New Vision of Care

June 2016

Bracknell

Ascot

Maidenhead

Windsor

Slough

Chiltern

NVC is a model of care for those living with complex conditions, produced in partnership with local people and professionals

Our aim is for a better experience of health and care for individuals, and financially sustainable services for our population

This presentation

- Explains the key elements of NVC
- Describes the model
- Illustrates what will be different and how we will make it happen

New Vision of Care

Proactive – achieving better health and independence

Through prevention; self-care; identifying warning signs and intervening early; and active engagement which supports people to live at home as long as possible.

All about partnership – working as a single system

Based on a partnership including local people, professionals from social care, health and the voluntary sector who care for people East Berkshire and South Buckinghamshire, with the leadership, systems and structures to provide a single, joined-up service.

Personalised – shaped around people

Recognising their unique circumstances; their individual needs, which change over time; and the full range of formal and informal support which keeps them well - provided by many different organisations, individuals and services, both locally and remotely (e.g. helplines, digital health, specialised hospital care).

Makes best use of the public pound

Through a clear focus on financial sustainability we make sure that every pound spent on local health and social care counts for our local communities.

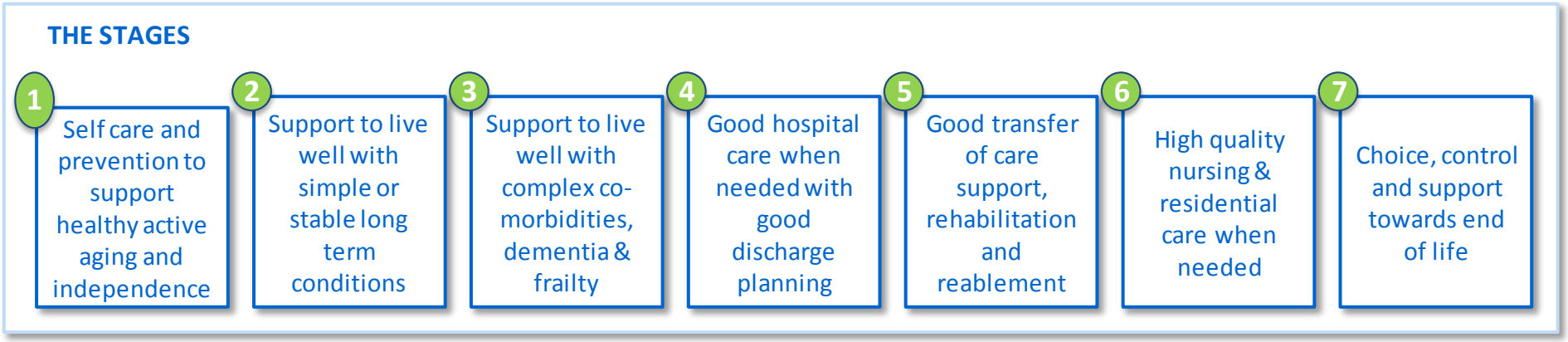
“In order to enable change, everyone needs to play a part.”

Mike Connolly (Lay Member)
NHS Slough CCG

https://youtu.be/f3leaLK-SrY

We created a model reflecting likely stages in all our lives

The model envisages that we will all require from time to time help and support through some or all of the following stages or phases. We are all in 1 but as our needs change we are more likely to also require 2 through to 7

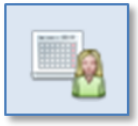


It is important to be clear what each of the stages consists of and who is developing and implementing them. It requires changes to existing ways of thinking and working .

It has a number of FEATURES

Systematic and consistent identification of those at risk

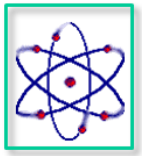
A 24/7 “Help Desk” with multi-media “signposting”



