Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Andrew Morgan, Chief Executive Lincolnshire Community Health Services NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 September 2015**
Subject:	**Update on Lincolnshire Community Health Services Clinical Strategy**

Summary:

The Clinical Strategy for Lincolnshire Community Health Services sets out a clear direction of travel over the next 5 years in line with national drivers and local commissioning intent. It's overall aim is to care for a diverse group of children and adults, by supporting them to manage their own needs and to access appropriate care when necessary.

Actions Required:

That the Committee consider and comment on the content of the report and the associated Clinical Strategy in Appendix A.

1. Background

Lincolnshire Community Health Services NHS Trust Board approved a 5 year Clinical Strategy , contained as Appendix A, that encompasses the outline vision of Lincolnshire Health and Care (LHAC) and the 5 year Forward View of NHS England (5YFV).

Since becoming a NHS Trust on the 1 April 2011, the organisation has successfully developed a range of specialist skills in the delivery of care outside of hospital and the strategy is underpinned by the national strategic context and local commissioning intent.

The key elements of the strategy are as follows:

- To encourage people to self-care or co-manage their long term conditions.

- To focus on keeping the patients in their own home or as close to it for as long as possible.
- To ensure staff have the appropriate skills and knowledge to care for a diverse and complex group of patients in the community.
- To establish and support complex care pathways, using a variety of bed based environments outside of an acute hospital setting
- To work with others locally and nationally to create new community models that are sustainable for the future by harnessing the power of the wider community.
- To work on the principle that in future patients will only be 'loaned' to an acute hospital for a defined period of time based on clinical need.

The strategy outlines that this will be achieved by further strengthening the access to services, building closer working relationships with other providers in the county and by supporting patients to take a greater responsibility for their own health care needs.

LCHS sees itself as the 'Care Navigator' of the system, ensuring that patients and families are able to access the system and receive the most appropriate care for their respective needs.

The key outcomes outlined in the strategy are as follows:

1. Person centred care will be appropriately co-ordinated.
2. People will be healthier and spend longer periods outside of an acute hospital setting.
3. Children will have the best possible start in life
4. Independence across the age range will be maximised with particular focus on those who are more vulnerable.

2. Conclusion

Lincolnshire Community Health Services has outlined in their Clinical Strategy intent to act as a care navigator in the community in order to manage a larger cohort of patients outside of the acute hospital setting. In order to achieve this they will be working with patients and families to take greater ownership of their own health needs and are working with other local providers to 'harness' the power of the wider community.

3. Consultation

The paper provides an update on current service and as such, no consultation is required.

4. Appendices

Appendix A - Clinical Strategy

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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Lincolnshire Community Health Services NHS
NHS Trust

Clinical Strategy

2015 - 2020

Putting you first is at the heart of everything we do

Title Description	**Clinical Strategy**
Author	Sue Cousland
Purpose	
Approved by	
Approval date	
Publication date	
Target audience	LCHS Trust Board Finance, Performance & Investment Committee, All staff
Circulation list	Trust Executive Group Trust management & staff
Associated documents	
Superseded documents	Clinical Strategy Version 1
Clinical Involvement	

Contents

OUR VISION

To be first choice for commissioners of integrated neighbourhood services

OUR MISSION

Provide high quality lifelong personalised care within local communities

OUR STRATEGIC AIMS

QUALITY • VALUE FOR MONEY • REPUTATION

OUR STRATEGIC OBJECTIVES

Listen to our users and their families, value their views and improve patient experience	Deliver safe services	Deliver a quality driven financial strategy
Develop and lead a workforce proud to be part of LCHS	Embed effective stakeholder engagement to influence service improvement	Manage the reputation of the organisation
Use technology to enhance patient experience and improve efficiency and effectiveness	Ensure the environment is appropriate, fit for purpose and meets and exceeds the needs and expectations of users	Deliver sustainable and profitable business growth
Be recognised locally as the system driver for integrated services	Develop a clear and robust commercial position to effectively manage our engagement with both commissioners and competitors	Increase focus on our external relationships and markets and adapt our service portfolio to sustain our leading position in the system

Patients FIRST

FOCUS	Improve clinical outcomes
IMPACT	Make a difference to the lives of those in our care
RESPECT	Respect your decisions and listen and respond to preference as well as need
SAFETY	Create a safety culture throughout the organisation
TEAMWORK	Be proud to be part of Team LCHS

Our Mission is:
Provide high quality lifelong personalised care within local communities".

Our Vision is:
To be the first choice for commissioners of integrated neighbourhood services

Our Values are:
To put our patients FIRST - 'It's more than just words…it's at the heart of everything we do.'

FOCUS
Improve clinical outcomes

IMPACT
Make a difference to the lives of those in our care

RESPECT
Respect your decisions and listen and respond to preference as well as need

SAFETY
Create a safety culture throughout the organisation

TEAMWORK
Be proud to be part of Team LCHS

Strategic Aims

In order to achieve our vision, we have clearly defined our strategic aims for the next five years in the following domains:

- Quality
- Value for Money
- Reputation

Quality is at the heart of everything that we do, as we deliver our services on a day-to-day basis. We are proud of our excellent service delivery and our high standards of care. Our patients confirm our quality and our high standards of care through their feedback and evaluation of our services

Value for money ensures our sustainability through organisational growth and improvement and guarantees that our services are efficient and effective, representing quality and worth to our public and commissioners.

Reputation will be the cornerstone of the organisational culture defining our organisation.

Everything that we do in the provision of health care is underpinned by these strategic aims.

1.0 Executive Summary

1.1 Trust profile

Lincolnshire Community Health Services NHS Trust (LCHS) is a young, vibrant organisation currently providing the majority market share for the provision of community based adult and core children's services to the population of Lincolnshire. Through the Strategy the organisation aims to be the provider of choice for health and social care provision in Lincolnshire and beyond.

Lincolnshire is a large county with an aging population, growing at a rapid rate. There are areas of economic deprivation; poor infrastructure making travel difficult and the main sources of employment are for 'low skill, low wage' employees.

There are higher than average incidences of Coronary Heart Disease, Stroke, Chronic Obstructive Pulmonary Disease, Diabetes, Cancer and Dementia.

1.2 The Clinical Strategy

Key elements of the clinical strategy

- Information and support for people to self-care or co-manage their long term conditions
- Recognising the importance of the home, the individual and their informal support network
- Alignment of specialist knowledge with primary and community care; More inter-professional collaboration
- Tackling the increasing level of long term conditions and frail elderly people living alone
- Developing simple joined up health and care pathways - reduce the divide

- Utilising beds for sub-acute to rehabilitation services, establishing a clear purpose, and including step up/down provision

- Developing new community models to support family health through partnerships and outcomes based commissioning

- Harnessing the power of the wider community - earlier action and prevention 'young and old'

- Developing an integrated systems model - patients are 'loaned' to hospitals

Offering an alternative to hospital stays

- 'Choose to admit' planned care policy at hospitals

- Single, single point of access

- Effective integrated community team with access to acute specialists

- Management of the patient through their hospital stay - expanding the case management approach

- Comprehensive follow up, assessment & rehabilitation during post-acute care

Key outcomes

- Person-centred, coordinated care

- Keeping people healthier and out of hospital

- Give children the best start in life, with better integration of services targeted at children and their parents

- Maximising independence and improving overall wellbeing for frail elderly

The ambition of the organisation is to complete the transformation from a traditional community based service into that of a Foundation Trust 'Service Integrator'.

As the 'service integrator' the organisation will take the lead in the coordination and delivery of a full range of integrated physical, mental health and social care services coordinated through a single contact centre. Services will be organised within our existing communities with integrated teams providing 'wrap around' services to the General Practitioner and other primary care based services.

An integrated responsive community team will pro-actively care for patients, while also responding an increasing demand for unplanned care. The focus will be on frail elderly residents, patients with one or more long term conditions and those that require generalist palliative care.

In the shorter term the aim will be to avoid inappropriate clinical attendance or admission to acute services. In the longer term the focus will shift to greater provision of care closer to home by the proactive identification of risk, supported by a robust infrastructure of case management in the community and promotion of self-care.

Response will be provided at the following key points:

> **Healthy communities** – with a focus on prevention of illness and encouragement to self-manage from 'cradle to grave'
> **In the patients home** - by putting a wide range of services in place to maintain independence either at, or closer to home
> **Pathways through the Acute Trusts** - by diverting people at the front door who are not in clinical need of acute hospital admission, by continuity of case management through the stay and facilitating early discharge and supporting recovery and rehabilitation in a community setting closer to home.

