Coventry City Council

Agenda

Coventry Health and Well-being Board

Time and Date
11.00 am on Monday, 4th April, 2022

Place
Committee Room 3 - Council House

Please note that in line with current Government and City Council guidelines in relation to Covid, there will be reduced public access to the meeting to manage numbers attending safely. If you wish to attend in person, please contact the Governance Services Officers indicated at the end of the agenda.

Public Business

1. **Welcome and Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of Previous Meeting** (Pages 5 - 18)

   (a) To agree the minutes of the meeting held on 24th January 2022

   (b) Matters Arising

4. **Chair's Update**

   The Chair, Councillor Caan, will report at the meeting

5. **Health and Wellbeing Board Membership**

   To appoint Kirston Nelson, Chief Partnership Officer/ Director of Education and Skills and Danielle Oum, Chair of Coventry and Warwickshire Integrated Care System as Members of the Health and Wellbeing Board

Development Items

6. **Covid-19 Ongoing Response**

   (a) Living Safely with Covid-19

   Presentation by Allison Duggal, Director of Public Health and Wellbeing

   (b) NHS Capacity

   Presentation by Phil Johns, Coventry and Warwickshire CCG

(c) Vaccinating Coventry

Presentation by Nadia Inglis, Consultant Public Health and Alison Cartwright, Coventry and Warwickshire CCG

7. **Health Protection Update**

Presentation by Nadia Inglis, Consultant Public Health

8. **Children in Crisis and Developments towards Children's Integrated Health and Care**

Update from John Gregg, Director of Children's Services

9. **Coventry and Warwickshire Integrated Care System Health Inequalities Strategic Plan** (Pages 19 - 26)

Joint report of Allison Duggal, Director of Public Health and Wellbeing and Rachel Chapman, Consultant Public Health

10. **Update from the Marmot Partnership Group's Call to Action** (Pages 27 - 30)

Report of the Deputy Chair, Dr Sarah Raistrick, Coventry and Warwickshire CCG

11. **Improving Lives (for Older People) - System Transformation Programme** (Pages 31 - 52)

Report and presentation of Pete Fahy, Director of Adult Services and Housing

12. **University Hospitals Coventry and Warwickshire Organisational Strategy 'More than a Hospital'** (Pages 53 - 64)

Report and presentation of Andy Hardy, University Hospitals Coventry and Warwickshire

13. **Coventry and Warwickshire Place Forum Update** (Pages 65 - 68)

Report of Kirston Nelson, Chief Partnership Officer/ Director of Education and Skills

Governance Items

14. **Integrated Care System/ Integrated Care Partnership Development**

Update from Phil Johns, Coventry and Warwickshire CCG and Danielle Oum, Coventry and Warwickshire Integrated Care System as

15. **Any other items of public business**

Any other items of public business which the Chair decides to take as matters of urgency because of the special circumstances involved

Private Business

Nil

Julie Newman, Director of Law and Governance, Council House, Coventry

Friday, 25 March 2022

Note: The person to contact about the agenda and documents for this meeting is Michelle Rose Tel: 024 7697 2645 Email: michelle.rose@coventry.gov.uk / Lara Knight Tel: 024 7697 2642 Email: lara.knight@coventry.goc.uk

Membership: L Bayliss-Pratt, Cllr J Blundell, Cllr K Caan (Chair), M Coombes, Cllr G Duggins, P Fahy, S Fox, J Grant, J Gregg, A Hardy, P Henrick, P Johns, R Light, S Linnell, C Meyer, Cllr M Mutton, S Raistrick and Cllr P Seaman

By invitation: Councillor G Hayre, K Nelson and D Oum

Public Access

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Michelle Rose/ Lara Knight
Tel: 024 7697 2645/ 2642 Email: michele.rose@coventry.gov.uk or lara.knight@coventry.gov.uk

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Coventry City Council
Minutes of the Meeting of Coventry Health and Well-being Board held at 2.00 pm on Monday, 24 January 2022
This meeting was not held as a public meeting in accordance with the Local Government Act 1972

Present:

Board Members:	Councillor J Blundell Councillor K Caan (Chair) Councillor P Seaman Melanie Coombes, Coventry and Warwickshire Partnership Trust Valerie De Souza, Interim Director of Public Health and Wellbeing Pete Fahy, Director of Adult Services John Gregg, Director of Children's Services Stuart Linnell, Coventry Healthwatch Professor Caroline Meyer, Warwick University Dr Sarah Raistrick, Coventry and Warwickshire CCG (Deputy Chair) Adrian Stokes, Coventry and Warwickshire CCG Superintendent Ronan Tyler, West Midlands Police
In attendance:	Councillor G Hayre Danielle Oum, Coventry and Warwickshire Integrated Care System
Other representatives:	Derek Benson, Safeguarding Boards' Chair Alison Cartwright, Coventry and Warwickshire CCG
Employees:	R Chapman, Public Health R Eaves, Safeguarding J Fowles, Public Health J Grainger, Public Health N Inglis, Public Health L Knight, Law and Governance R Nawaz, Public Health

Public Business

30. **Declarations of Interest**

There were no declarations of interest.

31. **Minutes of Previous Meeting**

The minutes of the meeting held on 4th October, 2021 were agreed as a true record. There were no matters arising.

32. **Chair's Update**

The Chair, Councillor Caan, placed on record his thanks to Professor Sir Chris Ham for all his work in support of the Board whilst Chair of the Coventry and Warwickshire Health and Care Partnership and then the Coventry and

Warwickshire Integrated Care System during the past three years. Sir Chris had helped and encouraged the partnership working to improve the health and wellbeing of local residents.

Councillor Caan welcomed Danielle Oum, the new Independent Chair of the Coventry and Warwickshire Integrated Care System, to her first meeting of the Board. Danielle addressed the Board informing of her priorities and key topic areas for her new role.

33. **NHS Capacity**

The Board received a presentation by Adrian Stokes, Coventry and Warwickshire CCG which provided the latest update on NHS capacity.

The presentation set out the latest numbers of patients with Covid in hospitals across Coventry and Warwickshire, currently 251 which presented a stable position at the current time. 10 of these patients were in critical care. Staff absence was currently running at 9.4%.

System working to support discharge was highlighted including partnership work which involved a System Multi Agency Discharge Event the week of 17th January and the Discharge task and finish group. Reference was also made to supporting community capacity with measures including:

- Additional blue bed capacity and exposed capacity commissioned for week of 17th January
- Expanding virtual ward capacity
- Work plan for pre hospital pathways to support admission prevention
- Expanding at pace community urgent response.

The presentation referred to virtual wards and the benefits to this approach, which included:

- Allowing patients to get the care they needed at home safely and conveniently, rather than being in hospital.

- A mix of a joint approach between Primary and acute care, acute and community care and GP care alone.

- Support could include remote monitoring using apps, technology platforms, wearables and medical devices such as pulse oximeters as well as face-to-face care from multi-disciplinary teams based in the community.

The Board were informed that further virtual ward capacity was coming on line towards the end of January in heart failure, respiratory, OPAT and frailty. Further details were provided about the numbers of patients being treated via the virtual wards.

The presentation concluded with an update on the current blue and exposed beds in the system. There were currently 7 blue beds in the community for medically fit for discharge patients who had a positive Covid diagnosis so and typically required residential care. There were 12 exposed beds in the community for medically fit for

discharge patients who had been exposed to someone with a Covid diagnosis and typically required residential care.

Members asked about the current position relating to unvaccinated staff and the measures being undertaken to encourage uptake of the vaccine.

RESOLVED that the update position concerning NHS capacity be noted.

34. **Covid Defences**

The Board received a presentation from Valerie De Souza, Interim Director of Public Health and Wellbeing on the latest Covid 19 position in the city including an update on Covid defences.

Key metrics indicated that there were 1,147.18 Covid cases per 100,000 residents in the city in the last 7 days as at 16th January, which was a significant decrease from 5th. The weekly percentage of individuals testing positive for Covid was also dropping, currently 28.7%. The numbers in hospital with Covid reflected that the vaccinations and boosters were successful, with very low numbers in ICU. 229,993 residents (70.1%) had now received their second vaccinations with 164,747 residents receiving their booster vaccination.

The presentation referred to the regional Covid trends, with the West Midlands rates having been increasing slightly (3rd out of 9 regions place). Coventry was currently placed 7th when compared to other West Midlands areas. Further details highlighted the current national picture. The seven-day rolling programme for the city highlighted that numbers had seen a significant drop in Covid cases.

The presentation provided key factors to show that the vaccines had weakened the link between catching Covid and getting seriously ill, providing statistics from January 2021 when the country was in lockdown compared to January 2022 with minimal restrictions in place.

Information was provided on the latest requirements for PCR and Lateral Flow Tests. The difficulty in accessing testing PCRs and the delays in results seen over the Christmas period had now largely been resolved. Locally the supply chain for home testing kits was improving and the city was now in a position to supply community groups, libraries and places of worship. Pharmacy and online ordering provision had been restored.

Reference was made to the updated guidance and regulations (Plan B) with a reduction in isolation to at least 5 days; LFT positives did not need confirmation with PCR s for most cases; the advice to work from home if possible was removed from 20th January; and the booster vaccination programme had now been extended to all adults and 16–17-year-olds.

The presentation concluded with a summary of the key messages and priorities.

RESOLVED that the contents of the presentation be noted.

35. **Vaccinating Coventry**

The Board received a presentation from Nadia Inglis, Consultant Public Health and Alison Cartwright, Coventry and Warwickshire CCG on the latest position of the vaccination programme in the city.

The presentation indicated that the vaccination roll out was continuing for all 12 years and older who were eligible. 12–15-year-olds were to have their second dose starting this month. The 5–11-year-old programme for those at clinical risk had been approved by ministers, details were awaited. The booster programme for 16+, people with long term conditions aged 16+ and health and care workers 3 months after second dose was ongoing. The flu programme for 50+, people with long term conditions (from 6 months+), plus pregnant women and all children aged 2-15 years on 31st August 2021.

The presentation referred to the Evergreen offer via Vaccinating Coventry. 14 community pharmacy sites in Coventry now delivering 1st, 2nd & boosters. Ongoing engagement was required with communities with lower uptake and a specific vaccination offer and planning was underway for a potential door knocking project. Offers were still being made for employers with on-site vaccinations or to link up with local vaccination centre and offers continued to be made for homeless community and asylum seekers.

Information was provided on the booster roll out in the city as follows: current booster uptake 33.4% (on 17/12), 46.3% (on 17/1) and 46/6% (on 20/1) for Coventry residents. The rate was 80% upwards in over 60s. Details were provided of the 11 Primary care/CWPT vaccination sites and the 14 community pharmacies in Coventry (alongside range of primary care network sites) offering boosters, alongside first and second doses.

The presentation concluded with details of the performance of the vaccination programme via the eight Coventry Primary Care Networks. The overall figures for the city were 73.5% of residents had received their first dose; 67.3% their second dose; and 76.8% of those eligible having received a booster vaccine.

RESOLVED that the contents of the presentation be noted.

36. **Children in Crisis and Developments towards Children's Integrated Health and Care**

The Board received a brief update from John Gregg, Director of Children's Services on children in crisis and developments towards Children's integrated health and care.

Work was progressing well for the integrated health and care system with the partnerships already in place which would be replicated. The recent focus had been on children in crisis with reference being made to the considerable pressures on hospitals for children in need of tier 4 beds which was a national as well as local problem.

The next area to consider was wider determinants of health, with an initial summit meeting taking place. It was the intention to look at asthma.

Members expressed support for the work currently being undertaken.

RESOLVED that the update on children in crisis and developments towards Children's integrated health and care be noted.

