New Vision of Care

in East Berkshire and South Buckinghamshire

Hypothesis

November 2015

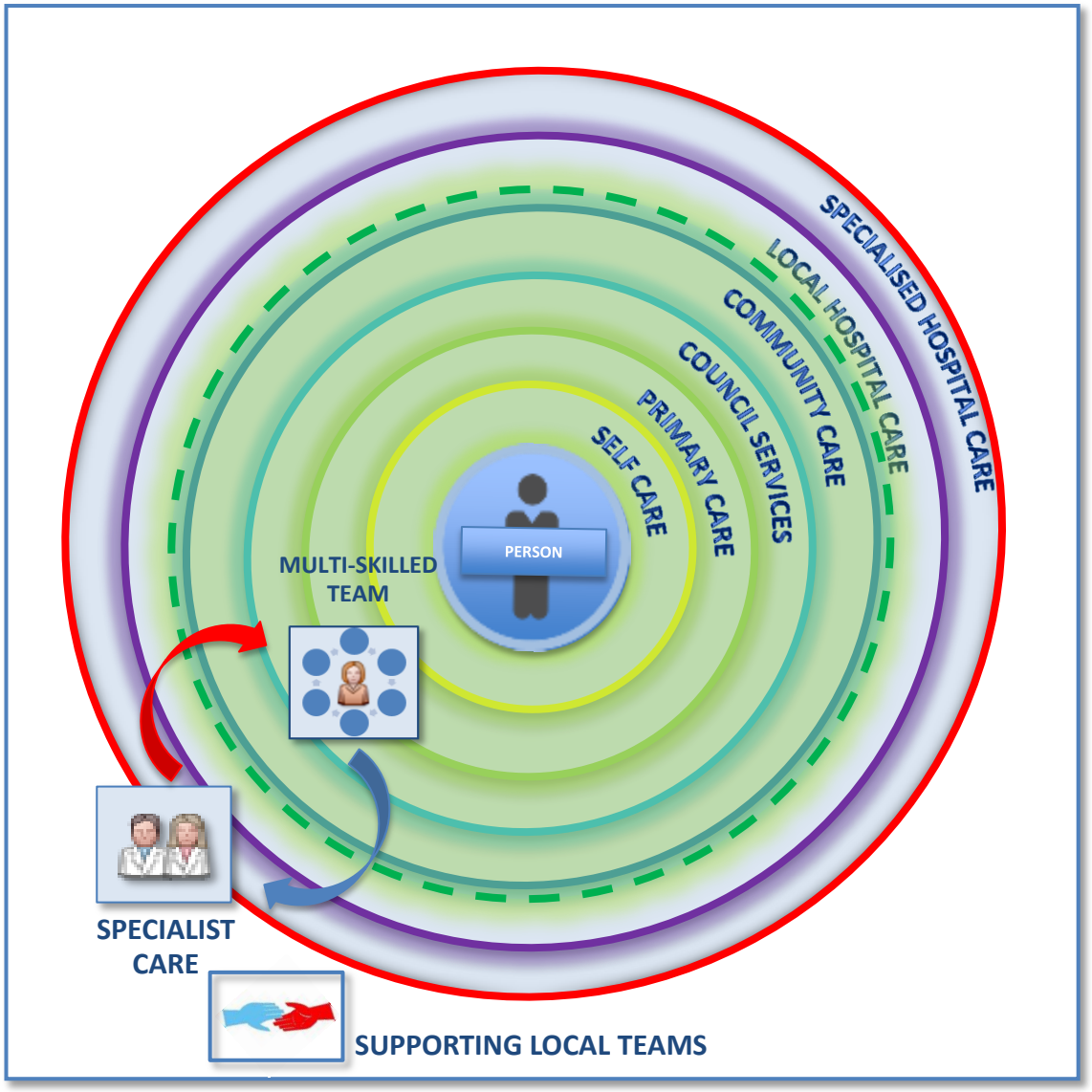
By agreeing & then applying the following Design principles…

The new vision of care will:

- Promote health, wellbeing and the quality of our lives
- Respect our choices and capabilities and encourage us to influence the care and support we received
- Help us maintain independence for as long as possible
- Be driven by our goals and ambitions and those of our family and carers
- Be easy to navigate day or night
- Make the right thing to do the easy thing to do
- Be holistic and integrated making best use of the strengths of the local system including the voluntary sector
- Be high quality
- Require us to tell our story only once by sharing our information securely with those that need to know
- Be adaptive, flexible, sustainable and affordable
- Be well governed
- Feature excellent safeguarding

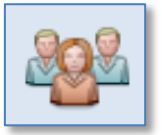
The way we provide care and support changes….