1.3 Drivers for Change

There are strong arguments for changing the way care is provided, which can be summarised in the following way:

> The drive to provide patient centred, high quality care
> The gradual increase in the age of people needing health care.
> Changing patterns of disease
> New opportunities and technologies for prevention of illness and self-management
> Innovative developments in the care of patients outside the hospital setting
> The need for increased efficiency saving whilst maintaining safe workforce models
> National and local drive for integrated services / pathways
> The need to support patients to have self management strategies
> The adoption of new technologies – ie Florence telehealthcare

For acute hospitals this will mean fewer beds, shorter stays, centralised services and much greater collaboration in working with other providers. For community care, the implication is that more health care is provided outside of hospital, working in closer partnership with providers of social, primary and acute care. This means input will be tailored to meet the increasingly complex needs of patients who will remain the central focus of the strategy.

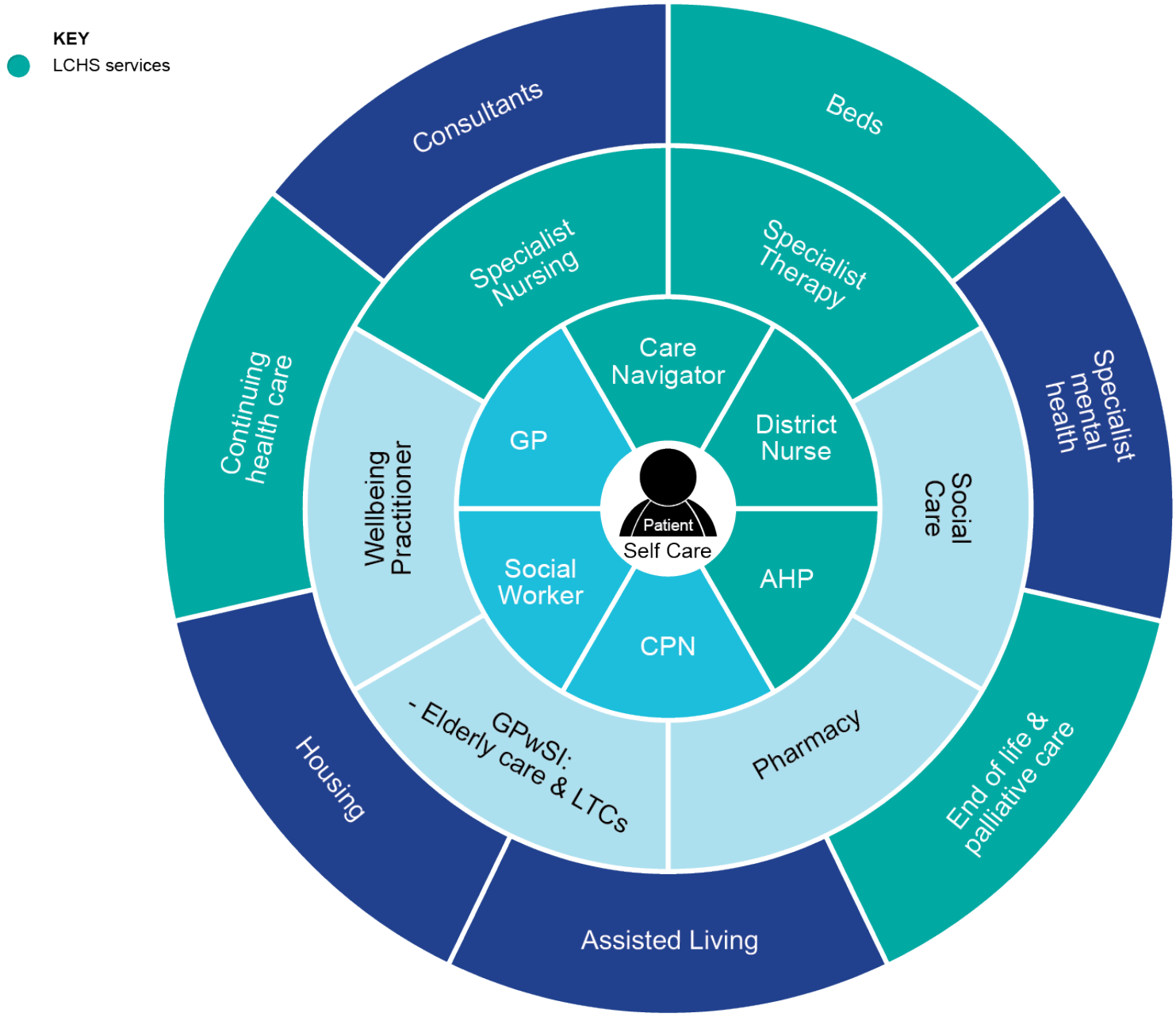
1.4 Recent developments

Within Adult Services, funding has enabled the organisation to establish schemes to support both the avoidance of inappropriate secondary care admission and expedite earlier discharge through the setting up of LCHS Contact Centre, discharge to assess and enhanced rapid response. Whilst these initiatives have had some impact on attendance in the Accident and Emergency Departments and the avoidance of inappropriate admission, they are beginning to deliver at scale and pace required to meet the changing needs of the population.

Lincolnshire Community Health Services has realigned its clinical workforce via the newly commissioned Community Response Specification (CRS), to ensure care is delivered by the right professional, in the right place at the right time. In addition to this workforce models providing safe staffing levels have been agreed for community hospitals and integrated community nursing teams.

It is planned that the integration model with social care which began in the East of the county with good evidence of benefit to both patients and commissioners, will be rolled out across the county.

New integrated pathways are being embedded supported through a Contact Centre with a vision for integrating the whole community response, supporting mobile working and improving outcomes for patients.


KEY
LCHS services
Consultants
Beds
Specialist mental health
End of life & palliative care
Assisted Living
Housing
Continuing health care
Specialist Nursing
Specialist Therapy
Social Care
Pharmacy
GPwSI: - Elderly care & LTCs
Wellbeing Practitioner
Care Navigator
GP
District Nurse
Social Worker
AHP
CPN
Patient
Self Care

1.5 The Future

Lincolnshire Community Health Services NHS Trust will play a significant role in delivering the Five Year Forward View in Lincolnshire as the prime service integrator for community care in Lincolnshire, which empowers patients, engages local communities and delivers more integrated and preventative care.

It is intended that the Clinical Strategy will build on existing pathways of care provision that have proved to be effective, and further development of frail elderly and long term conditions pathways to managed patients through both community and acute care episodes, with Lincolnshire Community Health Services being the prime Service Integrator or prime provider for Community Care in Lincolnshire.

1.6 The Benefits

A number of quality improvements and service benefits have already begun to emerge from the early delivery of the strategy. These include:

- Improved outcomes and experiences for patients and carers
- Appropriate levels of care being assigned to patients ensuring the right clinical pathway is achieved for each patient
- Reduction in clinically inappropriate admissions to acute hospitals.
- Appropriate workforce skills, capacity and confidence matched to increasing complexity of patient need
- Increased involvement of the GP in directing care and retaining clinical leadership
- More advanced monitoring of quality and financial outcomes

2.0 Background

Lincolnshire Community Health Services became an NHS Trust on the 1st April 2011, through the Transforming Community Services (TCS) programme (2009). There is an acute awareness that the Trust in conjunction with partners will experience some of the toughest challenges faced by the National Health Service since its inception. Following successful CQC assessment in 2014 and an overall rating of 'Good' LCHS will continue its Foundation Trust Journey in 2015, this will be a result of continuing to develop high quality community services rather than a separate aim in itself.

The Trust has successfully developed a range of specialist skills in the provision of community care in a largely rural setting covering over 2,350 square miles. Care delivery has historically been delivered locally via a business unit structure, with boundaries aligned to that of the Clinical Commissioning Groups.

A diverse service portfolio is provided both in the patient's home and from an additional 67 sites across the county, including Community Hospitals, Health Centres, Urgent Care Facilities and GP surgeries, 24 hours a day, 365 days of the year.

There is a real opportunity for the organisation to change the way that the health and social care system works in Lincolnshire, in order to redress the balance in provision of services to support more care closer to home. This can be achieved by providing safe alternative services when admission to an acute hospital setting is not clinically indicated. For frail elderly and vulnerable residents this can often be counter intuitive to the promotion of continued independence in a familiar care setting.

The trust in conjunction with other key partners has taken the lead in proactive identification and management of patients and people with health needs, to ensure they are safe and well at home, manage their lifestyles with self management strategy's and supportive responsive care.

The Clinical Strategy has been developed using both the national strategic context and local commissioning intentions

3.0 Drivers for Change

3.1 National

Challenges facing the NHS in England

The financial pressure facing the NHS is unprecedented. During the course of this Parliament the National Health Service must deliver £20 billion of efficiency savings. With fifty per cent of the current health budget spent in hospitals, transforming how care is provided in alternative settings has become critical. In addition there are other key drivers such as demographics and health needs that make the development of new services and pathways of paramount importance.

