Leicestershire Partnership NHS Trust

Clinical Strategy 2014 to 2019 (Refreshed in 2017)

Summary

The Clinical Strategy is the overarching strategy for achieving the vision and the strategic objectives set by the Trust Board. The Clinical Strategy emphasises the need for right service models and a relentless focus on improving quality and productivity. It then sets out the principles for the right service models as well as key mechanisms for creating relentless focus on quality and productivity. Implementation of the Clinical Strategy is achieved through setting the direction for other strategies as well as driving our transformation programmes. A diagrammatic representation of this is shown as below:

Contents

1. Foreword

The National Health Service (NHS), the world's largest publicly funded health service, continues to change rapidly and this presents many opportunities as well as challenges. To maximise the opportunities for the population of Leicester, Leicestershire and Rutland (LLR), we believe that we should develop a true partnership between the users of our service, their carers, the public, our front line staff and our partner organisations in driving a continuous improvement in the quality and cost effectiveness of the care we provide. This Clinical Strategy provides an overarching framework to make this happen.

A key priority for our organisation is quality and a sustainable improvement in quality needs the following:

- Listening continuously to our users which include our service users, their families and carers
- Work in an integrated manner improving the coordination of care and delivery of services
- Our staff working together in teams to deliver the right care for our users at the right time and place
- Enhancing the power of front line clinicians to innovate and improve the care continually.

This Clinical Strategy sets the vision for the development of our services over the next five years. This will support the aspiration of our organisation to become an integrated community trust to improve the health and wellbeing of the population of LLR.

Dr. Peter Miller
Chief Executive

2. Introduction

Leicestershire Partnership NHS Trust (LPT) provides high quality integrated mental health, learning disability and community care services. The Trust was created in 2002 to provide mental health, learning disability and substance misuse services. The Trust serves a diverse population of approximately one million people across LLR with residents having come from over 50 difference countries. The Trust has a budget in excess of £250 million and employs over 5,800 staff in a wide variety of roles.

The Trust works with general practitioners (GPs), local hospitals, Social Services and other Local Authority departments such as housing and education. We also work with voluntary organisations and local community groups.

Our services are organised across three clinical directorates: Adult Mental Health and Adult Learning Disability Services (AMHLD); Families, Young People and Children's Services (FYPC); and Community Health Services (CHS)[1]. Staff working with different members of the same family are increasingly creating networks across the directorates to support our whole family approach.

We are also a teaching Trust, which means we proactively engage with and conduct research and provide training and education for medical, psychology, nursing and therapy students.

This document sets out the Trust's Clinical Strategy for continually improving the quality and cost effectiveness of services, whilst ensuring we meet the health needs of the people of LLR.

3. Our Vision, Values and Strategic Objectives

[1] See Appendix 1

Our vision is to improve the health and wellbeing of the people of LLR by providing high quality, integrated physical and mental health care pathways. There are three key parts to this vision:

- **Improve** We believe that we are on a journey of continuous improvement to ensure that we consistently apply best practice and achieve outcomes comparable to the very best of our peers. An improvement focus will also enable us to achieve our financial targets and meet the needs of regulators and our health economy stakeholders.

- **Leicester, Leicestershire & Rutland:** We are part of the health and social care system in LLR and we play an important role in ensuring that people of LLR receive the best health and social care as possible to live healthy and independent lives. This ambition is captured in our Sustainability and Transformation Partnership Plans.

- **Integrated Care Pathways:** This might mean trying to transcend traditional boundaries between professional disciplines, mental and physical health as well as primary, secondary and social care. In all cases we will try to take a 'care pathway' approach, moving from historic, fragmented and episodic models towards those that provide a seamless start to end journey for service users and their families.

Our vision statement defines who we are as a Trust and our staff work to a set of strong core values which are Respect, Compassion, Trust and Integrity.

The Trust has four strategic objectives:

1. **Quality** – Deliver safe, effective, patient centered care in the top 20% of our peers.

2. **Partnerships** – Partner with others to deliver the right care in the right place at the right time.

3. **Staff** – Staff will be proud to work here and we will attract and retain the best people.

4. **Sustainability** – Ensure sustainability.

4. National Strategic Context

NHS Five Year Forward View

Aimed at addressing the three health gaps: Health and Wellbeing, Care and Quality, Funding and Efficiency:

1. Prevention with focus on obesity, smoking, alcohol and other major health risks.
2. Integrated approach across physical and mental health, primary and secondary care and health and social care.
3. Adoption of new care models that promote integration, prevention and sustainability.

Five Year Forward View for Mental Health

Aimed at parity of mental health, prevention and early intervention

1. Improving access to high quality mental health care for children and young people.
2. Increased access to psychological therapies.
3. Improved access to mental health support for service users presenting in acute hospital settings.
4. Adult mental health services to provide timely access to evidence- based, person-centered care, which is focused on recovery and integrated with primary and social care and other sectors.
5. Prevent avoidable admissions and support recovery for people with severe mental health problems and significant risks/safety issues in the least restrictive setting as close to home as possible.
6. Improved care pathways across secure and detained settings.

Transforming Care for People with Learning Disabilities

Empowering people and families:

1. Choices and say for people and their families in their care;
2. More care in the community, with personalised support provided by multi-disciplinary health and care teams
3. Innovative services to give people a range of care options, with personal budgets, meeting individuals' needs
4. Intensive support earlier for those who need it, so that people can stay in the community, close to home;
5. Inpatient care when required is only for as long as it is needed.

Future in Mind

Making sure that children and young people have timely access to effective mental health care:

1. Emphasis on building resilience, promoting good mental health, prevention and early intervention
2. Improving access to the right care without barriers
3. Joined up care with care pathways which are easy to navigate.

5. Local Strategic Context

The LLR Sustainability and Transformation Partnership

General Principles of the LLR STP are as follows

1. To deliver high quality, person centered, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person resulting in a reduction in the time spent avoidably in hospital.
2. To reduce inequalities in care (both physical and mental) across and within communities in LLR.
3. To improve the positive experience of care across all health and social care settings.
4. Ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system.
5. Achieving financial stability.
6. To improve the utilisation of our workforce and the development of new capacity and capabilities where appropriate, in the people and the technology we use.

The following work streams are in progress to achieve the above aims:

A. New models of care focused on prevention and moderation of demand growth
- Home first
- Urgent and Emergency Care
- Integrated Teams
- Resilient Primary Care
- Planned Care

B. Service Configuration to ensure clinical and financial sustainability
- Acute Reconfiguration
- Maternity Services
- Community Hospitals

C. Redesign pathways to improve quality of care and outcome
- Prevention
- Long Term Conditions
- Cancer
- Mental Health
- Learning Disabilities
- Children's, Maternity, Neonates
- Continuing Health Care and
- Personalisation
- Specialised Commissioning

D. Operational efficiencies through cost improvement, back office efficiencies and medicine optimization.

E. Supporting the transformation with enablers such as IM&T, workforce and estates

Transformation driven with Better Care Fund in LLR

Leicester - Prevention, early detection and improvement of health-related quality of life, reducing the time spent in hospital avoidably and enabling independence following hospital care.

Leicestershire - A unified prevention offer for local communities, better integrated and proactive care for those with long term conditions, integrated urgent response and better hospital discharge and re-ablement.

Rutland – Improved services even though there is greater demand and less money, having people cared for in their own homes with reduced lengths.

6. Challenges and Way Forward

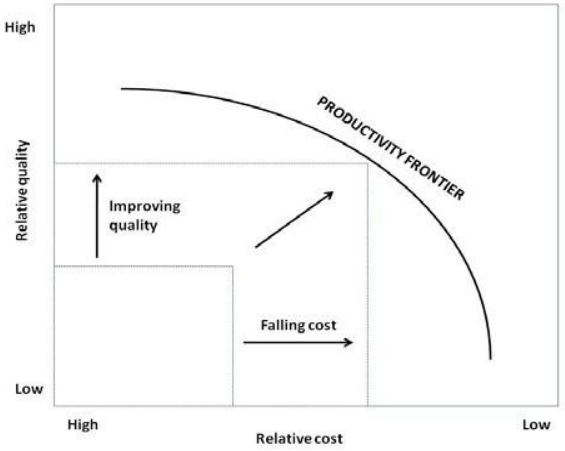
On one side the changes in population needs such as ageing and increase in demand for services for children and on the other side reduction in local authority and social care funding would challenge the sustainability of our existing service models. Although focus on left shift (moving to more community based services) and parity for mental health care are likely to help us secure more investment, the increasing health needs of the population and increase in operational cost means that the operational efficiency of services need to be improved considerably.

