The Great North Care Record Vision

Our Vision Statement – June 2016

A note on terminology used. Throughout this document the words 'patient', 'service user', 'customer', individual and 'citizen' are all used. They are used inter-changeably and in some cases the most 'appropriate' word is selected. It is acknowledged that different parts of our health and care system use different terms. We have attempted to include this difference, whilst still maintaining clarity within this document.

Our Great North Care Record Vision

In the next four years the *Great North Care Record* programme will make lasting changes to our experience of health and social care.

The **Great North Care Record** will make **information more widely available** and **accessible** to support frontline care, individual self-management, planning and research, enabling:

- **Professionals and carers** to have **legitimate access** to the **right information** at the **point of need**, ensuring our population get better, safer care regardless of **setting** or **organisation**.

- Improved access to information, allowing **individuals** to **better understand** and **manage their own wellbeing and care**.

- Improved data access and analytics, allowing **better population health planning** based on **demand**, and enabling the **development** and **deployment** of more **innovative treatments**.

> *"Personalised care will only happen when statutory services recognise that patients' own life goals are what count"*
>
> Five Year Forward View, 2015

Our **regional governance structure** will provide **single leadership** towards the aims of our common vision for the Great North Care Record in the North East and North Cumbria. We will **develop integrated communities** to achieve these aims, working **across organisational boundaries** and **enabling collaborations** based on **specialism** and **interest**.

We will develop **common standards and infrastructure** to allow secure access and exchange of information across our region, introducing efficiencies while at all times **respecting** the **rights** and **confidentiality** of **our population**. Use of open standards will give us **control of data** across the region.

The North East and North Cumbria can become the safest place in the world to receive care and the best place in the world to do research.

Our partnership

2 The Great North Care Record

We are a diverse group of organisations united by a common purpose and a common vision.

Our ***common purpose*** is to serve the 3.6 million people in the North East and North Cumbria by meeting their needs for health care and social care.

Our ***common vision*** is that, by sharing information securely and effectively, we will make a **lasting contribution to the health** and **well-being** of our population.

This vision is matched by *a commitment*: to keep working together until we have made it a reality, underpinned by our *common values and principles* (section 6.)

Our goal is to share information, not data, to improve outcomes, not processes, to connect people, not computers.

We recognise that our partnership will evolve.
As founding partners of the Great North Care Record, we are already a diverse group. We include providers and commissioners, NHS and local government, universities, social enterprises and statutory bodies. We expect the Partnership to become even more diverse as time passes, including representatives of citizens of the North East and Cumbria. To realise our vision we may need to expand to include partners from the voluntary sector, commercial organisations, and other partners across our region and beyond. Our membership may change as Government policy and other factors change the structure of health and social care provision.

Our vision for the Great North Care Record does not depend on one particular configuration of organisations. It is not a passing enthusiasm. It is a hopeful yet realistic description of the way we want to put information at the service of our populations now and in the future. Our **programme is emergent** to allow for inevitable changes both within the local environment and nationally.

We recognise that our technology strategy will evolve.
This vision is not a rigid plan. As our organisational systems evolve and change. The Great North Care record will continue to provide the 'glue' that holds them all together. As new technology becomes available, we will exploit it. And as the previously impossible becomes everyday reality, so we will explore new opportunities and develop new solutions.

We recognise that our working cultures will evolve.
As we seize the opportunities presented by technology, we will re-examine our working practices and our habits of thought. We will change the way we work as well as the tools we use.

We recognise that the relationship between citizens and services will evolve.
We have always understood that there is a 'triangle of care' between the patient or customer, their carers and family members, and the professional. These relationships are not static. Our vision is to strengthen them. In particular, we intend to support citizens to manage their own health and wellbeing, and to enhance the vital work of carers. What counts in the end are the life goals of patients and service users and the quality of the life they share with those close to them.

Ultimately, **the Great North Care Record belongs not to us, but to the people we serve**. As the Partnership grows and changes, the vision stays. It will develop. It will become clearer as more of it is realised. But it is here to stay. We, and our successors, will make sure of it.

This document forms the standing instructions for the Great North Care Record Programme. There are many uncertainties ahead. No one can predict what will happen in the coming years. We believe that the vision contained here has a lasting validity. It is our commitment to each other as partners, and to our populations.