For acute care this means that services need to be transformed, with fewer beds, smaller wards and in some instances complete conversions of the way in which hospitals work.

For community providers this means that more care needs to be delivered either closer to home or at home by providing better integrated care services, supported by innovative practice and advances in modern medicine.

- Changes in patients' health needs: Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget
- Personal preferences: many (but not all) people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care
- Changes in treatments, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease.
- Systems: there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want
- Changes in health services funding growth

- Unacceptable variations of care provided to patients
- Providing speedier and consistent treatment for cancer
- Ensuring readily accessible GP services
- Delivering preventative services and integrating health and social care

Key drivers

- Two sets of forces are reshaping the geography of care
  - Specialisation versus generalisation
  - Regionalisation for scale effects (e.g. high end imaging capabilities) versus digitisation and miniaturisation (e.g. hand-held technologies)
- Achieving the three dimensions of care integration:
  - primary and specialist services
  - physical and mental health services
  - health and social care
- Evolving patient expectations:
  - people are living longer, with more individuals living with multiple and complex health conditions
  - patients will want access to high-quality services anytime, any place, anywhere
  - people are more informed, active and engaged in their own health
  - people are increasingly seeking a co-productive and holistic model of care
- The new dynamics of care:
  - Personalisation: Tailoring care to an individual's needs through a combination of companion diagnostics linked to personal therapies
  - Standardisation: removing unjustified variation in care and treatment
  - Anticipatory care: moving away from healthcare systems that principally rely on people pitching up to see a health professional when they get sick - towards healthcare systems that are much better able at stratifying risk, identifying upstream care opportunities, and targeting interventions accordingly.
  - Co-production: recognising that it is often the "experts by experience" who bring the assets, insights and commitment that will reshape the way care is provided

National priorities

- Getting serious about prevention (e.g. incentivising and supporting healthier behaviour; targeted prevention)
- Empowering patients (e.g. improved information; supporting people to manage their own health; Increasing the direct control patients have over their care
- Engaging communities (Supporting carers, encouraging community volunteering; stronger partnerships with charitable and voluntary sector organisations
- Developing new models of care:
  - Dissolving traditional boundaries between primary care, community services, hospitals, mental health services and social care
  - Managing systems – networks of care – not just organisations
  - Out-of-hospital care needs to become a much larger part of what the NHS does
  - Services need to be integrated around the patient
  - 7 day working
  - New models for primary care and urgent & emergency care

3.2 Local drivers

Within Lincolnshire the provider of hospital acute care has been facing financial and operational difficulties for many years. This has been one of the factors prompting a county wide review of sustainability, which in turn is expected to set a blue print for the future configuration and delivery of services.

Key health challenges for Lincolnshire

- Changing demographics - inward migration, increasing birth rate, ageing population, health inequalities
- Economic and health inequalities with low wage economies and ill-health being related
- Children's health and lifestyles e.g. obesity, smoking, sexual health & mental health
- Poor transport and highways infrastructure
- An ageing population: residential/hospital care and long term health conditions - here is a high prevalence of coronary heart disease, stroke, chronic obstructive pulmonary disease, cancers, dementia, obesity and diabetes
- Inequalities for people with disabilities including those with learning disabilities.
- Prevention relating to smoking, alcohol, obesity and maintaining independence

Challenges and Issues facing Lincolnshire's health and care system

The health and social care system in Lincolnshire faces a number of significant challenges.

The provider of hospital acute care has been facing financial and operational difficulties for many years The Keogh review concerns over the quality and safety of some services and the recent Care Quality Commission (CQC) review has resulted in ULHT remaining in Special Measures with further improvement work required.

In addition, the initial review and engagement stage of the Lincolnshire Health and Care programme identified that:

- Services are fragmented
- Service models do not reflect published clinical evidence
- Unwarranted variation in care,
- Some elements of care can be better provided closer to home
- Workforce structure, Information Management and Technology (IM&T), payments and incentives, and other factors are not supporting system wide transformational change. –
- Recruitment poses significant concerns with many substantive posts filled by locum arrangements and use of temporary staffing remaining high.
- ULHT has one of five hospital sites in the country with the lowest combined day and night nurse staffing levels.
- Recent engagement with primary care teams in Lincolnshire also reflects difficulty with GP recruitment

Other relevant local issues and developments include:

- Lincolnshire County Council's review of the Care Act implications
- Lincolnshire County Council is re-commissioning care home bed stock and long term domiciliary services
- The establishment of a pooled health and social care budget, the Better Care Fund of £197.30m, to support integrated working through the LHAC programme
- Intermediate care is subject to review and re-commissioning

3.2.1 Lincolnshire Health and Care

The outcomes of the Lincolnshire Health and Care review will undoubtedly impact on this strategy; however it is expected that a core component of the blue print will be the need to shift more activity from acute hospital based care to an integrated health and social care model delivered in the community.

3.2.2 Unplanned Care

LCHS has delivered targeted initiatives which have had some impact on the level of attendance at Accident and Emergency DepartmentsLCHS supports an unplanned care model, directed from the Contact Centre and provided at fixed sites by our Out of Hours bases, urgent care centers, Walk in and MIU and MIU/MIIU Center's and in the patients home via our rapid response and home visiting Out of Hours teams. How these services work together with Proactive care teams to provide wrap around community provision will be key moving forward.

Unplanned care activity in community services is projected to rise over the course of the next five years by over 3,000, contacts per year. Lincolnshire Community Health Services are currently reviewing all joint care pathways and the potential to work in closer collaboration with all health and social care colleagues. It is intended that the workforce organisations will be further developed to support these pathway revisions. The organisation will perform more of a 'gate-keeping' role in Accident and Emergency Departments and take the role of Service Integrator in the management of frail and vulnerable patients in the community.

During the winter pressure period following Christmas 2014 new initiatives included A&E streaming to OOHs practitioners based in the department, Rapid Response Practitioners based at the 'front doors' of ULHT sites, liaising with EMAS to prevent admission for some patients and locating an Advanced Nurse Practitioner with the EMAS Control Desk to divert rapid response practitioners to attend calls and prevent the unnecessary deployment of ambulances and crews.

The projected rise in population demand within Lincolnshire will inevitably pose further significant challenges to the effective management of resources in the community and the delivery of planned efficiencies over the next five years.

The service integrator role will ensure that services are delivered differently providing in support of a more effective use of both the acute and community sector resource

3.3 Service Integration

There is a growing understanding within the Lincolnshire health and social care community of the need to improve the integration of services across the system.

Whilst there are many successful examples of integration in the county these have not yet been at the scale or pace required to fundamentally transform the delivery of care at a service level. Within Lincolnshire the Neighborhood team model has been piloted in 2014 and major roll out is planned for 2015. Although the model is being defined through the early implementer pilots, the ideal model suggests local community services work together as a fully integrated team providing services to respond to the needs of a defined community. It is likely the team will have core membership of baseline community services including primary care practitioners, nursing, therapy, social care and mental health resource. In addition an outer ring of specialist support i.e specialist nursing, therapy and medical expertise, teams that may support one or more teams based on disease prevalence/ local need. All stakeholders in Lincolnshire have acknowledged the need for change and with Lincolnshire Community Health Services could perform the lead role across the county as the service integrator for all residents from the 'cradle to grave'.

3.4 Expectations of Commissioners

In Lincolnshire, Commissioners expect to purchase safe, effective high quality services, specified and agreed through core contracts and assured through core performance indicators. It is expected that a close working relationship will continue to underpin all future developments in the transformation of care required to ensure a viable mode of delivery in the future.

However, the organisation is cognisant that long term financial sustainability will be based on the ability of the organisation to completely transform the existing pathways of care. It is envisaged that establishment of the Integrated Transformation Fund will support collaborative working with a range of other providers to provide clinically and cost effective pathways of care.

Innovative and courageous commissioning will be absolutely paramount to the success of this transformation to ensure that funding flows follow the patient. This may result in new currencies for commissioning and a requirement for providers to demonstrate different and improved outcomes for patients.

3.5 Expectations of the Public

The population of Lincolnshire expect Lincolnshire Community Health Services to continue to deliver high quality patient care. Introduction of the Community Response Specification will ensure this care is delivered by the right person, in the right place, at the right time by health and social care professionals that are committed to the principles set out in the Chief Nursing Officers Strategy for Nursing: Department of Health 2013.

In order to sustain and improve our locally-earned reputation, and to continue to be at the forefront of delivering good clinical care, Lincolnshire Community Health Services as a five year Integrated Business Plan (IBP),that sets its strategic intent to both improve and sustain its core services and cautiously grow its business using existing expertise.