Leicester is also one of the most diverse and multicultural places in the UK with its residents coming from over 5 countries. Leicester sees diversity as its strength but the health needs of a population with such diversity needs careful planning and pro-active ways of reaching out in to the communities as many barriers may prevent access to health care for the population. The trust needs to take bold steps in developing innovative ways of reaching out to the population learning and adapting to the changes in population needs.

GP federations, third sector and private health care organisations are likely to emerge as potential competitors for some of the services provided by LPT currently. However approached pro-actively some of these organisations would also provide opportunities for collaborations. For example, forging partnerships with GP federations are likely to help us achieve better integration as well as sustainability, and establishing strong relationships with good third sector/private health care providers with credibility will enable us to improve access, quality and outcome while reducing the operational cost. However the "readiness" of our services to make the most out of these relationships would be vital in deciding our success or failure.

Michael Porter and Elizabeth Teisberg (authors of the book *'Redefining Health Care: Creating Value-based Competition on Results'*) argue that the primary goal of any health provider should be value based competition based on result. In a subsequent paper, it is argued that a clinical strategy should focus on six key imperatives:

- Organise into integrated practice units;
- Measure outcomes and costs for every patient;
- Move to pathway-based payment mechanisms;
- Integrate care delivery across different provider organisations & facilities;
- Expand truly excellent services across geography; and
- Build an enabling information technology platform (principally a shared care record).



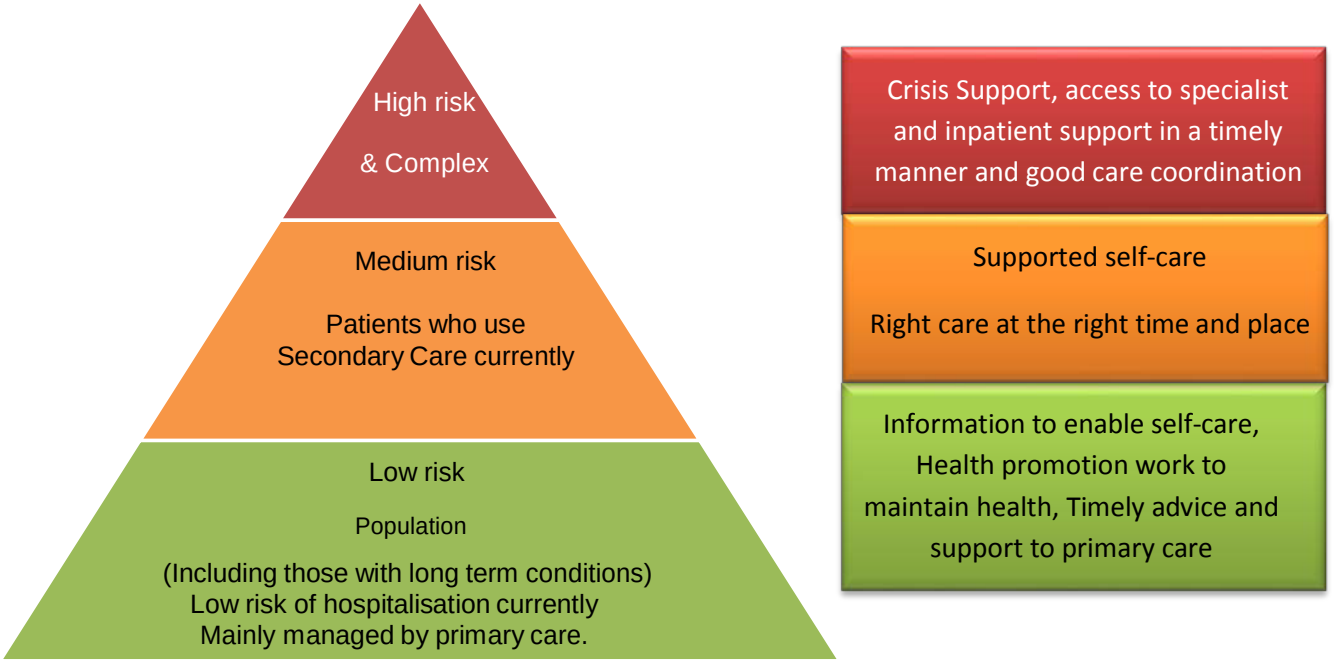
One helpful way of thinking about this is for services to identify best- practice comparator providers in terms of quality and cost. Those who are at the margins of what is possible can be described as being at the 'productivity frontier'. The challenge for services is to identify where this frontier is, what it looks like and then strive to match the best. Such a journey is a 5-10 year one and can drive major improvements in both quality and cost simultaneously.

The position of our services in relation to the productivity frontier is likely to make them successful competitors or attractive collaborators. This is however not a fixed position and is affected by a variety of internal and external factors. The best strategy in this context would be to create an environment for continuous improvement of the quality and cost of the care we provide. The continuous improvement is only possible when the front-line staff are driving this in partnership with the people who receive the service. Senior leadership including the Trust Board needs to assess where LPT services are on the journey to this frontier and take active steps to create an environment that supports and encourages continuous improvement.

The strategic context (both national and local) outlines the need for more collaboration across health and social care in LLR to focus on prevention, early intervention and improve efficiency and effectiveness of care delivery. The 'Kaiser Triangle' is much written-about in academic literature as a model for thinking about this. Originating from "Kaiser Permanente", an integrated health care organisation in the United States, it is based on statistical analysis of acute admissions within a patient population. Its thesis is that patients/service users can be stratified into three main risk groups:

- Level 1: 80% of patient population at low risk of hospital admission
- Level 2: 15% of same population at higher risk hospital admission
- Level 3: 5% of same population at very high risk of hospital admission

Typically, without anticipatory care plans and support being put in place, the highest risk groups (those at the 'top' of the triangle) would end up needing a disproportionate amount of resources.



The above implies that services require differentiated pathways to meet the needs of people with high, medium and low risks. There should be a range of high intensity planned physical and mental health care, to serve that small proportion of the population who have the most complex care needs and are at greatest risk of admission. The interventions should be designed to provide effective anticipatory care with good coordination to support service users in their homes by minimising risk, promoting recovery and preventing the need for unnecessary admissions.

At the same time, it is important for us to develop and deliver low intensity interventions designed to serve the broader population to improve and maintain their health to prevent them 'moving up the triangle'. Secondary healthcare organisations like LPT would play a facilitating role in developing community resources to make this happen providing this in partnership with our service users and carer's, primary care, social care, voluntary sector and other community organisations. In one way or other the investment of efforts in this area is vital for us to deliver effective pathways for the care of our service users and their carers in a seamless manner.

A golden thread that runs throughout this approach is that of the principles of recovery as a central theme in developing our work. Having its roots in the mental health movement, this approach is as relevant to all long term health conditions.

The Centre for Mental Health[2] (2016) state that; *Recovery is about building a meaningful and satisfying life, whether or not there are recurring or ongoing symptoms.*

The key themes in recovery are:

- ***Agency*** *– Gaining a sense of control over one's life and one's illness*
- ***Opportunity*** *– Building a life beyond illness*
- ***Hope*** *– Believing that one can still pursue one's own hopes and dreams even continuing presence of illness.*

So, to make recovery possible for people, services need to be designed and operated differently. The objectives of a recovery orientated service are different from those of the traditional, 'treat –and- cure' health service.

The recovery approach also requires a different relationship between service users and professionals. This is a shift from staff who was seen as in the position of expertise and authority, to someone who behaves more like a personal coach or trainer.

This co-productive approach requires commitment, investment and the development of our services. Our conversations that need to focus on and embrace the opportunity that this approach could bring in transforming the service user and carer's experience of being involved co-productively in receiving our services. Collaborative care and relapse planning is a core activity that can influence and shape this.

7. LPT's Clinical Strategy

We want to use our strengths as an integrated Trust and our skilled and agile workforce to catalyse opportunities for transformational change in our health economy. Through our network of physical and mental health community services, we aim to provide 'right care, in the right place, at the right time' with our partners, to significantly reduce the need for acute health interventions and periods of hospital care. Therefore playing a proactive and important part in providing a solution to the challenges the health economy is facing.

