

Clinical and care strategy

April 2026 – Version 1.0



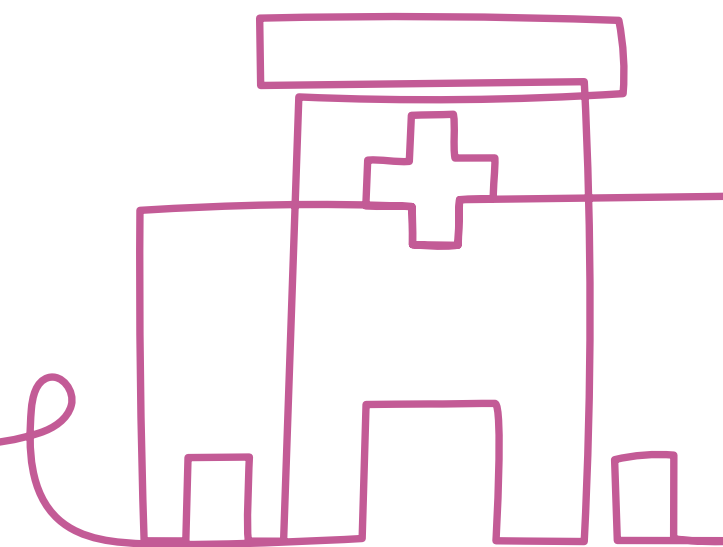
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Welcome

A message from our
Chief Medical Officer and
Chief Nursing and AHP Officer



We are pleased to share our **Clinical and Care Strategy with you. This is an ambitious blueprint to drive change in the way we deliver and support clinical and care services, and our staff to better meet the needs of the communities we serve. We will drive innovation, embrace digital solutions and, working in partnerships, provide care that fits with the needs and expectations of our patients and maximises their health and care outcomes.**

The people we serve have given us clear feedback that they want to lead happy, fulfilled lives in touch with their families, friends and communities. They cherish their independence and prefer to live at home or in the community with support and want us to work with other organisations to enable this to be a reality.

We have listened to this and together with the feedback from our staff developed our strategy. It fully aligns with National/ Governmental priorities, Local Government and local Integrated Care Board strategies.

Our staff and colleagues are at the heart of everything we do. Working within our Trust values of Integrity, Compassion, Inclusion, and Ambition – our staff are the people that can and will make the lives of our patients and communities better.

We must transform how people access our support by reducing inequality, improving accessibly, and how we share information digitally in real time about the care and support we provide. We will ensure our clinical care is grounded in the needs and agreed decisions our patients are happy to make about their care.

None of this change can be achieved without our partners from the NHS, Local Government, the third sector and importantly schools, early years providers and broader educational providers. We expect to lead on collaborative cross organisational work – ensuring our great leaders keep the needs and outcomes of the resident/patient as the most important driver for change.

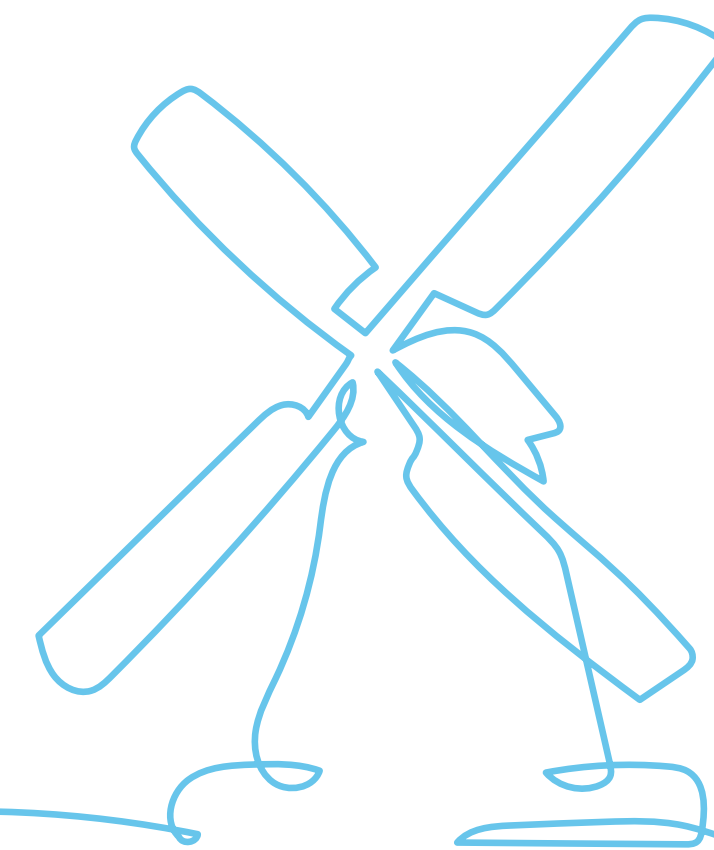
Our strategy will lead to new pathways, processes and ways of doing things. Our vision of great care, however, will be defined through the eyes and experience of our patients and communities. We are aiming to help people live the best possible quality of life; provide care that will be most comfortable and convenient to them and help people to stay healthy and happy as long as possible.