This clinical strategy is fundamental to the delivery of the five year plan, and details the journey in respect of the transformation required over the course of the next 5 years.

Key to this journey is to ensure our services continue to listen to our Patients to ensure all our contacts promote a positive experience and optimum outcomes. The organisation is committed to ensuring the patients voice is strong both in the planning of services and how they are delivered, as well as how they are Implemented in everyday practice.
Direct contact, patient focused feedback by both internal and external mechanisms remain a high priority, as well as the continuation of the strong links with Lincolnshire Healthwatch.

4.0 Where are we now?

4.1 About the Trust

Lincolnshire Community Health Services is a young and vibrant organisation which holds the majority market share for the provision of community based adult and core children's services to the population of Lincolnshire. As such the organisation has developed specialist skills in delivering care across a large rural county with a dispersed population of 738,000 people covering a geographical area in excess of 2,350 square miles.

The unique combination of characteristics in Lincolnshire are as follows:

> The population is growing faster than the national average
> The population is aging more rapidly than many other areas
> Young people do not tend to settle in the county
> The population is becoming more diverse with growing clusters of migrant settlement
> There are pockets of high economic deprivation
> Employment tends to be 'low skills', 'low wage'.
> The transport infrastructure is poor, rendering access difficult.

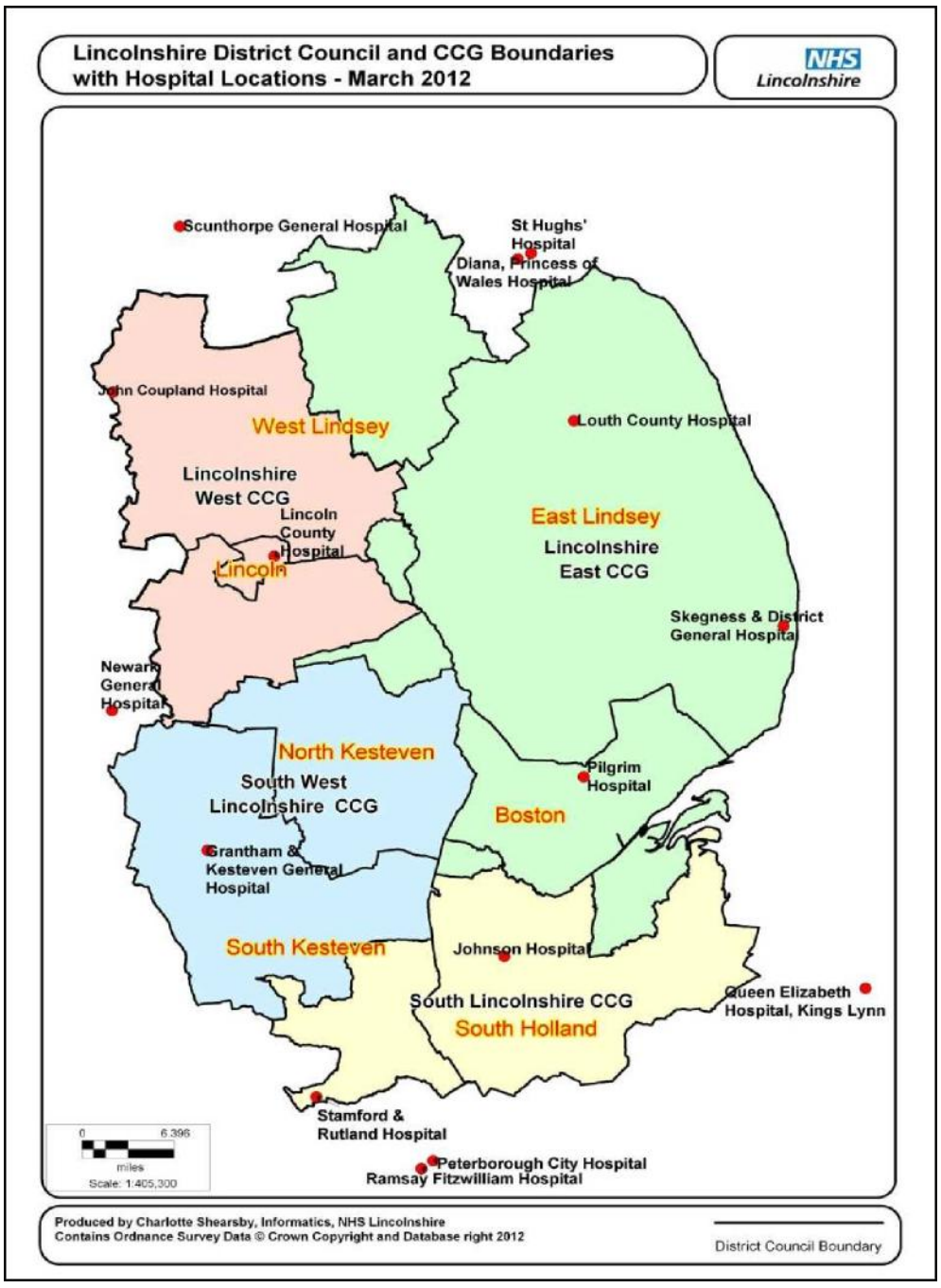
The county also has a higher that the national average incidences of long term health conditions including:

> Coronary Heart Disease
> Stroke
> Chronic Obstructive Pulmonary Disease
> Cancers
> Dementia
> Obesity
> Diabetes

Ref: Lincolnshire Research Observatory (LRO), 2012

4.2 Clinical Commissioning Group Boundaries

Figure 1 outlines the existing Clinical Commissioning Group boundaries and the location of Acute and Community Hospitals within the county.



4.3 Workforce Profile

Lincolnshire Community Health Services currently employs 2,800 staff, to deliver a wide range of services from multiple sites across the county. The operating budget is circa £102 million.

Core community services are currently aligned to the Clinical Commissioning Group boundaries via a business unit structure. Family and Health Lifestyles delivers core children's services and specialist services in a separate business unit across the county.

Operational Services are supported by a range of corporate functions, as follows:

> Finance

> Workforce and Organisational Development

> Information Management and Technology (IM&T)

> Performance

> Strategy and Commercial Development

> Contracting

> Communications

4.4 Existing Service Portfolio

Lincolnshire Community Health Services portfolio is diverse, (*Figure 2*) providing integrated community services to adults and children in a variety of settings such as:-

> Community hospitals
> Primary care
> The patient's own home
> Health Clinics

There are a wide range of specialist services which make the organisation an attractive proposition as a viable and competitive aspirant Community

FoundationTrust. Services currently operate from sixty-seven sites across the county, and the operation of the minor illness and injury service in Peterborough.

Figure2

4.5 Contractual arrangements

The Trust's main contract is commissioned by Lincolnshire East CCG (LECGG) on behalf of all the Lincolnshire CCG's and is delivered by block contract in the main. This includes service specifications for the delivery of 'expected services', which is monitored through robust internal contract management processes.

In addition, the organisation has a Joint Venture agreement with Lincoln County Council (LCC) and United Lincolnshire Hospitals NHS Trust (ULHT) for the provision of Integrated Community Equipment Services (ICES) under Section 75 and Section 8 agreements, together with contracts for the provision of care into Children's Centres, the Speech and Language Therapy service (SALTs) and School Nursing. NHS England presently continue to support Health Visiting commissioning via Public Health locally.

4.6 Market position

LCHS have worked hard to understand the trusts role in the changing health economy. Knowledge and expertise has been drawn from all our stakeholders; including staff, commissioners, other providers, patients and the public in order to review emerging developments in the health and social care market to inform our future strategy.

LCHS currently holds the majority market share in the provision of community services which are mainly delivered by a block contract. Whilst the trust is well placed to withstand competition, it is also cognisant that it has to sustain and improve this position.

4.7 Clinical Strategy - Adult Services

Lincolnshire Community Health Services has a robust track record of working with its partners and stakeholders to deliver new and innovative solutions to meet the needs of patients and commissioners. In recent years non recurrent funding has been received to develop the following services:

4.7.1. Community Response Specification

The contract for community nursing services was, until 2011/12, a 'core block contract' which did not contain any level of clinical detail or description of service delivery models or patient outcomes. In 2012/13, the contract for community nursing services was commissioned as a wider community services contract – the Community Response Specification (CRS).

The CRS contract consists of 3 elements:

1. Community Nursing
2. Assisted Discharge
3. Rehabilitation

At the request of the commissioners, the Community Nursing element of the CRS contract was implemented from the 1st April 2013 and now provides an activity based contract, demonstrating benefit to both patients and commissioners. It also provides assurance within the organisation that high quality, clinically effective care is provided, aligned to the Quality Improvement Strategy.