THE NEW VISION OF CARE - INTRODUCTION



PERSON

We all need to manage our health and give ourselves the best opportunity to lead a healthy and independent life. We sometimes need help to make healthy choices and need services that support wellness so we can maintain and restore our health and are less likely to become dependent upon more complex services.



FAMILY & CARERS

There will be times when we and our families need more support and to work more closely with care providers to meet our more complex needs - so the new vision of care proposes that, as our needs increase, we will get closer to the centre of a local partnership where we work together with a multi-skilled team to help meet these changing needs.

LOCAL AREA

This multi-skilled team will include all the council, health and voluntary services we normally use but arrange them so they behave like one single organisation that will help promote and provide holistic care and support to meet our preventative and more complex needs.

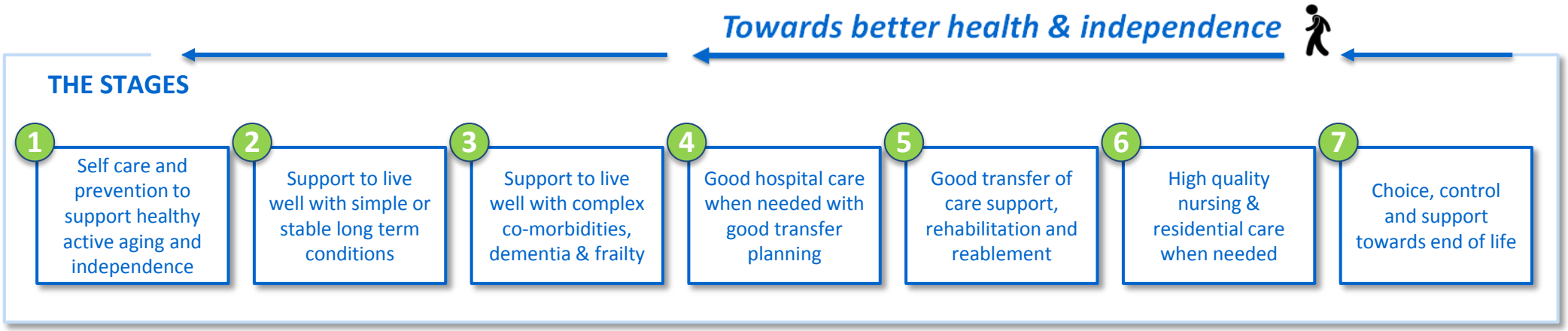
MULTI-SKILLED TEAM

These can include connecting us when necessary to: housing, addressing isolation and loneliness, preparing for winter, identifying and addressing fuel poverty, prioritising minor needs that limit independence, planning timely access to aids, as well as meeting the more complex health care needs that often come as we get older.

In this way our local multi-skilled team reduces the sometimes disjointed or uncoordinated services that we experience today into a single service covering health, social care and the voluntary sector, that interfaces seamlessly along the stages of the model

THE STAGES

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



The current approach is **reactive** we wait until we get sicker and so move unnecessarily towards the right. The New Vision of Care is **proactive** using prevention, self care and early intervention at every stage to overcome this and keep us to the left…

Towards better health & independence

STAGE 1

Towards better health & independence

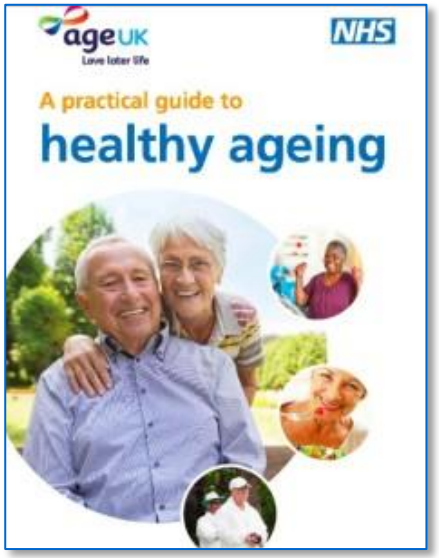
THE STAGES

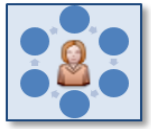
1. Self care and prevention to support healthy active aging and independence
2. Support to live well with simple or stable long term conditions
3. Support to live well with complex co-morbidities, dementia & frailty
4. Good hospital care when needed with good transfer planning
5. Good transfer of care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

