is at home. This should:

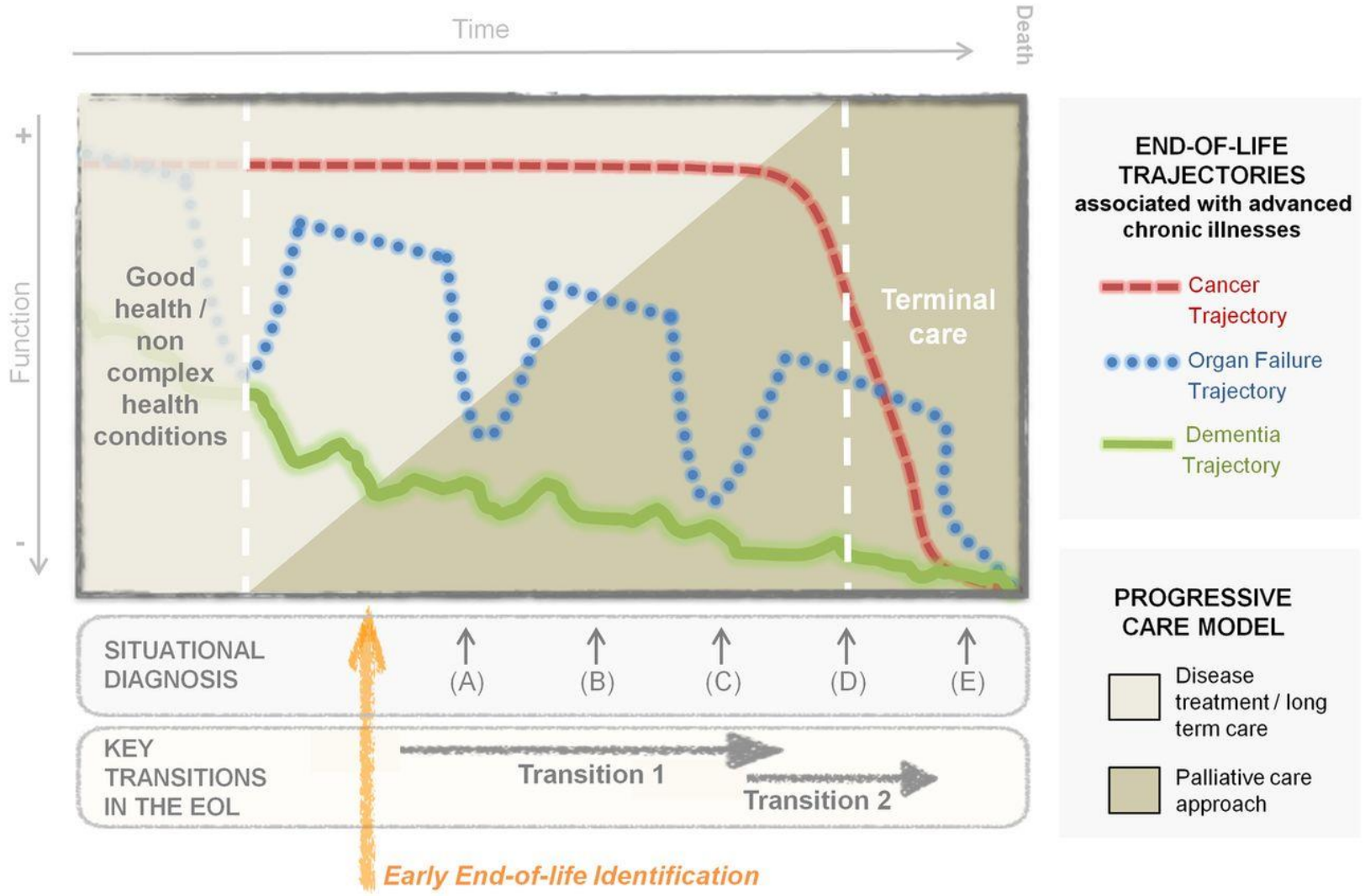
- Reduce use of **avoidable unplanned care** by ensuring people have access to the planned health and care support they need in the community
- Reduce, reducing the need for more costly health and care provision downstream
- **avoidable exacerbation of ill health**

4. Who is Proactive Care for?

Proactive Care prioritises individuals with multiple long-term conditions who are at the **greatest risk of using unplanned care** (ambulance call outs, A&E attendance and/or emergency admission), through:

1. Population segmentation to find those individuals who have multiple long-term conditions and who are (1) **frail and/**or (2) experiencing health **inequalities (defined as Core20PLUS)** and/or (3) currently **using unplanned care for routine care needs unnecessarily**
2. Further prioritisation (through population segmentation and/or risk stratification) to identify those most likely to be greatest risk of unplanned care use in the next 2 years.

