New Vision of Care

What is it?

NVC is a model of care for those living with complex conditions including frailty . This has been produced in partnership with local people and professionals

What our patients want from New Vision of Care

- "Promotes health, wellbeing and the quality"
- "That services are easy to navigate"
- "Respects choice and enables us to influence the care and support we receive"
- "Helps us maintain independence for as long as possible"
- "Is driven by our goals and ambitions and those of our family and carers"
- "Makes the right thing to do the easy thing to do"
- "Is holistic and integrated making best use of the strengths of the local system including the voluntary sector"
- "Requires us to tell our story only once by sharing our information securely with those that need to know

Goals of the Programme

Active Screening and early identification of risk factors

Use of comprehensive geriatric assessment where appropriate

Adoption of single Trusted assessment and use of care planning by all sectors

A single health and care shared patient record

Use of combined personal health and care budgets

Use of telehealth (cardiac, respiratory and diabetes)

Use of near patient testing

Direct referral to services and for diagnostics by professionals without the need to refer back to the persons GP

Consistent use of personal recovery guides/service navigators for both patients and carers

Expanded use of social prescribing

Rapid access to out of hospital urgent care health and care services within 2 hours

Consistent use of discharge to assess models

Increased use of Ambulatory care models

Core elements

1. Self care and prevention to support healthy active aging and independence
2. Support to live well with simple or stable long term conditions
3. Support to live well with complex co-morbidities, dementia & frailty
4. Good hospital care when needed with good transfer planning
5. Good transfer of care support, rehabilitation and reablement
6. High quality nursing & residential care when needed
7. Choice, control and support towards end of life

Enablers

- 6 projects which enable and facilitate system STP alignment and agreed change including workforce development, shared care record, Elderly Frail Index and Collaborative leadership
- Other core programs include BCF, Connected care, Primary Care

Expected Outcomes (To be quantified)

- Increase in numbers of people who feel supported to manage their LTC
- Reduction in spend on inappropriate hospital based care and conveyances to hospital
- Reduction in spend on long term nursing and residential care
- Increase in spend on extra care accommodation and time to assess beds
- A increasingly skill mixed workforce which includes expanded use of the voluntary sector
- An enhanced role for NHS111 taking complexity out of the system for the public
- A model of Primary and Community Care which optimises capacity through the use of technology, different roles and integrated MDTs

Key Measures (targets tbc)

- Reduction Attendances at A&E
- Reduction in numbers receiving long-term community-based care
- Reduction in avoidable inpatient activity for people with Ambulatory Care conditions
- Increase in proportion of people using health and social care who receive self-directed support, and those receiving direct payments
- Increased in the proportion of people dying at home/place of their choosing
- Reduction in hospital admissions among users of specialist mental health services – split by elective and
- emergency admissions

Workforce Development

What is it?

The aim of this work stream is to build on the work of the Care design group and identify the workforce changes and developments that will be required to successfully implement it

What are the deliverables and Timescales?

This project will deliver in phases aligned to the STP agreed priorities. The focus will be to enable alignment and drive implementation within a system wide structure

- Phase 1- focus on STP alignment including becoming a member of the workforce development board
- Phase 2- focus on key areas of identified change and agree the engagement
- Phase 3- deliver the change with key NVC projects across the identified workforce areas

Where does it fit?

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How does this align with STP ?

- Workforce development is a key project for both NVC and a key programme of change for STP
- The STP alignment will take place at both strategic and operational levels with the introduction of a workforce development board
- The project will focus on readiness and align its actions to three core areas A: Implementation of the shared care record which is a core area of transformation for the system B: Engagement with integrated care and C: alignment with integrated care hubs
- STP has identified unskilled workforce as a priority area. This project will seek to focus on this area within the workforce development board

Expected Change

- For NVC and STP to make a difference change needs to be implemented within the workforce
- It is expected changes will be made in both structure ie roles and 'ways of working' to enable system wide benefits to be realised
- Identification of key competencies required for the workforce

Core Benefits

- Understanding of current workforce structure
- Assessment of desired state workforce and roles to enable key changes
- Implementation of agreed change projects which include the shared care record part of the Connected Care programme enabling data to be recorded using one record and executing based on key agreed parameters
- Identification of new skills, competencies, behaviours and interpersonal skills required within the workforce

Key Outcomes

- STP has identified shared care record as a priority, this is an important area and one which needs to be considered both at a technology and business process change level. This will require a change in how the workforce records data
- Improvements are expected to be made in how work is undertaken to impact staff satisfaction rates, improved patient experience, reduction to staff turnover, reduction in available vacancies and overall staff sickness

Mapping

What is it?

The mapping project focuses on understanding current projects NVC partners have invested in and comparing their delivery model with the proposed NVC approved core 7 steps

What are the deliverables and Timescales?