The new contract for community based services has therefore been defined in clinical pathways which work together to support the following aims:

- Delivery of more services to patients in the community / closer to home
- A reduction in acute hospital based care
- Active admission avoidance where it is deemed clinically appropriate
- Discharge from acute sector when patients are medically stable

Clinical pathways are used to manage the quality in healthcare as it has been demonstrated that their implementation reduces the variability in clinical practice, which improves outcomes for patients.

The CRS project has documented the pathways in three key documents to support the different levels and areas of implementation:-

1. The Community Response Services Specification provides the outline of the contractual infrastructure
2. The Financial Hierarchy Framework
3. The Community Nursing Catalogue supports the implementation of the specification from an operational perspective

The pathways are designed ensure clinical staff can exercise appropriate decision making within a recognised framework so as not to override clinical judgement or individual patient requirements. This 'care bundle' approach has allowed the organisation to move towards the implementation of a shadow tariff, which will be fit for future purpose.

The development of integrated nursing teams serving defined localities will further refine the Community Response Specification as patient care plans support agreed interventions over a defined period of time to improve health outcomes. Service line reporting will be implemented for the twelve teams identified for the optimum operating model and will ensure the capacity and skills of staff are matched to the needs of patients. See appendices three and four

4.7.2 Community bed provision

The organization provides a number of Community Hospitals and other support for bed based care in the community. Models of care vary from a consultant led sub-acute hospital at Louth, three nurse-led community hospitals to rehabilitative nursing and therapy support to commissioned and spot purchase beds in care and nursing homes, and a hospice run in partnership with the Butterfly Trust.

Our strategy is to support as many patients as possible to remain well and independent at home, but where intensive support and rehabilitation, respite care or choice of end of life care will benefit patients, LCHS bed based care provides a range of services to meet those needs.

It is likely that commissioners will wish to review and possibly flex the number of community beds available to meet a range of needs for patients. Models to increase access to sub-acute care, provide step up services for patients and assessment and support on a day basis for frail elderly patients are to be developed.

In response to a reduced level of bed capacity in the Acute Trust this winter a partnership approach has been taken with Lincolnshire Partnership Foundation trust to open two wards for elderly care assessment and rehabilitation prior to supported discharge at home.

4.7.3 Urgent Care Models

Urgent care continues to see increasing demand from patients, both in terms of primary care contacts through out of hours services,

requirements for urgent assessment and support at home and attendances for both injuries and illness at urgent care centres.

Out of hours services are currently provided through local models embedded in business units, the future model plans to move to centralized access and deployment through the contact centre, with advice, face to face attendances and home visits provided through a mixed model of call advisers, GPs and rapid response practitioners. Streaming of primary care patients has been operating effectively in ULHT A&E departments managing patients and reducing pressure on A&E staffing.

Urgent care centre models are being reviewed to ensure models provide a full range of services for patients attending with either injuries or minor illness. Pathways are being improved for access to diagnostics and referral of patients who have an acute medical need.

4.7.4 Independent Living Team

The Independent Living Team Pilot was successful in bringing together services that were previously separated by organisational boundaries and behaviours and this services is now consistently being provided across all areas.

The Independent Living Team gives added value of an integrated service by co-joining a Community Response and Rehabilitation Service (CR and R) with and Assessment and Reablement Service (LARs). The LARs element being provided by Lincolnshire Partnership Foundation Trust, demonstrating integrated working in localities.

The service has grown quickly and been independently evaluated as being able to deliver some valuable benefits for those using the services, such as:

> An improved outcome for patients that supports independent living.

> A positive experience

> Reduction in the need for higher levels of on-going support in the

community

> Accessible referral process

> Professional feedback indicates that practitioners support the

integrated approach

> Streamlined and more efficient process

> Allows for swift decision making to take place

> Clearer outcomes are apparent to all

As a direct result of the success to date the ILT service is now being integrated into the community integrated team model to offer patients access to all pathways locally through one team.

4.8 Clinical Strategy – Family and healthy Lifestyles

Family and Health Lifestyles Business Unit currently provides Health Visiting, School Nursing and safeguarding services, which includes services to vulnerable children and young people. A range of therapy services such as Speech and Language, Occupational Therapy and Physiotherapy services to children are also provided. Additional services such as Sexual Health, Smoking Cessation and Specialist Dental services are also managed directly by the Business Unit.

This portfolio of services works to support the Public Health and Department of Health outcomes agendas. Services are commissioned through Public Health England via Local Authorities and Public Health, in partnership with local Health and Wellbeing Boards. Commissioning colleagues are supported by the Board in implementing identified high impact changes, such as pathways to manage childhood obesity (DH 2011).

It is anticipated that the commissioning of these services will move to local commissioning arrangements through Lincolnshire County Council from 2015.

It has been recognised that provision of children's community services in Lincolnshire is fragmented and does not provide integrated services to children in Lincolnshire. Families tell us that they have to attend multiple appointments and assessments with a wide range of clinicians who often have not share information. A review commissioned by NHS Lincolnshire and conducted by Tribal in 2009 recommended the implementation of an integrated service based around the needs of the child or young person. These recommendations were not taken forward at the time. In 2011 a small working group from all providers was asked to reconsider the Tribal work and make recommendations for addressing the fragmentation in children's services. This resulted in the Transforming Children's Services paper which has not yet been implemented.

The Children & Young People's Health Outcomes Forum Annual Report 2013-14 provides evidence of the benefits and challenges of integrated working. This includes key issues in achieving improved health outcomes for children and supporting young people as they transition to adult services. It particularly highlights the benefits of community based integrated care in keeping children and young people healthy in their communities and opportunities to develop appropriate outcome measures for children.

This document captures a vision of the benefits that could be realised from integrating the Community Children's Nursing team and the integrated Children's Therapies team.

The Community Children's Nursing team provides education, specialist advice and support, and nursing care to children and young people aged 0-19 years with an identified specific nursing need who are living within the Lincolnshire geographical boundaries and are under the

care of a consultant i.e. consultant paediatrician, consultant community paediatrician, consultant surgeon.

The Children's Therapies team is an integrated team of physiotherapists, occupational therapists and speech and language therapists. The team works on a county-wide basis to provide both early intervention and specialist therapy to children and young people aged 0-19. The team are part of the Family & Healthy Lifestyles business unit at LCHS.

Both teams work with a similar cohort of children and young people, children with long term conditions and/ or complex health needs. This includes those children with a life-limiting and/or life threatening condition and children requiring palliative and end of life care.

The integration of the Children's Therapy and Community Children's Nursing team would create an integrated Complex Children's team comprising both nurses and therapists in a similar model as the proposed Adult integrated teams. The benefits of this may include:

A single integrated nursing and therapies teams for children with complex needs and long term conditions which simplifies interaction for families.

Foundation for a 'neighbourhood team' for children with complex health and care needs. Person-centred coordinated care for children and young people with a key objective to keep children well and out of hospital.

Adoption of the MDT approach encapsulated in the proposal for a Child Development Centre model described in Transforming Children's Service as the standard operating principle for children with complex needs. This could be located in a permanent facility such as Kingfisher ward or could be delivered as a 'virtual CDC' from facilities at community clinics, community hospital sites and/or children's centres. The addition of community paediatricians to the team could strengthen this integration and team working.

Opportunities to simplify care pathways by joining up services and working more closely with partners including CAMHS, Children's Centres and other providers.

Implement the role of the care navigator as central to coordinating the health and care needs for the child or young person.

Closer integration between universal services and specialist care. Opportunities for early intervention, to support families pre- and post-diagnosis and to consider needs of wider family as well as those of the child.

Opportunities to create new roles to support improved health outcomes for children with long term conditions, for example, a children's nursing and health visiting/school nursing practitioner supporting 'nursing' needs in children with long term conditions and supporting their transition to adult services.

Improved communication between Community Children's Nursing, Community Paediatrics and Children's Therapy professionals through the use of a single record keeping platform (SystmOne) to facilitate information sharing. SystmOne is currently used by Children's

Therapies and Community Paediatricians but not by Community Children's Nurses.

Improved strategic planning and service development to meet the needs of children with complex needs in Lincolnshire such as services for the management of cystic fibrosis, long term ventilated children, palliative care and AHI discharge from hospital.

Holistic assessment that meets both nursing and postural needs, reduces duplication and more integrated care delivery. Potential benefits include improved tissue viability assessment and management and improved management of ICES expenditure.

Potential to structure integrated children's team around the adult neighbourhood team model. This would allow us to improve the transition to adult services and improve the quality of care through this phase for young people with long term conditions and ongoing nursing/medical needs.