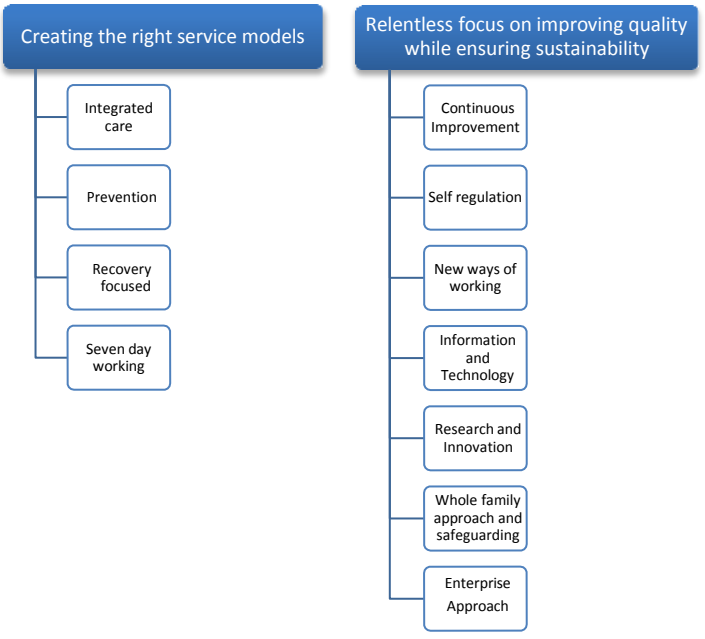
We will focus on delivering high quality, effective and evidenced based community based care interventions, using every opportunity for prevention, early intervention

[2] https://www.centreformentalhealth.org.uk/recovery

and to promote a co-productive approach to recovery. We will support people who use our services to be a partner in their own mental health and physical care, reducing the need for acute health interventions including inpatient care.

We will focus relentlessly on improving quality and efficiency in our care delivery at the same time by working on continuously improving the integration between physical and mental health services, between primary and secondary care and between health, and social care. We will improve our whole family approach by joining up practitioners working with different members of the same family to provide the protective factors that supports service users continuing to live well in the community. We will work at the forefront using of innovative approaches and technology to support our staff to be increasingly more mobile and flexible in their service response in our local communities.

This Clinical Strategy outlines high-level principles and processes for making our four strategic objectives happen. It is intended as a framework for Service transformation and improvement. It is not intended as a tool for creating more meetings and committee driven papers. The Clinical Strategy underpins our aspirations and our commitment to continuously improving the quality of the service we deliver. We will evidence this in our results as tangible outcomes which will continuously seek enhance the experience of those who use our services, their carers and families, our partners and our staff. The strategic aims are as follows:



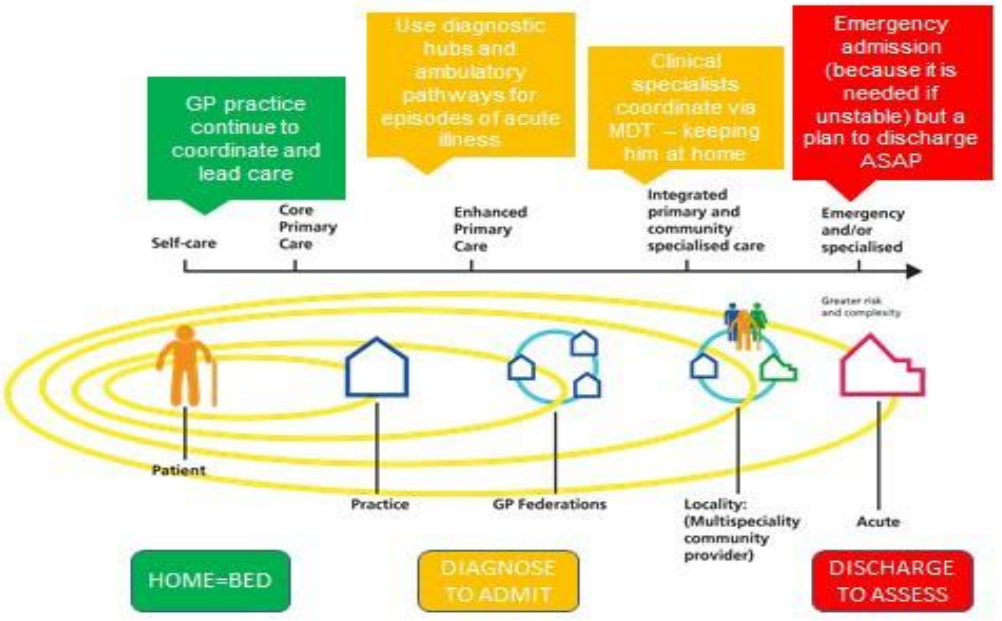
The above principles as outlined in this strategy have been developed from National Strategies, our STP principles, regulators, national and international evidence base as well as views of our staff and service users. Each principle covers more than one strategic objective. For example what is included in the “New ways of working” will contribute to improvement in quality, productivity and staff morale. Broadly these overarching principles will enable us to deliver the strategic objectives provided these are implemented consistently and maintained across all service areas.

Creating the Right Service Models

The overarching model of care across LLR is Home First. This approach requires all teams, organisations as well as individual professionals to ask “How can we keep people at home by providing the right care in the community closer to home?” Following the principles of ‘Kaiser Triangle’ the health and social care teams aim to support prevention and providing upstream interventions as best as possible. The focus of interventions in long term health conditions including mental health should be driven by the principle of recovery where we co produce the support through collaborative care planning that people need to achieve their recovery in a person-centered way.

8. Integrated Care

Integration of care (physical and mental health) within a geographical place is the focus of Better Care Together, the LLR STP. Working towards multi speciality community provision services provided by primary care, LPT, social care and other organisations will be brought together to deliver care in an integrated manner. The model of integration wraps around the patient and their GP practice, extending the care and support that can be delivered in community settings through multidisciplinary working, with the aim of reducing the amount of care and support delivered in acute settings, so that only care that should and must be delivered in the acute setting will take place there in the future. It is designed to improve health outcomes and wellbeing, increase our citizens, clinician and staff satisfaction and at the same time moderate the cost of delivering that care. As demonstrated below:



The development of place based integration is focused on improving the health outcome of the population, moderate demands for services as well as improve the experience of care at the same time. Although the initial priority is for adults with five or longer-term health conditions with or without a frailty marker, it is expected that over a period of time, this is how the mental health and physical care and social care services would be provided in LLR.

There are 11 places known locally as localities or neighborhoods are mapped below:

LPT has initiated a Multi Specialty Community Provision Project to evaluate the state of readiness as well as organise our approach to integrate the service provision to ensure we are maximising the opportunities for our users as well as our staff. In order to do this effectively we would need to exploit the potential of our existing strategic initiatives fully. These strategic initiatives include such as agile working, estate optimisation, leadership and organisational developmental approach focusing on devolved leadership, IM&T strategy focusing on enabling ease of access to information and information sharing, stakeholder and partnership strategy focusing on identification and strengthening of strategic partnership and self-regulation underpinned by principles of continuous improvement.

The project currently has been designed as four stages:

- Place our CHS Community Nursing Services and management into the LLR Integrated Locality Teams Project (focusing on adults with five or more long term conditions, with a frailty marker regardless of age, impaired function) and/or where acute care costs are predicted to be three times the average over the next 12 months.
- Provide an opportunity for the Executive Team and/or Trust Board to lay out the Trust's principles for the multi-specialty provision of out of hospital community services.
- Determine how our enabling services need to support multiple specialty community provision and cooperative partnership working and local decision making with other service providers.
- Prepare the Trust's other out of hospital community services for the locality and sub-locality working, placing them into the LLR project as required but the timetable for the project.

Integrating Mental and Physical Healthcare

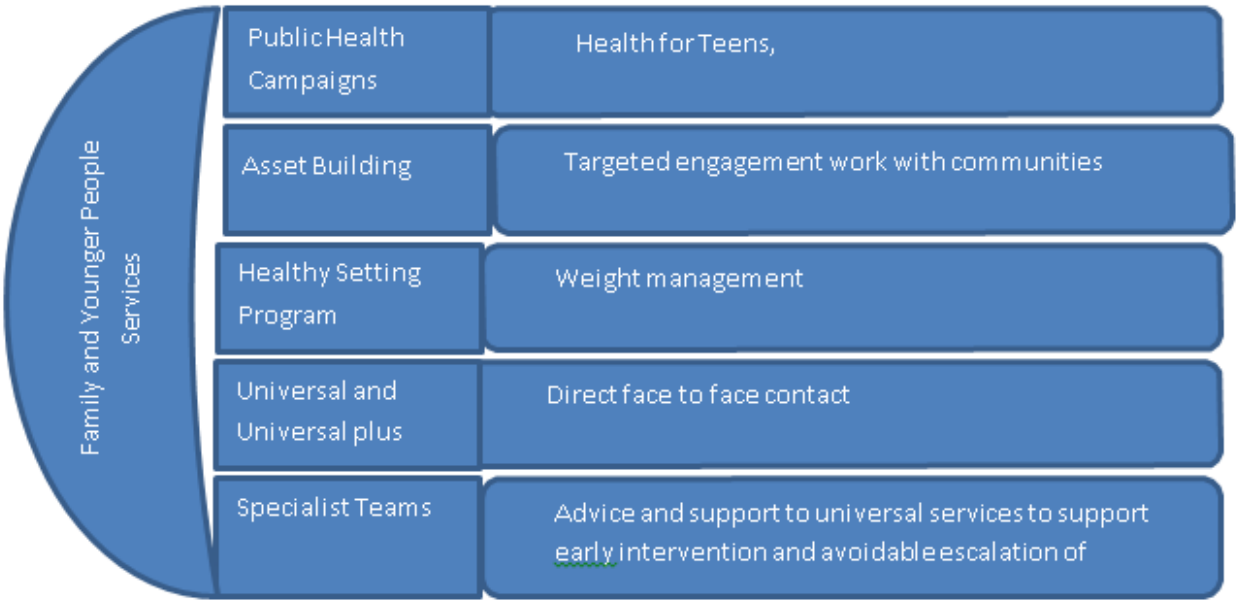
Integrating physical and mental health care is one of the key focuses for us as a combined Trust and this in turn will enable us to begin to address the parity of esteem between mental and physical health care. The 'five year forward view in mental health' promotes integration as one of the key elements. This will involve the following:

