**The Ranworth Proactive Ambulatory Care Team**

The Ranworth PCN Proactive Ambulatory Care Team is a healthcare initiative aimed at improving patient care by providing proactive, out-of-hospital treatment and support, particularly for individuals with complex or long-term health conditions registered with us as housebound or resident in a care or residential home. We have around 900 housebound patients and 450 care home beds. This approach is designed to prevent hospital admissions and reduce the need for emergency care by managing conditions in the community and enhancing patient outcomes.

**Key Features of the Proactive Ambulatory Care Team:**

1. **Early Intervention**: The team focuses on identifying patients at risk of deterioration or hospital admission and provides early intervention to manage their health more effectively outside the hospital setting.
2. **Multidisciplinary Team (MDT)**: It typically includes a mix of healthcare professionals such as doctors, nurses, physiotherapists, occupational therapists, and other specialists. This ensures that all aspects of the patient's health and care needs are addressed.
3. **Personalised Care Plans**: The team works with patients to create individualised care plans, ensuring that treatments and support are tailored to each person’s specific needs, preferences, and health conditions. Work with community care and secondary acre to create frailty passports.
4. **Home Visits and Virtual Consultations**: The team will conduct home visits to monitor a patient’s condition and provide necessary treatments. Virtual consultations (e.g., via phone or video calls) may also be used for ongoing monitoring and support.
5. **Preventing Hospital Admissions**: One of the key goals is to reduce the need for emergency hospital admissions by managing conditions more effectively in the community, ensuring patients get the care they need before their health deteriorates.
6. **Integration with Other Services**: The proactive ambulatory care team often collaborates with other healthcare services like other NHS organisations, mental health services, social care, and other community-based services to provide a comprehensive approach to patient care.
7. **Completion of contractual requirements**: QOF work, care home wards rounds, etc
8. **Managing End of Life Care**: Palliative Care MDTs, MyCareChoices Register, etc

**Benefits:**

* **Improves the capacity and access for our most vulnerable patients**
* **Improves capacity within the PCN:** These are additional roles funded under the National PCN pilot programme
* **Reduces Pressure on Hospitals**: By preventing unnecessary admissions and readmissions, the program helps to reduce the burden on hospitals and emergency departments.
* **Improved Patient Outcomes**: Patients receive timely, targeted care, which can lead to better health outcomes and quality of life.
* **Cost-Efficiency**: Providing care in the community is generally more cost-effective than hospital care, both for patients and the healthcare system.

The proactive ambulatory care model is part of a broader shift within the NHS toward more community-based, patient-centered care that aims to keep individuals out of hospitals and support them in managing their health conditions more effectively at home.