NHS
East of England
Community Health and Care
NHS Trust

Clinical and Care Strategy

April 2026 – March 2031 Version 1.0

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Welcome

A message from our Chief Medical Officer and Chief Nursing and Allied Health Professionals (AHP) Officer

We're 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 enable our staff to better meet the needs of our communities. We'll spark innovation, embrace digital solutions and work in partnerships to provide care that fits with the needs and expectations of our patients to maximise 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've listened and, together with the feedback from our staff, have used these insights to develop our strategy. It fully aligns with national and 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 who can and will make the lives of our patients and communities better.

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

This change can only be achieved by working with our partners in the NHS, local government, the third sector, schools, early years providers, and broader educational providers. We expect to lead on collaborative cross-organisational work and ensure our leaders keep the needs and outcomes of residents and patients as the most important driver for change.

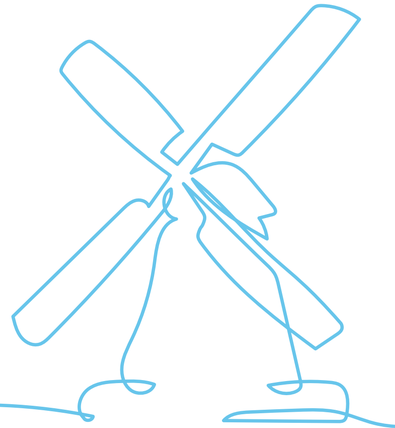
Our vision of great care will be defined through the eyes and experience of our patients and communities and will lead to improved ways of doing things. We aim to help people live the best possible quality of life. To provide care that is comfortable and convenient to them. To help people to stay healthy 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



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 serve a population of 3.5 million people, providing care and support from the start through to the end of life in people's homes, local clinics, and community hospitals.

This Clinical and Care Strategy sets out how our services and infrastructure need to change to realise the ambitions set by the Government in its 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. They'll be professionally and structurally connected with other health, care, and educational providers in these areas. Together our core purpose will be improving outcomes and reducing health inequalities. Our patients need us to make it easier for them to access and experience coordinated 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'll work as partners with health, social care, and educational providers, to push the boundaries in 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. Over time, our models of care will move from being reactive to proactive and preventative, underpinned by data analytics and insights.

This 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 we need to make straightaway. This includes reducing the waiting times in our services over the period of this strategy, to be within the constitutional standard of 18 weeks. We also need to ensure community nursing teams can provide the required volume of planned care interventions in our populations, 365 days a year. We must support all of our services to become more preventative in approach.

Plan on a page

Our mission

Our 7,000 staff across the East of England will deliver and support our services focused on achieving 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 that we have a healthy culture. This is vital as it underpins how our staff are supported so 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 that change is needed, therefore our vision will be:

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

As part of this Clinical and Care Strategy we will ensure we:

1. **Put 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.

Our four priority service areas

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 Visitor and Family Support Services with early help and pre-school providers.
- Narrowing the gaps in school-readiness across all demographics.

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 programmes targeting families at risk.

Children and young people neighbourhood care and support

- Needs identification tool available to parents, carers and teachers to promote early access to advice, guidance, self-care and further support.
- Integrated multi-agency teams organised around neighbourhoods, 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.

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.
- Reduce waiting times for neurodevelopmental assessments to below 18 weeks.

Regional centre for neurodisability

- 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 or 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 and 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.