Proactive Care Cohort – initial focus on frailty

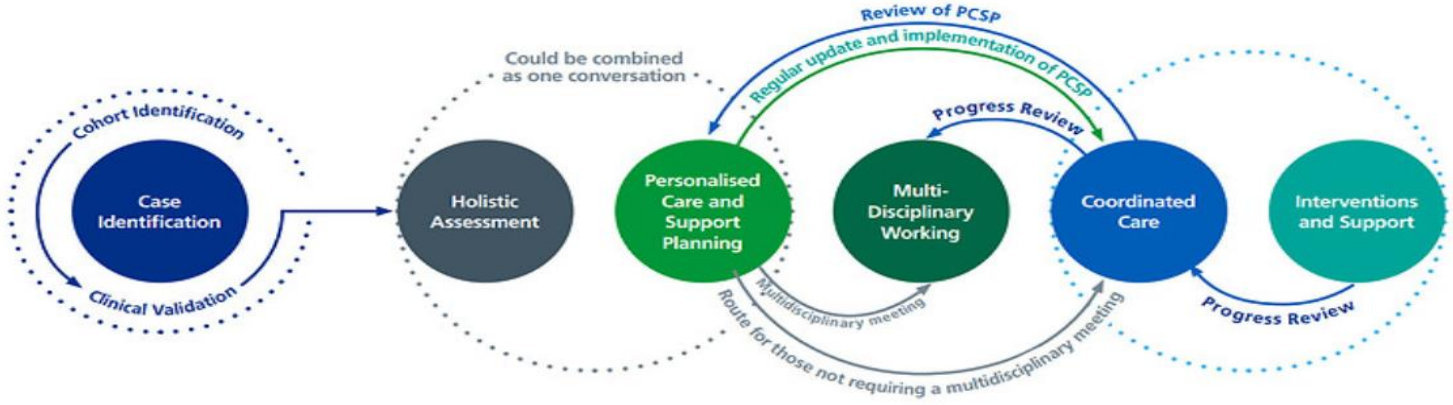


Summary of Proactive Care (2/2)

The Proactive Care model comprises six components, which individually are common to some other models of care. PC is unique in the way these components combine; supported by **data driven approaches** to identify individuals, and with clear **evidence-based interventions** delivered by an **integrated care** team across the NHS and our partners locally.

Core components of the care model

1. **Case identification:** Systems use population health management and data-driven approaches to identify which of the three national cohorts to prioritise for PC, based on current or risk of UEC usage. Providers must clinically validate individuals as appropriate for PC before inviting for an assessment and maintain dynamic case lists to allow for individuals to be added and removed as required.
2. **Holistic Assessment:** individuals who accept the offer of Proactive Care are invited to undertake a Holistic Assessment, which identifies the health, social and self-care needs of the individual. It also covers details about the individual's personal circumstances, health history and current needs
3. **Personalised Care and Support Planning**: individuals should be empowered to take an active role in making decisions about their care through coproduction of a Personalised Care and Support Plan (PCSP) focussing on what matters to the individual and their health and wellbeing ambitions as well actions which will be taken to meet the needs identified in the Holistic Assessment.
4. **Multidisciplinary working**: Multi disciplinary teams (MDTs), comprising a number of agencies, will review the information available about the individual to recommend and deliver care. The membership will be tailored to the needs of the individual.
5. **Coordinated care**: All individuals will have a named coordinator assigned, either an ARRS role or a member of their MDT. The named coordinator should support the individual to understand the recommended interventions for their care and provide regular reviews of their progress and updates of their PCSP.
6. **Interventions and support:** the Interventions Framework will provide a common set of interventions and support which could be available to those receivi



Proactive Care Framework

Aims

- Providing "*a framework for delivery of proactive, personalised care to be delivered by Multi disciplinary team such as integrated neighbourhood teams"*

What it contains:

- **Information on the cohort for Proactive Care** (people living with frailty, health inequalities, reliant on unplanned care)
- **Detail on the Proactive Care model and the six components**
- **Addressing health inequalities** and key considerations
- **Enablers:** partnerships and leadership, workforce, digital capability
- **Governance:** quality governance and information governance
- **Links with other programmes and models**

To note:

- The document has been developed using national and international evidence of impact, and has been developed with people with lived experience, clinicians and professionals, systems, and wider health and care stakeholders.