This project will be delivered in phases during fiscal 2016 and involves all NVC partner organisations. The key deliverable looks to enable a current state assessment and offer an opportunity analysis

- May-June: Planning and framework development including data collection tool
- July-September: Pilot framework with CCG's and collate data including BCF projects. Begin training partner organisations using the framework and understanding total data collection expectations
- October-November: Complete 80% data capture with all NVC organisations
- December-March: Understand collected data [90% will be qualitative], review collected data, outline trends and identify scale opportunities for NVC engagement

How does this align with STP ?

- NVC service delivery model agreed by partner organisations optimises 7 clear phases beginning with self care which is a recognised STP priority
- Understanding current investments will be important to enable a clear determination of the change projects which are already in place, being delivered and the potential to scale
- The data collection methodology enables an understanding of why the current NVC partners have invested in specific projects and how these are being organised. The opportunity to partner across a number of geographies may become apparent during the data review phase
- NVC will need to share the data review with STP and ensure opportunities to develop greater scale, pilot and change realisation can be optimised

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Expected Change

- Current investment outside of BCF and NVC is largely undertaken by organisations independently with some exceptions
- The mapping project will identify each partner organisations invested projects and outline trends where possible including potential opportunities to develop scale

Core Benefits

- Understanding current state investments which NVC partners have agreed as projects will help determine where resources are currently absorbed, how they are being organised and where the opportunity may be to collaborate
- The value will be to determine opportunity for NVC to engage and enable scalable advantage Data collection will therefore be driven with a single framework implemented with project managers

Key Outcomes

- 80% of data capture is expected to be ensured by end of November with some flexibility to continue the process where required in December
- 90% of the data collected will be qualitative and requires focus on understanding projects and their current execution. This will enable a trend assessment
- Using the assessment opportunities for further collaboration will be identified

Shared Care Record

What is it?

wide-spread deployment of an integrated digital care record platform, accessible from Berkshire's main strategic health and social care systems to a single view of information from Primary, Secondary, Community / Mental Health and Social Care.

What are the deliverables and Timescales?

Tranche 1 – November 2016

Primary Care Data Feed
Clinical systems: ,EMIS
InPS Vision, Microtes
Acute Data Feed (RBFT)
Encounters:
ED, Inpatient and Outpatient
Social Care Data Feed - Adult
Wokingham Council
Bracknell Forest Council
Embedded access to Connected Care for OOHs, BHFT, BFC and GPs using EMIS

Estimated users 500

Tranche 2 – February 2017

Primary Care Data Feed
Clinical system:,TPP (SystmOne)
Acute Data Feed (RBFT)
Acute Correspondence:
Discharge summaries and letters
Radiology reports
Social Care Enhanced Data
Wokingham Council
Bracknell Forest Council
Community & Mental Health Data Feed
Embedded access to Connected Care for RBFT, SCAS and GPs using Vision
Estimated users: 1500

Tranche 3 – May 2017

Acute Data Feed (RBFT)
Lab results
Acute Data Feed (FHFT)
Encounters:
ED, Inpatient and Outpatient
Social Care Data Feed - Adult
Slough Council
Reading Council
West Berkshire Council
Community & Mental Health Enhanced Data Feed Embedded access to Connected Care for FHFT users
Estimated users: 3000

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How does this align with STP ?

With the ability to draw this rich information from the various organisational systems to present a person centric view it enables:

- Early identification of people who are regular attenders to hospital and putting in place provision to better support them , thereby improving their standard of life.
- Better transfer and care support planning through easily accessed information in relation to the person.
- Choice, control and support towards end of life via integrated dynamic care plans focussed around the individual.
- Having a person / patient held record (PHR) for the citizens of Berkshire, enabling the individual to hold and manage their care (digitally enabled self-care)

Expected Change

- Collaborative working between health and social care
- Reduction of paper records
- Having a person / patient held record (PHR) for health and social care for the citizens of Berkshire
- The person being more engaged in the care and services they are provided
- More seamless transfers of people between care settings
- Production of integrated dynamic care plans including end of life preferences.

Core Benefits

- More collaborative working between health and social care
- Reduction of paper records
- Having a person / patient held record (PHR) for health and social care for the citizens of Berkshire, that contains accurate data and information from commissioners, health and social care providers and citizens, enabling the individual to hold and manage their care (digitally enabled self-care)T
- The person being more engaged in the care and services they are provided
- More seamless transfers of people between care settings
- Production of integrated dynamic care plans including end of life preferences.
- Better commissioning of services across all organisations and more opportunity for joint commissioning

Key Outcome Measures

- Reduction in unnecessary NEA
- Reduction in duplicate tests
- Better use of Resources / Cost reduction
- Reduction clinical errors