37. **Coventry Domestic Abuse Strategy**

The Board considered a report and received a presentation from Rachel Chapman, Consultant Public Health which informed of the results of the Domestic Abuse Needs Assessment; the updated Domestic Abuse Strategy and progress in delivery of the requirements of the Domestic Abuse Act 2021.

The report indicated that at their meeting on 12th July 2021 the Board had received a report on the Domestic Abuse Act 2021 which set out the wide range of provisions and responsibilities in the Act to protect victims and children, including the establishment of a Domestic Abuse Local Partnership Board as a statutory board of the Local Authority.

Under the duties set out by the Act, a needs assessment for domestic abuse support for victims and children in Coventry had been carried out. The needs assessment incorporated a comprehensive engagement exercise which included surveys completed by 71 survivors and 51 practitioners, multiple focus groups and more than 30 interviews with stakeholders. The intelligence from this was supplemented with data from multiple sources and a literature review. While the initial focus of the needs assessment was on accommodation-based support, the information gathered enabled analysis of current needs across the wider agenda of domestic abuse.

The Executive Summary contained the key findings and 23 recommendations across the following areas: criminal and civil justice system; perpetrators; health services; safe accommodation for victims and families; support for victims and their children; housing; and individuals with no recourse to public funds or language challenges. A copy of this summary was set out at an appendix to the report.

The Board noted that a series of actions have been developed in response to the needs identified with lead agencies nominated to take the work forwards. Delivery of the action plan will be monitored by Domestic Abuse Steering group, reporting to the Local Partnership Board. A copy of the action plan was attached at a second appendix to the report.

The current Coventry Domestic Abuse Strategy 2018-2023 was reviewed in light of the findings of the needs assessment. The current 4P framework of Prepare, Prevent, Protect and Pursue supported a systematic multi-agency approach to tackling Domestic Abuse and fitted well with the needs assessment findings. The strategy had been extended to 2025 to enable delivery of the action plan. The needs assessment, action plan and strategy extension had been approved at by full Council.

The City Council had received Government grant funding of £849,930 in 2021/22 to "fulfil the functions of the new statutory duty on Tier 1 Local Authorities relating to the provision of support to victims of domestic abuse and their children residing within safe accommodation". The funding for future years was dependent on the new burden assessment. The report detailed the additional provision that had been commissioned using the grant.

The presentation summarised the main parts of the Domestic Abuse Act 2021 and highlighted the current rates of domestic violence in Coventry and the West Midlands. Progress to date was outlined along with details about the Needs Assessment. The four priority areas of the Domestic Abuse strategy were highlighted along with details of the services commissioned from 2019 and the new services commissioned in 2021/22. The presentation concluded with details of the various Working Groups.

RESOLVED that the results of the needs assessment, the updated Domestic Abuse Strategy and the action plan be noted.

38. **Suicide Prevention - Strategy Refresh 2022**

Juliet Grainger, Public Health, introduced the report which set out the current position of the work programme delivered as part of the Coventry Suicide Prevention Strategy 2016 -2019 and the Coventry and Warwickshire NHSE funded suicide prevention programme between 2018 – 2021. Reference was made to the refresh of the strategic oversight arrangements for Suicide Prevention across the Coventry and Warwickshire Health and Care Partnership and emerging Integrated care System. The report also informed of the intentions to develop the future strategy for Coventry.

The report indicated that NHSE funding from the national suicide prevention programme was awarded to Coventry and Warwickshire during 2018 – 2021 as a Wave 1 site due to sub regional prevalence rates being above the national average. A comprehensive programme of activity was overseen by the Coventry and Warwickshire Health and Care partnership and delivered through the local Suicide Prevention partnerships. Details of the suicide prevention initiatives were set out at an appendix to the report. The Board were informed that the most recent Suicide data showed that the rates in Coventry dropped slightly from 2017 – 2019 at 10.6 per 100,000 (England 10.1) to 2018 – 2020 at 10 per 100,000 (England 10.4).

Legacy activity from the programme had now been devolved to the Coventry and Warwickshire suicide prevention steering groups. Local strategies, partnership arrangements and action plans were being reviewed to incorporate the NHSE programme evaluation and the real time suicide surveillance data insights.

The report set out the local context and priorities. Feedback from the respective Coventry and Warwickshire suicide prevention multi agency steering groups during November and December 2021 identified that organisations found value in the partnership meetings, communications and networks however many were attending meetings in both areas which they felt could be amalgamated. Further

details in terms of priorities from the feedback which highlighted what the plans should include were detailed.

It was the intention to develop a single Coventry and Warwickshire Suicide Prevention Strategy to:

- Provide an overview of the national / regional context
- Outline the shared strategic ambitions for suicide prevention
- Reflect system, place (city and county) and local priorities
- Outline mechanisms for delivery, impact and governance
- Acknowledge the role and contribution of all system partners in delivering the ambitions of the Strategy.

To deliver the strategy it was proposed to develop a new and evolving joint Coventry and Warwickshire Suicide Prevention Delivery Plan. The report set out the requirements for this plan. Reference was made to the partnership arrangements and the proposal to develop a joint Coventry and Warwickshire Strategic Steering Group. The responsibilities for the Group were detailed.

Other proposals highlighted in the report included exploring the option for a joint Coventry and Warwickshire Suicide Prevention Network; the ongoing development of the Coventry and Warwickshire Suicide Prevention Learning Panels; and participating in the regional suicide prevention leads peer support network (West Midlands).

The Deputy Chair, Dr Raistrick expressed support for the future arrangements for suicide prevention and for the initiatives that were already in place. The Chair, Councillor Caan expressed his thanks for all the good work that was taking place.

RESOLVED that:

(1) The successful outcomes of the NHSE funded Coventry and Warwickshire Health and Care Partnership suicide prevention programme between 2018 -2021 be noted.

(2) The proposal to develop a single Coventry and Warwickshire Suicide Prevention Strategy by the Autumn 2022, overseen by a joint, strategic steering group supported by a delivery plan and multi-agency network forum, be endorsed.

39. **Coventry and Warwickshire Health Inequalities Strategy**

The Board received a presentation from Rachel Chapman, Consultant Public Health, on behalf of the Coventry and Warwickshire Inequalities Task Group, which provided an update on progress with the ICS Inequalities Strategic Plan.

The presentation set out the background and national requirements for the strategy which involved a 5 year strategic inequalities plan that was fully embedded and delivered at ICS level. The strategy had the following aims:

- To strive towards health equity for the population of Coventry and Warwickshire.
- To make reducing inequalities the golden thread through all of our work

- To challenge the whole system on how they can contribute and embed action.

Health inequalities were unfair and avoidable differences in health across the population, and between different groups within society. Data provided information about male and female life expectancy across Coventry and Warwickshire. The strategy to tackle health inequalities was based on a Population Health approach using the four pillars. The major projects within these four areas were highlighted. Reference was made to Coventry being a Marmot City and to the key role of the Board.

The presentation detailed the Core 20 Plus 5 initiative which was designed to drive targeted health inequality improvements using a target population (the most deprived 20% of the population) tackling the following 5 key clinical areas of health inequalities: maternity; early cancer diagnosis; severe mental illness; chronic respiratory disease; and hypertension case-finding. Details of Coventry and Warwickshire's most deprived populations by location were highlighted.

It was proposed that there be a focus on the 'Plus' groups - groups that risked "falling between the cracks" with poor outcomes. Proposed groups were:
i) Coventry and Warwickshire:
Transient and newly arrived populations, (gypsies and travellers, boaters, refugees and asylum seekers)
Families who are at risk of poor outcomes
ii) Coventry:
People on long term sickness benefit
iii) Warwickshire:
People with a disability (sensory and development)
Rural isolation
Ethnic minority groups.

The presentation set out the following six local high impact actions to address inequalities:
(i) Financial strategy – applying universal proportionalism
(ii) Economic recovery – engagement with wider businesses and the local LEP
(iii) Workforce – diversity and recruitment
(iv) Population health management – data monitoring and engagement
(v) Commissioning and procurement – support social value and local supply chains
(vi) Digital inclusion – joining up Digital Transformation Board and bottom-up approaches.

Further information was provided on the evidence-based approach that would be used; the system delivery; and the governance arrangements including the role of the Health and Wellbeing Board to enable delivery. Ownership and overall responsibility for the Strategy would belong to the Integrated Care Partnership / Integrated Care Board. Plans for system engagement were also detailed which included this Board as part of the Coventry element. The presentation set out how success would be monitored from inputs; activities; outputs; outcomes; and impact.

The presentation concluded with the following next steps:

- System engagement
- Develop the Governance framework
- Identify major inequalities work programmes with the biggest impact, and how to shift resources
- Develop the monitoring framework.

Members asked about when co-production would start to make a difference that could be measured. The importance of co-production and sharing knowledge and ideas was acknowledged.

RESOLVED that the contents of the presentation be noted.

40. **Social Care White Paper - People at the Heart of Care**

The Board considered a report of Pete Fahy, Director of Adult Services and Housing which provided an update on the content and main provisions of the Adult Social Care White Paper 'People at the Heart of Care' issued on 30 November 2021.

The report indicated that the long anticipated White Paper aimed to have three main objectives to deliver as follows:

- People had choice, control, and support to live independent lives
- People could access outstanding quality and tailored care and support
- People found adult social care fair and accessible.

The paper sought to address the issues of:

- Information and Advice - more help nationally on information and advice
- Empowerment of service users and unpaid carers - help more disabled people into employment; keeping open the possibility of allowing the public to appeal certain social care decisions; renewed push for LAs to offer more direct payments and personal budgets with associated support; and commitment to revisit the national 2018 Carers Action Plan
- The role of Housing - increasing the supply of supported housing
- Improving pay and conditions of care staff - the only references to helping improve the pay and conditions of front-line care were the via the 6.6% increase in the National Living Wage
- Care market - shaping a healthy and diverse care market
- New technology and digitisation – more alarm systems, falls prevention aids, smart devices generally in people's homes and care homes
- Digital Social Care Records – expectation at least 80% of social care providers to have a digitised care record in place by March 2024 that could connect to a shared care record
- Prevention - more emphasis on whole family, whole system approaches to prevention linking closely with the newly formed Office for Health Improvements and Disparities (OHID).

The White Paper provided greater clarity on how some on the social care reform monies announced in September 2021 were to be deployed across different areas which were set out in the report. This funding equated to £1.05bn over three years (1.65% of the total national spend on Adult Social Care for 2020/21) and was part of the £5.4bn announced in September 2021. The paper also reminded that

£3.6bn from the £5.4bn announced in September 2021 was to fund the care cap and financial thresholds and to help fund the "Fair Cost of Care" for which a subsequent communication from the Department of Health and Social Care on 16 December 2021 specified the requirement for each local authority to undertake a 'fair cost of care' exercise with an emphasis on residential care and home support for people aged 65 and over, and produce a provisional market sustainability plan by September 2022.

The Board noted that within the White Paper a strong emphasis was placed on better data, assurance, inspection and intervention. There was indication of where the focus of CQC would be for when Adult Social Care became a CQC regulated service from April 2022 (once the Health and Care bill becomes an Act). The report highlighted these areas which broadly covered responsibilities under Part 1 of the Care Act 2014.

The White Paper also stated that the matter of health and care integration was to the subject of a separate White Paper. No specific timescale for this was provided.

RESOLVED that the following be noted:

(1) That the aspirations of the White Paper are positive and ambitious.

(2) The resourcing to deliver these ambitions does raise a question regarding how deliverable the ambitions are in reality.

(3) The issue of pay and reward of front line care staff remains unresolved.

(4) That Social Care will be entering into a new regime of oversight and review by the Care Quality Commission likely to commence in 2023.