- Providing good mental health care in physical health settings in acute hospitals and community hospitals (developing 24 hour access to liaison mental health services)
- Our staff who work in physical care settings (such as community hospitals) having skills in identifying and providing initial care planned support for mental health problems and sign post for specialist help where this is required.
- Staff in our mental health care settings are able to identify, care plan for and meet physical health needs of our service users with severe mental health problems.
- Working towards "place based integration" which includes both physical and mental health care provision in our local communities.

9. Prevention

Prevention is a key focus in NHS 5 year forward view, 5 year forward view in mental health as well as the Better Care Together. Nationally, prevention and early intervention in long term conditions like Type 2 Diabetes, mental health and cancer remain the priorities. Prevention could only be achieved by collaborative effect of all partners in the health system. The diverse population of the community we serve becomes an important partner in this endeavor. LPT sees the focus on prevention as an integral part of all service models that we develop.

An example of prevention being integrated in the service model is illustrated below:



Developing an effective model for prevention and personal recovery in mental health is part of the mental health work stream in Better Care Together (LLR STP). The work stream focuses on improving the range of support available in the community such as information and practical support to improve mental wellbeing and resilience.

All age mental health transformation within LPT is forming an integral part of the mental health work stream and this is focused on an end to end coproduced pathway redesign. One of the main aims of this programme will be to develop an improved focus on the prevention and early interventions to help support service users to live well in their own homes. In addition, coproduction of risk management and relapse prevention plans with service users will seek to reduce the focus on crisis management and on inpatient treatment episodes[3].

An example of this is in our Community Health Services (CHS), where prevention is an integral element of the integrated locality team development as well as the Home first work stream.

In addition, our trust is developing further key initiatives which help us improve our approach to prevention.

Asset Based Community Development (ABCD): The aim of 'asset based practice' is to promote and strengthen the factors that will support positive health and wellbeing, protect against poor health and will in turn influence the development of local communities and networks that sustain health and wellbeing. This approach will improve people's life chances by focusing on what enhances their health and wellbeing and reduces preventable health inequalities. A health asset is described as any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and wellbeing. These assets can operate at the level of the individual, family or community and can build resilience and help people to recover after illness and keep them well. From an individual practitioner point of view an asset based approach is about facilitating a collaborative conversation with individuals which provides the space for them to identify their motivations, strengths, skills and capacities as well as their social connections and assets in their community which can help them to stay healthy. Identifying an individual's capabilities and motivations presents an opportunity to talk about how they want to actively participate in taking responsibility for managing their own health and wellbeing whilst growing a positive sense of self.

This approach is particularly important for supporting people with long term health conditions, as a focus on self-management requires a good knowledge and understanding of their condition and requires a creative use of the physical, social and material resources around them.

The community and network building approach is focused on locating the assets, strengths, skills and capacities of citizens and local organisations, rather than focusing on their needs and deficits. The aim is to help people improve their resilience, independence and strengthen their wellbeing by focusing on what can be achieved through communities working together. In LLR there is a wealth of voluntary organisations, community groups and individuals who have expertise in supporting people in their local communities. As an organisation, we encourage practitioners and services to build relationships and work together with communities in order to create and connect individuals with activity that compliments their treatment and

[3] See Appendix 2

helps them to stay healthy. This is central to the recovery model that underpins our transformational works.

LPT through its charitable fund supports an “ABCD Team” which has developed the following plans to build our capability in actively delivering an asset based approach:

- Support for the existing workforce: Through embedding asset approaches into supervision and ongoing team development and service training, including increasing exposure to community settings.
- Embedding asset approaches in education and training: By basing the education and training of health and care professionals on person and community centered principles, with curriculum reform at much greater scale at all levels of the system including universities, royal colleges and professional regulators.
- Expand training across the system by providing support for the Voluntary, Community and Social Enterprise (VCSE) sector: Education and training should be available to volunteers, peer mentors, carers, voluntary sector professionals and others who work alongside formal health and care services.
- Develop new and deeper forms of engagement between the formal health and care system and citizens, including carers, volunteers and employees with lived experience, and using models of co-production to improve ways of delivering services.
- Develop a set of core outcomes that reflect the impact of the workforce using asset approaches within their everyday practice.

LLR health prevention work stream (as part of the Strategic Transformation Plan for LLR) prioritises the focus of prevention on preventable health risk factors related to smoking, alcohol use, obesity and physical inactivity. There is also an emphasis on prevention on other work streams such as mental health, home first and developing integrated mental health, physical and social care teams.

Making Every Contact Count (MECC): This health conversation approach maximises the opportunity at every contact with service users by healthcare professionals for people to consider changes through adopting healthier lifestyles by providing advice, support and signposting to lifestyle services. LPT has already been promoting MECC by developing staff through an e-learning approach, which improves a clinician’s ability to take the opportunity to have a focused conversation with service users about making lifestyle changes as well as improving the ability to refer on for further supportive life style interventions. LPT has been working with health and social care system partners in improving our proactive delivery of MECC as a framework for prevention through using the Commissioning for Quality and Innovation (CQUINs) as well as the prevention work stream of Better Care Together.

Creating a Smoke Free Environment: LPT has been an early adopter of ‘Smoke free initiative’ as well as making our inpatient areas smoke free. There is a trust wide smoke free action group established to continue to improve the range of advice and support available to the users of our service as well as our staff for stop smoking.

10. Recovery Based Approaches

We are committed to a recovery based approach across mental health and physical care services provided by the Trust. Predominantly developed in mental health, recovery principles as an approach are transferrable across all of our services. We believe recovery is about building a meaningful and satisfying life as defined by the person themselves, whether or not there are ongoing or recurring mental health and physical symptoms or problems. We believe in supporting service users with long term health conditions on their road to recovery and helping them to build resilience and strength.

We accept that recovery does not always mean a lack of ill health; it is not the same as a 'cure', and is focused into supporting a person in taking control and finding meaning in their lives that enhances wellbeing. It is for the person to choose what recovery means to them and is actively developed as a co productive and collaborative approach with the service user, carers, friends and family. As a Trust, we also provide services for those who are terminally ill where recovery will not be realistic however living the 'best life' and 'having hope' is still an important part of living a life that is meaningful.

The vast majority of people who use our mental health and physical care services, their carers and families will benefit from our collaborative recovery based approach. The care plan is the fundamental collaborative communication tool that can help facilitate this process.

There are three constituents which make up a recovery based approach; hope, control and opportunity:

- *Hope* is central to recovery and can be enhanced by each person understanding how they are able to have more active control over their lives and through being supported by and learning from other people with 'lived experience' how to find a way forward in their lives. In the initial stages of recovery an important role of our staff is in the way that they support the person in having conversations that foster hope that they can live their lives well even in the face of often long term physical and mental health conditions. Through continuing collaborative conversations, the person will begin internalise this hope and strengthen the recovery process.

- Working in a collaborative approach is an important element of supporting the service users to feel like they are taking *control* of their life while supporting the person in making the choices that they feel are right for them

- In supporting the person, taking the *opportunity* to find out what support they may need to enhance their social network and relationships , what opportunities may be available to engage in further education/training as well as work experience or support to return back to work so that as a valued member of the community.

The Trust has examples of good practice in delivering recovery based approaches however we do not yet have an integrated approach to recovery across the range of services we provide. This is in development currently and being constructed through a developing community of practice and interest[4] where clinicians who are interested in developing an active recovery approach in their services with service users are

[4] ImROC 10 Key Organisational Challenges

coming together to listen to leading thinkers and activists in the field of recovery as masterclasses. In addition, practical applications of recovery in clinical practice will be being developed over time through using the 'Team Recovery Implementation Plan' (ImROC, 2015)[5]. This is being supported by Nottingham University and ImROC[6]. Coproduction of collaborative care plans is a key focus of this work.