Potential to adopt innovative developments such as discharge to assess to ensure that children spend as little time in acute hospital as necessary and then return to care at home.

Potential to use functionality of Contact Centre to coordinate response to the child's needs across health and social care.

A platform for development of future models of care including paediatric admission avoidance pathways.

5. Market Position

5.1 Strategic Intent

The strategic intent of the organisation can be summarised as:

> Being the specialist provider of out of hospital care
> Becoming a service integrator to facilitate the shift of care from acute hospitals into the community
> The main deliverer of integrated care pathways
> Striving to provide continuous service improvement using innovative practice
> Ambition to acquire aligned services
> To have a relentless focus on Care and Compassion
> To have an increased focus on listening to patients and their families and acting on their views

In essence *"To be the first choice for health care, closer to home"*

5.2 The Future Solution

The Trusts Integrated Business Plan (IBP) and Quality Improvement Strategy (QIS) set a clear direction of travel for the organisation to effect a radical change to the existing model. Additional pathways of care need creating to encompass statutory, private and voluntary sector providers.

This vision is underpinned by a robust Workforce and Organisational Development strategy, detailing how the organisation intends to transform its workforce to respond to the following changes:

> Provision of more care, closer to home
> Prevention of clinically inappropriate hospital admission
> Supporting earlier discharge from hospital whilst ensuring patients are able to continue their treatment without interruption.
> Provision of a simpler form of access to care via a 'One call does it all' approach, coordinated from the contact center, which also will avoid duplication
> Working as a wraparound to General Practitioner and Primary Care Services
> Keeping in close touch with patients and carers, adjusting quickly to changing needs.
> Ensuring the right kind of skill is provided for every situation
> To offer expertise as an 'integrator' of care to a wider market
> Ensuring value for money is delivered across all services
> Provision of an agile, streamlined and professional workforce
> Above all, providing the highest quality of care

5.3 How Will We Get There?

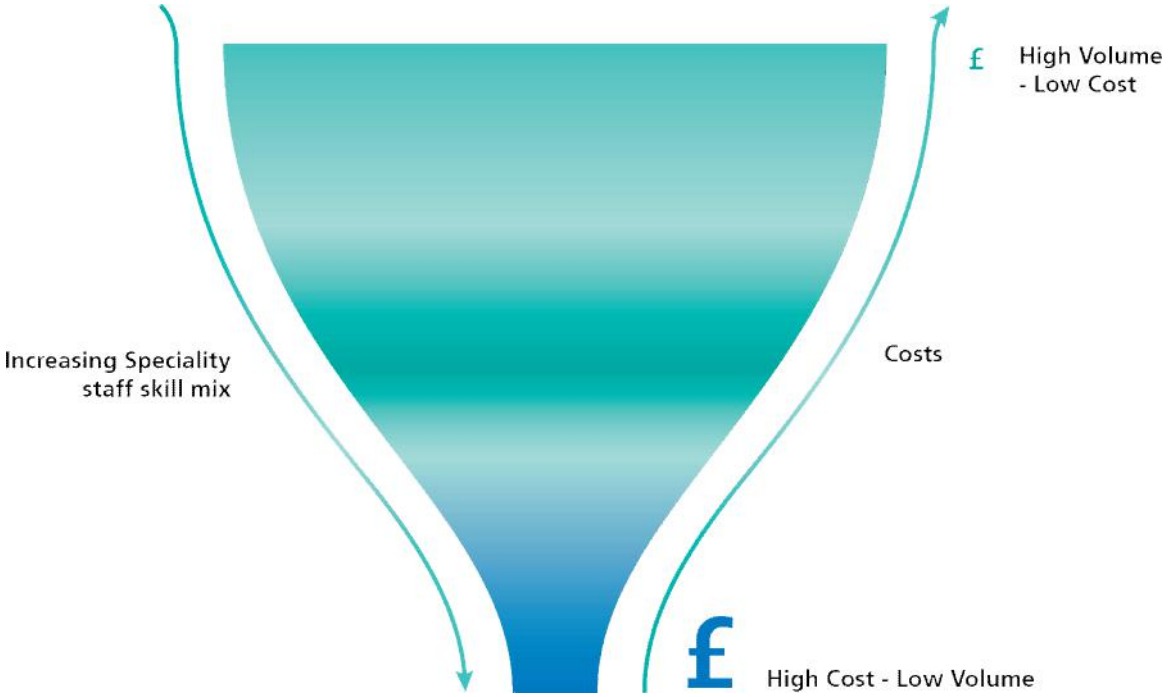
To deliver our strategic vision Lincolnshire Community Health Services intends to adopt a business model that describes our added value as an aspirant Community Foundation Trust, within the wider health and social care community. It will define the manner by which we intend to value our customers and stakeholders, describes our growth aspirations, to ensure our longer term financial viability. In essence it reflects what our customers want, how they want it, and how we can organise to best meet those needs, whilst remaining financially viable.

The business model outlined in Figure 3, demonstrates how core services within the organisation can be segmented to define our core offerings. It articulates how community services (at the middle - top end of the inverted figure) will deliver high volume, low cost care within the market, in contrast to the acute sector, where provision is predominantly high cost, low volume.

Our proposition translates into our future models for care delivery by addressing the efficiency requirements that need to be made in the NHS, through delivering more activity at the 'middle to top end' of this model.

Figure 3

Business Model



In essence an efficient and well run Community Service can provide a viable clinical and cost effective solution to the majority of issues facing the acute sector by tipping more activity into the high volume, low cost alternative service, delivered closer to the patient's home environment.

5.4 What This Means

The business model describes our vision for keeping people at home by delivering end to end integrated services with Lincolnshire Community Health Services as the service integrator. This will allow the organisation to take control of the current complex, and ineffective care, across community and urgent care environments. Patients will be appropriately navigated into more sub-acute services, provided at a lower cost

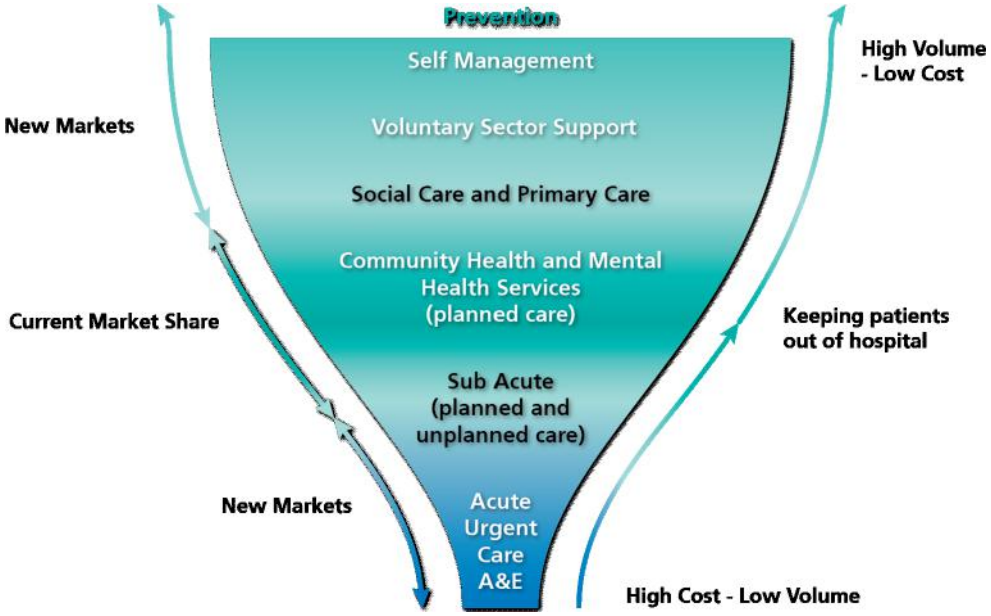
The model outlines primary care as the hub for the integrated multi-skilled teams based in each of our communities and the organisation intends to build on the delivery model already established in the early implementer neighborhood team pilots. This will allowed the alignment of existing community nursing, adult social care teams and community psychiatric staff to surround GP practice localities. The intention is that this will be underpinned by shared care arrangements, supported by trusted assessor and key worker principles. The local GP's will continue to provide clinical oversight of care delivered in the community with the trust acting as the 'Service Integrator'.