41. **Coventry and Warwickshire Place Forum Update**

The Board considered a report of Valerie De Souza, Interim Director of Public Health and Wellbeing which provided an update on the outcomes of Coventry and Warwickshire Place Forum meeting held on 17 November, 2021.

The report indicated that 40 members attended the online development session which followed on from separate development sessions held by each of the Boards, facilitated by The King's Fund, in September and October 2021. The meeting provided the opportunity to understand the statutory changes to the Integrated Care System and to consider the future role of the Place Forum in this context.

The Forum received presentations as follows:

- Coventry and Warwickshire Place Forum – the journey so far and key achievements: emphasising the unique collaboration between the two Boards which provided a strong foundation on which to develop ICS governance in the new legislative context

- Statutory Integrated Care Partnership: outlining the forthcoming legislative requirements for the ICS, including creation of an ICP, which would be a

statutory committee responsible for promoting partnership arrangements and developing an Integrated Care Strategy to address the health, social care and public health needs of the system

- System Health Inequalities Plan: detailing the requirement to produce a strategic inequalities plan for the system by March 2022, embedding the national NHS 'Core 20 Plus 5' framework, and outlining how the plan was being developed

- Sharing learning from Health and Wellbeing Board development sessions: common themes arising from the separate sessions related to ICS/ICP development, the role of Health and Wellbeing Boards and the role of place and communities.

The report included a summary from discussion and breakout sessions as follows:

- There was plenary discussion and facilitated break-out groups, focusing on the added value that the Place Forum offered to the system, and shaping its role and format within the emerging ICS governance arrangements

- There was agreement that there needed to be greater clarity about roles, responsibilities and accountability within the system, and that it was important the governance was coherent and could be described to the public, so they could understand where decisions were made and by whom.

- A key principle was that to build on the strong partnership working that already existed through the Place Forum and Health and Care Partnership Board.

- There was continued commitment to working collaboratively through the system changes and opportunities that arose.

Additional information was provided on the key actions and next steps.

RESOLVED that the contents of the report and the next steps and actions resulting from the Coventry and Warwickshire Place Forum meeting held on 17 November 2021 be noted.

42. **Children and Adults Annual Safeguarding Board Reports**

The Board received a report of Rebekah Eaves, Safeguarding Boards Manager, concerning the 2020/21 Annual Reports of the Coventry Safeguarding Children's Partnership and Coventry Safeguarding Adults Boards, copies of which were set out at appendices to the report. Derek Benson, Independent Chair of the Safeguarding Partnership and Board attended the meeting for the consideration of this item.

The report concerning the Adults Board Annual Report detailed that the Safeguarding Adults Board was a partnership of organisations that worked to both prevent and end abuse of adults with care and support needs in the city. The Board included a wide range of organisations that had a role in safeguarding.

The Board had three priorities for 2019-2021:
i) To be assured that safeguarding is underpinned by the principles of 'Making Safeguarding Personal' and that adults are supported in the way they want
ii) To be assured that services and agencies have appropriate systems, processes and training in place to support and safeguard adults effectively.
iii) The Board to seek to understand and respond to safeguarding issues arising out of the Covid-19 pandemic.

The report detailed the governance arrangements; information about Coventry's population; the outcomes for Coventry adults; highlighted how the Board have made a difference; informed about safeguarding adult reviews; reported on safeguarding awareness week; reported on learning and development and learning even. Appendices to the report set out Board Membership and the Coventry Safeguarding Adult Board Business Plan for 2019-21.

The report concerning the Safeguarding Children Partnership Annual Report set out the priorities for 2020-2022 for the Partnership as follows:
i) Neglect
ii) Extra familial harm including a contextual safeguarding approach
iii) Making the system work
The report set the local context; detailed the Partnership; set out progress against the priorities; and highlighted the child exploitation indicator tool. Information was provided on the neglect conference and the local authority designated officer. Details of the signs of safety were set out along with right help right time to help; quality assurance and learning from reviews. Other areas covered were training; the Safeguarding Together Action Group; and the voice of the child. The performance score card was set out at an appendix to the report.

Members asked about where they could find information on individual safeguarding reports.

The Chair, Councillor Caan, thanked Derek Benson, for all his work on safeguarding in the city.

RESOLVED that the contents of the Coventry Safeguarding Children's Partnership and the Coventry Adults Safeguarding Board Annual Reports for 2020/21 be noted.

43. **Integrated Care System/ Integrated Care Partnership Development**

The Board received a brief update from Adrian Stokes, Coventry and Warwickshire CCG on the development of the Integrated Care System (ICS) and the Integrated Care Partnership (ICP).

The Board were informed that the earliest date that Coventry and Warwickshire could become a statutory ICS was 1st July, 2022, which had moved back from the earlier date of 1st April. This was dependent on legislative proposals passing through Parliament. Work was ongoing on the Governance arrangements to make sure everything would be in place for the start of July including the ICP. Reference was made to close working arrangements that already existed through the Health and Care Partnership. He referred to the aims of the ICS: improved outcomes; tackling inequalities; enhanced productivity and value for money; and help the

NHS support broader social and economic development. Reference was also made to the three layers of the system – primary care networks, place and system, with work ongoing in all areas.

44. **Any other items of public business**

There were no additional items of public business.

(Meeting closed at 3.40 pm)

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 4tn April 2022**

From: Allison Duggal, Director of Public Health and well-being
Rachel Chapman, Consultant Public Health

Title: Coventry & Warwickshire Integrated Care System Health Inequalities Strategic Plan

1 Purpose of the Note

1.1 The purpose of this paper is to inform the Coventry Health and Wellbeing Board about the progress on the Coventry & Warwickshire Integrated Care System (ICS) Health Inequalities Strategic Plan and provide an opportunity for Board members to make any recommendations or comments as part of the development process.

2 Recommendations

The Health and Wellbeing Board is asked to:

1. Note the requirements for a Coventry and Warwickshire ICS Health Inequalities Strategic Plan;
2. Support the recommended local priority population groups for the strategic plan (covering newly arrived and transient communities and people on long-term sickness benefits);
3. Make any comments and recommendations as part of the development of the plan.

3 Information/Background

3.1 The Coventry and Warwickshire Integrated Care System (ICS) is required to provide a 'Health Inequalities Strategic Plan' to NHS England/Improvement by 28th April 2022. The plan must set out a locally agreed strategic approach for addressing health inequalities based on a recognised model of health and must include the NHS health inequalities priorities as set out in the NHS Long Term Plan.

3.2 The plan should be Place-based and should involve the local Director of Public Health. It has to be owned by decision making bodies within the developing ICS.

3.3 A programme of engagement is underway with partners and key NHS workstreams to develop the plan.

3.4 The local plan will build on existing work which aims to embed consideration of and action on health inequalities in all that we do and shift how we work with local communities.

4 Progress to date

4.1 A programme of engagement with partners and key NHS workstreams is currently underway to shape the Strategic Plan and ensure the approach takes into account the needs and inequalities within Coventry.

4.2 In January 2022 the shadow Integrated Care Board (ICB) agreed 8 principles for the plan:

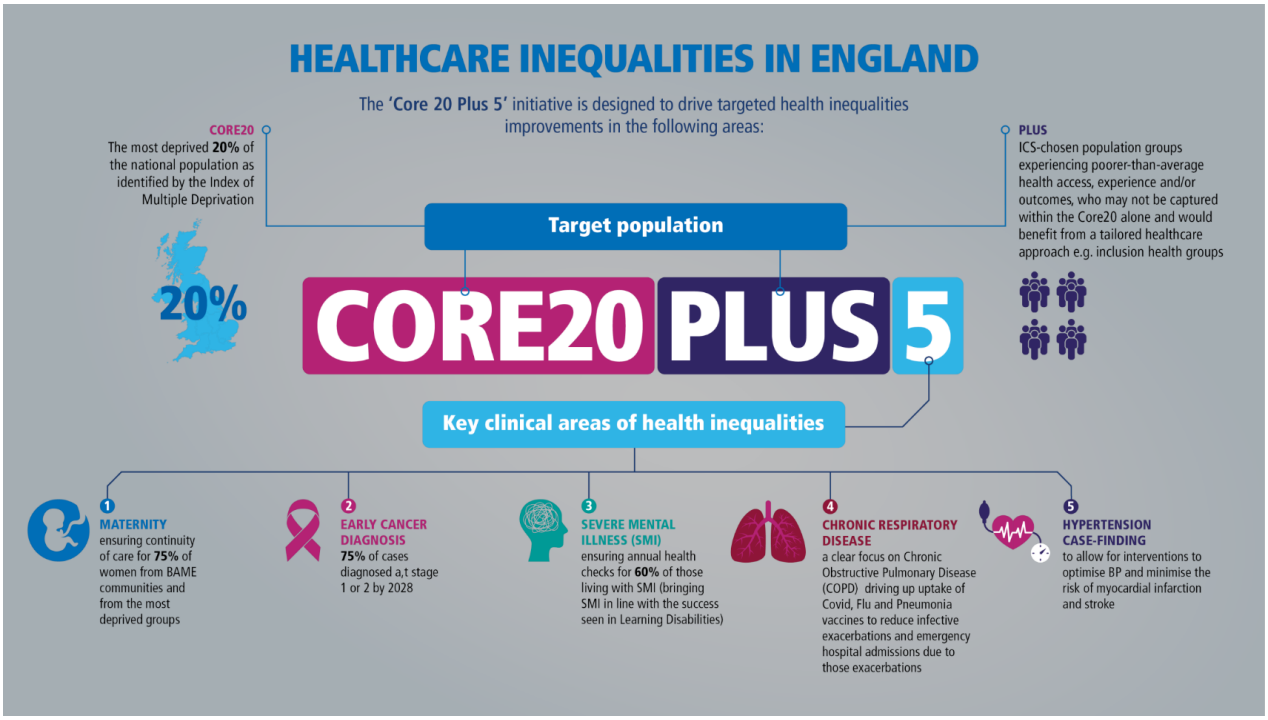
- Addressing Inequalities is core to and not peripheral to the work of the C&W ICS
- Strategic Plan will be based on the King's Fund model of Population Health
- Built around the Core20+5 health inequalities framework
- Evidence-based approach
- Encourage innovation
- Community co-production
- Embed reducing health inequalities across all ICS work
- Reducing inequalities is key to decisions on the prioritisation and allocation of resources

4.3 The King's Fund model of Population Health includes the impact of the wider determinants, individual behaviours, places and communities as well as health and care on people's health. It is already embedded as an approach within our system, it is well recognised by partners and is the basis for the Health and Wellbeing Strategies for both Coventry and Warwickshire. Use of this model prompts the system to consider the breadth of influences on inequalities and to act beyond the health and care domain to achieve sustainable impacts.

4.1 The Core20+5 framework has been developed by NHSE/I to support the reduction of health inequalities at a system level. It is composed of 3 parts:

- "Core20": the 20% most deprived areas as defined by Index of Multiple Deprivation nationally.
- "Plus": these are specific groups identified locally who experience poorer than average health outcomes but may not be captured within the Core20. For Coventry and Warwickshire these are proposed to be transient and newly arrived populations, includes homeless, gypsies and travellers, boaters, refugees and asylum seekers. In addition, for Coventry, people who are on long term sickness benefit will be considered as a Plus group.
- "Five" Key clinical areas of health inequality:
  - **Maternity**: continuity of care for women from Black and Minority Ethnic (BAME) communities in the most deprived areas
  - **Early Cancer Diagnosis:** 75% of cancers diagnosed at Stage 1 or 2 by 2028
  - **Severe Mental Illness (SMI):** annual health checks for 60% of those living with SMI
  - **Chronic Respiratory Disease:** a focus on Chronic Obstructive Respiratory Disease (COPD), driving up uptake of COVID, Flu and Pneumonia vaccinations
  - **Hypertension Case-Finding:** to allow for interventions to optimise blood pressure (BP) and minimise the risk of myocardial infarctions and stroke.