The Leicestershire Recovery College also a good practice example which provides an excellent range of recovery based courses, seminars and workshops for people who are or have accessed adult mental health services. This recovery provision is also for their relatives, friends and loved ones and for our own Trust staff. The courses are aimed at supporting people to recognise and develop their personal strengths, resourcefulness, resilience and talents to become experts in their own self-care, helping them to achieve their aspirations and goals in life.

The College has been co-produced and co-developed with people who use mental health services who have lived experience alongside a range of external organisations and services. The Mett Centre coaches people in the principles of recovery through programmes of activity which supports the transition back into their local community. The challenge for us an organisation is making recovery an integral part of the services we provide. Resources like the Recovery College, Mett Centre, Arts in Health and Community Based Recovery Hubs will complement an integrated model of service where recovery is central to supporting people with long term physical conditions including mental health.

The developing 'all age mental health transformation' approach which has begun in 2017, aims to integrate recovery based approaches as part of the care we provide. This will provide the opportunity to golden thread of recovery principles and coproduction in practice in a consistent way across the whole of our service provision. These activities to develop the transformational approach will include:

- Co-designing the pathways and services in partnership with service users, their carers and staff.
- Improving collaborative and shared decision making where service users and their carers are seen as equal partners in their care.
- Delivering services closer to local communities and maximising the opportunities for recovery and independence by identification and use of community resources.

11. Seven Day Working

In developing the Trust's services, we also need to ensure that we consider all the relevant standards for community and mental health services from the nationally set 10 clinical standards for 7 day working. The 10 key standards and further details of the 7 day working could be accessed from this link: https://improvement.nhs.uk/resources/seven-day-services/#h2-the-10-clinical-standards

We have undertaken an initial self-assessment against the standards. We acknowledge that some of the standards would need to be adapted to reflect the service models in a community and mental health trust as well as new ways of working.

[5] Team Recovery Implementation Plan (2015) Nottingham Healthcare NHS Trust

[6] Implementing Recovery – A New Framework for organisational change (2009) Sainsbury Centre for Mental Health

Nevertheless we are determined to uphold the key principles of seven day working to reduce variations in care. These standards are considered and integrated in our transformation programs.

Relentless Focus on Improving Quality While Ensuring Sustainability

Our quality Strategy (2016/17 to 2018/19) provides a framework for delivery of our quality improvement priorities and describes how we will improve the quality and safety of patient care delivery. It has four strategic aims as outlined below:

- Ensure that we meet or exceed all national and local standards and targets
- Embed an effective self-regulation system that establishes a culture of personal ownership for quality
- Demonstrate year on year improvements in patient satisfaction and patient involvement
- Deliver our Quality priorities through an annual quality improvement plan that is communicated to all staff and stakeholders.

Continuous improvement of the quality of care we provide and self-regulation are two key fundamental principles embedded within this strategy.

12. Continuous Improvement

We have a robust system of clinical audits for clinicians to identify and drive improvement in the work they deliver and we take part in all the relevant national audits to bench mark our services against other organisations. We also have a framework for identifying the standards of best practice from National Institute of Clinical Excellence (NICE). We are evaluating our services against the standards using Baseline Assessment Tools (BAT) and developing improvement plan where our services are not meeting the evidence based standards.

Credit: Institute for Healthcare Improvement

However, we all have an individual and collective responsibility for creating an improvement cycle that will keep our services effective, safe and personalised. We will do this by identifying and recording the right measures, benchmark our performance in quality and productively and actively keep taking steps to improve our performance. A true partnership is evolving between our frontline clinicians and those who use our services, their carers and families and this is vital in making the improvement cycle work. LPT will support the continuous improvement approach by:

- Supporting a culture of openness and learning.
- Enabling and continuously developing the improvement capability of our staff through training and sharing learning experiences through a community of practice.
- Making it easier for staff to access information on individual and team performance to support quality improvement in action.

In order to lead on continuous improvement, our front line staff and operational managers need good information that tells them where 'the productivity frontier' of their service is (as outlined in the value based competition) and what their position currently in relation to the productivity frontier. This knowledge along with the growing improvement expertise will enable our teams on the frontline to develop and create continuous improvement cycles in their work.

Applying continuous improvement in productivity will involve the use of relevant and accurate data, followed by improvement action and rigorous focus on delivery.

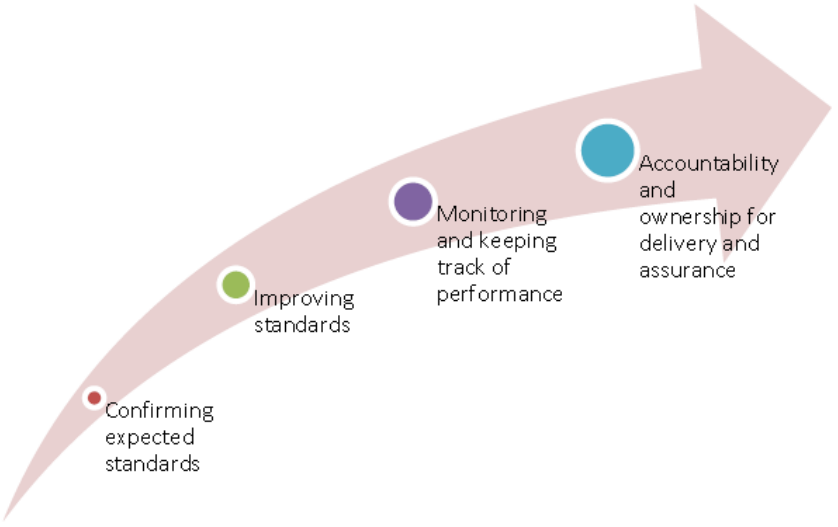
- Data – Providing a service / team level dashboard that is relevant and accurate and using data to drive improvement.
- Objective Setting: Agreeing appropriate targets for each service
- Tracking delivery rigorously.
- Providing Support: Giving assistance to drive change, measuring implementation and productivity.

Our cost improvement programs are aimed at improving the value of our services through optimizing productivity and quality at the same moving services to a position as close as possible to the productivity frontier. We are currently working on developing "Patient-level information and costing systems (**PLICS**)".

In order to maximise our opportunities for actively undertaking continuous improvement in quality and productivity, we have introduced a common improvement model (We Improve) which will enable staff to lead change and improvement initiatives. 'We Improve' promotes the culture of continuous improvement and is underpinned by a training and development programme and supporting evidenced based resources. 'We-Improve' is providing our staff with a powerful bank of knowledge and a means of improving the patient experience whilst strengthening our leadership capability by facilitating a culture of learning, growth and transparency.

13. Self Regulation

Our approach to self-regulation as outlined in our quality strategy has been encapsulated in the 'Step-up' approach (please see our Quality Strategy for details).



This approach enables teams to identify areas for improvement and demonstrate compliance with the expected regulatory requirements. It is based around the CQC's five key questions. Our frontline teams will use peer review to benchmark quality standards across similar service types or request an objective partial review of the quality of their services from staff working outside of their team and service.

The process involves a four step process which encompasses team and peer review and facilitates the utilisation of improvement plans and methodologies to improve standards. Our self-regulation approach underpinned by a culture of "continuous improvement" is the bedrock of our Quality Improvement Programme as it presents a risk-based step-down or step-up process.