Most care is provided by ourselves with the help and support of our family. Helping us with **wellness** – including the ability to make better lifestyle choices and improve our self-management skills - is key to getting better health and wellbeing. So the new vision of care has at its core the promotion of wellness - self help, self care, prevention and early intervention so we remain independent as long as possible

As our needs increase we should engage with our families to plan the care we need and create a **Care & Support Plan**. As our needs increase these need to be assessed so we can be sign-posted for additional support and, particularly in the early stages, we can do a lot for ourselves with the right education about our condition and how best to manage it. Examples of this could include: encouraging us to be more active, taking simple precautions to prevent us falling and getting injured, and to make sure we have the right medicines and manage them properly to avoid having too many and their potentially harmful interactions.

There are **risk identification and stratification** tools that doctors can use that take the current evidence about our conditions and our situation to help identify those of us at risk of our conditions becoming worse. This is to stop us deteriorating to the extent that we may develop a clinical condition that doctors call 'frailty' (this is the point where even a minor ailment may tip us into becoming more dependent on other people and services). This can be avoided if recognised early and there is pro-active support to help us build up our resilience, avoid unnecessary complications, and a crisis such as a trip to A&E or needing to spend sometime in a care home whilst we recover.





The new vision of care is for us to work with our local **multi-skilled team** doing self help, self care, prevention and earlier intervention. The team will be there to help and support us with this and, when needed, provide for our urgent health and social care needs, particularly out of hours when we may be feeling most vulnerable. There will be shared arrangements for health and social care to provide mutual support to prevent unnecessary admissions to hospital or care homes including ensuring we have rapid access to specialists to get additional help when needed

STAGE 2

Towards better health & independence

THE STAGES

1. Self care and prevention to support healthy active aging and independence
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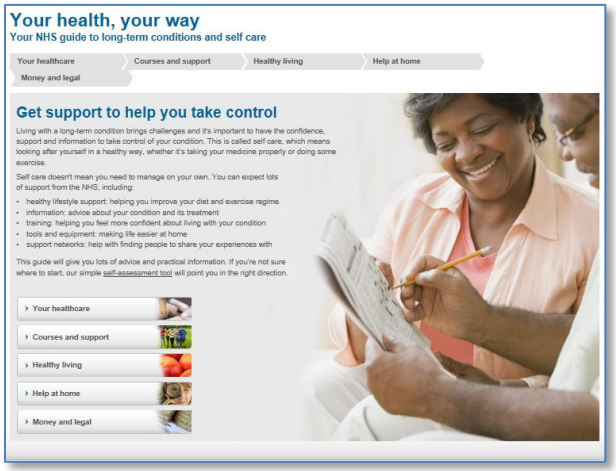
7. Choice, control and support towards end of life

A key aspect of our increasing needs is **managing our Long Term Conditions so they remain simple and stable**. This often requires managing what doctors call 'co-morbidity' - having two or more conditions at the same time which can mean we may require more professional support. To provide this the new vision of care proposes there will be Care Coordinators who will form a relationship with us and our GP to help us develop and stick to our care and support plans.

The Care Coordinator will be part of the Multi-skilled team that has our GP team at its' core helping identify and meet our preventive, acute and chronic needs. Care Coordinators will help smooth our experience, for example by arranging the extended or enhanced local services we need, connecting us with the voluntary sector, helping organise our specialist consultations, transport if needed, etc. The Care Coordinators will have a good knowledge of us and the local resources available to help us, they will be good communicators who will build and maintain strong relationships with us and with the services we use. The Care Coordinator may also help by: **Maintaining our information**; Identifying those of us at risk of getting worse or becoming 'frail'; Improving our self care skills; supporting our care and support planning; ensuring recall and follow-up; assisting us with lifestyle changes and self management skills such as diet and exercise

As a our needs increase these will be met as much as possible by extending and enhancing the multi-skilled team by adding more specialised health and social care support. Depending upon the local circumstances this additional support may sometimes be co-located with our multi-skilled team, whilst at other times it may be available via a wider federated network and shared with other teams.



