Edition 1

NEW VISION OF CARE

Towards better health and independence

New Vision of Care is a model of care for those living with complex conditions, produced in partnership with local people and professionals. Our aim is to provide a better experience of health and care for individuals, and to ensure financially sustainable services for our population. This is an ambitious programme of work involving all organisations providing health and social care in Chiltern and East Berkshire.

A social movement!

The new vision of care gives us a roadmap for new ways of working.

We aim to create a social movement, where people both help shape development of services but also understand the benefits of changing their own behaviour.

How will we do it?

This is a complex programme and several workstreams have been set up with more to come:

- Shared Care Record
- Electronic Identification of Frailty
- Workforce Development
- Collaborative leadership
- Finance
- Mapping

Read on for more information about each area.

New Vision of Care is:

Proactive – achieving better health and independence.

Through prevention, self-care, identifying warning signs and intervening early, with active engagement we aim to support people to live at home as long as possible.

Personalised – shaped around people.

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

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.

Making 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.

Shared Care Record

To enable this new way of working to be effective, we need to share information that is held in different organisations. Those providing care can only see information that has been gathered in their organisation. Hospital doctors can only see information on a patient's hospital record, social care workers can only see information they hold and community health workers can only see information on their records. This makes integrating care more difficult.

All health and social care organisations across Berkshire are working together on a system where key information is shared. This might include details of medications being taken by a patient, the care plan set up by social services, details of carers and other important information that would enable the professional caring for the individual to have the right information without delay, improving the care they provide, improving efficiency in the way they work and improving the experience for all of us when we need care.

Share your care....

is a call to action

Electronic Identification of Frailty: Treating frailty as a long term condition

Identifying people at risk of frailty means care can be targeted.

Frailty is often considered to be inevitable and a feature of becoming old.

When people become frail they are vulnerable and can very easily find themselves admitted to hospital and their independence being put at risk.

If frailty was treated more as a long term condition, our approach to supporting people can change to being proactive, looking to prevent frailty as much as possible and to organise care in a way that avoids mild frailty developing into more severe frailty.

We will be developing tools to help identify people who are already mildly frail so that we can prevent the frailty developing further.

We will be exploring how tools can be developed to identify people at risk of frailty so we can delay or avoid it damaging health and independence.

Workforce development

For services to be integrated effectively, ways of working, culture and staff development are key. This work will be ongoing across all organisations. For example, training is being implemented for staff about using the new shared patient record.

This is being implemented over the coming months and will ensure professional staff in health and social care have appropriate access to information on individual's records. This is important for developing single shared assessments and will allow all to be confident that information about medications and other care being provided is current and accurate for all involved in the care of that individual. It will also mean patients will 'only have to tell their story once' which has been a particular frustration for people.

Workforce plans are being developed to support integrated care for shared care, intermediate care and integrated hubs

Collaborative Leadership

Leadership across all organisations is going to ensure this new way of working and delivering care will grow. This work area will look at what collaborative leadership requirements are needed at all levels of health and care organisations.

This will mean health and care staff will feel empowered and confident to build integrated care arrangements so they are person-centred.

The work has started but it is early stages.

Finance

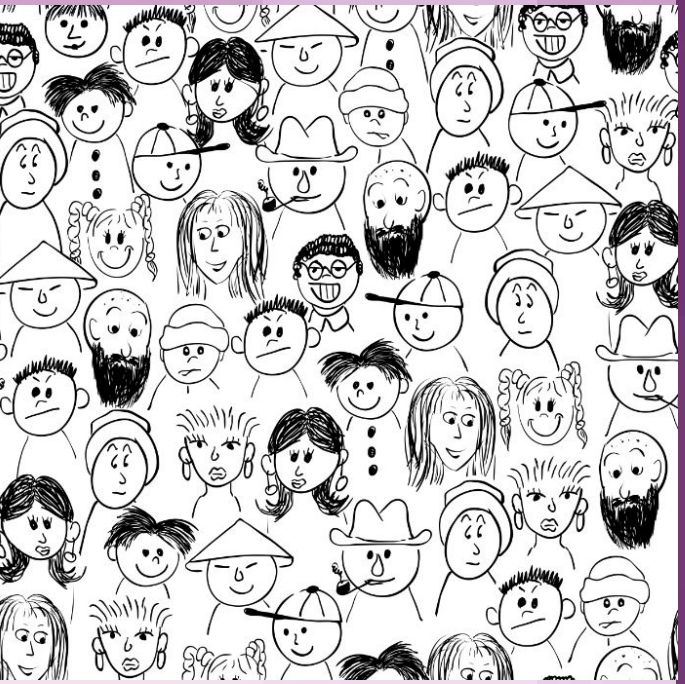
Financial sustainability is key for this programme and there are strong links to the wider Sustainability and Transformation Plan.

Going forward, the financial plans will be brought together to ensure all changes being developed are together contributing to the financial stability and sustainability of all organisations involved.

Mapping

There are many different initiatives and projects currently looking to improve and develop services in both health and social care. Some of these are being funded through the pooled budgets (better Care Funds) in each Local Authority. Others are working across different provider organisations.

This piece of work is bringing together information about all these projects and initiatives and mapping them against the New Vision of Care principles to identify which are contributing to the delivery of the programme.



What happens next?

- Complete the mapping of all programmes and projects across organisations that together will contribute to New Vision of Care.
- A further workshop is being planned to bring together people who have been involved so far to review the results of the mapping exercise and agree how they want to remain involved.
- Berkshire Healthcare Foundation Trust and GP practices will be the first services to contribute key information into a shared patient record accessible to those professional staff caring for that person.
- A Panel has been established with local people and representatives from voluntary organisations who support them. The Panel is open for applications. To join please visit Health Connect.
- A Voluntary Groups Forum is to be set up to share information and to meet 2 or 3 times per year.