Our Vision in Practice

Our **population** (the patients, customers and citizens we serve) will be safer, more in control, and more involved in decision-making. They will have a well-founded confidence that the professionals who are listening to their story have the whole picture, in so far as they have chosen to share it. Health outcomes and measures of wellbeing will improve. The Great North Care Record will accelerate the diffusion and implementation of solutions, particularly those which enable **people to interact with their own records and manage their own care**

Our **staff** (the health and social care practitioners we employ) will have more efficient and enjoyable working lives. They will be able to make decisions with more certainty and less risk. Because record keeping will be more productive, they will spend less time on administration and paper-work, and more time offering care. Job satisfaction will increase and frustration will decrease. Time will be better spent. The people who lead and organise services (managers) will see value for money improve and waste reduce. This will happen because process costs will fall, in the same way as they have in other industries. It will be easier to launch new services, because the information needed to operate safely will already be available.

Commissioners (the people who plan and fund services) will be able to target services with more precision at the people who need them. Because information moves safely and securely across organisational boundaries, transfers of care are safer and more seamless. Because interoperability is built in from the start, reconfiguration of services is quicker, cheaper and safer. Use of expensive, disruptive, stressful and risky unplanned care will decrease. Over time, commissioners will develop an increasingly rich understanding of the way in which their populations access and interact with services. And because the Great North Care Record offers a holistic picture of services, it is a tool for understanding how changes and interventions interact and combine to alter outcomes.

The Great North Care Record is able to achieve this because:

1. We are **embedding technology** and **changing the way we work** together to plan and deliver care

2. We are commissioning **shared information and technology solutions**

3. We are **creating the Great North Care Record programme** to help us co-ordinate the changes and measure what we are achieving

4. We are working to **agree how information is shared and kept safe** so that it does more good and less harm

The better experiences we are creating are the result of better working practices, supported by a flow of new technology. At the heart of our new working practices will be **a new approach** to **sharing information and using technology** with and about the people we serve.

This new approach is illustrated in the "Stories from the Future" found throughout this vision statement. These are fictional scenarios describing the way the Great North Care Record will impact people's experience. Here we describe the thinking behind them.

During the life of the programme, we will change the way in which we think about, plan and deliver services. The following graphic summarises our ambition for the way in which services will shift and co-operate with each other and with the people they serve.

We have inherited a model designed to cope with short, isolated episodes of illness. It is no longer the model we need. We will shift the focus

- from *reacting* to episodes to *predicting* and *preventing* them
- from "discharging" people to *supporting* them
- from services designed around illnesses to services *designed around individuals*

This ambition will be achieved by the transformation taking place in all areas of our work.

Here the focus is on the way in which the Great North Care Record programme will contribute.

- In **episodic care**, people access services in response to crises. Following a period of urgent care they are then 'discharged.' If there is uncertainty about whether they are well enough to cope at home, there is an anxious and busy period while a safer setting is identified and brokered. The whole process is risky. Information which would be useful for reducing risk or for planning for an emergency does not flow to where it is needed and is wasted. Insufficient information may be available at either end of the episode, and the person may be over-treated or over-investigated at the start, or held too long at the end of it. Lacking the tools to anticipate a crisis, services scramble to catch up when it arrives.

Helping to change this risky, reactive, fragmented pattern of service delivery is one of the key goals of the Great North Care Record.

The Great North Care Record will help deliver significant change to create services which are firstly better *coordinated* with one another, and secondly, better *integrated* around the life goals and preferences of the individual.

- **Better coordinated services** will be able to share information to reduce risk and to make better use of resources. They will do this by:
  a) ensuring that important information about patients and customers is shared and available whenever and wherever it is needed
  b) creating and using shared care plans which reflect the activity of many providers and which anticipate future needs
  c) communicating more effectively across organisational boundaries to manage transfers of care

- **Better integrated services** will be personalised. This means that care for those most in need will be assembled around the person, regardless of provider, taking into account the individual's own priorities, social context, and clinical need.

  Rather than being passively moved along a care pathway, the individual, supported by expert advocates such as community nurses, social workers and care navigators, will actively build their own care packages and ensure that plans for the future reflect their own wishes and priorities.

  Patients and customers, supported by professionals as needed, will be able to use information technology to:

  • access their records and care plans and add to them
  • access and change appointments
  • monitor their own health

  Evidence shows that patient safety improves when patients are more involved in their care and have more control.

  Berwick Report, 2013

  Better integrated services will be safer by design. Over time, we will be able to research and implement systems which are able to:

  - give early warning of worsening health
  - flag up risks to patient safety and offer intelligent feedback to care professionals
  - automate routine tasks and decisions and reduce workload

  Better integrated services will be better not only for those who use them, but also for those who work in them, on them, and lead them.