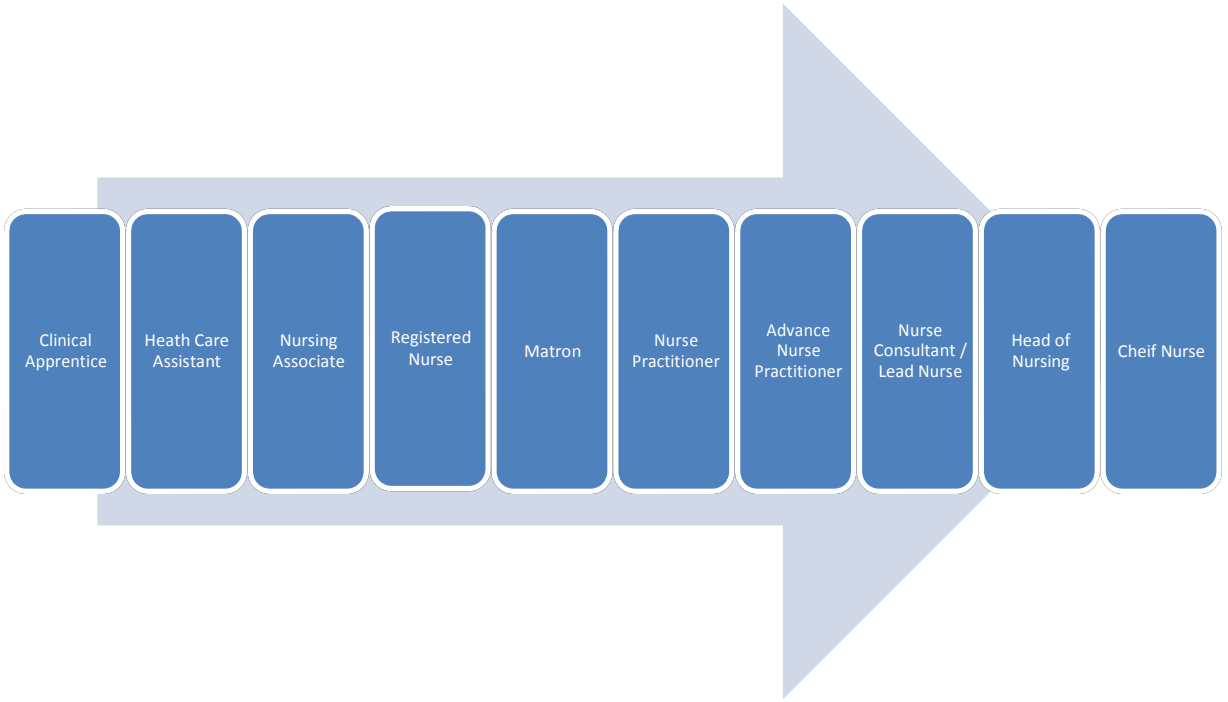
14. New Ways of Working

There are well recognised challenges to ensuring we have a modern skilled workforce at the right capacity to provide high quality care to our service users. The future sustainability depends on us developing the right service models supported by an engaged workforce working in ways radically different to how we have worked so far. The roles, skills, the workforce models as well as technology needs to enable the staff to work in a more productive and creative manner most suited to the needs of the population that we serve. Ensuring that our workforce has the right number, skills, values, roles and behaviors to meet the needs of new models of care is the focus of our People Strategy (2016/17 – 2020/21). The strategic aims include developing and implementing career development pathway, empowering staff to make local improvement and supporting cross system working.

There is a national challenge in the numbers of skilled health professionals from a medical, nursing and therapy perspective. Focus on "left shift", (a term used to describe the shift of focus from inpatient to community/reactive care to more proactive prevention) and new ways of working bring additional demands on the skills and deployment of workforce. We must recognise the emergence of new roles that complement traditional ones within new care models. In order to do this effectively we need to map out the skills and capabilities required for each role within them around the needs of service users so that we are ensuring that the right clinician is delivering the right care to the patient. This will create opportunities to free up the activity for those roles for which we have challenges to recruit. In addition, by ensuring that clinicians provide the care most matched to their skills and knowledge we would expect staff satisfaction to be increased aiding the appointment and retention of highly skilled clinicians.

A good career development pathway need to ensure that the trust support the staff progress to the level of their ambition and capability. They enter the pathway at any level determined by their existing qualifications and can progress and develop within the Trust to various levels of expertise.

Illustrated below is an example of a career pathway for nurses

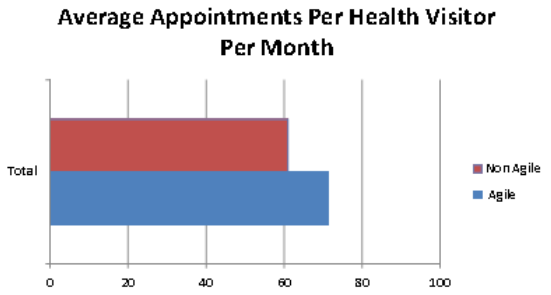


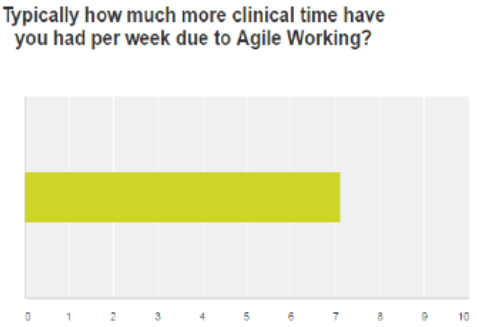
Introduction of physician associates as well as assistant practitioners will create similar career pathways in other professional groups like medical and allied health professionals. Our people strategy will support the development of career pathways like this example for all professional groups with specific numbers and targets for each role. Career advisors and trained managers will support staff in career planning.

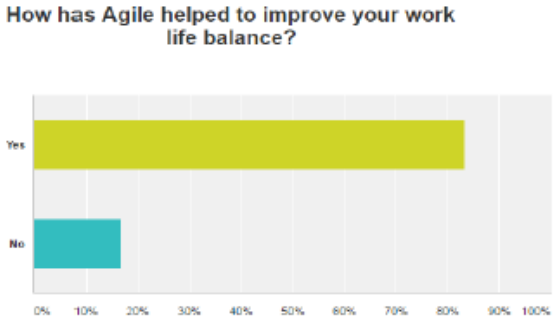
Agile Working: We will empower our staff to work with maximum flexibility and minimum constraints to optimise their performance and deliver the best care as possible supported by devolved leadership model, enhanced communication and information technology. It is based on the concept that "*work is an activity we do, rather than a place we go*". We are using agile working as a transformational tool to allow staff to work smarter by eliminating all barriers to working efficiently. We believe that the agile working will make our services responsive, efficient and effective. The benefits of agile working are:

- Improvement in productivity: Reducing the need to travel to a fixed place of work will make our staff more productive leading to timelier and higher quality work.
- Improvement in staff satisfaction and wellbeing: Staff will feel more motivated; less stressed and feel more committed to LPT as an employer of choice.
- Staff's performance will become outcome based rather than on time served based.
- Use of technology will divert administrative duties to admin support or computer systems free up frontline staff for maximum clinical contact.
- Estates will be rationalised and transformed to support agile working as an encouraged choice.
- Service users will be able to choose a more personal service which is more flexible to their needs using agile workforce supported by right technology.

However, it is important that the staff own the change rather than the model being imposed. Our initial pilot in a Health Visitor team, with a 'triple win model' (benefits for service users, staff and the organisation), shows positive impact as illustrated below:







However, a change like this at an organisational level can only be achieved if the staff are engaged and supportive of the direction of travel. Agile workforce will enable us deliver truly integrated care in the community with less barriers for people to access the care.

Effective Use of Our Estate Base to enable the new ways of working: Our organisation is predominantly a community provider of health services. Through agile working we are changing the way staff are able to deliver the care closer to home wherever possible. However access to building based resources whether it is for a confidential consultation, a specific intervention or staff to meet and network is essential. We also provide a number of highly specialised services including our inpatient services which need a critical mass of specialist skills to be safe and efficient. Our Estate Strategy is focused on optimisation of our estates. The guiding principles from clinical perspective are:

- Identification of highly specialist services which need to be centralised to ensure patient safety and efficiency. This needs to be done through a robust evaluation process including the use of national evidence.
- Creating community Hubs across LLR to create resources our community based staff could access either for direct patient care or their networking, development or some quite thinking time. Overarching principle is less fixed office bases but at the same time making it easier for staff to access appropriate spaces to carry out their work. Clinical strategy recognises the importance of timely access to spaces to allow clinical work that protects confidentiality, privacy and dignity. The challenge for us an organisation is in ensuring the timely access to ensure that waiting for the space is not affecting the productivity of our staff.

15. Information Management and Technology (IM&T)

IM&T is a key enabler of the Clinical Strategy. The use of right technology and information will help in the following:

- Revolutionising the way we interact with service users: Use of the right technology will help us to enable our service users to manage their health better (information through web site, apps or messages on self-care), use the right services in a way they feel more comfortable (online information/messaging through the phone/apps, tele-consultation), design the best care for their health needs supported by our staff (shared care records) achieving better health and independence.
- Technology will also enable our users to shape the development and delivery of our clinical services through interacting with us in an ongoing manner.
- Improving the integrated care: Facilitating ease of access to information not only by our staff but also by staff from our partner organisations in timely and flexible manner will enable integrated care (shared care records with primary and social care, real time task management enabling care coordination, sophisticate workflow enabling our staff to work to the evidence base/guidelines/care pathways).
- Improving the productivity: Avoiding duplication, unnecessary delay in access to information, unnecessary travel as well as reducing the need for estates base associated with its entire infrastructure requirements will lead to greater productivity. (paperless referrals, where possible use of a single system reducing the need for additional communications, online task management reducing the need for face to face meetings).
- Create a cycle of continuous improvement by giving feedback to our staff on their productivity, patient experience and outcome at individual level, team level, service level as well as at the Trust level.