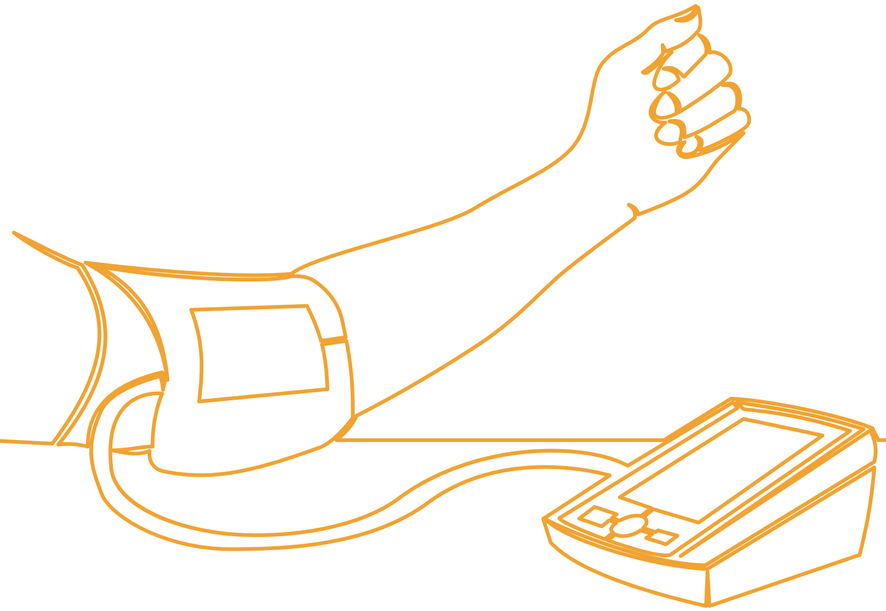
4 Unscheduled care

Hospital at home

- Hospital-level capability delivered at home as a default for frail older people.
- Virtual Ward 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 and social care coordination.
- Flow navigation to prevent unnecessary emergency department (ED) attendance, using same-day emergency care where appropriate.



Why these four service areas?

Children and young people

Up to 22% of families in the area we serve are in the low income bracket and there are areas within our geography that are among the most deprived in England.

The Government (Department for Education, March 2025) recognises that children from disadvantaged backgrounds are less likely to be school-ready. Targeted approaches are needed to change this.

Our approaches need to ensure a great start to life that will lay the foundation for health and learning.

We currently have unacceptably long waiting times for neurodevelopmental assessments and our referral rates are below the population prevalence levels. We need to develop pathways that are evidence-based and designed to cope with current and future pressures.

Children with complex needs currently have to travel to centres outside of the East of England for their neurodisability support. We'll 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. This means models utilising neighbourhoods. In response to this, and to the Children's Wellbeing and Schools bill, our focus needs to be on the impact of our work with multiple statutory partners.

The Government is also proposing wide ranging changes to the Special Educational Needs and Disabilities (SEND) system and our approach will need to alter.

Why these four service areas?

Adults and older people

Some of the counties we serve are home to a higher proportion of elderly people. In Norfolk, for example, 25% of the population is elderly, compared to the national average of 18%. We also serve some of the UK's most deprived areas; people living in them are 2.3 times more likely to be 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. It embeds 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 ages". 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'll change as we deliver our Clinical and Care Strategy

Regional centre for neurodisability

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

They already collaborate with our partners in acute hospitals, and we'lllook 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 coordinate 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 - providing enhanced support across the Trust - will also be expanded.

Movement disorders

This includes children with 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 swallowing support, assisted ventilation and relevant respiratory technical teams will be supported holistically through a one-team approach.

Other specialist services

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

Availability of investigations

In collaboration 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 or severe frailty

Moderate or 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 at the heart of neighbourhood working, to deliver the Government's mandate to the NHS.

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

We need to redesign 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 care to be provided, without older people experiencing avoidable crises or the harms of inpatient admission (such as deconditioning), with a core focus on carer support.

The approach is supported 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 improve quality of life.
- ✔ Physical, mental health and social care need to be managed together with improved support for those with living with dementia and delirium.