We look forward to working with you all, to make this a reality.

Dr Caroline Kavanagh
Chief Medical Officer

Kate Howard
Chief Nursing and AHP Officer

Introduction



The East of England Community Health and Care NHS Trust exists for one simple purpose: to deliver consistently high-quality health and care services in our local communities. More than 7,000 colleagues provide care and support from the start of life through to the end of life, in people's homes, local clinics and community hospitals – serving 3.5m people.

This clinical and care strategy sets out how all our services and infrastructure need to change to realise the ambitions set by the Government in "Fit for the Future: The 10-Year Health Plan for England." This will mean that most of the care we provide (for children, young people and adults) will have their base in local neighbourhoods/places and be professionally and structurally connected with other health, care and educational providers in these areas. Together we will ensure improving outcomes and reducing health inequalities is our core purpose.

Our patients need us to make it easier for them to access and experience co-ordinated and personalised care, and this strategy has a strong emphasis on improving our digital and analogue capabilities.

A key intent will be to support people to receive care closer to home and reduce reliance on acute hospital settings. This has been a shared ambition of successive Governments and the NHS for many years, and our strategy reflects our responsibility as a specialist community Trust, to make this ambition a reality.

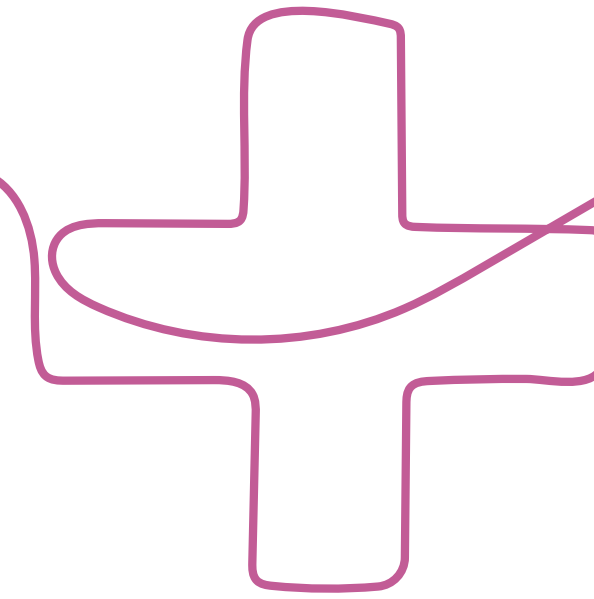
We will always work as partners with health, social care and educational providers, pushing the boundaries and using our expertise, leadership and resources to support new ways of working.

The communities we serve in the East of England deserve care that is accessible, high-quality and joined up. Our models of care will, over time, move from being reactive to proactive and preventative, underpinned by great data analytics and

insights. The strategy sets out the small number of national and local priorities, which will be a core focus. It also sets out ambitious ways of operating, that are far more person centric and will be implemented in all the services we provide.