Proactive Care: Interventions and Support Offer publication

Supporting activities to address needs identified in the PC model

Aims

- **Help clinicians and other professionals plan and deliver services** and supports for those eligible for PC
- **Provide a common approach to understanding what interventions and supports** may be needed, across all systems and places
- **Provide a comprehensive, but not exhaustive, list of interventions and supports** that could be provided, while allowing local flexibility to innovate or use established and evidenced local offers
- **Suggestive, rather than prescriptive** – provides an indication of the types of services and supports that might need to be in place to address the PC requirements of individuals.

What it contains:

- A list of categories of interventions and support which could be considered, depending on a person's individual requirements
- A description of what these categories cover
- Some examples of more specific interventions that could be delivered as part of each category
- Links to evidence and resources that will be added to over time.

To note: some areas will already be well served by a range of options that can meet PC. For many clinicians, especially those who are used to working in an integrated, cross-sector way, this document hopefully sets out a recognisable picture of good practice. It does not intend to overturn any well established and effective ways of working that local teams may have.

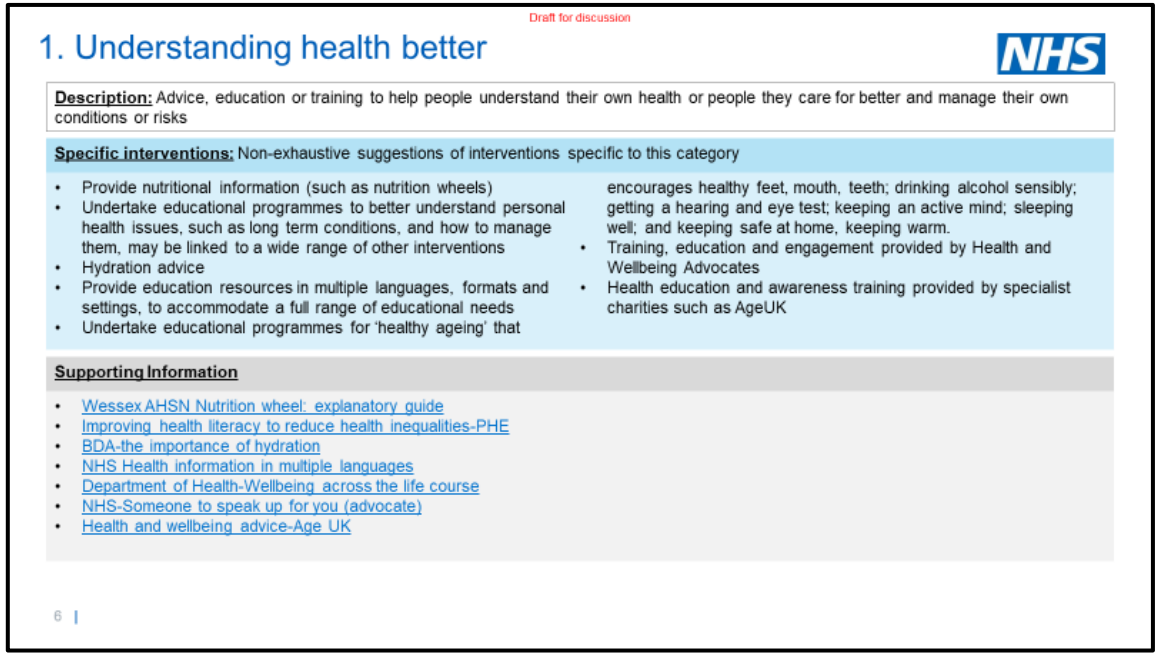
Overview of the Interventions Framework

Living Well
1. Understanding health better
2. Behaviours to improve health and wellbeing
3. Enabling exercise and physical activity
4. Better diet, nutrition and healthy weight
General Support
5. Social Prescribing
6. Regaining skills and function
7. Support with issues related to housing
Targeted Support
8. Mental wellbeing, loneliness and isolation
9. Reducing the risk of falls and fractures
10. Support with cognitive and memory problems
11. Managing medications safely and effectively
12. Continence support and avoiding urinary tract infections
13. Addressing specific conditions, pain and symptoms
14. Treatment and support for addictions