The Multi-skilled team will have good **IT, communications, help desk and multi-media support** to achieve this and will be able to make services as seamless as possible. Good care & support planning will help all members of the multi-skilled team maintain a good working knowledge of our personal care goals and to be clear about their own role in helping us to achieve these goals. This should bring better teamwork, and with good leadership should help build strong relationships and the behaviours that support them

In this way, as our needs change, the Multi-skilled team will gain and lose members from our perspective – wrapping a **person centred service** around us and our needs

STAGE 3

Towards better health & independence

THE STAGES

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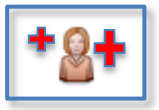

Complex co-morbidities - Our long term conditions and co-morbidities can often become more complex and get worse without us realising and then something will come along like a fall, heavy cold, or colder weather that may send us into a crisis of needing urgent support. This can be avoided by doctors using tools that help find people who are getting worse but may not realise it. This is sometimes called identifying and managing risk and 'case finding'. This is where the Care Coordinator can help to identify people like this and prevent the crisis from occurring.

Risk stratification and case finding helps identify if we have worsening conditions, are becoming more complex or likely to suffer from the clinical condition that doctors call frailty. By doing this we are able to access support services early so our condition has a better chance of improving. This includes accessing earlier more specialist support to reduce the likelihood of an unnecessary unplanned admission to hospital or residential care. The tools include simple tests, questionnaires and assessments to help confirm the extent of our conditions on our ability to function in different circumstances and how this can be supported or improved. One of the factors that can make our situation more complex is the onset of dementia and, by identifying this early, it is possible to access good dementia care and benefit from earlier support. It is also possible we will benefit from **reviewing the medicines** we take and reducing the harmful interactions that can occur when we are taking many drugs at the same time

When we have more complex conditions we can also benefit greatly from quicker help and support with **urgent health and social care** needs, particularly out of hours when we may be feeling most vulnerable. There will be shared arrangements for health and social care to provide mutual support to prevent unnecessary admissions to hospital or care homes including ensuring we have rapid access to clinics and other services to get additional help when needed and to be able to directly access reablement services within our localities

These approaches in many instances can avoid admission by providing access to enhanced services, with the local multi-skilled teams using discharge to assess, virtual or community wards, rapid access clinics, etc. to enable us to get the help we need when we need it. This includes **specialists supporting the local teams** by working with and within the multi-skilled team providing services directly in the local area either through supporting clinics, home based services, or virtually through telephone, technological enablement, etc. This means it will be a normal practice for doctors, nurses and others to work across traditional hospital and local settings, within several different teams.

STAGE 4

Towards better health & independence

THE STAGES

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The new vision of care relies upon **specialised and hospital based care** (inc. mental health, inpatient services, emergency care, etc.) being available quickly when we are at higher risk of deteriorating or experiencing a crisis. This includes having units, areas and wards (including A&E) that are suitable for our needs as we get older

Hospital based **specialist care** will focus on those of us that are at highest risk, most complex or 'frail'. There will be sufficient capacity for those of us with these needs because those of us who don't need to be in hospital will be being cared for elsewhere. There will also be improved dementia, mental health and specialist care for conditions such as stroke that will be centred on us as people & respect our dignity. There will be continuity of care by our most senior specialist doctors and nurses with sufficient ward rounds and A&E cover each day, seven days a week, to ensure early assessment and decision making so we remain in hospital no longer than is necessary for our needs, ensuring our safety, preventing avoidable harm, ensuring hydration and nutrition, etc. so we can be discharged as soon as possible.

There will be common **shared assessments** across both hospital and local multi-skilled teams with everyone sharing the same care and support plan. To achieve this all partners (including mental health, the voluntary sector, us and our carers, etc.) will be involved in our **care and support planning** so, at the time we are admitted to hospital and whilst we are an inpatient, there will be proactive planning to ensure we are discharged home as soon as possible. To support this there will be more effective transfer support at weekends and out of hours.