There are improvements our organisation needs to make straight away. This includes reducing the waiting times in our services over the strategy period to be within the constitutional standard of 18 weeks; ensure community nursing teams can provide the volume of planned care interventions in our populations 365 days a year and support all of services to become more preventative in approach.

Plan on a page



Our mission

Our 7,000 staff, spanning half of the East of England, delivering and supporting our services we be focused on our Mission –

‘To deliver great health and care services in our local communities’.

Our culture and values

A fundamental role of our leadership is ensuring a healthy organisational and team culture.

This is vital as it underpins how are staff are supported, in order that they can provide great care to our patients.

The Trust values of:

**Integrity,
Compassion,
Inclusion and
Ambition**

create a working ethos and culture that enables everyone to thrive at work.

Our vision and focus

We know change is needed, therefore we developed our vision:

‘Transforming lives and building healthier communities together’.

To achieve this, we’ll focus on four areas:

1. **Best start in life**
2. **Support for Children and Young People with Complex Needs**
3. **Neighbourhood Care**
4. **Unscheduled Care.**

Our priorities

Over the clinical and care strategy period we will ensure we:

1. **people in control of their care**
2. **value our colleagues**
3. **work in partnerships**
4. **innovate and transform our organisation.**

Success will be to transform the lives of those we support and in partnership with our local residents and other organisations, create healthier communities, where people can thrive.

The four service areas to be prioritised

1 Best start in life

School readiness

- Ensuring children reach developmental milestones by age 5
- Early years interventions (speech and language, social/emotional development, evidence-based parenting programmes)
- Health visiting and family support services with early help and pre-school providers
- Narrowing gaps in readiness between disadvantaged and other children

Adverse childhood experiences and trauma-informed care

- Early identification and intervention for children experiencing trauma, abuse, neglect, or other forms of adverse childhood experience
- Training workforce across health, education, and social care in trauma-informed approaches
- Prevention programs targeting families at risk

Children and young people neighbourhood care and support

- Needs Identification Tool available to parents, carers, teachers to promote early access to advice, guidance, self-care and further support.
- Integrated multi-agency teams organised around neighbourhood, including education, social care and voluntary sector organisations.
- Implementation of patient portal and 'request for support' technologies.
- Joined-up data to support proactive individual care and population health planning.



2 Support for children and young people with complex needs

Centre of excellence for neurodevelopmental conditions

- Improved pathways for autism and ADHD assessment and diagnosis
- Integrated education, health, and social care with specialist multidisciplinary teams
- Reducing waiting times for neurodevelopmental assessments to below 18 weeks

Regional centre for neuro-disability

- Specialist services for children with cerebral palsy, epilepsy, brain injuries and other neurological conditions
- Multidisciplinary assessment and treatment in conjunction with hospital tertiary centres
- Equipment and technology provision, including respiratory and ventilation expertise
- Dental, visual and audiological expertise for children with complex needs
- Transition planning to adult services