The Interventions Framework (IF)

- Purpose of the Framework:
  - Provide a common approach across all systems and places to help establish Proactive Care.
  - Set expectations and promote integrated, personalised care, including clinical and non-clinical interventions, mental and physical health interventions and activities delivered by a range of providers.
  - Be a comprehensive but not exhaustive range of interventions which allow for local flexibility to innovate. We will seek to update the framework to build on & share innovations.
  - Inform programme planning and delivery to understand what services may be required to meet people's needs
- It contains:
  - Categories of interventions to be considered, and the benefits to individuals who will receive them.
  - Examples of evidence-based interventions which could be delivered as part of each category, including related links to evidence and resources. Interventions available in a system will vary by system.

- The has been reviewed by clinical leads, and it is proposed that it will be updated based on new evidence and interventions to include.


Draft for discussion

1. Understanding health better

Description: Advice, education or training to help people understand their own health or people they care for better and manage their own conditions or risks

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Provide nutritional information (such as nutrition wheels)
- Undertake educational programmes to better understand personal health issues, such as long term conditions, and how to manage them, may be linked to a wide range of other interventions
- Hydration advice
- Provide education resources in multiple languages, formats and settings, to accommodate a full range of educational needs
- Undertake educational programmes for 'healthy ageing' that encourages healthy feet, mouth, teeth; drinking alcohol sensibly; getting a hearing and eye test; keeping an active mind; sleeping well; and keeping safe at home, keeping warm.
- Training, education and engagement provided by Health and Wellbeing Advocates
- Health education and awareness training provided by specialist charities such as AgeUK

Supporting Information

- Wessex AHSN Nutrition wheel: explanatory guide
- Improving health literacy to reduce health inequalities-PHE
- BDA-the importance of hydration
- NHS Health information in multiple languages
- Department of Health-Wellbeing across the life course
- NHS-Someone to speak up for you (advocate)
- Health and wellbeing advice-Age UK

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Proactive Care: Interventions and Support Offer publication

Supporting activities to address needs identified in the Proactive Care model

- The publication organises PC interventions and supports into 15 broad categories of positive health and wellbeing outcomes for people receiving PC.
- These categories are grouped into three main areas, Living Well, General Support to help people live well and Targeted Support for specific health issues.

To note: some areas will already be well served by a range of options that can meet PC. For many clinicians, especially those who are used to working in an integrated, cross-sector way, this document hopefully sets out a recognisable picture of good practice. It does not intend to overturn any well established and effective ways of working that local teams may have.

Living Well
1. Understanding and managing health better
2. Behaviours to improve health and wellbeing
3. Enabling movement and physical activity
4. Better diet, nutrition and healthy weight
General Support
5. Social Prescribing
6. Regaining skills and functional ability
7. Support with issues related to the home environment
Targeted Support
8. Mental wellbeing, loneliness and isolation
9. Reducing the risk of falls and fractures
10. Support with cognitive and memory problems
11. Managing medications safely and effectively
12. Continence support and avoiding urinary tract infections
13. Addressing specific conditions, pain and symptoms
14. Treatment and support for alcohol, tobacco and other drug dependence
15. Palliative and End of Life Care

Proactive Care – Intervention and Support Document ISO - Housing

Support for people in all housing circumstances and tenures

e.g. home owners, renters (private, social and supported housing), aimed at tackling unhealthy, unsuitable, precarious housing issues that impact on health and wellbeing and/or supporting moves

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Unhealthy homes
- Unsuitable homes
- Precarious housing and support to transition/pathways
- Supporting information

Ambitions for the Community of Practice

About

An **action-orientated online community** dedicated to developing members' capabilities to plan and deliver the Proactive Care model in every ICS across the country:

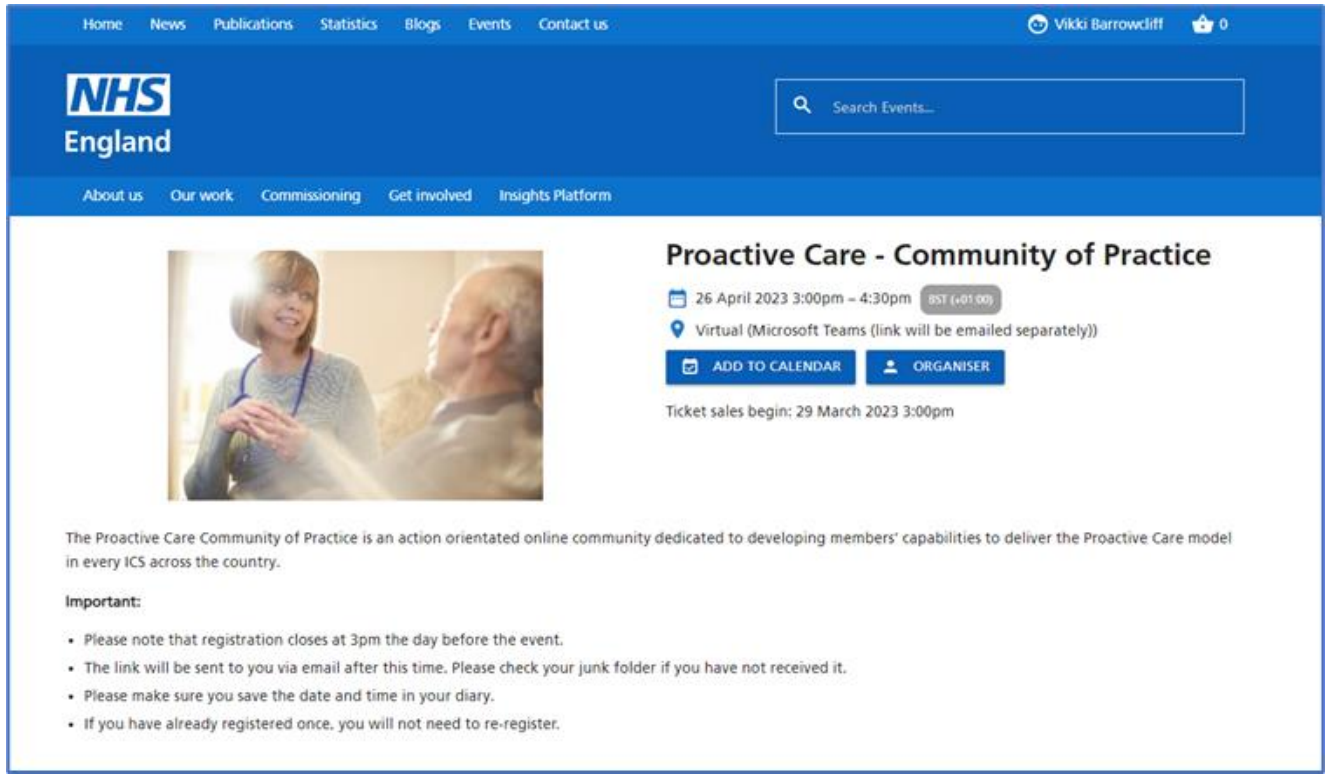
- **Connect people** – provide a dynamic learning environment connecting people setting-up and delivering Proactive Care programmes
- **Share knowledge** – provide a community where participants can share ideas, experience and best practice and also showcase great work happening across the country
- **Support collaboration** – offer a space for peer learning and share problem solving – facilitating collaboration and helping systems and providers to connect and reflect on "what works" to support implementation of the six elements of the Proactive Care model.

Ambitions for the Community of Practice

To register for future Community of Practice sessions, please visit

https://www.events.england.nhs.uk/events/proactive-care-community-of-practice-641b1cbbe6fbc

You will only need to do this once, and you will receive the joining link for the session on the day.



Closing comments and next steps

Sign-up for Future Community of Practice events on Multiverse

Key dates for the diary:

- **Case identification** – 26 April, 15.00-16.30pm
- **Holistic Assessment** – 24 May, 15.00-16.30pm
- **Personalised Care and Support Planning** – 28 June, 15.00-16.30pm
- **Multidisciplinary working** – 26 July, 15.00-16.30pm
- **Coordinated Care** – 23 August 15.00-16.30pm
- **Interventions and support** – 27 September 15.00-16.30pm

To continue conversations between workshops and access tools and resources visit the **Proactive Care Future NHS platform**

For further information about the Community of Practice email: england.communitycare@nhs.net

Thank you

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