This framework does not preclude consideration of other groups experiencing health inequalities but provides a focus for concerted system-wide efforts.



4.2 The 5 clinical areas have been selected due to existing inequalities and with Cancer, Circulatory and Respiratory illness being the biggest killers. Action in these areas if vital for having an impact on health outcomes for all population groups.

4.3 Maternity has been included following findings from the national Confidential Enquiries into Maternal Deaths and Morbidity which found maternal mortality rates among Asian women were twice as high than in White women, and four times higher in Black women compared to White.

4.4 People living with a SMI are a national priority due to the gap in life expectancy for this cohort, which is 15-20 years lower than the general population and largely due to physical health conditions.

4.5 The 5 clinical priorities are primarily focused on secondary and tertiary prevention approaches (identifying significant risk factors or early signs of disease in order to intervene and prevent further ill-health, or preventing exacerbation of existing illnesses). Such approaches are likely to provide swifter return on investment for local systems than primary prevention approaches, however for longer-term and sustained impacts on health inequalities applying primary prevention to reduce the prevalence of risk factors is required.

4.6 Broader partnership activity is required to promote healthy behaviours, address inequalities in the wider determinants of health and create healthy environments in which residents live, work and play within is required in order to harness longer-term improvements in health equity.

5 Health Inequalities in Coventry

5.1 Coventry suffers from high levels of deprivation, with 26% of residents living in areas in the 20% most deprived in England. This equates to 96,654 of the city's residents living in the most deprived areas. As a Local Authority area, men and women in Coventry experience

significantly lower life expectancy than the England average. Whilst there are pockets of deprivation in all parts of the city, the areas with the highest levels of deprivation and lowest life expectancy are in the central and north-east of the city, with pockets in the south west and south east.

5.2 Health outcomes also vary between population groups. Key groups experiencing health inequalities, and recommended as local priority population groups were identified from local and national evidence, the impact of the Covid19 pandemic and discussion with partners.

5.3 **Transient communities – Refugees/Migrants:** Coventry has a long history of welcoming refugees and asylum seekers to the city. However, due to the recent international situation, exacerbated by COVID-19, Coventry and Warwickshire have seen an unprecedented rise in numbers.

5.4 **Asylum seekers:** In April 2019 there were 569 asylum seekers accommodated in Coventry under the Home Office Asylum Dispersal arrangements. The latest figures (December 2021) show this number has risen to 2055 – 1592 in Serco run accommodation and 527 in initial accommodation (3 x local hotels). This is an increase of 361% and is unprecedented locally and regionally.

5.5 **Refugees:** With regard to resettled refugees, both Coventry and Warwickshire are welcoming refugees from both Syria and Afghanistan among other countries. Alongside the 36 Syrian families who were originally being supported in Warwickshire, Warwickshire have made a pledge to resettle an additional 63 families between April 2021 and April 2025 (through UK resettlement and Afghan programmes). In Coventry, we have 968 existing Syrian, Yemeni, Iraqi, Sudanese and Afghan refugees currently in the city, with a further 121 Afghans arriving into the city over the course of 2021. In addition to the asylum seeker hotels outlined above, there is a further hotel in the city housing Afghan refugees who are seeing out their quarantine period before moving out of the city.

5.6 Asylum seekers and refugees can have complex health needs. Common health challenges can include: poorly controlled chronic health conditions; untreated infectious diseases or missing vaccinations; poor mental health related to previous trauma and/or to isolation as a newly arrived resident; and women may have additional need ante- or post-natally, associated with late presentation to healthcare, previous trauma, malnutrition or poverty. Despite these health needs there is no evidence of a disproportionate use of healthcare resources. In fact asylum seeker and refugees often face barriers accessing services whilst also facing barriers to accessing services, including language and cultural barriers along with a lack of understanding of UK health systems

5.7 **Gypsies/Travellers:** Gypsies and travellers have the poorest self-reported health outcomes of all ethnic groups. National research suggests life expectancy is reduced by 10-12 years compared with the settled community and remain one of the mot socially excluded groups within the UK. Higher infant mortality rates contribute to this gap in life expectancy and cause significant distress to individuals, families and communities. Such inequalities arise due to a range of factors including discrimination, poor accommodation, poor health literacy, a lack of trust in health providers and barriers in accessing health services. Ibn the 2011 Census, 57,680 people identified themselves as Gypsy or Irish Travellers across England and Wales, with 151 in Coventry (0.05% of the resident population).

5.8 **People who are experiencing homelessness**: In 2020/21, 16.6 per 1,000 households (2,503 in total) were owed a duty under the Homelessness Reduction Act in Coventry. It is recognised that homeless populations have significantly worse physical and emotional health outcomes compared to the general population. The following factors should be considered:

- Reduced life expectancy
- Physical health and accelerated ageing
- Mental health and alcohol & drug use
- Autism and learning disability

5.9 The physical and mental health impacts of being homeless, as well as barriers to accessing services, including digital exclusion, contribute towards premature mortality for this cohort.

5.10 **People on long-term sickness benefits:** The 2010 Marmot Review concluded that being in good employment is usually protective of health while unemployment, particularly long term unemployment, contributes significantly to poor health. However, being in work is not an automatic step towards good health and wellbeing; employment can also be detrimental to health and wellbeing and a poor quality or stressful job can be more detrimental to health than being unemployed. Unemployment and poor quality work are major drivers of inequalities in physical and mental health.

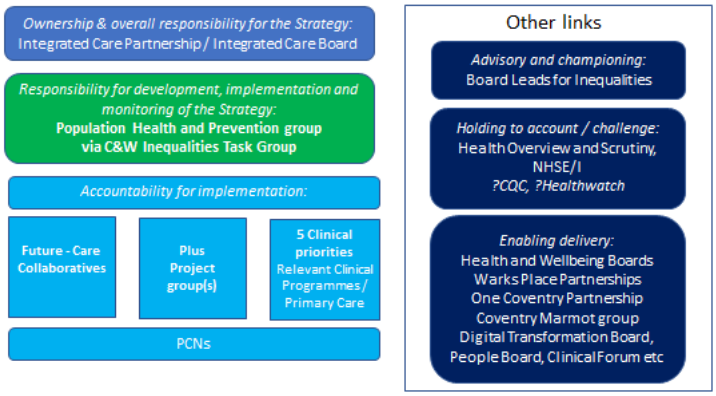
5.11 People who are long-term unemployed have a lower life expectancy and experience worse health than those in work. Employment is one of the most important determinants of physical and mental health. There are approximately 14,600 people in Coventry who are on long term sickness benefit.

https://www.coventry.gov.uk/downloads/file/31254/director_of_public_health_report_2019_-_bridging_the_gap

6 Delivery of the Strategic Plan

6.1 The proposed governance arrangements are shown in the diagram (below).Responsibility for delivery of the strategic plan will be through the Integrated Care Partnership and the Integrated Care Board. The Population Health, Inequalities and Prevention system group will oversee development, implementation and monitoring. Delivery will be through the Care Collaboratives, PCNs and specific identified workstreams. National accountability for delivery will be to NHSE/I and local accountability through Health Overview and Scrutiny. The Health and Wellbeing Board has a key role to play in enabling delivery, in particular joining up the healthcare elements with the other quadrants of the Kings Fund model.

Proposed governance arrangements:

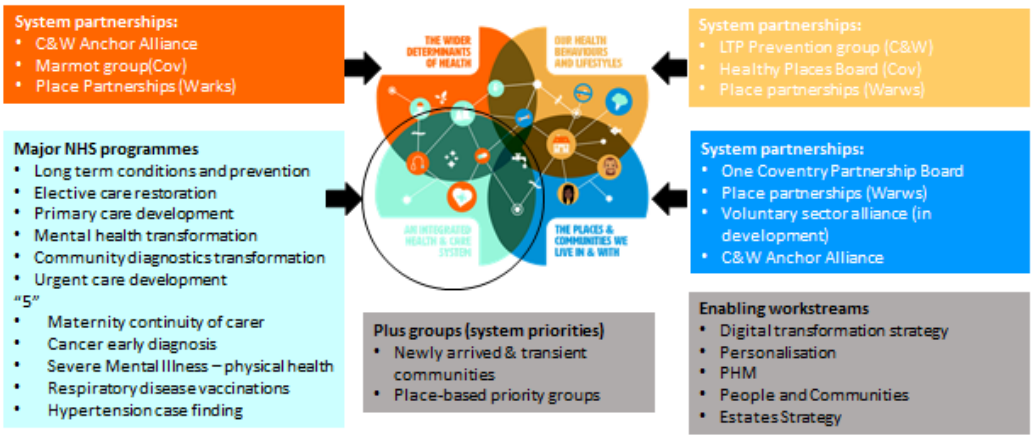


6.2 Delivery of the strategic plan will be through a number of workstreams:

- Major NHS transformation programmes eg community diagnostics expansion, mental health transformation, primary care development where the focus will be on the "Core 20" population
- Specific "plus group" workstreams
- "5" key clinical areas
- Enabling workstreams eg System Digital strategy

6.3 In addition, the wider work on health inequalities will continue to be delivered through the existing partnership arrangements eg One Coventry partnership, Anchor Alliance, Marmot group. The system-wide approach to health inequalities is summarised in the diagram:

HI Strategic Plan - system delivery



6.4 A monitoring framework based on “access, experience and outcomes” is being developed to measure and monitor change as a result of this strategy

7 Next steps and timescales

7.1 A programme of engagement with key partners to further shape the plan based on the Core20+5 model and embedded within our wider population health management approach is taking place between November 2021 to April 2022.

7.2 The draft Coventry and Warwickshire Health Inequalities Strategic Plan will be shared with NHS England/Improvement by 31st March 2022, who are expected to provide feedback prior to a final version being adopted locally from the end of April 2022.

8 Recommendations

The Health and Wellbeing Board is asked to:

1. Note the requirements for a Coventry and Warwickshire ICS Health Inequalities Strategic Plan;
2. Support the recommended local priority population groups for the strategic plan (covering newly arrived and transient communities and people on long-term sickness benefits);
3. Make any comments and recommendations as part of the development of the plan.

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Appendices
None

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 4tn April 2022**

From: Dr Sarah Raistrick, Chair Coventry and Warwickshire CCG

Title: Update from the Marmot Partnership Group's Call to Action

1 Purpose

1.1 The purpose of this paper is to present an update on the work of the Marmot Partnership Group's 'Call to Action' campaign across Coventry and Warwickshire, which aims to encourage businesses and organisations to make changes to improve health and reduce health inequalities.

2 Recommendations

2.1 Coventry Health and Wellbeing Board is recommended to:

i. Endorse the continuing approach of the Call to Action to engage with businesses and organisations across Coventry and Warwickshire to raise awareness and support actions to tackle health inequalities
ii. Offer suggestions and advice around strengthening our approach
iii. Consider how each member's organisation could strengthen their own action

3 Information/Background

3.1 A Marmot City since 2013, Coventry was the only one out of the initial seven cities to remain as a Marmot City, reflecting the on-going commitment to tackling this through a long-term, partnership approach. In recent years, many others have joined, such as Greater Manchester, Newcastle, Gateshead, Bristol and Somerset. An academic evaluation of our Marmot City approach was published by UCL in 2020. Additionally, the Director of Public Health Annual Report called 'Bridging the Health Gap' was published in 2019.