These changes will not be achieved in a single leap. Our ambition is to build maturity over time. There are already examples of better co-ordination and integration across the region. The Great North Care Record will aim to accelerate progress.

As its benefits spread through our communities, it will unlock the creativity and energy of leaders, service designers and professionals towards new solutions to the challenges of integrated care and support emerging models of care.

Esther's story

"Esther was abused as a child and had suffered long-term mental health problems as a result. She had been managed across several mental health providers and council services over many years, and she found this all disjointed and became very disillusioned with services.

Providers have separate records and sometimes paper copies were sent between services, but this was rare and often uncoordinated. Her GP was the only one with her full notes.
Her poor mental health meant that she was smoking more and sadly she developed lung cancer from smoking.

She became more unwell and had an end of life care plan. This was held at the GP practice and was often not known about in the hospitals. Thankfully when Esther died and an ambulance came the paper copy was found, meaning they didn't have to call the police or take her to hospital. However, they didn't have the information before coming and this nearly happened.

Esther died having seen many people unnecessarily because they didn't have access to her notes and she had to keep being reassessed.

She consumed huge amounts of health care **which she didn't want** and the **NHS can't afford**.

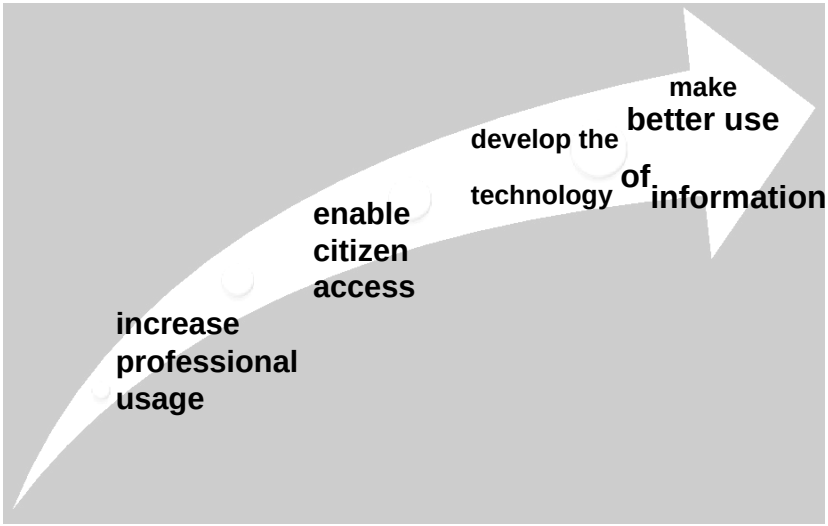
We have to do better for her, for our care organisations and all the staff who work in it. The Great North Care Record provides a means of making improvements.

4 The Great North Care Record: Technology Platform

The first stage of the Great North Care Record will link some of the key care record systems used by statutory health and, where we can, social care organisations in the North East and North Cumbria.

This technical achievement is the visible result of our commitment to work more closely together. For the first time, it is possible for professionals to trace interactions across multiple different health and social care services.

As professionals use the Great North Care Record technology, we will see measurable benefits: greater efficiency and reduced risk. However, this will just be the beginning.



Over time, our investment will bring the Great North Care Record to more people, in more useful ways. In the coming years, we expect:

- To allow our patients and service users to interact with their own records and exchange information with us, or with their own 'circle of trust.'
- To increase the number of health and social care professional users with access to properly joined up records
- To develop the way health and social care professionals interact with the technology so that it is easier to use and more relevant to what they want to achieve
- To build new and innovative applications on the platform that has been created
- To use the technology as a tool for service planning and population health and research

The Great North Care Record will not replace any organisational IT systems. We will instead utilise and complement the data they manage.

4.1 Technology for citizens

The "Narrative for Person-Centred Coordinated Care" (National Voices/TLAP 2013) says that **care is integrated** when **we can say the following**:

- **I can plan my care** with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.
- **I tell my story once.**
- The professionals involved with my care talk to each **other**. They all work as a team.
- When I use a new service, **my care plan is known in advance and respected.**
- When I **move between services or settings**, there is a **plan in place** for what happens next to me.

> *"I can plan my care…*
> *I tell my story once…"*
>
> National Voices 2013

The Great North Care Record will use technology to make good on these aspirations.