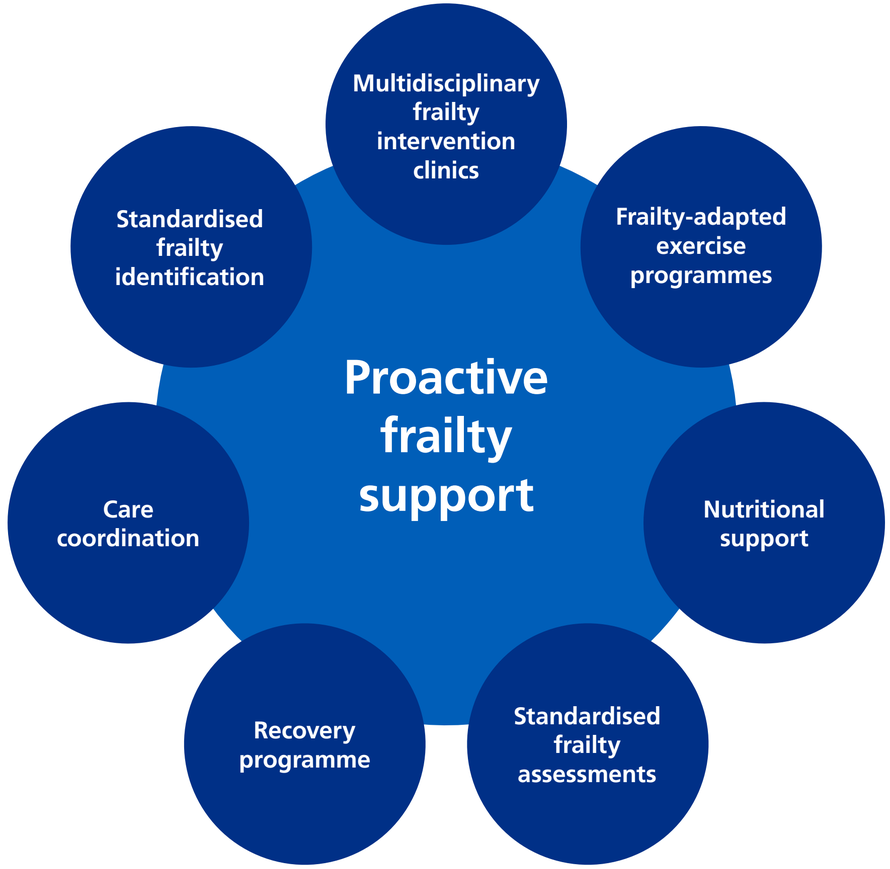
Transforming support for those living with moderate or severe frailty

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 in Norfolk, and around 28,000 in Bedfordshire and Luton.

Urgent Response, Virtual Ward and hospital wards will work as one service under common accountability (Managerial and Clinical) and intervene according to the complexity and intensity of each patient's needs, and the speed of response required.

Hospital-level care at home

- Same-day clinical assessment
- Senior clinical leadership/oversight
- Point-of-care diagnostics
- IV therapies, oxygen, medications
- Daily multi-disciplinary team 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 will be able to manage their own appointments and communicate with us easily, supported by a single patient record and full NHS app integration.
- Our patients will be partners 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, including the risks they are willing to take with their own care and support.
- We will develop and implement needs identification tools for professionals and users of our services.
- We'll enable and use intelligent and focused remote monitoring, linked with our patient portal and patient records.
- Patients will have outcome measures developed with them and shared in real time.
- For people who struggle with technology, we'll ensure equity of access to our services.

Priority 2:

Valuing our colleagues

- We'll 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'll deliver high-quality, innovative learning that strengthens the development of skills and competencies across our workforce.
- We'll 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'll embed a culture of inclusiveness and make sure that our Trust is a place where people feel valued and want to work.
- We'll invest in the health and wellbeing of our workforce and improve the working environment and equipment used by our teams.

Priority 3:

Working in partnerships

- We'll use our estate to develop community neighbourhood health campuses, enabling collaboration and shared use by multiple health and care providers, and supporting the shift towards community and primary care-based services.
- We'll develop common data definitions and reporting for all service areas.
- In collaboration with primary care councils, the education sector, the voluntary sector and NHS partners, we'll implement four new service models: Best start in life; Support for children and young people with complex needs, Neighbourhood care; and Unscheduled care.
- Working with council partners, we'll develop sustainable models to optimise care for those supported at home, on discharge from acute hospitals, and reduce the use of bedded care pathways.
- We'll 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'll train, recruit and rotate our clinical staff with health partners, to enhance joint working and keep our clinician's skills up-to-date.
- We'll work in partnership with academic institutions and industry to deliver high-quality research, education, and training.

Priority 4:

Innovating and transforming our organisation

- We'll agree with strategic NHS commissioners how we can play a greater role in leading pathways and/or population health groups (of all ages).
- We'll expand our Quality Improvement and Research approach to support changes in care delivery.
- We'll develop greater capabilities and experience to manage medicines, pharmacies and drug distribution, to support our care delivery.
- We'll 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.
- We'll create an AI and automation centre of excellence that drives rapid innovation, embedding innovative technologies into services, and empowering our workforce with the skills and tools to transform care.
- Our Trust will take greater financial risks to support investment in meeting the health and care needs of our community.

Thank you for reading.

If you have any questions please contact:
eec.communications@nhs.net