3.2 At the Coventry Health and Wellbeing Board meeting on 27th July 2020, it was agreed that the Marmot Partnership Group would take the strategic lead on supporting the system to address health inequalities relating to COVID19. This has resulted in the development of the health inequalities Call to Action in recognition that reducing inequalities can only be achieved by the joint efforts of organisations and businesses across the city.

3.3 The Marmot Partnership presented a paper to the Health and Wellbeing Board on 25th Jan 2021 regarding the development of a system-wide 'Call to Action' campaign, initially focussing on the role of businesses in the reduction of health inequalities, but also asking Health and

Wellbeing board organisations to begin to consider how their individual organisation could take action in two specific ways:

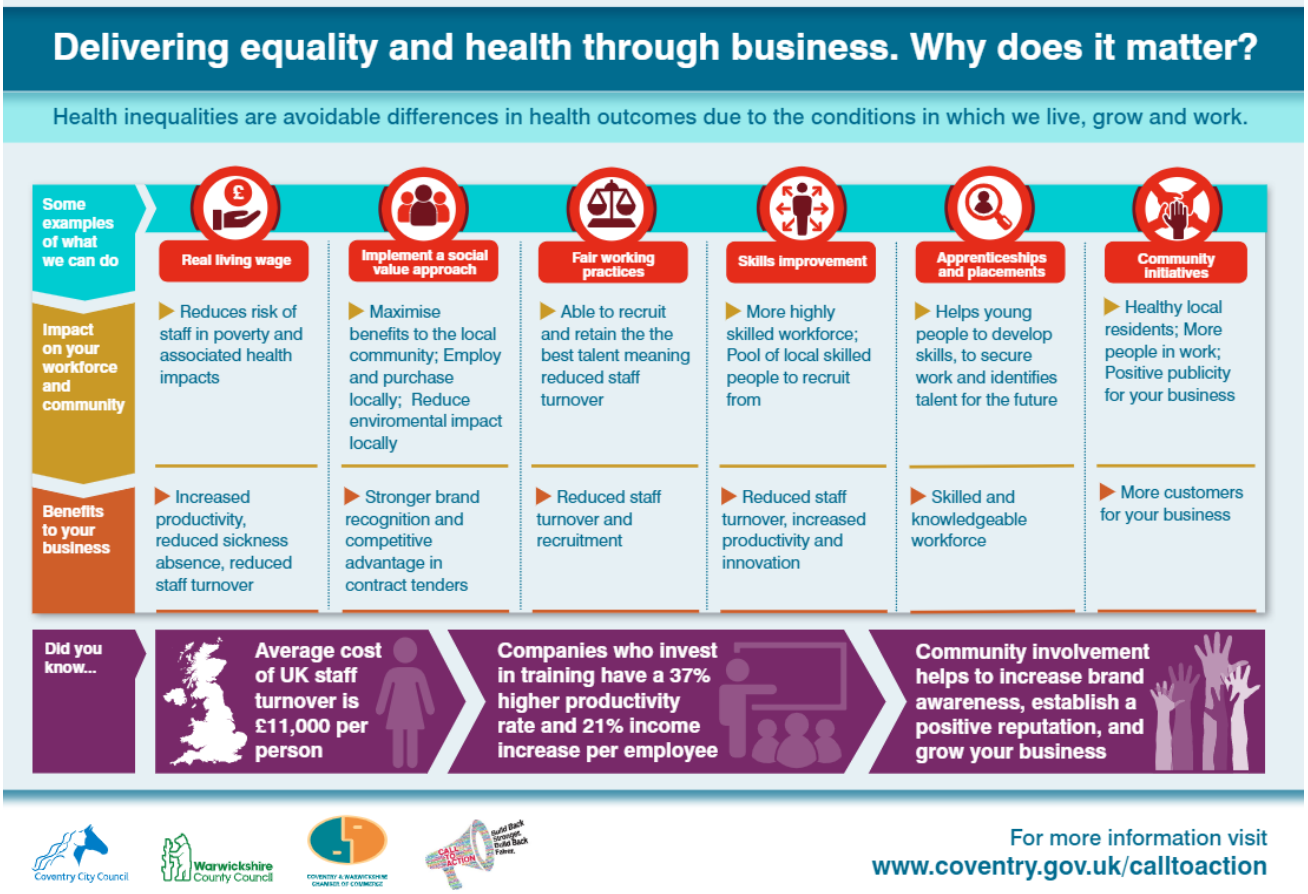
i. a robust review of HR equality polices and processes using a recognised tool and
ii. embedding a social value approach.

Both these core areas will enable a system-wide approach to reducing general health inequalities within our communities.

3.4 Progress so far

The 'Call to Action' Campaign (see below) requests all organisations to take action to make a difference.

Infographic for Businesses



To launch the campaign an online promotional event was held in June 2021 attended by Sir Michael Marmot and Sir Chris Ham championing the campaign and the need for businesses to do more.

Understandably, businesses have had a raft of challenges to focus on, such as supply chain disruption, increasing costs and skills and recruitment difficulties. Our approach is to both

continue to work on this 'Call to Action' but also to seek out ways in which we can become more effective. We are continuing to:

- Ask businesses to make a commitment to take one or two suggested actions, evolving as the project progresses.
- Raise awareness of health inequalities and what that means to businesses, offering 1-2-1 consultation sessions where requested.
- Work with Economic Development to provide links/referrals to businesses.

We have also identified other levers and ideas to energise this campaign; through Kickstart, Thrive, Business Advisors (including low carbon advisors) and other existing connections and relationships.

We have briefed the Anchor Alliance Development Group about the Call to Action. As large employers, these institutions have the potential to have a big impact in tackling health inequalities as employers.

4 Next steps

- Legal and General are partnering with the Institute of Health Equity to explore how businesses can contribute to reducing health inequalities, establishing a place-based network to support taking action on health inequalities. Coventry will be hosting a West Midlands Regional roundtable event (supporting by UCL and Legal and General) and will be the first location to host this event. The plan is for other parts of the country including Greater Manchester to then replicate this.

- Further meetings between Public Health, Economic Development and Employment and Skills have been arranged to discuss how the Marmot Partnership's Call to Action initiative can engage more effectively with businesses. Suggestions include supporting officers in health inequalities training and developing criteria for a business assessment and award system.

- To ensure links are strengthened between this area of work and the Anchor Alliance; the Coventry Pound, the NHS inequalities strategy and the One Coventry Plan, to maximise the impact on reducing health inequalities

- The Marmot Partnership is also renewing its action plan around its key priorities

5 Options Considered and Recommended Proposal

i. Endorse the continuing approach of the Call to Action to engage with businesses and organisations across Coventry and Warwickshire to raise awareness and support actions to tackle health inequalities
ii. Offer suggestions and advice around strengthening our approach
iii. Consider how each member's organisation could strengthen their own action

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 4 April 2022**

From: Pete Fahy – Director of Adult Services and Housing

Title: Improving Lives (for Older People) – system transformation programme

1 Purpose

To brief the Coventry Health and Well Being Board on the progress and next steps in respect of the Improving Lives work underway across health and care.

2 Recommendations

The Board are asked to **note and support** the contents of the report and the attached Programme Update

3 Information/Background

The work referenced in this report and the accompanying appendix is the product of the first phase of a programme work aimed at improving outcomes for older people. Expressed in activity terms the levels of acute attendances, emergency admissions and emergency readmission for adults over 65 in Coventry are considerably higher than those of comparator organisations. This has been the position for a number of years and although improvement programmes and initiatives have been deployed to improve this position overall performance has not shifted significantly.

In order to tackle these issues afresh an in depth diagnostic of urgent and emergency pathways for older people in Coventry has been undertaken by operational improvement specialists Newton. This diagnostic work has identified a range of opportunities to reduce emergency department attendances which in turn has the potential to reduce the number of non-elective beds required through reduced admissions and shortened length of stay leading to improved outcomes for older people in Coventry. Outside of the hospital setting opportunities to improve our approach to admission avoidance and supported discharges (people that need care and support immediately following a hospital stay) have also been identified.

Although the key metrics that this work is aimed at improving on are in relation to acute activity this is very much a system issue across all aspects of primary, community, acute and social care for which the diagnostic has clearly shown that there is an opportunity to bring about improvements to the existing pathways.

In respect of next steps, the four key organisations involved – UHCW, CWPT, CWCCG and the City Council have committed to entering into a design phase which is currently underway. The purpose of this design phase is to co-design and test with operational leads and front line staff a set of sustainable solutions to the opportunities identified in the diagnostic. This design approach will ensure the buy-in and commitment of the staff that are fundamental to making change happen should the programme proceed to implementation.

Progressing this programme of work is a key priority area for the Coventry Care Collaborative and provides one example of how organisations are working together to find new ways of improving outcomes for the people of Coventry. Although the focus of the work in people aged 65+ any improvements in pathways should also have an impact on people of different ages that use those pathways.

A summary of the work completed in the diagnostic phase is attached as an appendix to this report.

4 Options Considered and Recommended Proposal

The opportunities presented through the diagnostic phase were such that all four organisations committed beyond the diagnostic to the current 'design' phase. Nothing has been committed to beyond the design phase at this point, which is expected to conclude in May 2022.

There are no specific recommendations or decisions for Coventry Health and Well Being Board at this point. However, the board is requested to support the programme of work as a key initiative that brings organisations working closer together to support the people of Coventry.

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Appendices

Improving Lives for Older People – Programme Update January 2022

Improving Lives For Older People

Programme Update

January 2022

Why Are We Carrying Out This Work?

What Are The Challenges Facing Our System?

To deal with the **elective backlog**, whilst maintaining care for non-elective demand, we need to shift care out of the acute, reducing the requirement for medical outliers and bed base, shifting the case mix of the acute to more elective/tertiary.

We are **underperforming against our comparators** when it comes to acute attendances, emergency admissions and emergency readmission for adults over 65. And these measures are all getting worse:

15,000 acute attendances per 100,000 population over 65 vs. 9,700 in comparators

8,600 emergency admissions per 100,000 population over 65 vs. 7,300 in comparators

22% of those over 65 readmitted to the acute within 30 days vs. 20% in comparators

Why?

We haven't established a **consistent and resilient alternative to the acute** hospital as a place of safety.

We have a high number of patients with a length of stay in and acute bed of 21 days or greater

We have **multiple fragmented services** across Coventry to facilitate admission avoidance.

We have made good progress in driving discharge improvement, however **key challenge remains of increasing demand** and our co-ordinated system response.

What Our Findings Showed

We have an opportunity to improve outcomes for older people in Coventry throughout our **entire system**

We have **strong foundations** in place to **improve outcomes;** we know where the problems are; a workforce who feel encouraged to improve the way they work; ownership of challenges by leaders

We have achieved a lot so far – we have showed there is a **commitment to start moving forward together** – rather than individually working to fix things in our own control

There are opportunities **across all services** that older people come into contact with when needing care:

- Better use of **community and primary care services** for older people who do not require hospital care
- Prevent number of **unnecessary admissions** to hospital by improving decision-making
- **Timely discharge** from hospital where acute care is no longer needed
- Promote faster recovery with better support in the community to maximise independent living

The fit – we will align this work with other programmes you might be working on that are **improving older peoples lives**

No single solution exists – all agencies need to **come together with robust plan to realise full scale of opportunities** – this is not about health, not about social care, it is about people's lives.

Why Cant We Do This Alone?

Workforce and citizen contribution to the diagnostic was critical to us understanding the opportunities and the programme will need further support going forward

Diagnostic – What did we do?