The Great North Care Record will tell the person's story by showing their **current medical history and a timeline** of their interactions with health and social care services. This will supplement direct contact between professionals by sharing the essential basics and enabling staff from different organisations to work as a team.

Over time, we hope to develop –

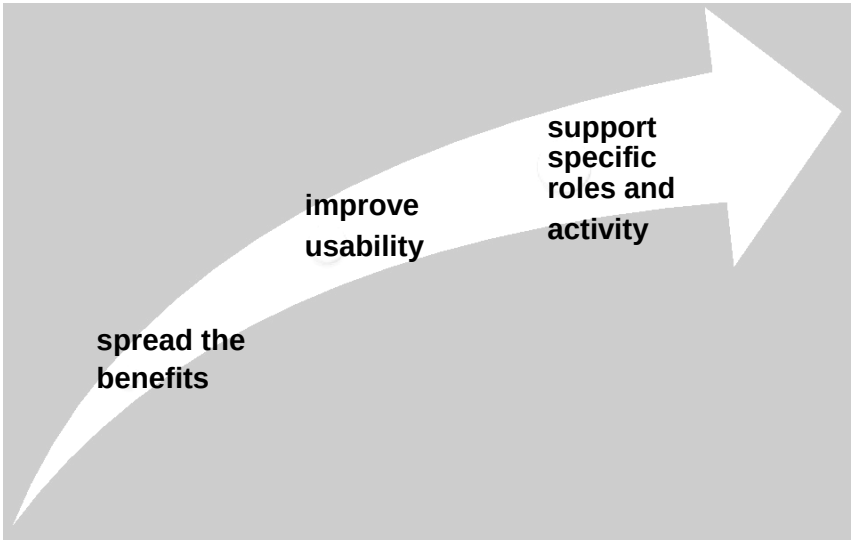
- **Person-centred care plans** which can be shared across the health and social care community. These will include not only current plans but anticipated future needs, for example, if the person's condition deteriorates, or if they unfortunately are nearing the end of their life. They will include medical, therapeutic, nursing and social care interventions.
- Over time, our citizens will gain increasing **control** over their care. **Personal Health Records (PHRs)** will allow people to view their own records, access test results, clinic letters, and exchange information and communicate with the team looking after them.
- We will encourage the development of **mobile applications** which enable service users to collaborate with professionals and interact with services in health and social care, just as they already do in many other areas of life.

4.2 Technology for health and social care professionals

The Great North Care Record will initially utilise a shared care record that is in use. This record:

- Reliably identifies the patient or service user
- Gathers information about them from across the health community
- Presents the information in a simple view enabling professionals quickly to find the information that is relevant to their own decision-making

In the early years of the programme, in line with the evolving priorities of the Great North Care Record partners, we will **scale** this deployment up from a few hundred users to 10,000 and beyond, spreading the benefits across the community.



Many of these health professionals users will use the Great North Care Record within their familiar organisational systems. As technology develops we will look to include Social Care partners as well. As these systems evolve and change, the Great North Care Record will **maintain the links** so that information continues to flow across the health and social care community.

We are already developing solutions so that –

- Health and social care professionals will be able to launch the Great North Care Record from *within* their organisational system, and find that they are already logged in and that the right record is open for view. This so-called **context launch** will make the experience far more seamless. In this way, the Great North Care Record technology will become increasingly usable, useful, and used.
- The Great North Care Record will **develop the information** that is shared within the care record so that it becomes **richer and a better enabler of better care**
- The Great North Care Record will work with partners to develop solutions for **mobile working** and to deploy applications on a range of devices that suit the working methods of professional staff.

The Great North Care Record will benefit health and social care leaders indirectly by **improving the effectiveness of the services they manage**, through its support for health and care professionals. More directly, managers have an opportunity to specify tools through the Great North Care Record programme which transform services, particularly through closer working with other departments or service providers.

Within the Great North Care Record programme, service managers have the opportunity to become Business Change Managers, leading the realisation of benefits from the Great North Care Record in their own departments or organisations (with appropriate support and investment, this could extend to the specification and development of **new applications** which transform working practices and deliver significant benefits and improvements.)

4.3 Technology for commissioners

Investments in the Great North Care Record will benefit our commissioning partners in a number of ways.

The Great North Care Record will **improve the use of resources**. As the Great North Care Record supports the transition from episodic, reactive care to personalised, integrated care, commissioners will see patterns of access to services align more closely to their commissioning intentions.