Our IM&T strategy (2015 to 2020) is focused on achieving the above aims. It is important that as an organisation, we need to consider:

- Commit to process mapping and clinical engagement to maximise the potential of an Electronic System in making the right thing easier to do.
- Use of well-connected electronic systems across all our service lines which enables better communication within the organisation as well as with our partner organisations. Reducing the number of systems we use to lowest as possible will be a priority. This means considering a single electronic patient record system where possible and investing in the connections between systems where this is not feasible.
- Support the full exploitation of the potential of the electronic patient records to enhance the clinical productivity (reducing time spend on recording and accessing information as well as making it easy to do with systems intuitively guiding the users to enter the right information).

16. Research and Innovation Supporting Improvement in Care Delivery

We believe it is important to integrate research in clinical service development and delivery. We have been investing in research and innovation and conducting primary and secondary research on health outcomes of the population including specific research projects on the needs of the multicultural population of Leicester City. Our research and innovation is a collaborative effort undertaken in partnership with our academic partners (University of Leicester, De Montfort University, Loughborough

University, and East Midlands Academic Health Science Network (EMAHSN)). Our Trust has a considerable potential to develop research on integrated service models both to improve service provision and attract research income. We will do this by:

- Having a robust governance structure for the delivery of the Trust's Research Strategy.
- Supporting our staff to deliver high quality research of direct benefit to the population of LLR.
- Providing skilled support and facilitation to staff and those who use our services in the development of grant applications.
- Promoting and developing patient public involvement for all research studies.

In the last two years, we have been successful in supporting several staff in pursuing research qualifications and making key academic appointments within the Trust. The relationships with our academic partners have been strengthened. Our Research and Development Strategy (2017 to 2022) is focused taking the next steps for creating a vibrant research culture and program within the trust. The strategic goals are:

- To identify, develop, support and promote the beacons of research excellence in the Trust
- To be the regional lead community and mental health services partner organisation in recruiting and delivering against the NIHR portfolio
- To enhance the utilisation of evidence and Trust data to drive improvements in care
- To attract, develop and retain research leadership and skills

Innovation: Successful innovation holds the potential to transform patient outcomes whilst simultaneously improving quality and productivity. LPT has been successful in seeing a number of innovative ideas through development in to practice with wide reaching impact. To harvest the full potential of innovation, we need to aim for a culture of innovation where our staff will be inspired to share innovative ideas, feel supported in developing the idea in to implementation within the trust as well as exploring opportunities in the wider NHS and beyond.

To support this we need a "system for innovation that continually scans for new ideas and takes them through to widespread use". Our Innovation Strategy (2015 to 2020) not only sets out an organisation commitment to create an innovation culture but a framework to support and encourage staff as active partners in innovation, empowering them to explore their ideas and adopt innovation from other areas. The strategy also sets out a clear path for any of these innovations where there is value in commercialising or spreading across the wider NHS. The key aims of this strategy are:

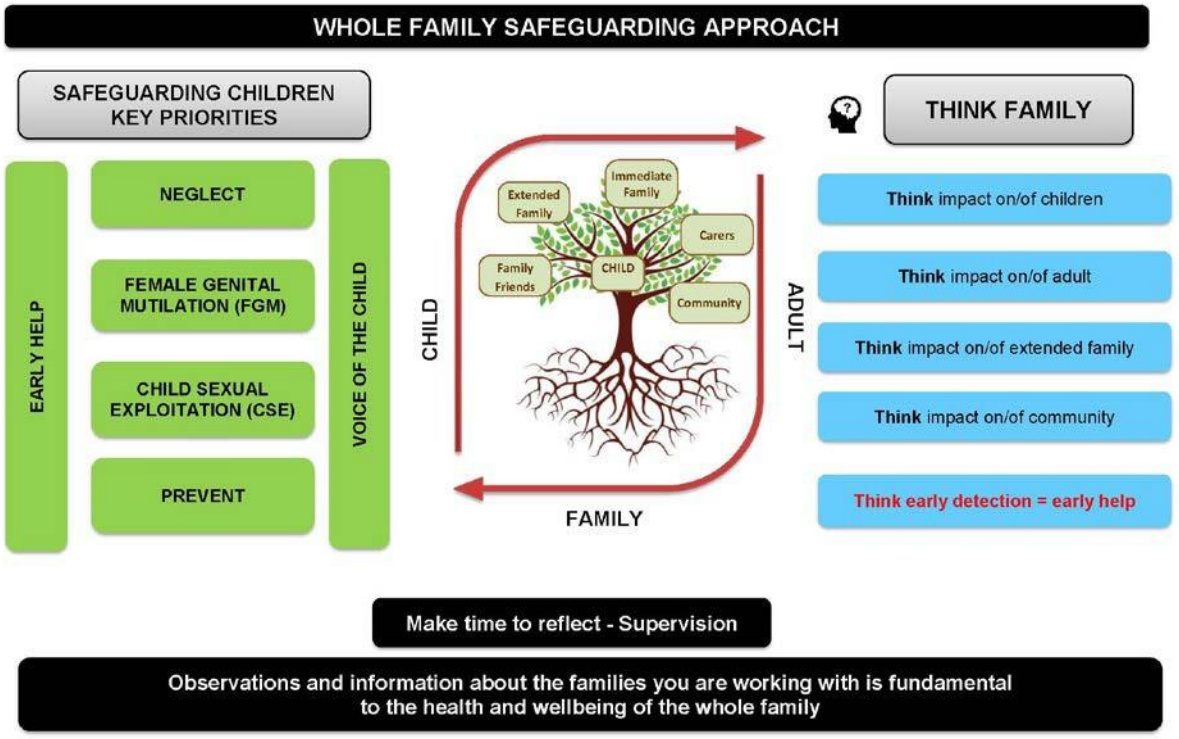
- Creating an environment for our staff to bring up creative ideas
- Support for developing the idea in to a testable innovation
- Implementation and sharing of innovation across the Trust
- Commercialisation and sharing of information across other health and social care organisations.

We have a number of innovation products (Chat Health, Health for Teens, ECT app, YODA app) which have not only helped us improve the quality and productivity of our services but are also being implemented in other organisations. We need to ensure that the emerging the existing service models exploits the potential these innovations.

17. Whole Family Approach and Safeguarding

The Whole Family Approach to integration of care is an important focus for our Trust as we provide a range of adult and children services. This approach ensures a joined up approach to families' needs by:

- Ensuring all services improve the identification of children in need and in need of protection through increased understanding of the impact of an adult's problems on a child's life.
- Recognising the needs of adults as service users and parents/carers.
- Ensuring good co-operation and collaborative working across organisations for information sharing and providing the family focused support.



In addition to providing a powerful framework for integration of care, the whole family approach enhances our ability to safeguard our service users. “Safeguarding” as an umbrella term covers child protection, adult protection (especially vulnerable adults), and domestic violence. We believe that everyone has the right to live their lives free from abuse. We work closely with partner agencies to support our most vulnerable groups of children and adults within society from abuse and neglect. We have positive links with the local Safeguarding Children's Board, Adult Protection Board, NHS Domestic Violence Group, police and social care.

We provide safeguarding training for all our and ensures easy access to expert advice and support through the dedicated safeguarding children and adults teams.
We also have a number of safeguarding groups within our Trust who monitor our performance, and identify any actions required. This ensures safeguarding is frequently reviewed to make sure our practice adheres to government standards.

18. Enterprise Approach to Ensure Sustainability

The Trust's enterprise framework is there to ensure that it proactively maintains, develops and diversifies its services for existing and new markets locally, regionally and nationally. This will enable clear service development decisions to be made in the future as it creates greater clarity on the Trust's future role in the system and where it is heading. It:

- Provides a clear framework for assessing the future direction for existing services
- Provides a clear framework for assessing and supporting enterprise activities in LPT
- Prioritises market opportunities and provide direction for future business development
- Highlights the areas of improvement required to enhance LPT's market reputation
- Provides clarity on the future organisational form and LPT's role within an Accountable Care System.

The Trust needs to have clear direction on the types of opportunities, markets and services that would fit with the vision, values and objectives of the Trust alongside those of strategic partners. Opportunities fall in to four categories:

- Protect, build or divest existing services in existing markets.
- Proactively develop or enter new markets for its existing services
- Proactively develop new services for existing markets
- Diversification into new services in new markets where appropriate to do so

19. What will be Different as a Result of This Strategy?

The success ultimately is measured by the outcomes we help our service users to achieve which will be measured through measures such as service user reported outcome and Friends and Family Test. However evidence of our organisation moving along the direction of clinical strategy would also be reflected in a number of ways. The following does not present either an exhaustive list or one that is intangible to change as we know the two years will present challenges and opportunities unknown now.