Hospitals without walls - Specialised doctors and nurses will have a population focus, not only providing an essential role within the hospital, but supporting care to take place as much as possible in the home or local area. They will work as part of a wider team outside the hospital which supports wellbeing and crisis avoidance with timely interventions and home based services as well as technological enablement where appropriate.

The 10 steps for effective discharge planning

1. Start planning discharge before or on admission.
2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.
3. Develop a clinical management plan for every patient within 24 hours of admission.
4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.
6. Review the clinical management plan with the patient each day, take any necessary action & update progress towards the discharge or transfer date.
7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.
8. Plan discharges and transfers to take place over seven days to deliver continuity of care
9. Use a discharge checklist 24–48 hours prior to transfer.
10. Make decisions to discharge and transfer patients each day

STAGE 5

Towards better health & independence

THE STAGES

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7. Choice, control and support towards end of life

The new vision of care requires comprehensive **rehabilitation and re-ablement** so we can 'step down' from hospital when we are ready or that can be used to avoid us having to go into hospital altogether if not appropriate. Rehabilitation and re-ablement alongside good support locally for transfers of care (see '10 Steps' of effective discharge on previous slide) includes services provided at home, within our local area or community, and using alternative providers such as the voluntary sector.

Reablement is where we agree realistic goals for our recovery with the multi-skilled team and aim for a period of intensive support that will minimise our need for ongoing support after that. It addresses all our physical, social and emotional needs. There is a lot of evidence that our dependence on long term services can be reduced, our health improved, our ability to live normal lives restored, and our perceived quality of life improved by doing this. There are also substantial savings to health and social services as well as improving our lives. When done in our local area using family, friends, and the third sector it helps us re-engage with our community reducing loneliness and isolation and having a significant impact on our wider wellbeing. The multi-skilled team are trained to work with us to do a good quality assessment to determine an effective programme and build this into our care and support plan.

Rehabilitation is based on the belief that we have skills, abilities and capacities that we can adapt to enable us to take part in daily activities with meaning and value. Like reablement assessment by the multi-skilled team helps us set our own goals that are built into our care and support plan aimed at increasing our activity and participation levels, through both general rehabilitation and specific programmes such as stroke, cardiac, pulmonary, etc.

STAGE 6

Towards better health & independence

THE STAGES

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7. Choice, control and support towards end of life

We may eventually start to become more dependent but we should only generally move into **nursing and residential care** when treatment, rehabilitation and other alternatives have been exhausted. Once we make the decision to move into nursing or residential care the new vision of care means we receive high-quality care that is person-centred and dignified, have the same access to all necessary health care as those living in other settings including : health promotion and chronic disease management, falls management, continence, nutrition, rehabilitation, psychological wellbeing, pain management, medicines management and prescribing, dementia care and emergency and crisis management.

There will be common **shared information and assessments** with everyone sharing the same care and support plan. To achieve this all partners (including mental health, the voluntary sector, us and our carers) will be involved in our care and support planning so we receive the same help and support in residential care as we would in other settings.

The new model of care also requires enhanced provision of physical and mental health services in care homes, preventing and avoiding admissions to hospital, better **training of nursing and care home staff** to support our reablement, help assess and improve our quality of life, to create positive environments within which we stay &/or live, and to understand and respond to our needs better when we have dementia and approach the end of our lives

Support to Care Homes

A number of interventions can be aimed at reducing admissions to hospital, including at end of life, and to improve the quality of life of residents. Typically involves training of care home staff by nurses in order to increase the skills and capabilities of both care and nursing staff, and/or providing additional capacity 'in-reaching' into the homes:

- Care home support teams
- Care home outreach services
- Training for care home staff
- Direct nursing and physiotherapy support to care homes
- Etc.