Systematic and consistent implementation of Care and Support Planning

Multi-agency teams to provide support…

…and co-ordination



Enhanced locality services and infrastructure

And ENABLERS

Sharing information

Collaborative Leadership

Workforce development

Aligning incentives

System governance and decision making

Communications and engagement

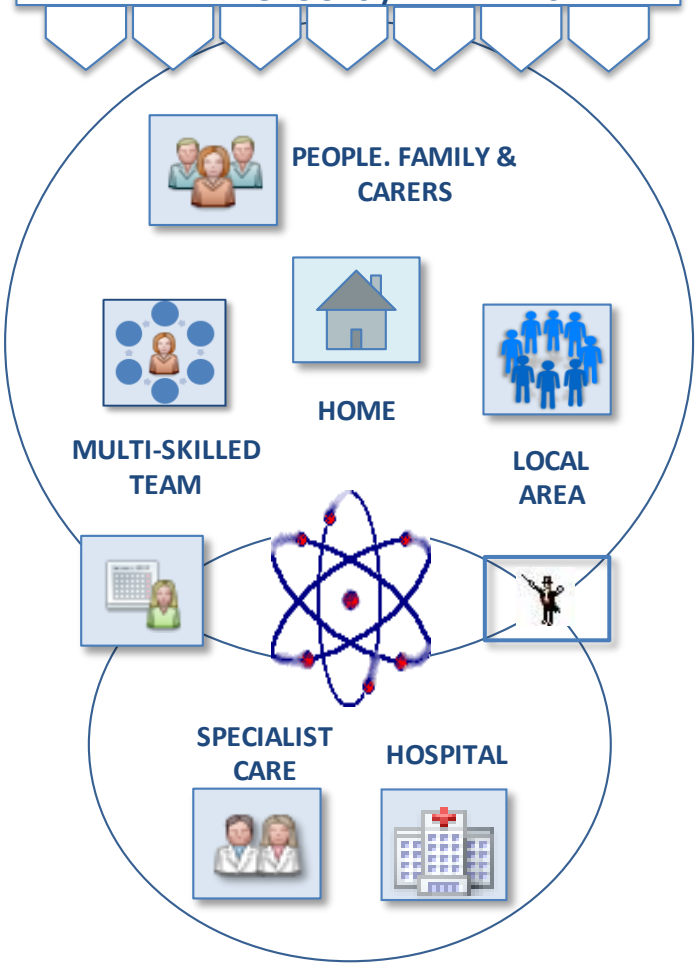
THE NEW VISION OF CARE

Towards better health & independence

THE STAGES

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

PATIENT GROUPS / PATHWAYS



ENABLERS

- Coordinated & Integrated Care System with Care Planning
- Aligned Incentives outcomes & resources
- Shared information
- Workforce development
- Collaborative Leadership
- System governance & decision making
- Communications & engagement

FEATURES

- Person centred promoting prevention, wellbeing and early intervention
- Information and multi-media sign-posting
- Identifying those who need care by using shared risk processes, case finding, & shared assessment
- Using a single care plan within a formal care planning process
- Delivering care plans using agreed protocols & processes through integrated multi-skilled teams
- Co-ordinated and monitored care delivery with care co-ordinators
- Enhanced localities working together with specialists

What does this mean for…

Changes in the system

Key elements

- Partner organisations have come together to develop and agree the vision and model of NVC
- We believe that putting the patient at the heart of things helps achieve the objectives of NVC to provide
  - Better health for people with complex needs
  - Better care for individuals
  - Better value and financial sustainability to the system
- We will change our behaviours so that we work together as a system and do not put our own organisations first

What are the benefits and messages?

- We will make sure that organisational decision making does not become a barrier to NVC
- We will pool resource and share risk where that is appropriate
- We will share information to help create a safe and seamless service for people.
- We will champion NVC and lead by example when working with partners.

People families and carers

Key elements

- We will have access to information and support so that we can take care of ourselves, and prevent unnecessary deterioration in our health and wellbeing. We will know who to turn to for advice.
- We will be helped to maintain independence as long as possible, and may be supported by technology.
- GPs and other professionals will be using tools to identify when we are at risk of deteriorating health.
- When we need it we will have a Care and Support plan, developed with us and our carers, available to all professionals involved in our care.
- Our care will be provided by a multi-skilled team of professionals who have access to specialists when needed.
- If we need to go into hospital there will be better continuity of care so that we can be discharged to home, or the place which best meets our needs as smoothly as possible.
- As we approach the end of life our wishes will be understood.

What are the benefits and messages?