> *"The challenge… is to pursue innovations that genuinely add value but not cost."*
>
> Innovation, Health and Wealth 2013

In particular, we expect access to unplanned care to fall significantly as care planning improves to better support the population living with long term conditions.

As care co-ordination improves, duplication of care will be reduced, or avoided with less effort, across the health and social care boundary.

The Great North Care Record has the theoretical potential to **improve commissioning intelligence**. The Great North Care Record technology is primarily designed initially to *provide front line care*. However, subject to the development of appropriate regional legal and information-sharing agreements, information could potentially be aggregated to provide information at population level: for risk stratification and demand modelling. Similarly, the Great North Care Record could support **service planning** – to design services which are more responsive, better used, and better meet the needs of the population without duplication.

As citizens begin to interact with services electronically, the Great North Care Record could provide a platform for **preventive interventions** – for example, people living with diabetes could receive offers of support to change lifestyle at the same time as they are accessing test results or booking follow up appointments.

4.4 Technology for researchers

Aggregated data from the Great North Care Record systems has the potential, subject to the appropriate legal, ethical and information sharing agreements, to offer researchers a holistic view of a population's health and social care needs and behaviours. Research areas could include:

- public health insight: prevalence
- impact modelling: innovation, uptake and outcomes
- policy research into whole-system changes, and the outcomes of multiple interacting changes

4.5 Technology for all

The technology opportunities set out above *do not represent a rigid roadmap*.

The Great North Care Record is not an inflexible IT project delivering pre-designed technology to a pre-set schedule. The pace of change will depend on the appetite and funding of the Great North Care Record partners.

The Great North Care Record technology should not be seen as a single tool which "does" some things and "doesn't do" others. Rather, it is a **strategic asset** for the North East and North Cumbria community which provides a platform on which solutions to some of our most pressing challenges can be built.

The architecture of this platform can be seen in the diagram shown overleaf:

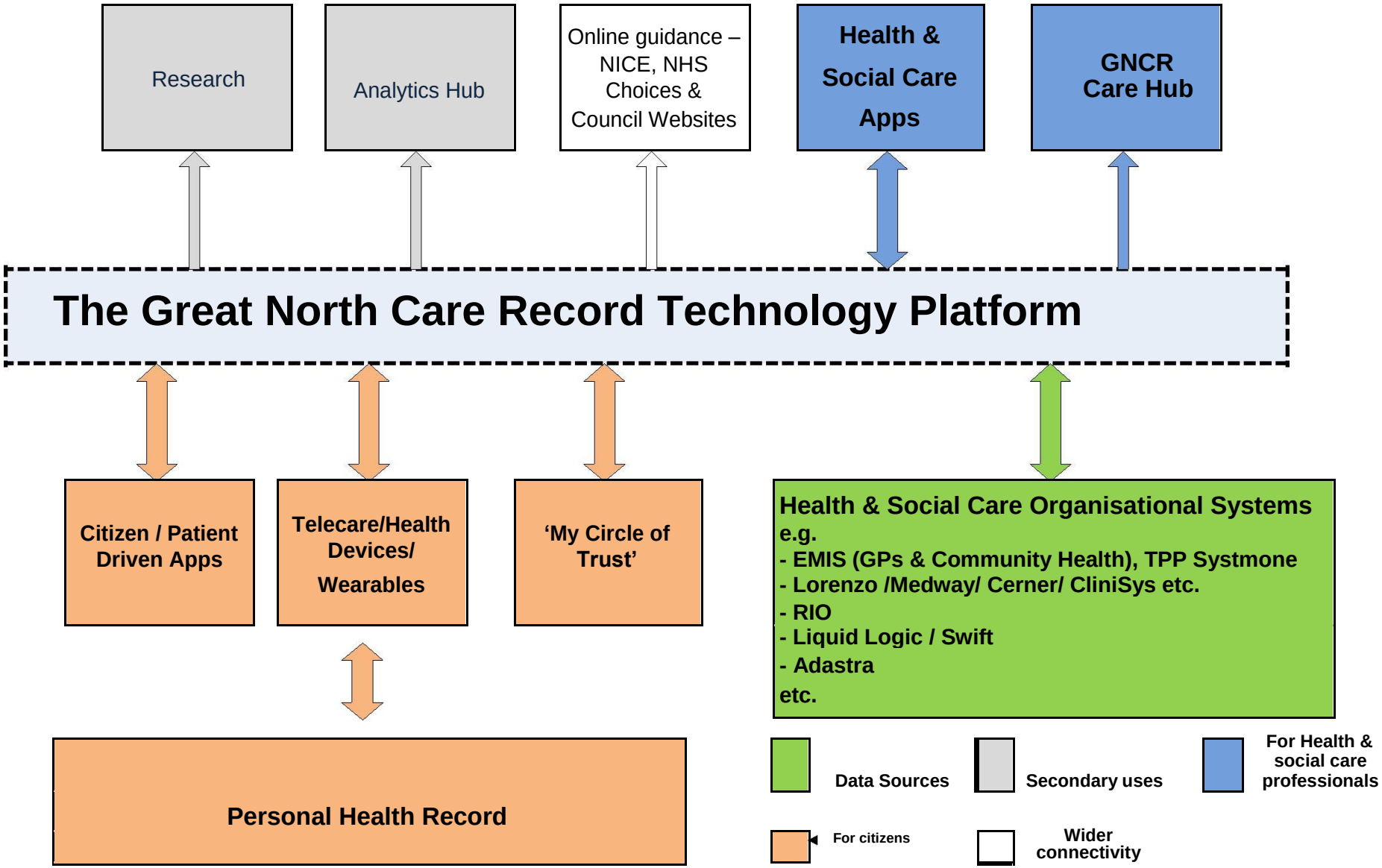


Figure 1 – Our strategic technology platform

The core capability of the GNCR already exists.

The **GNCR Technology Platform** illustrated reflects the ambition for a suite of solutions based on open architecture and standards that together ensure that data can be exchanged between the information systems used by the GNCR partners. This platform is:

- *Secure:* information can only be viewed by people who have a valid reason
- *Standards-based:* it uses recognised national and international architecture standards, so that new applications can be connected without expensive bespoke development

The GNCR Technology Platform will also allow an increasingly developed ecosystem of other applications to make use of the connectivity it provides, such as –

- Personal Health Records, which are owned and maintained by individuals using dynamic consent.
- 'My Circle of Trust' (applications designed to allow carers and family members to support people in maintaining their health record, interactions with services, and lifestyle)
- Mobile applications designed to make specific tasks easier, whether for service users or providers
- Connection to wearables, tele-care and health devices and similar applications

Triangulated with other information sources, the information aggregated by the Technology Platform could potentially have a rich range of secondary uses for planning and research.

As information governance becomes increasingly sophisticated, the platform will offer commissioners and researchers a unique "place-based" or population-focused view of health and social care activity in the North East and Cumbria.

"*The NHS is not yet exploiting its comparative advantage as a population-focused national service."*

Five-year forward view, 2015

Strategic capability

5 The Great North Care Record: Developing our strategic capability

Achieving our vision will mean that we will develop significant new capability across our Partnership.

The single most important capability is that expressed by our own Partnership.

The success of the Great North Care Record programme is absolutely dependent on our ability to overcome the challenges that are built into the nature of such an enterprise.

To the extent that we are able to manage the diversity of our cultures and organisation types, make difficult choices together, and maintain a sustained commitment to the long term goals of the Great North Care Record in the face of significant short-term challenges, we will be successful.

> *[We] require a new type of partnership between national bodies and local leaders*.
>
> 5 Year Forward View, 2015

The need to develop this kind of system leadership at local level is increasingly recognised at the national level and is reflected in the governance arrangements we are developing.

The Great North Care Record is an investment in population health.

We recognise that the context of the Great North Care Record may change significantly over the life of the programme.

There are already challenges in managing the varying boundaries of our organisational remits. Some of us are responsible for a specific urban or mixed population. Others in the Partnership operate across a wide geographical area of which The North East and North Cumbria is only a part. These geographical boundaries will change, as patterns of service provision develop, as our providers grow and change, and as we identify the need to work more closely with each other and with neighbouring health and social care communities.

Technology itself will create opportunities for sharing work and information in new ways.

By the end of the programme, our local health and social care boundaries may have changed or superseded. In such a fluid scenario, the one relatively fixed point is the population.

Our principle will be that as new opportunities arise for the Great North Care Record they will be seized to the extent that they benefit or at least do not adversely impact our population. More generally we will develop our capability to use information to benefit not only the care of individuals but of the population as a whole.

We will develop our understanding of how care can be organised and delivered to give people an explicit role in their own care. This includes a measure of **choice and control** and the ability to join up services in the way that suits one best.