STAGE 7

Towards better health & independence

THE STAGES

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7. **Choice, control and support towards end of life**

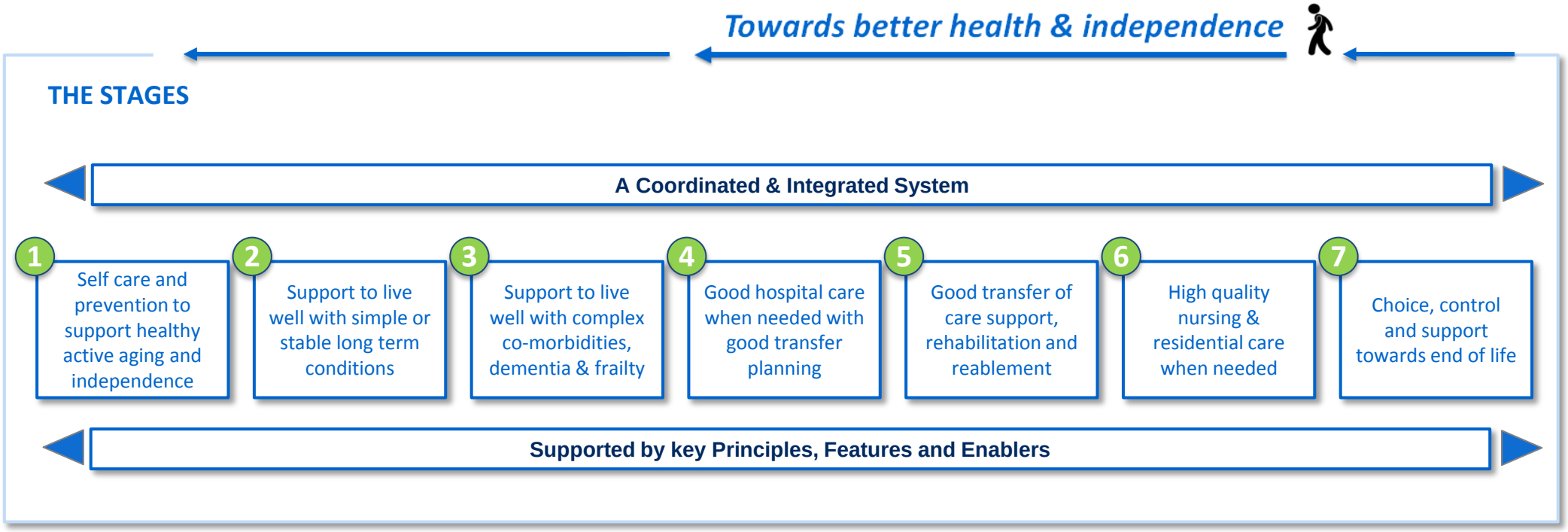
END OF LIFE CARE

As we approach the **end of our life** the new vision of care is for us to discuss and plan so we receive timely help when we need it. End-of-life care services will provide high-quality care, support, choice and control, and will avoid 'over-medicalising' and 'over-hospitalising' what is a natural phase of our lives.

It also demands better management of our end of life, with a workforce aware of our needs, able to identify that we are entering the final stages of our life, and **trained to support** this by helping us to better understand our needs and including these in our care and support plan.

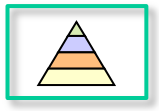
This means strengthening the **co-ordination** and provision of end of life and palliative care services, particularly for those of us with dementia, better medical and specialist support to those of us in care homes and better provision of home based end of life and palliative care for those of us able to choose to die at home. This also includes avoiding unnecessary hospital admissions and working to ensure we die in our place of choice

Within a coordinated and integrated system…

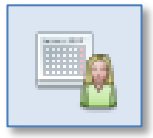


The success of the new vision of care is dependent upon creating a coordinated and integrated system that is focussed upon our changing needs. To achieve this requires a fundamental change in how everybody thinks, sees and does things. This requires the adoption of a set of key Principles, Features and Enablers

KEY FEATURES

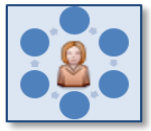


Systematic and consistent identification of those of us at risk using evidence based tools from self-assessment at home, within the local community, at our GP's surgery, through to the hospital specialist. This includes using our information to 'case find' those of us who are showing signs of deterioration to avoid us going into crisis and losing our independence.