Workshops – participation in multi-disciplinary teams working without organisational boundaries allowed us to identify opportunities to improve outcomes for older people at each part of the system

Deep Dives – citizens and the workforce supported the programme team to really understand the reasons why parts of the system weren't operating optimally through 1:1 conversations, shadowing and data. This gave us real depth of insight

Citizen Engagement – we listened to citizens who use the service to understand the experience from their perspective – this is crucial to designing a patient centred and outcome focused solution

Environment for Change – We asked you about the environment in which you operate to understand constraints and pressures that stop you being able to operate as you would ideally like

Design – What will we do next?

Workshops – We'll run workstream focused workshops to help us generate, iterate and select design ideas to take forward to testing and piloting in the next phase of work

Design Groups – We'll run workstream design groups with multi-disciplinary teams to design solutions to the opportunities we identified in the diagnostic.

Testing and Pilot planning – When we have our initial designs, we must test that these work. We'll form small pilot groups to test the initial design solution with and ensure it delivers improved outcomes for older people before implementing at scale

Planning and Implementation – with support, we'll plan how we are going to test the initial designs and then roll these out across the system

People Want To Collaborate And Make Improvements

There are three key enablers to mobilise people for positive change

#1

PROVIDE SYSTEM LEADERSHIP

"If we don't have our directors and executives aligned then it's very difficult to move this working together forwards without it being very bureaucratic, which is how it feels at the moment."

Believe that leaders are aligned on a shared vision for improving the health and wellbeing for older people.

60%

Believe that leaders recognize the challenges colleagues face to make improvements.

#2

ENABLE WORKING ACROSS ORGANISATIONAL BOUNDARIES

People want to collaborate but...

"When you've got business sensitive information it's difficult to know whether you're allowed to share it or not and have those free conversations that would enable better patient care."

45%

...of colleagues get access to information from other organisations.

43%

... of colleagues feel their data-driven decision making is enabled by technology and policies & procedures

"Our biggest challenge is to accept that we need to stop working in an organisational way and start to genuinely cut across our organisational boundaries."

48%

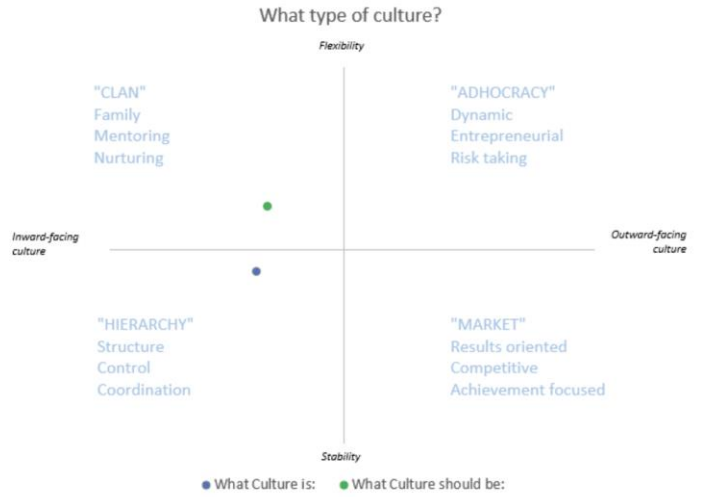
... of colleagues make decisions with people from other organisations

57%

... colleagues trust the data they use to make decisions

#3

FOSTER A CULTURE OF DOING THE RIGHT THINGS WELL & DOING THEM TOGETHER



Colleagues see a future for a more collaborative, nurturing and team orientated culture.

What Opportunities Did We Identify To Improve Outcomes?

What Does Ideal Look Like For The People Who Need Our Care?

In an ideal world, how would our system function?

Embed Enablement Mindset

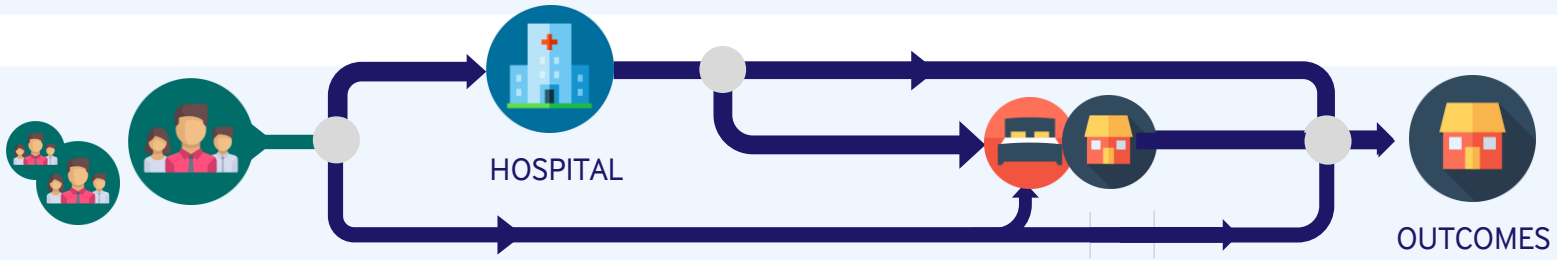
1 Stay in the community rather than going to hospital if you don't need it

2 Return to the community from hospital as soon as you are fit and ready

3 The best hospital discharge and long term care decision for the patient and the system

Consistently measure performance

Effective approach to change



Utilising our current resources more effectively

Working in partnership

4 The right amount of time in a short term setting and the best next step decision

5 The most effective short term support at home to maximise independence

Effective Decision Making

What Could The First Steps Look Like For The People Who Need Our Care?

1700

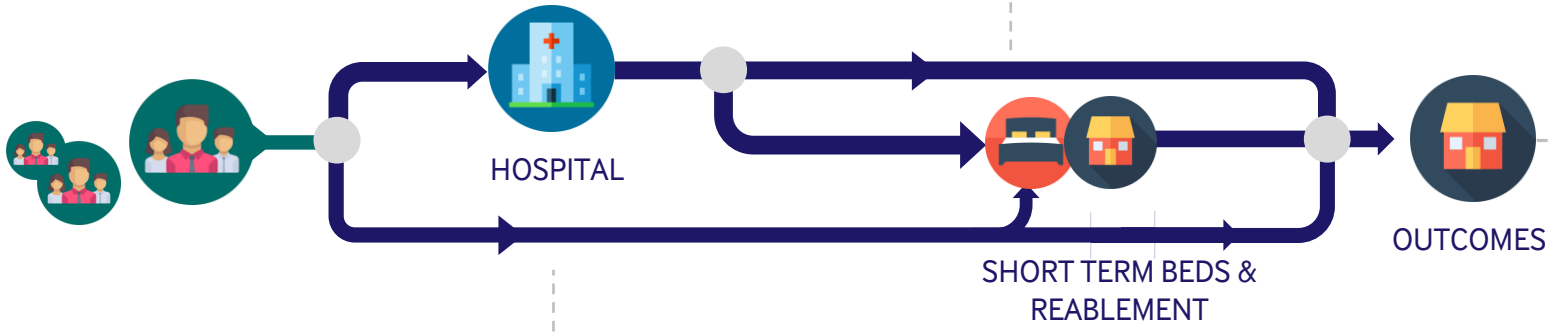
fewer attendances to the ED each year

180

fewer starts into short term bedded care each year

30

fewer starts each year into long term bedded care



Supporting an additional

1600

clients to remain independent for longer in the community

98

fewer beds through reduced admissions and a shortened length of stay

Releasing

80 hrs

of Domiciliary Care each week in newly commissioned packages through improved reablement

DRAFT CONTENT

There Are Good Foundations To Build From

had excellent care from the palliative care team and my GP"

"The leaflets for who can help are available are really good."

" I thought the green pathway [planned surgery] works well."

"The Speciality nurses are very accessible and experienced."

"111 works well once you get through and they generally route you to the right place."

Citizen Forums

...in **93%** of the cases that we reviewed, the service to prevent the attendance or admission already exists

"There's an absolute willingness and passion to make a difference."

"We achieved significant things as a partnership because we changed the way that we operated, and we took a much more user centric approach."

"During Covid we stopped focusing on our own organisational processes and started focusing on the user rather than the user having to navigate our processes."

95%

...of colleagues have good working relationships strengthened by Covid

92%

...of colleague's trust and respect those they work with.

94%

... of colleagues feel they are encouraged to improve the way they work.

System Colleagues

Anticipatory Care, Hospital Attendance and Admission

We have the opportunity to improve the our anticipatory care by improving access to community services before escalations in patients needs. We can also prevent non-ideal hospital attendances and admissions by better decision making at the point of need and providing services outside of the acute hospital

- 42% of all escalations in need could have been prevented prior to attending hospital
- Advanced care planning is critical to preventing these escalations, with practitioners citing that in half all cases, ACP's were a key measure to prevent this
- This advanced care plan should not stop at a respect form but should truly plan for the next stages of an older patients life.

- 37% of all attendances were considered 'non-ideal' by practitioners
- In 46% of these attendances, a healthcare professional referred the patient to the acute setting
- In nearly all of the cases, the healthcare professional was making a risk averse decision or didn't know about the preventative service
- In 81% of non-ideal attendances, the person was conveyed to hospital by emergency ambulance

- We make non-ideal decisions, possibly driven by frailty and not just degrees of illness
- We need to support decision making in ED to reduce non-ideal admissions through better sharing of information
- Case reviews highlighted urgent response, community risk assessment and falls risk assessment/response as a key community service for reducing admissions
- We need to support decision making in the community by increasing knowledge of community services and which patients need to be admitted to A&E

System **visibility & Connected Services**

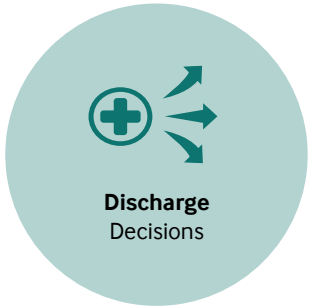
- Develop connected and collaborative partnerships with a data driven culture, where services are visible to decision makers and information flows between critical services

DRAFT CONTENT

Hospital Flow

We have the opportunity to improve the time that a patient spends in hospital, both from admission to being clinically well enough to leave hospital and from being clinically well enough to being discharged

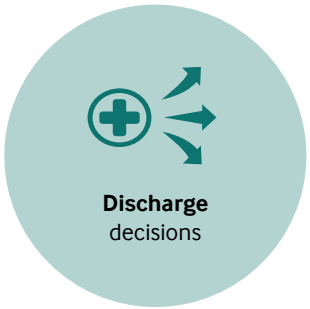
- We make fewer decisions on the weekends and not until 9am on weekdays. This causes a backlog of patients to build up, requiring more beds
- We need to support the decision making to happen sooner to ensure patients are not waiting longer than necessary when deemed medically fit
- Widening the scope and reach of the UH@Home can help support the decision to make patients medically fit sooner and help to bridge the gap between acute and community services. These services can also be used to help prevent patients from needing admission in the first place



- We are still performing assessments prior to discharging patients– this is contributing to delays in pathway 1, 2 and 3
- The IDT backlog is causing a delay after the patient is medically fit for discharge and is the most common reason that someone is waiting to be discharged
- If we were to do this prior to being medically fit, the package of care process could be started earlier – awaiting a POC and awaiting a placement contributed to 22% of all delays. The team can't currently do this due to the backlog of assessments created by the lengthy assessments
- Packages of care can't be sourced until this is completed – can we de-couple this process?