- Our processes will support this role rather than frustrating it

- We will work to close the information gap between practitioners and the people they care for. Our processes will start and finish with those we care for, and be visible and comprehensible to them.

- We will develop our approach to **information governance** so that we strike the right balance between keeping people's private information secure, and sharing information to promote wellbeing and protect from harm.

  We will invest in information governance that strikes a balance between protection and beneficial sharing

  Working at all times within the current legal frameworks, we work to harness the power of aggregated information which can help us make better decisions about how we organise care. We will develop information sharing protocols which allow aggregated information to be used for commissioning and research purposes, at a regional level where possible. Agreeing these protocols will not be easy, but we must make best use of the information we hold on behalf of our population.

- We will develop our approach to **safeguarding** so that it takes account of the new processes that can be enabled by the Great North Care Record technology, balancing the duty to share information with the duty to protect it.

- We will develop our understanding of **professional responsibility** to meet the new opportunities provided by the Great North Care Record. Co-ordination is already part of the duty of care, but we will enable this to happen more easily. We will support professionals as they develop their ability to rely on the judgements and assessments of others in order to inform provision by their own service.

- We will develop an approach to **patient safety** that reflects the fact that many risks to safety arise at systems level – as a result of cumulative error across the system. We will design working methods that reduce these risks and use technology to support them by giving better visibility of the clinical context.

- We will develop our skill in **continuous improvement methodology**. We will measure and monitor the effectiveness of the changes in process that we make, making timely changes on the basis of accurate current data.

- We will **continue to develop the governance** of the Great North Care Record programme so that it can meet the needs of a diverse partnership. The Great North Care Record platform is a strategic asset that will serve a population of over 3 million people. As it matures, it will support a range of applications that may target discrete areas of geography or need. It is neither necessary nor desirable to involve the whole Partnership in every project. We will develop governance and funding procedures that allow self-funded projects to be sponsored by smaller coalitions of the Great North Care Record partners without impacting those who will not benefit.

- Overall, we will learn how to create **maximum value from our investments**. This means more than value for money. It is a conscious attention to innovation as a means of securing long-term opportunity. Working with our academic and industry partners we will adopt and diffuse not only technology but cultural and process changes that can be shown to work.

Our principles and values

6.1 The Great North Care Record Values and Principles

Values and principles have been identified that have helped facilitate the development of the Great North Care Record vision. **We will expect all individuals and organisations to adhere to these** as we further develop our collaborations, and they will be used as an ongoing reference-point for discussions and decisions. Consistent with the programme more values and principles will emerge and this list will be added to:

Values	Principles
Openness	➢ What we build we will share ➢ We will be transparent on the use of data ➢ We will be transparent on the process for developing and implementing the programme ➢ We will use open technology standards where feasible.
Fairness	➢ There will be consistency of approach ➢ There will be equity (of access, involvement and decision making)
Respect for privacy and choice	➢ We will uphold patient and data confidentiality ➢ We will promote greater access, choice and self-management ➢ We will give the individual a choice of how we their your information
Ambitious	➢ We will seek regional solutions for all involved in care provision, planning and research. ➢ We will seek better control of data and infrastructure to further care provision ➢ We will create a culture of continuous improvement
Inclusive	➢ Organisations will act in a collaborative manner for the good of the region. ➢ We will all work on behalf of the people of the North East and Cumbria
Apolitical	➢ We will put the care of people ahead of organisational interests ➢ The quality and safety of care is paramount ➢ There will be shared ownership to improve the efficiency of services

Our plan

6 The Great North Care Record: managing the change

6.1 Securing success

The founding partners in the Great North Care Record are initially supported by funding from Connected Health Cities and the Academic Health Sciences Network for the North East and North Cumbria, but partners will be expected to support the Great North Care Record level of central programme funding at the latest from 2018 onward.

This will provide to develop a partnership to:

- delivery and support of the core technology product to allow the flow of information between the mainline systems of the partners
- a central team to manage delivery
- development of the programme and technology, subject to agreement across the partnership on priorities

The partners, as accountable organisations in our own right, retain responsibility for change management:

- aligning the Great North Care Record benefits with their own internal strategies
- realising benefits from new technology within their own organisations[2]
- identifying additional technology, in line with this vision, that will increase benefit
- identifying new opportunities
- collaborating with other partners on development, delivery and investment

Further, the Partnership is *collectively* responsible for:

- programme governance and direction
- management and co-ordination of business change *within and between* organisations

[2] Each Partner may wish to identify one or more Business Change Managers to oversee the realisation of benefits in line with their own strategy. E.g. an existing operational manager with sufficient authority to manage changes to working practices of the sort set out in this Vision. Partners can ensure that these individuals are supported in this role by writing the realisation of the Great North Care Record benefits into their appraisal targets or Personal Development Plans.