3 Neighbourhood care

Transform support for those living with moderate/severe frailty

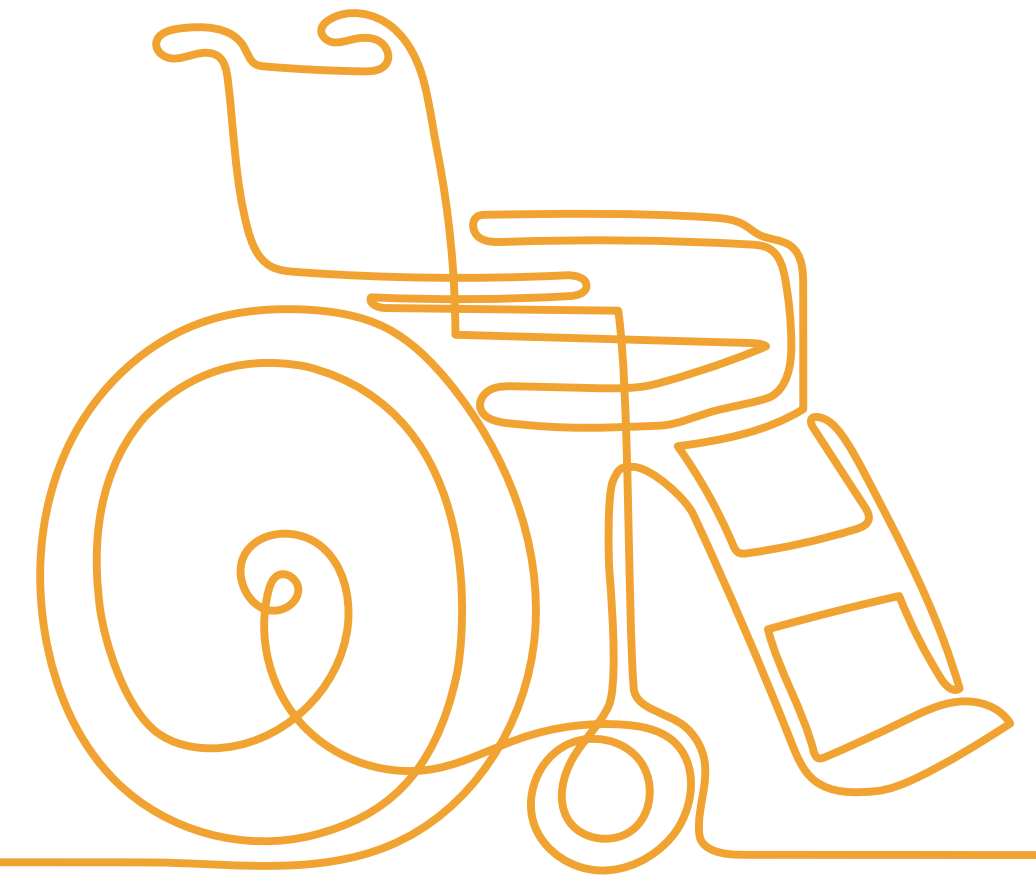
- Proactive identification using frailty indices
- Comprehensive geriatric assessment in community settings
- Targeted interventions – supporting physical, mental health and social care needs
- Coordinated care planning to prevent hospital admissions in all care homes

Proactive care for people with multiple long-term conditions

- Case finding, predictive analysis and risk stratification
- Multidisciplinary team support with partners in primary care/ networks in neighbourhood teams
- Personalised care plans; self-management support and health coaching, including ensuring that people living with HIV are healthy and well

Exemplary end of life care

- Early advanced care planning conversations, digitally recorded and shared
- Coordinated palliative care across community, primary, secondary and hospice care
- 24/7 specialist advice and rapid response
- Supporting more people to die in their preferred place
- Integrate 'continuing health care' in mainstream partnerships with hospice providers



4 Unscheduled care

Hospital at home

- Hospital level capability delivered at home as a default for frail older people
- Virtual wards and urgent response services working with remote digital monitoring
- Supported by community nursing, therapy, pharmacy and medical teams
- Use of new digital advances to facilitate home care

Multi-agency hub in each geography

- Integrated urgent care access point
- NHS 111, out-of-hours GP, ambulance service, mental health crisis, social care coordination
- Flow navigation to prevent unnecessary ED attendance, using same-day emergency care where appropriate



Why these four service areas?

Children and young people

Some areas within our geography are in the most deprived areas in England, and up to 22% of families have low incomes where the children are eligible for free preschool places.

The government (*DfE Mar 2025*) recognises that children from disadvantaged backgrounds are less likely to be school-ready, so targeted approaches are needed to change this.

Our approaches need to ensure a great start to life that lays the foundations for health and learning

We currently have unacceptably long waiting times for neuro-developmental assessments, and our referral rates are below the population prevalence levels. Hence, we need to develop the best evidenced and designed pathways to cope with current and future pressures.

Children with complex needs, travel to centres outside of the East of England for their Neurodisability support. We will create a Centre of Excellence in collaboration with other partners, to provide this standard of care locally in the East of England within community settings.

Governmental policy (across all Departments) is focusing on local care delivery; models utilising neighbourhoods and with the Children's Wellbeing and Schools Bill - our focus needs to be increasingly on the impact of our work with multiple statutory partners

The Government are proposing wide ranging changes to the SEND system and our approach will need to alter.