Discharge, Intermediate and Long-Term Care Summary

We have the opportunity to improve our discharge decision making, improve our reablement effectiveness and reduce the number of people leaving hospital with long-term packages of care, resulting in more people achieving their maximal levels of independence



- A third of people going to temporary beds could go home with the correct package of support
- Reduced dispersion of community therapists to non-core provider locations, increasing hours spent with patient
- 140 per year people going home with support rather than to temporary beds during the intermediate period

- Develop a reablement focused service with our partners and care providers
- Increase the effectiveness of reablement by 20%, reducing long term care needs
- Reduce intermediate care exit delays by package step downs, increasing carer capacity and improving independence outcomes for users

- Improving the patient time with physiotherapists who are referred for reablement will improve long-term outcomes for up to 50% of the people in P1
- A combination of discharge decision making and improving reablement effectiveness of P2 patients will result in fewer people going into a long-term residential bed

System **visibility & intelligence**

- Develop data driven culture, frontline teams and management using clear and accurate data to drive their daily decisions, enabling the outcomes above

DRAFT CONTENT

How Will We Know We're Making A Difference?

1

Opportunity Matrix

Throughout the diagnostic, we have spent time calculating the potential opportunities across the system. To understand current performance we have benchmarked a number of variables that are combined to quantify the opportunity to improve outcomes for older people

2

Identify KPIs

For the areas where an opportunity exists, we will identify the important KPI that is impacting the outcome of an older person adversely and we will design our solution to address this specific area.

Our initial design solutions will be focused on impacting this variable.

3

Monitor Performance

Throughout testing our design solution and implementation, we will carefully monitor the impact the design is having on the outcomes for the older person. This will be continually tracked, reported and the design will be iterated and improved to ensure that this continues to improve to an acceptable level

What is Next?

What do we do next?

We want to proceed to implementation initial designs that we can test and iterate to ensure they improve they outcomes for older people as we expect – to do this, we will undertake a bridging/design phase

Diagnostic

We have worked with staff to understand the problems with our current ways of working and **rigorously assessed** what areas we needed to focus on in our transformation

During the diagnostic we've worked to understand each part of the system, specifically on operational opportunities and the environment that colleagues work within

Bridging/Design

Based on the diagnostic findings, we work with operational leads to **design the high priority solutions**

We test this through a **series of practical pilots** ensuring staff can input and future ways of working are **fit for purpose**

We make sure that the programme architecture, future operating models, governance and working processes are **set-up for success**

We make sure the numbers are right and that we are **ready to commit** to the implementation programme.

Implementation

Before roll out, we'll work with everyone to **make sure you're ready** and are provided with the right skills, information and support you need, at the right time

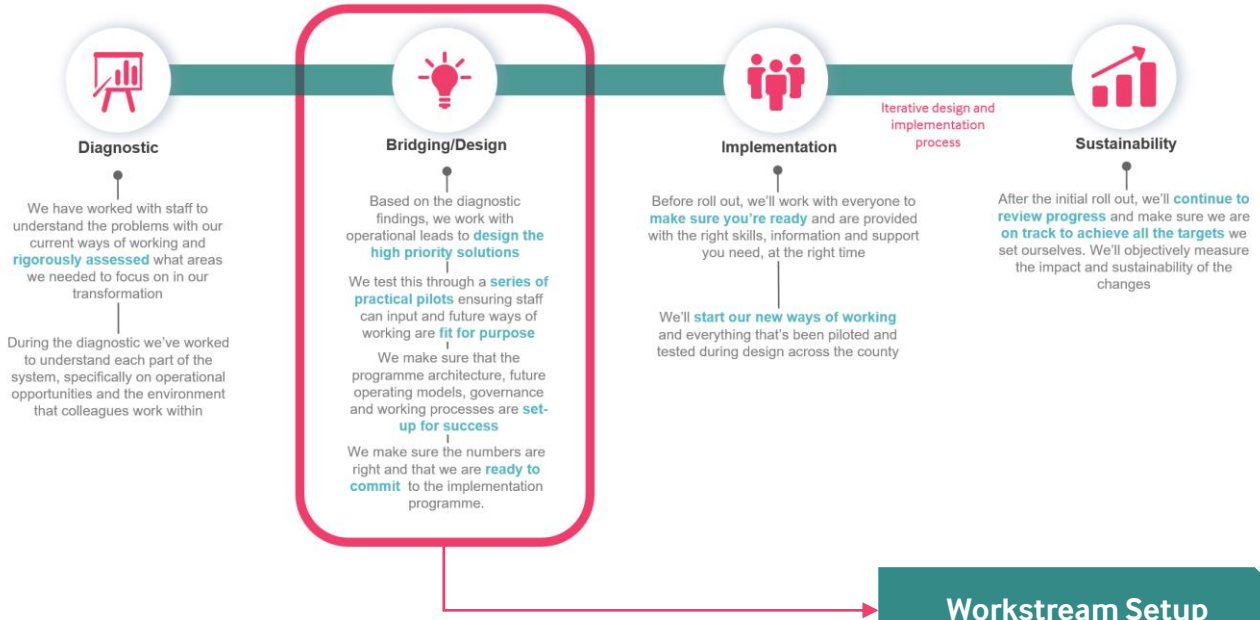
We'll **start our new ways of working** and everything that's been piloted and tested during design across the county

Iterative design and implementation process

Sustainability

After the initial roll out, we'll **continue to review progress** and make sure we are **on track to achieve all the targets** we set ourselves. We'll objectively measure the impact and sustainability of the changes

What do we do next?



The bridging phase will be split up into the following steps:

Workstream Setup	Design Workshops	Design Selection	Test and Pilot Planning
We will spend time breaking down the opportunity areas into workstreams and identifying 'design teams' who will lead the way in creating a solution to improve outcomes for service users	We will host regular design workshops with multi-disciplinary attendees to seek appropriate solutions and new ways of working that will address the opportunity areas	We will peer review these options with front line staff and determine if they are feasible solutions – these solutions will then be taken forward to implementation for piloting	We will plan testing and piloting of the initial design to ensure they deliver the desired outcomes – we can iterate and retest at this point. Successful designs will then be implemented at scale in the next phase

DRAFT CONTENT

People Want To Collaborate And Make Improvements

There are three key enablers to mobilise people for positive change

#1

PROVIDE SYSTEM LEADERSHIP

"If we don't have our directors and executives aligned then it's very difficult to move this working together forwards without it being very bureaucratic, which is how it feels at the moment."

Believe that leaders are aligned on a shared vision for improving the health and wellbeing for older people.

60%

Believe that leaders recognize the challenges colleagues face to make improvements.

#2

ENABLE WORKING ACROSS ORGANISATIONAL BOUNDARIES

People want to collaborate but...

"When you've got business sensitive information it's difficult to know whether you're allowed to share it or not and have those free conversations that would enable better patient care."

45%

...of colleagues get access to information from other organisations.

43%

... of colleagues feel their data-driven decision making is enabled by technology and policies & procedures

"Our biggest challenge is to accept that we need to stop working in an organisational way and start to genuinely cut across our organisational boundaries."

48%

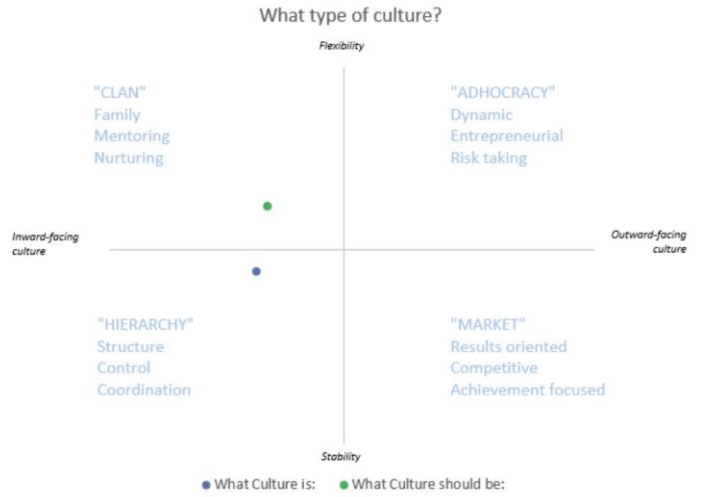
... of colleagues make decisions with people from other organisations

57%

... colleagues trust the data they use to make decisions

#3

FOSTER A CULTURE OF DOING THE RIGHT THINGS WELL & DOING THEM TOGETHER



Colleagues see a future for a more collaborative, nurturing and team orientated culture.

Are People Working Within The System Ready For Change?

We asked people across all organisations in the system how they felt about change

94% Agree that they work force are encouraged by leaders to improve the way they work

83% Agree that they are encouraged to improve they way they work with other teams

82% Agree that a culture of continuous improvement is embraced with the people that they work with

People within the system say they want to improve outcomes for service users and are ready to embrace change!

NHS

University Hospitals Coventry and Warwickshire NHS Trust

Your views invited to shape our organisational strategy for 2022-2030

More than a hospital

More than a hospital – thank you

We've been on an incredible journey over the last few years and achieved so much together in delivering great healthcare. As a Trust our five year partnership with Virginia Mason Institute and the establishment of our improvement system (UHCWi) have given us the tools and techniques to bring about change and deliver improvements to the quality of the care we provide for our patients. The commitment by our staff to provide excellent care was very visible for all to see during 2020/21.

Covid – a springboard for transformation

Responding to the Covid pandemic showed us all the benefit of working in partnership for the people of Coventry and Warwickshire. We were united in the battle against Covid with individuals, communities and businesses - all helping us to make a difference, however big or small.

Reflecting on the impact that Covid had on us as individuals, our families and on those people who are vulnerable, there has never been a better time for us to ensure that we place more emphasis on keeping people fit and healthy. Many people have fed back to us the life changing impact living through the pandemic and their promise to take this opportunity to make long lasting lifestyle improvements.

We need to continue to help build and strengthen resilience within our communities and be more proactive in reaching out and ensuring people can access the services they need. We recognise that we cannot achieve this on our own and are working hard with our partners to create more joined up services to support the health and wellbeing of our population.

Healthcare is changing

The new Health and Care bill published on 6 July 2021 set out key changes to reform the delivery and organisation of health services in England to create services that work together with a strong local focus and fundamentally improve the health and wellbeing of local people not just provide health care services when they are ill. In the near future, we will be increasingly connected to all the health and care organisations in our local area, collaborating more closely to deliver joined up care for our local communities. These new ways of working will be supported by evolving governance, finance and commissioning structures with regulatory oversight from NHS England and Improvement at a system level.

This transition to care that is more proactive, preventative and centred around individuals' needs presents our Trust with significant challenges and opportunities. Effective collaboration with partners is vital to overcoming these challenges and delivering the best care for our patients.

Next steps – building better health together

Our draft organisational strategy 2022-2030 sets out the next part of our journey for University Hospitals Coventry and Warwickshire NHS Trust. Every one of us has an important part to play in this and we really would like to hear your thoughts and feedback as well as give you the chance to shape the way we deliver this. Please take your time to view our survey and video **(see details on the back page of this document)** and let us have your views to help us deliver a better future together. We will share the findings and publish our strategy in April 2022.

Dame Stella Manzie DBE
Chair

Professor Andy Hardy
Chief Executive Officer

1 Rooted in our communities

Leader in healthcare

Our last organisational strategy stated the vision for our organisation to be a "national and international leader in healthcare." It recognised how passionate we are about improving the quality of our care for our patients and being the best we can be. That goal of being the best we can be, continues. However, we want to add to it.

Rooted in our communities

Good health requires more than a hospital or the services within. It requires access to good housing, exercise a healthy diet, meaningful employment and a feeling of belonging and support.

By effectively utilising our considerable resources and influence we can be a major contributor to the good health and wellbeing of our local population. That is why our new vision reflects the new world we are in **"to be a national and international leader in healthcare rooted in our communities".**

For example, as one of the biggest employers in Coventry and Warwickshire, with more than 80% of our staff also living in the area with their families relying on us as an employer we can really make a difference in strengthening the future health of our population now and for future generations.

