NHS
Brighton and Hove
Clinical Commissioning Group

Proactive Care Programme: FAQ

What were the aims and objectives of Proactive Care?
Proactive Care was launched by the CCG in April 2015 with the aim of delivering a model of care that improved the identification and management of patients at risk of deterioration in independence and an unplanned hospital admission. It was designed to improve the health outcomes for patients based on holistic and personalised care planning, case management, with a focus on self-management, early intervention and health and wellbeing.

What decision has been made now the programme has come to an end?
A focused task-and-finish group was established in early February 2017 to review the implications of the end of the programme. This was chaired by a CCG Clinical Lead and reported to the CCG's Senior Management Team.

The task and finish group commissioned a comprehensive independent evaluation of the programme in March 2017, which concluded that, whilst some benefits were identified from the programme, it did not deliver the key intended outcomes of the investment, which were to reduce avoidable unplanned hospital admissions or A&E attendances.

The task and finish group, therefore, recommended that the elements of the programme where these benefits, or their value-for-money, could not be assured should be discontinued. It also however recommended that the elements of the programme that have been considered successful should be maintained and developed as part of the Caring Together programme.

How was the evaluation carried out?
The evaluation was led by a Brighton and Hove Public Health Consultant and undertaken by an NHS public health organisation within NHS Arden and Greater East Midlands Commissioning Support Unit (Solutions for Public Health). Its final report was considered by the Senior Management Team on 3 May 2017.

Following this, the task and finish group was asked to develop proposals for the various components and functions of Proactive Care following the discontinuation of the programme. These proposals were considered, developed and refined by the CCG's Commissioning Operations Meeting on 9 May 2017, by the CCG's Executive Team on 16 May 2017, and the Senior Management Team on 17 May 2017. The final decision was made by the Governing Body on 23 May 2017.

Which areas are being discontinued?
The elements of the programme not being continued are the Care Coaches, Whole Person Assessments and dedicated Proactive Care GP services.

Which areas are being maintained and how will this happen?
The elements of the programme that are being maintained are:

- **Arrangements for cluster working** – an interim arrangement will be developed to allow cluster working to continue and be built on as part of the new model of care being developed for the Caring Together programme.
- **Better Care Pharmacists** – The Governing Body supported the proposal that this programme will continue, and the CCG will agree a process with the provider on the way this will be taken forward.

- **Risk-stratification** – this will continue to take place and be developed by the clusters using the Sollis tool and other clinical methods.

So you can guarantee that cluster working will continue?
Yes. Cluster working is fundamental to local plans for transforming local Primary Care and the CCG will continue to support this work financially.

How quickly will the interim arrangement for the clusters be up and running?
We are currently working on an interim arrangement to ensure the cluster working in primary care will continue without interruption after the programme ends on 30 June 2017. This will then support the work being carried out as part of Caring Together to develop a new model of primary care that will be in place from April 2018.

What are the implications for currently enrolled Proactive Care patients?
We will ensure adequate communication and support arrangements are in place and will work with the provider to ensure patients are supported through these changes.

What are plans for the 'Sollis' risk stratification tool?
We envisage migration of the tool to the CCG following clarification of any Information Governance issues. In the absence of Care Coaches or Proactive Care GPs, work will be needed to ensure best use of the tool as it has capability beyond that of a conventional risk stratification tool with possible city-wide Primary Care benefits. In the near future we hope to clarify options for appropriate use of risk stratification data.

Will Multidisciplinary Team working continue?
Yes but with less emphasis on actual Multidisciplinary Team meetings given absence of Care Coaches and Proactive Care GPs.

Will the Proactive Care steering group continue?
No. However, GP representation on relevant Caring Together Committees is vital and we will need to discuss whether current cluster leads (clinical and PMs) will be part of this process.

Will work on SCRAI and contingency planning continue?
Yes. Proactive Care teams have helped kick-start this process but the bulk of this work was always going to be done by non-Proactive Care teams given potential numbers of patients. Identification of moderate to high frailty risk patients should be possible in the near future via EMIS or SystemOne as part of GMS as is use of SCRAI in this cohort of patients.

Will role of Community Navigator change?
No. These are a separate service to Proactive Care, although some aspects of role overlap with Care Coaches. We are currently discussing possible implications of ceasing the Proactive Care programme with the Community Navigation team.

Will Care Coaches or similar be part of a new model?
We are uncertain at this stage. Various models from elsewhere have used different approaches to a 'Whole Person Assessment' with variable evaluation and perceived benefit.

What are the implications for relationship with IPCTs?
Access should be unchanged. Hopefully any established links will be maintained, as with adult social care.