Why these four service areas?

Adults and older people

The demography of our region means in some counties we are already supporting a much higher proportion of the population who are old (e.g. Norfolk 25% vs national average 18%) and those living in the most deprived areas have 2.3 times higher odds of living with multiple long-term conditions.

These population demographics affect the approaches we need to take, with health and care partners to meet current and future demand for support.

The Government's 10-Year Health Plan for England sets a high-level strategic direction for the NHS, embedding neighbourhood health as a central delivery priority – alongside strategic shifts of care from hospitals to community-level care, prevention, and digital transformation.

Lord Darzi, in his review for the Government stated, "General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population age"

The NHS Plan and health care policy is centred on the need for proactive, targeted and multidisciplinary/agency neighbourhood care

The National Audit Office in their 2025 report stated "The scale and impact of our ageing population will only grow in the future. Without effective support and earlier interventions in the community, the NHS risks encountering people living with frailty only when it is too late and independence cannot be recovered"



**Examples of what
we will change
as we deliver
our clinical and
care strategy**

Regional centre for neuro-disability

Community paediatric teams are experts in managing children with complex needs.

They already collaborate with our partners in acute hospitals, and we will look to create a Centre of Excellence for children with complex needs so that they and their families do not have to travel to centres outside of the East of England.

This collaboration would include community paediatrics, neurology and respiratory working with airway technical teams. We want to provide local care in the East of England within community settings and move from a traditional model where care is predominantly provided in acute hospitals. We would grow specialist multidisciplinary teams to meet the needs of our children and families.

As a Centre of Excellence for neurodisability we will co-ordinate and support the holistic needs of our children, including:

Neurodevelopmental

Supporting complexities driven by neurodiversity and mental health conditions. We already provide neurodevelopment assessments and will increase the skill mix of our teams to ensure smoother pathways and shorter waits to be seen. The successful digital model across the Trust to provide enhanced support will also be expanded.

Movement disorders

This includes children epilepsy, cerebral palsy, and brain injury who may have spasticity or other movement issues. Where wheelchair and other specialist support services are required, children and young people will be seen, and the necessary equipment provided without delay.

Complex respiratory and ventilation issues

It is not uncommon in children with complex neurodisability to require respiratory review and support. Those needing assisted ventilation and relevant respiratory technical teams will be supported holistically, including problems with swallowing - a one team approach.

Other specialist services

This will include vision, hearing, and dentistry as it is not uncommon for CYP with neurodisabilities to have complications with these areas, which can be unrecognised but cause concern for families.

Availability of investigations

In partnership with our acute and diagnostic partners we will be responsive to investigations, and they will be undertaken locally.

Transforming support for those living with moderate/severe frailty

Moderate–severe frailty is best managed when care is proactive, multidisciplinary, and function-focused.

Frailty is a dynamic, treatable, long-term condition with acute exacerbations. The strongest evidence supports structured, multidisciplinary interventions, not isolated or reactive care. This should be the core of neighbourhood working to deliver the Governments' mandate to the NHS.

Our support (with other partners) should become focused on reducing the impact of frailty for any individual and offering fewer single interventions and more holistic support for their needs. The model should support the needs and wishes of an individual and not work to a pre-defined service model that has no flexibility for individual preferences.

We need to re-design how our care and support is provided for people living with moderate or severe frailty and those that care for them, to focus on the following:

- Deliver proactive, community-based care that preserves and restores function, independence, and wellbeing, until the end of their life.
- Develop an integrated Frailty Service with two clear purposes:
 - **Role one: Proactive Frailty Support** planned, time-limited cycles focused on improving an individual's function
 - **Role two: Acute Frailty Response at Home** same-day, hospital-level capability delivered in people's homes

This focus will enable hospital-level intensity of care to be provided, but without an older person having to experience avoidable crises nor the harms of inpatient admission such as deconditioning – with a core focus on carer support.