- Benefits for people include:
  - Potential for greater control and self-determination
  - Proactive identification of those who may be at risk, greater ability to avoid crisis
  - More joined up care, less 'stop-start', provided closer to me in my local community
  - Better access to specialist care and advice when needed
  - Less unnecessary visits to the GP, to outpatients, and less likelihood of avoidable admission to hospital
  - I will tell my story only once, including my wishes and choices for all stages of life.

Primary Care

Key elements

- I will have a number of tools which help me identify patients at risk of deterioration
- An IT hub will give me access to information and a directory of services, including supporting technological enablement when needed
- I will be a lead member of a multi-skilled team involving professionals from health, social care and the voluntary sector, with access to specialists when needed.
- There will be shared records for all my patients, and a care and support plan for those who need it.
- Care co-ordination will help secure continuity of care for all my patients whether they are at home, in hospital, or in residential care.

What are the benefits and key messages?

- Easier access for the support my patient needs.
- Better care co-ordination will enable me to focus my time on clinical priorities.
- I will also have access to specialist advice and intervention when I need it.
- I will know more about my patient and the care they are receiving.
- My patients will be better informed and supported to make beneficial lifestyle choices and will stay well and independent for longer.
- Patients will feel better supported and are likely to need less GP appointments and visits.
- Crisis is more often predicted and averted, but if one happens, then care options will be clear to all professionals, leading to less avoidable admissions.

Working in the community

Key elements

- I will be a member of a multi-skilled team including members from health, social care and the voluntary sector, with access to specialist help when needed
- An IT hub will give me and local residents access to information on self care and prevention, plus a means of identifying and accessing services when needed.
- Care coordination will be a key feature of the service we offer
- I will have access to a person centred-shared record , including a Care and Support Plan for those who need it.
- There will be a process for streamlining and sharing assessments
- The emphasis of my role will change to become more proactive as those at risk of deterioration are identified early
- The range of person-centred services in my locality will expand and integrate.

What are the benefits and messages?

- I will receive training and personal development to work in this different way
- Barriers to joined up working will be removed so that we can act as a single organisation
- The 'right thing to do' will become the easiest thing to do
- The IT hub, shared record and Care and Support plan will streamline my work so that there is more time for the patient
- I will be able to reflect the wishes and choices of people and carers in the care provided
- I will be helping people to take more responsibility for their own care, prevent deterioration, and stay independent for longer
- If people go into hospital or residential care it will be part of my role to ensure continuity of care both during their stay and afterwards.

Working in hospitals

Key elements

- Continuity of care will be assured through care co-ordination and working across traditional boundaries
- Hospitals will have access to shared records, shared assessments and individual Care and Support plans
- Multi-skilled community teams will be better at predicting and avoiding crisis.
- Multi-skilled teams will have access to specialist input from the hospital
- Hospital staff will work integrally with multi-skilled teams
- Capacity and integration of rehabilitation and reablement will be improved

What are the benefits and messages?

- I will have access to much more complete information on patients who come to the hospital
- I will work as in a single team with community staff to both avoid unnecessary admission and to ensure good transfer of care out of hospital.
- It will feel like a “hospital without walls”.
- People will only be in a hospital bed due to clinical need and will have shorter stays in hospital
- My specialist skills will be available to people in the community to help them stay well and independent for as long as possible.

The Care Act

'The general duty of a local authority,….in the case of an individual, is to promote that individuals well being''

- By putting people, their wishes and choices, at the heart of NVC we wholly subscribe to the wellbeing principle underpinning the Care Act

The NVC Model supports the new duties of Local Authorities related to people living with complex conditions

- The features promoting self-care, early identification of risk, maintaining independence and avoiding crisis, support the duty to **prevent, reduce or delay** peoples' needs for care and support
- The duty to provide **information and advice**, relating to care and support for adults and carers is integral to our features and enablers
- Through our joint working we help meet the statutory requirement for LAs to **collaborate** and **cooperate** with other public authorities
- NVC is all about providing **joined up care,** so helps with the duty to promote integration with NHS to achieve that.
- It also contributes to the duty to work with community partners to ensure a **wide range of care and support services** are available