

Leicestershire Partnership NHS Trust Strategic Priorities and Risks 2015/16

Dr Peter Miller
Chief Executive Officer



Leicestershire Partnership NHS Trust

We provide integrated mental health, learning disability and community health services for a population of a million people in Leicester, Leicestershire and Rutland.



Health Improvement to school nursing, health visiting to CAMHS, Community hospitals, community services, end of life care to MHSOP, LD, IAPT to acute mental health wards, podiatry to low secure services, community paediatrics and Diana Nursing, immunisation programmes to community mental health.



Values



Strategic Objectives



LPT in Numbers



156 sites



240,000 occupied beds days



1.49m community contacts



166,000 active caseload at any one time



5486 staff; 4,712wte

Income
£273m
Planned
surplus of
£2.6m

Delivering
83% of a
5.5% CIP
plan



Integrating our Clinical Services

Focusing our services on families in geographical localities that are aligned to emerging primary care clusters, local authority boundaries or health community-wide networks, so that our services operate seamlessly with each other, with primary care, with social care and with the voluntary sector. Our services will be co-ordinated and accessed locally, the key impacts of which will be:-

- Improved access to services, enhancing the service user experience and allowing earlier intervention.
- Reduced duplication of contacts and activities within and across agencies from better coordination, therefore improving service user experience and reducing costs.
- Earlier intervention with reduced escalation of health conditions and therefore improving health and reducing specialist service contacts.
- Better health and social care system integration reducing back-room (eg administration and management) costs across statutory agencies.



Adult Mental Health & Learning Disability Services

- Development of the adult mental health care pathway
- Enhance adult community mental health services
- Supporting people with a learning disability to remain in the community



Development of the Adult Mental Health Acute Care Pathway

We will review, redesign and implement acute care pathways for adults with mental health problems that prevent the need for admission, improve access and responsiveness to key acute mental health services. The key impacts of this change will be:-

- Easier access to the right services, at the right time and in the right way, improving the service user and referrer experience and enabling earlier intervention. This will be achieved through the remodelling of the Crisis Resolution Team whereby the introduction of a new organisational model will promote timely response
- Reduced hand-offs within and across agencies by improving partnership working and awareness, reducing delayed discharges and length of stay with the introduction of the housing support pilot which is aimed at reducing delayed hospital discharges attributable to housing related issues.
- Deliver a sustainable set of services by providing alternatives to hospital admission, promoting recovery and independent living by commissioning of a Crisis House and Step Down Bed facility aimed at providing an alternative to hospital admission.



Enhance Adult Community Mental Health Services

Development of community mental health care pathways for adults to include alignment with primary and voluntary and community sector support to ensure that people who are not in a crisis but are unwell are identified early, seen quickly and supported to remain in the community. The key impacts of this change will be:-

- Improved confidence within community mental health, primary care and the voluntary and community sector to support adults with a mental health problem with their health and social care needs to improve recovery rates, increase resilience and reduce escalation to the acute means of service provision.
- Clearer understanding of the care pathway to improve patient and carer experience.



Supporting People with a Learning Disability to remain in the community

The overall aim is to develop safe, effective and person centred community learning disability services which work in partnership with others to improve the health and well-being of adults with learning disabilities. In order to meet this aim we will:-

- Restructuring of the current teams and improvement in the efficiency of processes.
- Further development of the model of care based around the 4 Tiers approach and supported by evidenced based care pathways, clinical strategies and specialist interventions.
- Development of an integrated approach to management and clinical leadership.
- Development of the estates and IMT structure required to deliver a more flexible and efficient service.
- Engage with staff and further develop partnerships across health and social care and with our service users and their families and work with them to improve intervention and enablement.
- Support the wider locality approach to multi-disciplinary team working and integrated joined up care, supporting and enabling access to mainstream health and social services for the LD population, to enable an integrated team approach.
- Enhance home treatment and crisis management, refocussing on the Outreach service to facilitate admission and discharge to the Agnes Unit.
- Provide the best quality of care to the people with LD who have the most complex needs within the care pathways.



Community Health Services

- Prevention and early Intervention
- Improving access to care and reducing waiting times
- Developing out of hospital care
- Whole system provision of care



Prevention and Early Intervention

Making Every Contact Count – Using our clinical contacts as well as our networks of professional and social relationships, we will continue to embed our work to Make Every Contact Count (MECC) empowering healthier lifestyle choices.