- benefits realisation

- project-level benefits management

The Great North Care Record programme team is accountable for:

- programme delivery
- contract management of technology suppliers
- project management of technology delivery
- overall programme financial co-ordination and budgeting
- benefits measurement skills and resources

6.2 Measuring success

The Great North Care Record will achieve measurable benefits at different levels:

- across the **whole system** of health and social care
- in **specific services, pathways and populations**
- in the **individual lives** of patients, customers and practitioners

Whole system benefits can be evaluated using established metrics relating to different areas of system performance:

- financial balance and financial resilience in the face of rising demand
- patient, customer and staff satisfaction scores
- hospital length of stay and admission rates for ambulatory conditions

*Outcomes such as these are by their nature the result of our behaviours and choices across the **whole economy**, including in some cases wider determinants of health and wellbeing.* Nevertheless, it is our ambition that the Great North Care Record will make a decisive contribution to these and related measures.

While it is certainly *difficult to attribute changes* in these whole system performance indicators to the effects of one programme or intervention, we expect to see positive changes. This is because the ways of working targeted in The Great North Care Record are aligned with our strategic direction.

We will achieve greater precision when we **target measures in specific pathways and with specific populations**. At this scale, changes can be introduced using an improvement methodology and project disciplines. In this case, **the projects themselves will devise their own metrics and, following delivery, these will be used to track benefits. The bulk of the programmes benefits will be tracked in this way.**

The specific impact of the Great North Care Record **on individual** working practices can be gauged by investigating the way health and social care users interact with the shared care record, and other applications and interfaces as they become available. Such interactions will be tracked using user statistics such as: number of distinct users, frequency of logons, and transactions executed at the expense of the older processes replaced by the Great North Care Record.

Our ambitions

7 Our ambition for the Great North Care Record

This document has set out an ambitious vision of a health and social care system that uses technology to help it solve some of its most pressing challenges. It sets out this vision confidently for three reasons:

- there is a increasing **consensus** about how we do health and social care in the face of rising demand and changing public expectation

- in mandating the Great North Care Record programme, our community is beginning to achieve something not widely matched: **agreement** on strategic direction across all the statutory organisations

- the technology platform at the heart of the Great North Care Record programme is **beginning to be deployed**: data from across our community is already flowing and accessible. New technology with be designed and implemented over the course of the next few years.

How far, and how fast, this platform may take us can only be guessed at. As we begin to realise the potential for change that we are unlocking, we may see opportunities that we have not yet glimpsed.

The road ahead is not without risk; there is always risk in significant change. There are many uncertainties. We need to invest in developing several significant new capabilities. But there is also very great opportunity. We are confident that we will, on the basis of what we have already achieved, avoid repeating the disappointments that have dogged technology projects in recent years. **We have big ambitions for health, social care and research in our communities. The changes set out here are some of the bigger ones.**

Technology has transformed our society in recent years. Many of the tools that seemed alien and strange only ten years ago are now such a feature of everyday life that we find it hard to remember what we did before we had them. We believe it is now our turn to do this for our citizens: to create new tools which quickly become indispensable and new ways of working which change all of our lives for the better.

Appendices

8 Appendices

8.1 Thanks and contributions

This document is significantly based on the Bristol 'Connecting Care Vision' (August 2015), and we acknowledge our friends there for producing such as an excellent document and allowing us to re-use its contents.

We are grateful to the many people who have contributed their thoughts and ideas to the creation of this vision statement. Thank you all.

8.2 Document History

Version	Author	Date	Notes
Draft 1	Joe McDonald		
Draft 1.1	Nick Booth	27/5/2016	
Draft 1.3	Mark Walsh / Donna Smith	12/6/16	
Issue 2	Louise Wilson	23.4.18	Review and minor amendments.

8.3 Accompanying Documentation

The main documents which accompany this document are –

a) *The Great North Care Record Governance Framework* – this provides more specifics on the different governance bodies – Work in Progress

b) The Great North Care Record *Programme Plan Overview* document – this provides more specifics on the projects planned and in the pipeline – Work in Progress.

[4] This document is a 'living document' – as compared to this Vision Statement, which we expect to have more longevity

- ENDS