The following services (detailed in Figure 4), will be provided by the organisation to ensure the delivery of the strategy:

> Single Contact Centre access for all health and social care professionals> Enhanced proactive care based on integrated case management
> Provision of a Rapid Response Service combining existing urgent care services to effect a prompt response across the county
> Fully integrated health and social care teams working effectively with Primary Care to provide 'virtual wards of patients' in the community setting
> Prevention of clinically inappropriate acute hospital admission
> Promotion of health promotion and self-management strategies
> Provision of intensive monitoring facilities 24 hours a day and more complex service delivery such as I.V. therapy.
> More effective use of existing bed based services to complement the delivery of care closer to home.
> A robust Medical team; underpinned Medical Workforce Strategy
Improved discharge processes from the acute sector

Figure 4

Intended Business Model for LCHS



It is our intention to build capacity in local communities and localities by stimulating and partnering voluntary sector providers and local community groups/ facilities. The voluntary sector plays a significant role in our health system, with the NHS currently spending around £3.4bn a year commissioning services it provides.

6.0 Delivery of the Vision

6.1 How do we Plan to Deliver this?

The trust fully recognises its role in the future delivery of health promotion and 'Care Outside of Hospital'. We intend to play a key role as Prime provider working with patients, public and commissioners to help deliver solutions to the whole health and social care challenge, from 'Cradle to Grave'.

The process of transforming care from that delivered predominantly in the acute sector to the community setting will be a huge challenge. The public however have acknowledged this as a priority as detailed in the document: High Quality Care for All, Department of Health, (2009).

In order for the organisation to achieve its aspiration of becoming the ***'First Choice for Healthcare, Closer to Home'***, there is a requirement for it to work with a wide range of partners to 'rebalance the healthcare system'. This will result in a radically different provision of integrated community services from cradle to grave.

Services will be refocused to achieve greater flexibility to meet both the needs of the patients and commissioners. A robust safe and effective workforce and organisational development plan, supported by a detailed appraisal and supervision process, will ensure staff are able to deliver the right care, at the right level and at the right time outside of the hospital environment.

Closer working relationships between preventative, proactive and urgent care will remain paramount to ensure the deployment of effective clinical interventions to maintain the majority of care in the community.

The Trust in the role of Service Integrator will reduce patient 'hand offs', further improve safety, release efficiency and increase its market share of provision.

By utlising innovative practice detailed in the Information Management and Technology Strategy, it is expected that staff will be able to be more productive, spending large amounts of their time focusing on caring for patients.

The organisation will continue to forge links with key stakeholders in the public and private sector to ensure it remains at the cutting edge of technology and practice.

As part of the longer term strategy, greater focus will be placed on the prevention and supported self-care agendas, to ensure all patients optimise their levels of functioning, recovery and independence. Health outcomes and individual goals will be improved irrespective of age, reducing inappropriate admissions, facilitating timely, safe discharge from acute services, providing meaningful assessments closer to home which will reduce the future reliance on institutional or more specialised care.

6.2 Supporting Strategies

This strategy should be read in particular conjunction with the following strategies:

> Workforce and Organisational Development – ensuring the right culture and training is embedded
> Workforce Plan– ensuring a competent workforce and appropriate succession planning.
> Medical Workforce – ensuring a competent and flexible medical input to the pathways
> Quality Improvement – setting the standards for high quality care delivery building on the successful CQC inspection outcome
> Estates – ensuring innovative and cost effective utilisation of all estate resource.
> Information Management and Technology – driving a single electronic patient record, solution for mobile working, timely data input, requisite IT skills and increase in productivity
> Patient and Public Involvement – ensuring the voice of the public is captured
> Stakeholder Engagement – ensuring the views of the Stakeholders are known

6.3 Integrated Business Plan

The overarching Integrated Business Plan (IBP) for the trust states the intent to develop clinically effective and responsive services with a view to delivering value for money services that meet the needs of the population.

Within the IBP, the organisations service developments have been defined as either natural, aspirational, efficiency or growth.

Natural efficiencies and growth is driven by expected changes in patient demographics. It is growth that follows service improvement and an increased retention of patient care, or the ability to generate internal efficiencies as a result of service diversification.

People are the key resource in the delivery of our services and comprise the most significant proportion of the cost base. The structured internal transformation programme is pivotal to the delivery of sustainable change and financial balance.

The trust has identified a number of opportunities for aspirational efficiencies and growth. The transformation of service provision will be dependent upon the development of strategic partnerships to improve the effectiveness and efficiency of care delivery and the implementation of innovative new pathways to meet the ever more complex clinical needs of patients.

6.4 Pathway Development

6.4.1 Frail Older People

The organisation has developed a high level frail older peoples' pathway designed to ensure integrated service delivery occurs at each stage of the patient journey. Implicit in the pathway is a reduction in 'hand offs' between care providers to improve the safety, quality and experience for patients and users of the services.

6.4.2 Out of Hospital

Out of Hospital Care is diagrammatically represented in appendix one, which outlines the process and infrastructure required to effect Urgent, Planned and Routine Assessments in the Community.

6.4.3 Avoidance of Acute Admission/ Step Down Facility

Appendix two describes the 24 hour strategy to avoid inappropriate clinical admission to the Acute sector in conjunction with a more streamlined process to support the step down from acute care as part of the patient journey.

6.4.4 Community Hospitals now have agreed pathways for:

- Rehabilitation
- End of Life Care
- Assessment of need and care planning

6.5 The Benefits

The pathway described in *appendix three* brings together existing services and identifies gaps in provision to inform a three year implementation plan. The aim is to provide a community approach to avoid unnecessary attendances/ admissions to acute services by responding at key points on the patients' journey.

6.5.1 For the Patient

The Contact Centre will simplify the access to the provision of care, which will be provided in the main by skilled professionals within integrated community teams. Extra support will be provided as required in conjunction with the voluntary sector.

A Rapid Response team will respond to crises and provide timely and effective support, navigating the patient through the maze of healthcare provision.

GP support will be accessed throughout the 24 hour period either in primary care or via a range of urgent care provision.

Unnecessary attendance at the local Accident and Emergency Departments will be prevented by diversion to appropriate services in the community.

Risk stratification and pro-active care will support keeping a large majority of the frail elderly community out of hospital. Intensive support will be suitable for some patients in a 'virtual ward' based in integrated community teams, whereby some of the treatments previously only available in the acute hospital will be provided at home, for example administration of intravenous fluids. The use of Telemedicine will ensure more complex patients will be able to remain safely in the community, linked to the rapid response service.

If a spell in hospital is needed, discharge will be timely and seamless by ensuring better coordination with social care and other supporting services. Treatments started in hospital will be continued at home or in other community settings without interruption.

6.5.2 For the Acute Sector and Commissioners

Our outline strategy provides an alternative community based solution for patients and commissioners alike.

By diverting and maintaining patients in the community, the need for large District General Hospitals will decrease over time and allow commissioners to release resource for more effective and innovative commissioning of services in the future.

6.6 Enablers to Delivery

In order to deliver the strategy the Trust recognises that it will have to influence a number of stakeholders and implement enabling strategies.

6.6.1 Development of new funding streams/tariff

It is essential that if activity is to shift from acute care to community based provision, that funding will have to follow the patient throughout their journey.

The organisation considers the Prime Provider model to be the most effective model to ensure efficient integration of older adult services. This will enable it to marshal and manage a network of providers on behalf of the commissioners. Prime providers have shared governance infrastructures with their partners and guarantee end-to-end service delivery to ensure the pathways of care work effectively.

Year of Care funding could be utilized to contract care differently, and align funding to improved patients outcomes.

6.6.2 Creating a Culture of Continuous Improvement and Innovation

Lincolnshire Community Health Services recognises that in order to develop new solutions it needs to create a culture of innovation throughout its workforce. The trust is exploring partnerships with academic institutions to build capacity for innovation and spread this throughout our everyday activity.

6.6.3 Partnering for Innovation and Delivery

LCHS recognises the need to form strategic partnerships to continue to innovate on service pathways and to strengthen capacity for delivery. The trust has developed a partnership evaluation tool to ensure that any future partners are assessed as being a strategic fit to the organisation and that the organisation is able to understand the respective risks and benefits of a potential partnership.

7. Summary

The National Health Service needs to be able to refine its ways of working in order to cope successfully with the anticipated increase activity and complexity of patient need.

Lincolnshire Community Health Services Clinical Strategy is a working document, outlining how the organisation will be best placed to provide the majority of out of hospital care in Lincolnshire and beyond, building on our extensive achievements and expertise in the community to date.

Delivering high quality services to the local population in challenging fiscal times will require partnership working with primary, secondary, social care, academic establishments, voluntary and private partners.