Information and 'sign-posting' for us all to be able to access the Care and Support Plan information we need (if consented) and the 'Directory of Services' we can use. It will operate 24/7 and be available by phone, email, internet, social media etc. to help guide and support us to the right services based on our plan and changing needs. It will also act as the hub for technological enablement, using IT to connect us to services and therefore creating a virtual single point of access to the information we need. This will work closely with the Care Coordinators to help ensure a seamless and high quality experience. For those of us identified as potentially needing a bit more help to avoid further deterioration the 'Hub' will rapidly arrange any care and support, including in a crisis, and then arrange for an updated assessment. This is to rapidly restore us to a more stable situation, retain independence and avoid unnecessary admission to hospital or care home.

Systematic and consistent implementation of Care and Support Planning for those of us needing a plan to maintain or restore our health, wellbeing and independence. A Care and Support Plan will be developed and agreed with us and our family that describes our goals, how they will be achieved, and what to do if there is deterioration or a crisis. It will include all the health, wellbeing and social care we need including that provided by the voluntary sector, private providers and when the time comes our end of life care. If consented it will be available to all health and social care professionals across the system.



Multi-skilled teams will help us develop and implement our Care and Support Plan. These local teams bring together the people and services required to support our needs. This will vary for each individual and so the team will have core members that we will work with more regularly and supporting members we will see less frequently but when we need to. The team may therefore include but not be limited to: our GP and GP practice and community nurses, our family and carers, social care workers, mental health staff, voluntary staff, and specialist clinicians. The Multi-skilled team will have access to all the information of the services we are currently using and will be able to contact key people involved in our care.

Care will be coordinated by the Multi-skilled Team. A Care Coordinator will act as our first point of contact and will help coordinate the delivery of our Care & Support Plan. The Care Coordinator is a new and important role to help manage and monitor progress with the care plan and for ensuring it remains updated and effective as our needs change.

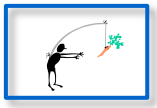
To achieve this requires enhanced local services. For multi-skilled team working to be effective it requires health, social and voluntary services working together using information technology to have good awareness of the situation of every one using services within their local area. This requires the multi-skilled team to work in new ways in our homes (including care home), seamlessly with our carers, family members, the voluntary sector, ambulance, domiciliary & residential care staff. This is often referred to by health and social care staff as better integration of services. Grouping people together in this way within the local area and providing better interconnection helps improve the critical mass, resilience and sustainability of locally based care to meet the needs of it's community.

KEY ENABLERS

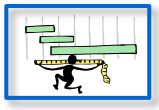
Sharing information is essential if we are to be able to have the different care agencies successfully integrate our care, do things once properly, and not overlap for example with multiple visits for similar things. Care Providers need to be able to share our data to do this and identify those of us at risk of further deterioration by using tools such as assessments and risk stratification. Sharing information with the multi-skilled team and via the information hubs helps to develop our care plan and make sure it is being managed properly. Care plans being available to others within the system can be really important, for example the ambulance crew or Emergency Department team if we have a crisis.

Collaborative leadership is managing our relationships so that we all succeed individually while accomplishing a collective purpose. This means clinicians and expert practitioners, informed by the people using their services, all working together to give ourselves the best opportunity to lead a healthy and independent life. It requires everyone to play their part within their team, to be able to lead and support the multi-skilled team, and to work across organisational and professional boundaries.

Workforce development is essential for the new model of care to be implemented. The model of care requires a workforce that is more flexible and able to work across different agencies and rotate between different posts and sectors. In particular the workforce needs to be trained to understand and meet our needs as we get older, how to assess our situation and condition and know when and how to intervene to help us maintain our independence.



Aligning incentives helps to align our actions to the same collective purpose. Working in this way helps to reduce overall costs whilst improving care. There is national and local recognition that current payment mechanisms need to be revised to enable resources to flow where they are needed to implement models of care like the one enabling the right incentives to be created for everyone in the system to achieve it . This includes the potential to introduce lead or other provider arrangements and the move to population and outcome based contracts.



System governance and decision making needs to support the development, implementation and ongoing management of an integrated model of care. This will include, senior support and decision making to the business case for the new model; clinical engagement in design and implementation; a workforce plan that supports the new model and clear performance management measures and systems for individual staff, the multi-skilled team and the wider system.