Asset Based Community Development – We will work in partnership with community groups, advocacy groups, social networks and leaders and families within the networks of social relationships in our communities to develop, promote and facilitate activities and behaviours that lead to improvement in the health and well-being.

Work Based Health Improvement Programmes – We will lead by example as provider of health care by promoting practices at work and within our staff that enhance positive health and wellbeing.

Risk Stratification and Case Management – Through our generic and specialist services such as our clinical coordinators, community nursing and therapy teams, heart failure and respiratory specialist nursing teams, we will work closely and in partnership with our GPs and primary care partners to provide pro-active multi-disciplinary care planning

The key impacts will be:-

- Staying healthy; enable people to stay well by making healthy lifestyle choices and adopting behaviours that improve and maintain their health and wellbeing.
- Early intervention to prevent urgent and emergency acute care.
- Reduction in inappropriate A&E attendance.
- Reduction in hospital admission for people with chronic illness.
- Early diagnosis of dementia.



Improving Access to Care and Reducing Avoidable Waits for our Services

Single Point of Access – We will expand and enhance the capability and capacity of our single point of access service to ensure that calls are answered swiftly and an effectively

Implementation of Memory Service Shared Care Agreement –in partnership with GPs to ensure we continue to improve our offer of early detection of dementia

One Chance to Get It Right – We will continue to develop the full spectrum of care prescribed through the five priorities for end of life care. We will work together with local partners such as LOROS, carers and families to support people who are reaching the end of their lives and to enable them to die in the place of their choice

Implementing Seven Day Services - through a number of our clinical services but we will continue to extend seven day provision of care to ensure that patients receive timely, integrated and personalised intervention when this is needed.

Continuing Health Care – We will work together with our commissioners, social and third sector partners, carers and families to ensure that patients receive a timely CHC assessment and that care packages

Psychiatric Liaison in Acute Hospitals – working with the acute sector by providing psychiatric liaison provision in the acute hospitals to address physical needs and support older people’s access to mental health services.

The key impacts will be:-

- Reduction in waiting times.
- More patients will receive treatment in their homes (in the community) regardless of the day of the week and those who choose to die at home will be supported to achieve this.



Developing Out of Hospital Care

Intensive Community Support Service (ICS) –, we will enhance the capacity and capability of our ICS. This will facilitate delivery of the Better Care Together bed reconfiguration programme by providing community based capacity for the equivalent of 130 beds in 2015/16 and additional 120 beds in the subsequent year.

Sub-Acute Care in Community Hospitals – Over the period of this plan, we will develop the capability and capacity to provide sub-acute care in our community hospitals.

Community Stroke and Neurology Services – We will work together with our commissioners and partners in acute care to provide an integrated community based specialist services for patients who have recovered from the acute phase of an episode of stroke or neurological illness.

In-Reach Teams – To facilitate the prompt and effective transfer of the most appropriate cohort of patients with the desirable level of acuity into community based sub-acute care and ICS beds, we will establish an In-reach team with the skills and experience to identify and expedite the prompt and smooth transfer of patients.

Enhanced Health in Care Homes – We will continue to provide an in-reach into care service into homes for people diagnosed with dementia and other mental health care in order to reduce the need for their admission into hospital.

The key impacts will be:-

- Ensuring that patients receive the right care in the right place at the right time, with care given by the right team.
- Releasing acute care beds for those who really need acute care.
- Ensures that patients are appropriately cared for in their own homes or as close to their homes as possible,
- Promotes self-care and personalised care.
- Promote reablement, independence and self-care of patients who have experienced acute episodes of illness
- Supports the long term sustainability of the local health economy.



Whole Systems Provision of Care

Coordinated Community Health Services (CCHS) – In the preceding year we implemented our CCHS programme which delivered the structured, systematic integration of our community. Over the planning period, we shall continue the process of internal organisational integration .

Specifically, we will:-

- Integrate and align our care pathways with County and City social care services from April 2015.
- Implement Phase 2 of our CCHS programme which draws community hospitals and specialist services into the integrated model.
- Develop partnership working with community groups and third sector organisations and join up internally with our FYPC division to progress Asset Based Community Development.
- Ensure that the health and well-being needs of carers of our patients are promoted and met.
- Develop and implement integrated physical and mental health teams for older people.