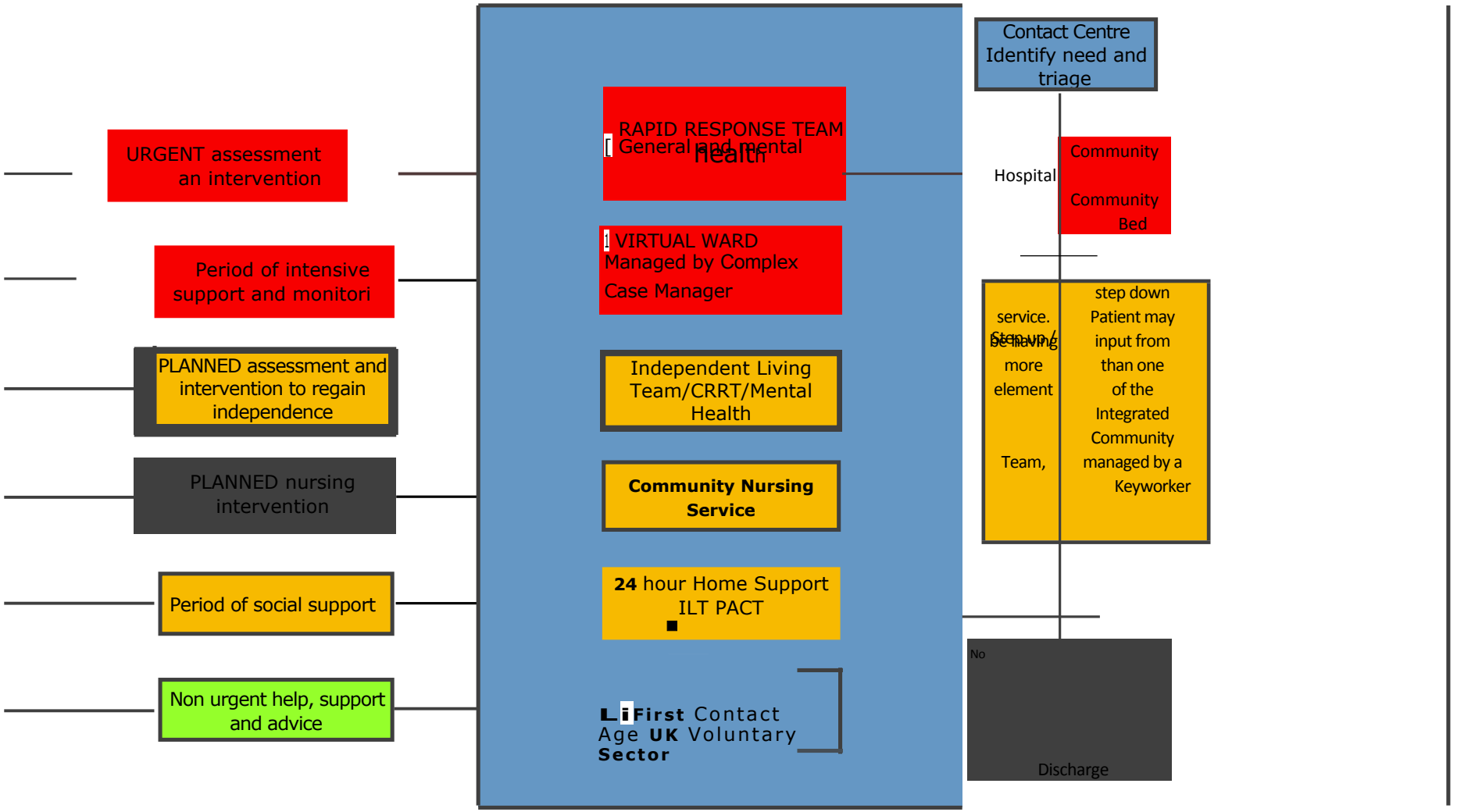
The organisation will use this strategy to build on its previous achievements and expertise. The unique selling point of the Trust remains the ability to provide effective Out of Hospital care effectively in a rural setting, across pathways with multiple providers.

The focus will be on further development of the preventative model, whilst building on the platform of proactive care. As these two areas become more established it is anticipated that the need for an intensive reactive/urgent response will reduce overtime.

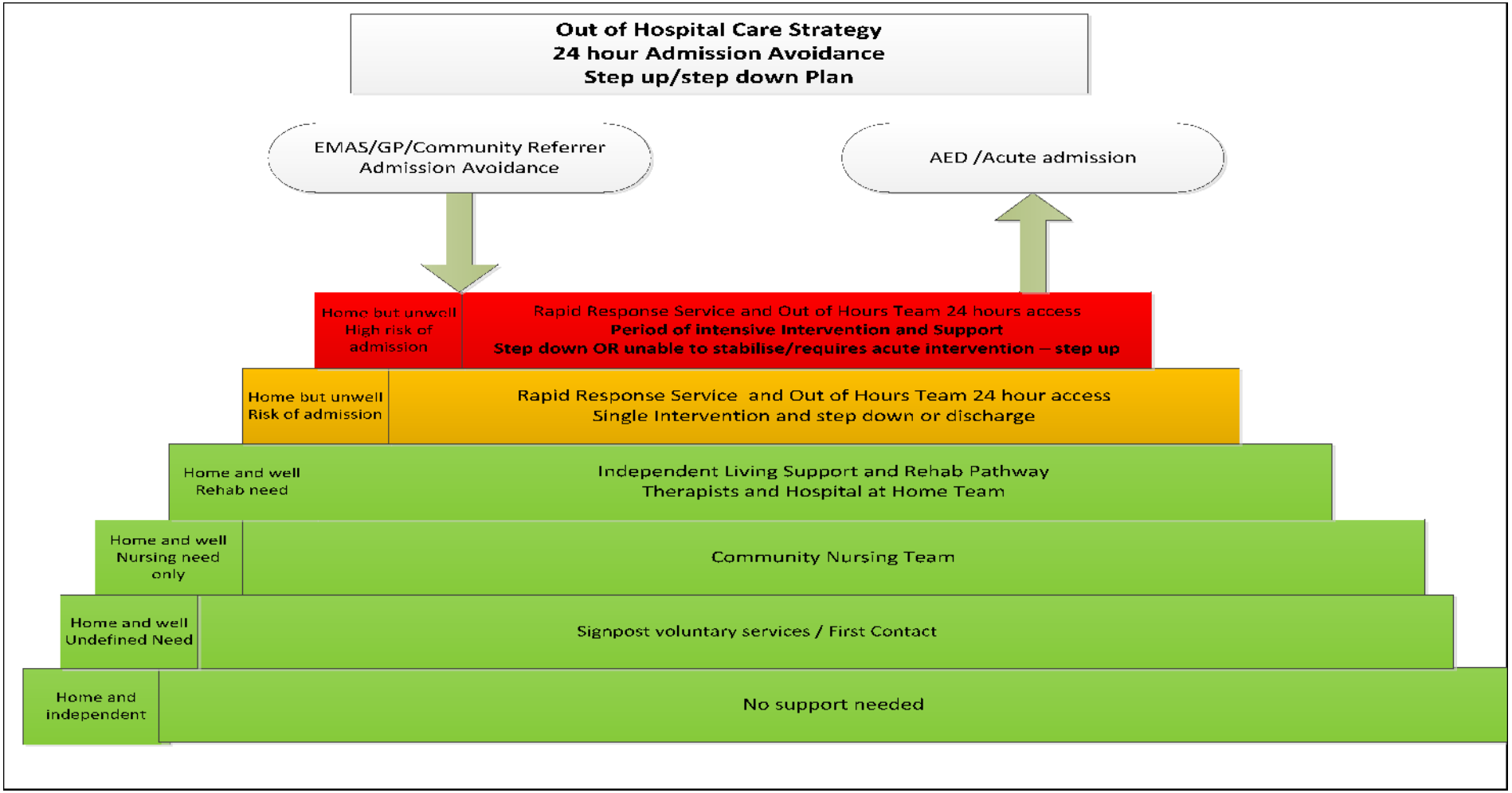
The Trusts aim over the next five years is to be recognised and acknowledged as a Prime provider of world class health and social care services:

‘To be the First Choice for Health Care Closer to Home’

Appendix 1 **Out of Hospital Care — diagrammatically represented**



Appendix 2


Out of Hospital Care Strategy
24 hour Admission Avoidance
Step up/step down Plan
EMAS/GP/Community Referrer
Admission Avoidance
AED /Acute admission
Home but unwell
High risk of admission
Rapid Response Service and Out of Hours Team 24 hours access
Period of intensive Intervention and Support
Step down OR unable to stabilise/requires acute intervention – step up
Home but unwell
Risk of admission
Rapid Response Service and Out of Hours Team 24 hour access
Single Intervention and step down or discharge
Home and well
Rehab need
Independent Living Support and Rehab Pathway
Therapists and Hospital at Home Team
Home and well
Nursing need only
Community Nursing Team
Home and well
Undefined Need
Signpost voluntary services / First Contact
Home and independent
No support needed

Appendix 3

LCHS Transformation and Implementation Plan