- Service models co-designed with service users their carers and families and sense checked against service user experience.
  - Partnerships with service users and carers are fully enabled
  - Pro-active care plans, risk and relapse management are co-produced with service users setting out agreements about how care is received.

- Maximising opportunities for prevention and early intervention
  - Support and interventions shifted to earlier in the patient pathway
  - Targeted interventions to further reduce health inequalities
  - Front line staff connecting better to support the whole family

- Care will be delivered in the location best suited
  - Shift what is appropriate from inpatient services to outpatient / community / primary care / self-management
  - Fewer hospital sites with more fit for purpose accommodation
  - Greater co-ordination and integration of care across care settings

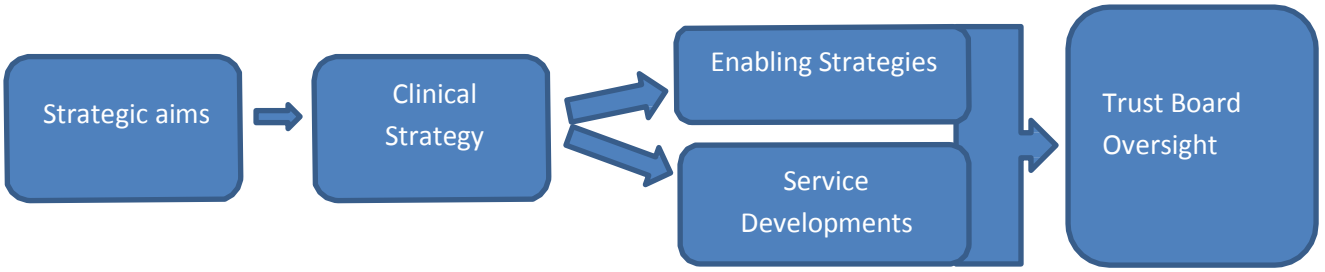
- Care will be delivered by the professional best suited
  - Health professionals will be up to date with training and knowledge to deliver the care they are expected to
  - Care is reliably delivered by the most appropriate member of the team

- Care will be further enabled by technology
  - Use of our interactive web site and “apps” giving people access to support from their home 24 hour and 7 days a week
  - Use of texting, online or tele-consultation as well as face to face discussion to access help
  - Information about patient history and treatment plans is shared electronically and accessible to professionals involved, and the patient/ client, to ensure best possible decisions

- Care delivery costs will be relentlessly reduced
  - Use of evidence based care pathways designed to reduce unnecessary duplication and variations in care
  - Care delivery transformed through continuous improvement, innovative transformations and use of technology.

20. Implementation of the Clinical Strategy

The Clinical Strategy (the overarching strategy for the Trust in implementing the strategic aims) is implemented through various service developments and other enabling strategies are illustrated here:



There are currently three main transformation programs within the Trust:

- Children’s Integrated Healthcare Service focusing on providing integrated model of service provision for children from 0 to 19 and up to 25 for children with special needs.
- All age mental health Transformation focusing on transformation of our mental health services
- Community Health Service transformation program focusing on improving productivity and quality of our community health services.

This strategy therefore provides overarching principles for the ongoing development of the transformation programs which are currently underway as well as the future ones.

The Trust Board has the oversight of all the three above transformation programmes. In addition, illustrated in the table in Appendix 1, are the various initiatives related to the strategic aims and how these are overseen by the Trust Board. The Clinical Strategy will need to be reviewed and refreshed year on year as the transformational programme progresses, develops and continues to have a tangible and active impact on improving clinical service delivery.

Appendix 1 – Delivery and Oversight of the Clinical Strategy

Strategic aims	Enabling strategy or Service development	Five Year Plan Initiatives (inc PMO Ref)	Governance Oversight
Integrated care Recovery Based Care Prevention	Multi-Specialty Community Provision	Integrated Locality Teams (280)	Service Transformation Group
	All age mental health Transformation	All-Age Mental Health Transformation (477)	Executive Team / Trust Board
	All age mental health liaison model	All-Age Mental Health Transformation (477)	Service Transformation Group
	0-19 Healthy Child Program	0-19 Healthy Child Programme (325)	Service Transformation Group
	Asset Based Community Development	Asset Based Community Development (290)	Service Transformation Group
	Making Every Contact Count		Clinical Effectiveness Group
	Smoking Cessation		Clinical Effectiveness Group
Continuous Improvement	Quality Strategy	Quality Strategy (330)	Quality Assurance Committee
	NICE Standards and Clinical Audits	National Clinical Audits (335)	Clinical Effectiveness Group
	Mortality Governance	Mortality Framework (334)	Mortality Surveillance Group
Self-Regulation	Quality Strategy		Quality Assurance Committee
New Ways of Working	People Strategy	Staff Health and Well-being (391) Retention and Reward (394) Recruitment Strategy (395) Talent Management (396) Leadership Development (397)	Strategic Workforce Group
	Agile Working	Agile Working (427	Service Transformational Group

IM&T	IM&T Strategy	Consolidate EPR Systems (423) Develop EPR (425)	Finance and Performance Committee
	LPT 2020 Our Digital Offer	Digital Offer (281)	Service Transformational Group
Research and Innovation	R&D strategy	R&D Strategy (366)	Clinical Effectiveness Group
	Innovation Strategy	Innovation Culture (368)	Service Transformational Group

Appendix 2 – Clinical Directorates

- **Families, Young People and Children's Division (FYPC)**

  FYPC includes mental health services for children and young people, health visiting, school nursing, pediatric medicine, health promotion, sexual health and nutrition services. Services are delivered in homes, community and neighbourhood centres, children's centres, inpatient units, schools and nurseries.

- **Adult Mental Health and Learning Disability Division (AMHLD)**

  Our adult mental health services provide both inpatient and community based services. We offer general psychiatric care for adults of all ages in the community and at a number of inpatient units. In addition to the locality based community mental health teams, we also have specialist teams working in the community offering a range of services such as crisis intervention, psychotherapy, personality disorder therapy and care for people with Huntington's disease.

  For adults with a learning disability we provide support from community based teams, short break residential services as well as inpatient treatment. We also offer specialist advice and support to other professionals to meet the health needs of someone with a learning disability.

- **Community Health Services (CHS)**

  The community health services division includes adult nursing and therapy services and mental health services for older people. Services are delivered through community hospitals, Intensive Community Support (ICS) and through many community teams who work in clinics, day services and people's own homes.

Appendix 3 – All Age Mental Health Transformation

Shared Principles

- Run co-design and engagement specific events and use existing forums and other mechanisms to shape the key principles around what interested parties want to see from the transformation.
- Use the previous work undertaken on developing principles in LPT and from Northumberland, Tyne and Wear (NTW) to provide a base for discussions

Analysis and Insight

- Undertake a Rio Notes review looking at ~500 notes with a similar sample taken from each locality/team and each cluster
- Complete Time in motion assessments (2 week) for all services interested in identifying ways of releasing time for clinical care
- Complete a narrative analysis of previous reviews and findings
- Review evidence base (particularly NICE) as a means to benchmark eventual model against
- Undertake individual process maps for each service using PTLs and bespoke meetings
- Review and summarise (to presentable form) findings, interpret with stakeholders (expert staff, service users and any other pertinent stakeholder) and use for modelling work

Co-Development

- Design and agree co-development/co-design approach/method with support from LIA lead, co-design experts in organisation and Asset Based Community Development team
- Using LIA like methodology, engage with stakeholders (service users, staff and others) across different locations, specific users/experts of service to consider a selection of targeted questions (of focal interest to attendees)
- Recruit a core and consistent group of stakeholders to help shape the model redesign and interpretation of findings
- Recruit a wider group of interested parties who are interested to be actively consulted with around different parts of model / pathways

Process Re-engineering

- Design a control method for developing, agreeing and fixing into place standardised processes
- Develop technical tools for modelling workforce requirements and shaping resource requirements in each element of the new systems
- Develop and agree change process that encourages continuous improvement and creativity/innovation whilst maintaining t h e fidelity of standardised processes/system

New Model

- Co-develop adaptations to previous designs of transformation models from LPT and from NTW
- Undertake intense workshops to develop detailed models against each of the elements of the overarching model/blueprint

Appendix 4 – References

- NHS Five Year Forward View: https://www.england.nhs.uk/five-year-forward-view/

- The Five Year Forward View for Mental Health: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

- Transforming Care for People with Learning Disabilities: https://www.england.nhs.uk/learning-disabilities/care/

- Better Care Together: Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership (STP): http://www.bettercareleicester.nhs.uk/Easysiteweb/getresource.axd?AssetID=47665

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