The key impacts will be:-

- As the left shift process transfers services to community based groups and voluntary/third sector organisations, we will ensure that our patients receive seamless, whole systems and person centred care.
- We will be well positioned, appropriately resourced and equipped as preferred providers of healthcare services for patients who exercise the use of their personal health and social care budgets.
- There will be better outcomes for patients, families and carers by their active involvement in care provision.
- Access will be enhanced for those who are deemed to be hard to reach, which will lead to the reduction in the current inequalities in health that exist across the communities in LLR.
- Patients with comorbidities involving physical and mental health conditions will have more timely access to mental or physical health intervention.



E-Health Innovations and Bed Utilisation

Nursing Technology Fund – Having secured funding through this fund in 2014/15, we will implement technology advances in nursing practices across all of our community hospitals. This project will digitally connect nurses in the acute and community trust,

Robotic Telepresence Solution – We will pilot a robotic telepresence solution that enables a clinician to be virtually present in a distant location

Efficient Use of Beds – We will optimise the use of our beds so that we can provide the same or increased volume of activity with fewer beds

The key impacts will be:-

- Improved access to care and reduction in waiting times; the optimal use of our space will ensure that we have more capacity to see more people and reduce waiting times.
- The use of technology will facilitate quicker intervention through the shared access to patients' clinical records.
- The prompt intervention will also lead to improved outcomes and enhanced patient experience
- Robotic telepresence ensures that patients can be seen and reviewed without the need to be physically present.
- Improved access to care and reduced waiting times.
- Supports financial sustainability of care.



Families, Young People and Children

- Strengthening communities
- Increasing knowledge and skills
- Alternative technologies
- Achieving Best Practice



Strengthening Communities

Rolling out a co-developed health planning and Asset-Based Community Development (ABCD) approach across LLR. This will strengthen, support, co-ordinate and build capacity within families and communities for self-help and to support each other, and aid in the design of local health and social care services. The key impacts of this change will be:-

- Improved confidence within families and communities to support each other's health and social care needs to increase resilience and reduce use of statutory agencies.
- Increased support for families from communities to allow quicker recoveries and less dependence on statutory services. This will lead to earlier discharges from services and a reduction in the number and frequency of follow-ups.



Increasing Knowledge and Skills across the Workforce

Through introducing new roles and integrating practice across teams there will be a transfer of skills and knowledge across the workforce. The key impacts of this change will be:-

- Increased capability in practitioners to support service users, reducing referrals to more specialised services, providing confidence in specialised service practitioners to discharge earlier and reducing the number of practitioners involved in the care of a child or family.
- Increased quality of interventions, and to intervene earlier improving service user health.
- Reduced workforce cost through the safe delivery of interventions by lower banded staff group than currently.



Introduction of Alternative Technologies

We will build on our pioneering work with social media, mobile and video technology to create accessible, agile and efficient services.

The key impacts of this change will be:-

- Increased accessibility to practitioner advice, building on our nationally recognised social media apps and virtual appointments to allow earlier intervention, reduction in face to face contacts and improve service user experience.
- Increased agility of workforce through mobile working technologies, reducing estates usage and travel costs, and improving productivity.



Achieving Best Practice in Clinical Delivery

To use and generate best-practice guidance to deliver effective integrated pathways and efficient delivery models which start and end with the community's role. The key impacts of this change will be:-

- Increased quality through standardisation of best practice and reduced costs associated with outlier practices, duplicated and unnecessary contacts.
- Increased productivity through lean processes and leading edge service design resulting in reduced cost per contact.
- Increased integration across agencies, supporting cross-organisational re-design and reducing of administration costs.
- Improved self-care through clarification of the role of community involvement in aspects of the care pathways resulting in reduced service contacts.



Other Priority Areas

- Innovation and Research
- Leadership development
- Continuous quality improvement



Challenges/Risks

- **Financial stability of health economy**
- **Workforce**
 - Capacity
 - Capability
 - Engagement
- **Sustained quality improvement**
 - CQC inspection outcome
- **Demand/Capacity and Access**



Thank You