The approach is backed up by clear evidence and focuses around:

- ✓ Comprehensive Geriatric Assessment (CGA)
 - multidimensional assessment addressing medical, functional, psychological and social needs. The evidence is robust that CGA reduces mortality, institutional care and functional decline when delivered properly.
- ✓ Proactive identification and intervention works better than reactive crisis management. The evidence supports systematic frailty screening and early intervention before crises occur.
- ✓ Continuity and coordination - fragmented care is a major driver of poor outcomes. Evidence shows integrated care models with named coordinators reduce hospitalisations and improves quality of life.
- ✓ Physical, mental health and social care needs to be managed together with an improved support for those with living with dementia and delirium.

Transforming support for those living with moderate/severe frailty

Based on the numbers of older people and using national categories to estimate need – the service would be leading work proactively and reactively for around 60,000 moderately or severely frail people at any one time in Norfolk and in Bedfordshire-Luton around 28,000.

Urgent response and virtual ward/hospital ward will work as one service under common accountability (managerial and clinical) and intervene according to the needs of the patient (complexity/intensity and speed of response).

Hospital-level care at home

Same-day clinical assessment

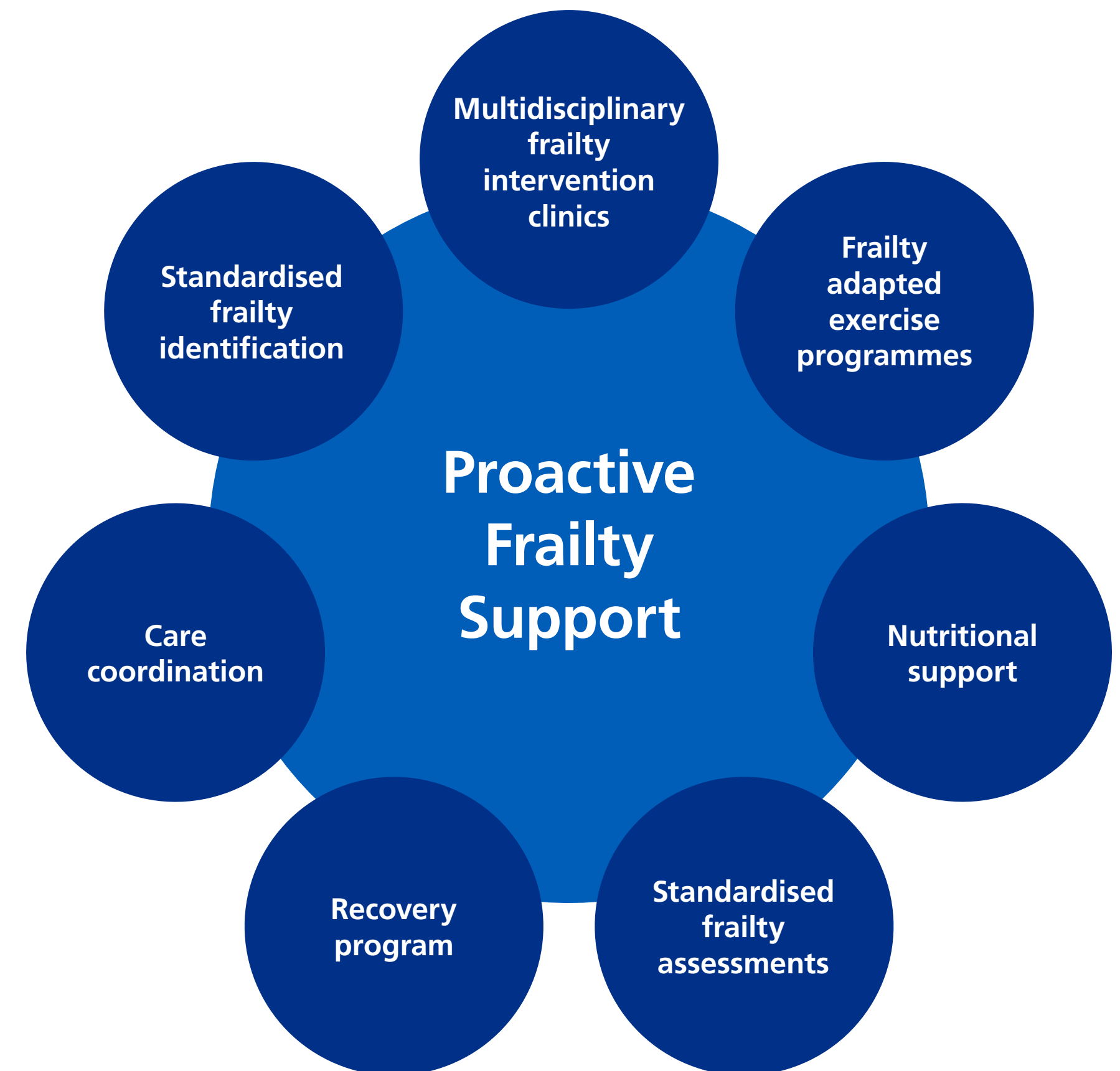
Senior clinical leadership/oversight

Point-of-care diagnostics

IV therapies, oxygen, medications

Daily MDT review

24/7 escalation and safety netting



**What will
be different
when we deliver
our priorities**

Priority 1: Putting people in control of their care



- People can manage their own appointments and communicate with us easily, supported by a single patient record and full NHS App integration
- Our patients will be a partner in defining their own care plan, have a digital copy of their live care plan and real time information about their appointments
- All of those receiving complex care will have their own care preferences set out and include the risks they are willing to take with their own care and support
- Develop and implement Needs identification Tools for professionals and users of our services to use
- We will enable and use intelligent and focused remote monitoring, linked with our patient portal and patient record
- Patients will have outcome measures developed with them and shared in real time
- For people who struggle with technology we will ensure equity of access to our services

Priority 2: Valuing our colleagues



Clinical and care strategy

- We will develop a future-ready workforce which supports neighbourhood working. This will include extending our advanced practice roles and strengthening the data and digital literacy of our workforce.