Communication and engagement with the public, people using the services and their family and carers, & internal and external stakeholders is essential for designing and implementing the new model of care. All Stakeholders have an important role to play in describing the case for change and informing the design of the new model of care. Similarly, health and care staff need to play a major role in design and implementation, through good engagement and communication. A large number of organisations are required to work together in new ways, and an effective stakeholder plan will be essential.

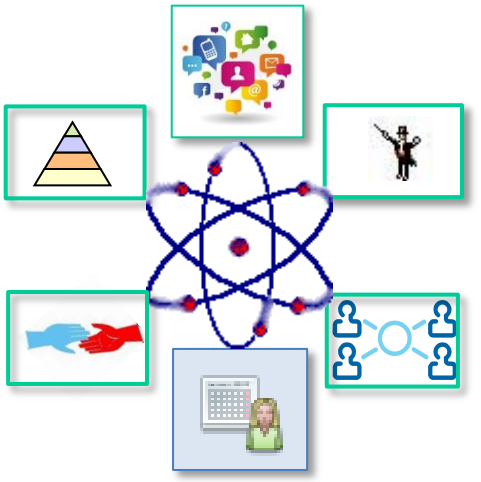
Which together help create….

Stages on a pathway

Key principles, features and enablers

A coordinated and integrated system

INTEGRATED CARE SYSTEM



CARE COORDINATION, PLANNING SHARED INFORMATION, HELP DESK WITH IN-REACH & OUT-REACH

THE STAGES

A Coordinated & Integrated System

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
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7. Choice, control and support towards end of life

Supported by key Principles, Features and Enablers

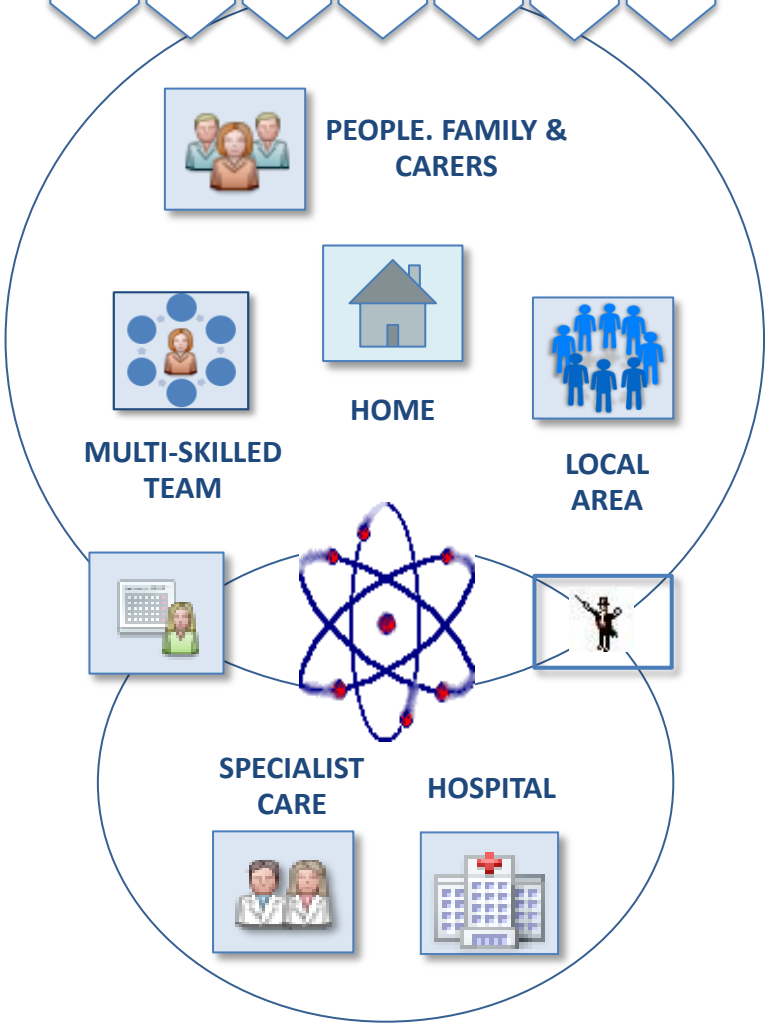
THE NEW VISION OF CARE

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