- We will deliver high-quality, innovative learning that strengthens the development of skills and competencies across our workforce.
- We will create accessible, flexible career pathways and training routes that support lifelong learning and progression. This will include supporting work experience and recruitment across the local systems in which we work.
- We will embed a culture of inclusiveness and make sure that our Trust is a place where our people feel valued and want to work.
- We will invest in the health and well-being of our workforce, which will include improving the working environment and equipment used by our teams.

Priority 3: Working in Partnerships



Clinical and care strategy

- Use our estate to develop community neighbourhood health campuses enabling collaboration and shared use by multiple health and care providers, supporting the shift towards community and primary care-based services
- Common data definitions and reporting for all service areas
- In partnership with Primary Care, Councils, educational sector, the voluntary sector and NHS partners we will implement four new service models: a Best start in life; Support for Children and Young People with Complex Needs; Neighbourhood Care and Unscheduled Care
- With Council partners, develop sustainable models to optimise those supported at home on discharge from acute hospitals and reduce the use of bedded care pathways
- Develop a new model with hospice partners using end-of-life funding (fast track)
- To support hospital level care at home in all geographies, we will train, recruit and rotate our clinical staff with health partners to enhance joint working and keep skills up to date for our clinicians
- We will work in partnership with academic institutions and industry to deliver high-quality research, education, and training



Priority 4: Innovating and transforming our organisation



Clinical and care strategy

- Agree with our strategic NHS commissioners how the Trust can have greater role to lead pathways and/or population health groups (all ages)
- Expand our Quality Improvement and Research approach to support changes in care delivery
- Develop greater capabilities and experience to manage medicines and pharmacy management/ drug distribution to support all of our care delivery
- We will develop data systems that provide greater insights and intelligence to ensure we can prioritise those with greatest health inequalities and help us understand the needs of our communities
- Create an AI and automation centre of excellence that drives rapid innovation, embedding innovative technologies into services, and empowers our workforce with the skills and tools to transform care
- Our Trust will take greater financial risk to support investment in meeting health and care needs of the community



Thank you for reading

If you have any questions please contact:
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