Collectively we all have a crucial part to play as both employees and residents in actively contributing to supporting the good health and wellbeing of the people of Coventry and Warwickshire.

Ensuring that local integration and being the best is in all we do

Our organisational strategy proposes three interconnected purposes or focus areas for UHCW for the next eight years - **local integrated care; research innovation and training, and being a regional centre of excellence.** In other words we wish to deliver the best care possible for our patients, delivered in a more seamless and integrated way with our health and care partners. Our staff are trained with the latest knowledge and research and they will always strive for the best outcomes for our patients. To help us to deliver the vision and the three purposes, we will have strategies which support quality of care, our people, digital technology and sustainability as we move into the future.

Patient Story

What integrated care will look like

Raj is a 55 year old teacher. Five years ago he had chemotherapy for cancer. He recovered and went back to work.

He has been feeling breathless and fatigued for about six months. It's really affecting his work.

Raj goes to his GP. His symptoms are not telling a clear story but his GP can use the GP data system to link his symptoms to his previous chemotherapy and help make a diagnosis of potential Heart Failure.

Raj's GP books blood tests and an echocardiogram at the local Community Diagnostic Centre.

Raj's results come back and show that he is in Heart Failure. Raj's GP links to the specialist Heart Failure team via the virtual advice and guidance system to discuss his care and organise a review.

Raj goes to the community clinic to see the specialist team who explain his diagnosis and plan. He is offered cardiac rehabilitation and psychological support and is linked into the patient support group.

His diagnosis, management plan and personal goals are documented in the shared electronic record which is accessible by Raj, his GP and specialist team. Raj knows that he can speak to his GP, specialist team or peers at the support group if he has concerns about her condition.

If his symptoms deteriorate he can access the specialist team directly or via his GP.

...Raj has lived with Heart Failure now for ten years. He is still working. There have been times when things deteriorated but he was able to quickly get help. He has never been admitted to hospital for care.

He now leads the patient support group and has used his teaching skills to co-design the education programme for patients with low literacy skills.

A vision for health

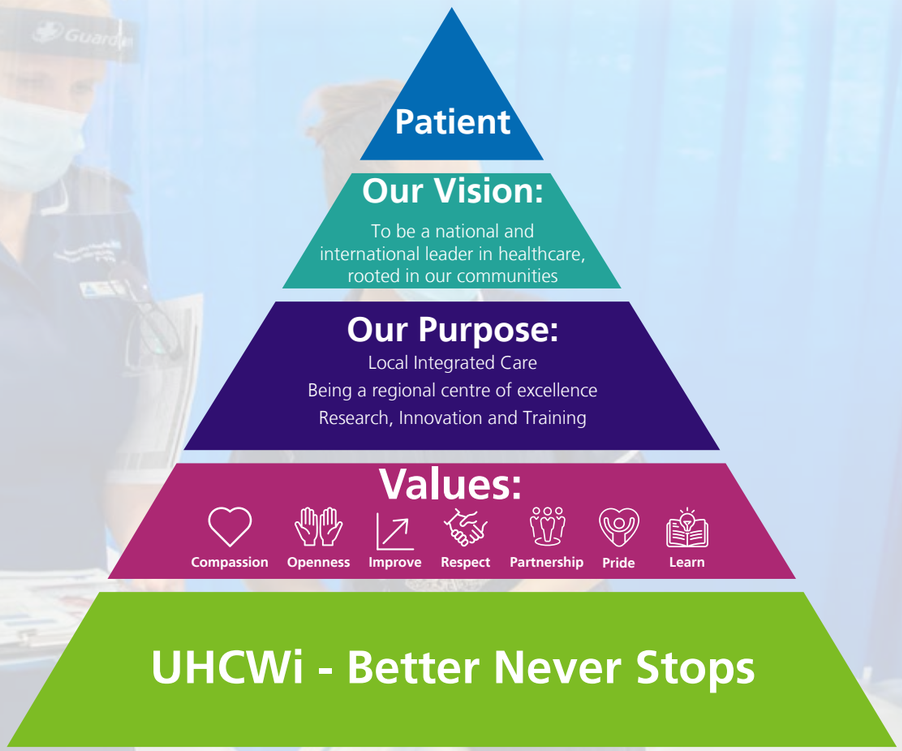
Transforming and improving health for Coventry and Warwickshire requires compassionate and collaborative **leadership**. For UHCW, leadership means supporting those around us to achieve and recognising our partners' strengths so we can all excel. Above all, it means leading the delivery of outstanding, joined up care for our communities.

The diagram below summarises our leadership approach with the patient first in all that we do and how everything we do connects for our care for patients. Our vision captures our ambition to deliver world-leading care for our communities, and our three purposes set out how we will achieve this.

We lead by living our values in every interaction with our patients, people, and partners. We will invest in enabling areas to improve care quality, treatment outcomes, and the experience of patients and their families.

Our commitment to improvement through the use of our UHCWi methodology continues driving us forward as an organisation as we know "better never stops".

Fig. 2.1 Our strategic triangle



3 Our vision, purpose, and values

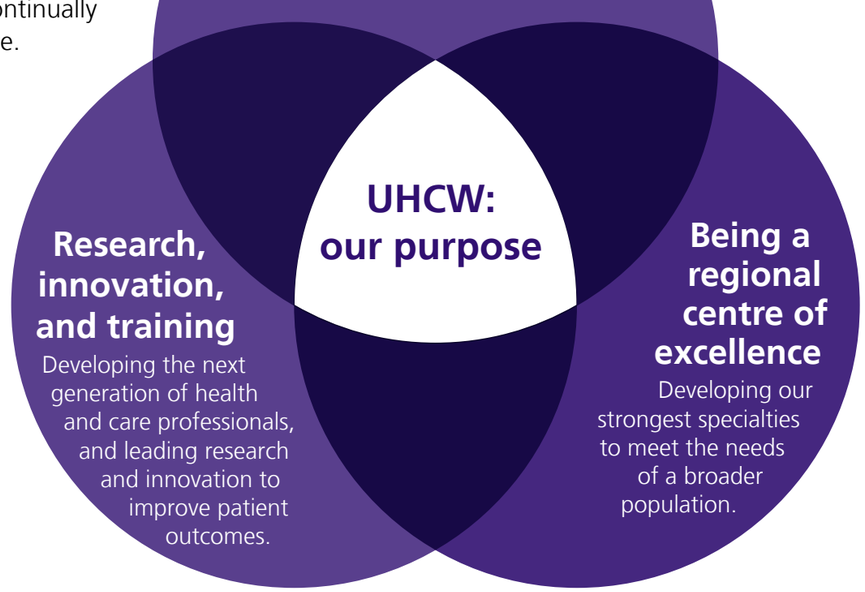
Our Vision

To be a national and international leader in healthcare, rooted in our communities

For UHCW, being a national and international leader means **delivering the best care for our communities.** It means **being exceptional in everything we do** – from providing proactive, joined up support for local people to delivering specialised services for those with the most complex health conditions. It means creating the best experiences and opportunities for our staff, and being a supportive and collaborative partner. Above all, in the changing health and care landscape we aim to be an **outstanding partner in local care**, with our regional work enabling us to improve care quality and outcomes for everyone.

Our Purpose

Our fundamental purpose is to deliver the best possible care for our local communities. We will achieve this by leading in all that we do, with our **three interconnected purposes** enabling us to continually improve local care.



Our Values

Our values reflect the culture we want to live in. Developed by our staff, our seven core values guide what we do daily to achieve what we envision. Whatever our role or level in our Trust is, we commit to uphold these values as we work together to deliver world-class care:

Compassion – We treat everyone with courtesy and compassion.

Partnership – We work in partnership to deliver and improve the services we provide for our patients.

Respect – We treat everyone with respect and dignity.

Improve – We are open to change and seek to innovate to improve what we do.

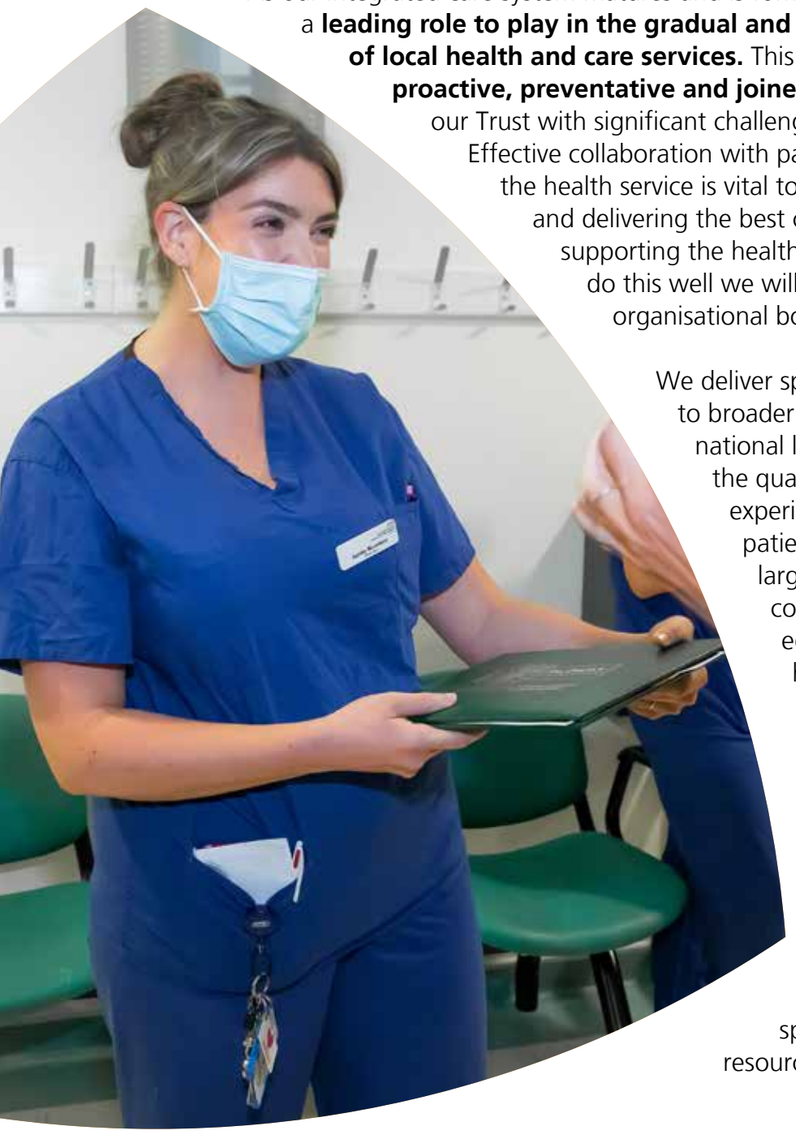
Learn – We see education, research, and innovation as central to improvement.

Openness – We act with openness, honesty and integrity in all we do.

Pride – We take pride in all we do and aspire to do.

So what does this actually mean for us?

Our purpose is evolving. Putting patients first remains at the heart of what we do. Integrating services around patients and communities is both a national and local priority and our role will move beyond providing care for people who are acutely unwell.



As our integrated care system matures and is formalised in April 2022, we have a **leading role to play in the gradual and sustained transformation of local health and care services.** This transition to care that is **proactive, preventative and joined up around people** presents our Trust with significant challenges and more opportunities. Effective collaboration with partners, inside and outside the health service is vital to overcoming these challenges and delivering the best care for our patients whilst supporting the health and wellbeing of our staff. To do this well we will need to work across traditional organisational boundaries and in different ways.

We deliver specialised and acute services to broader populations at a regional and national level, which helps us to improve the quality of care, outcomes, and experience that we deliver for all patients. We are also one of the largest teaching hospitals in the country, and engage in cutting-edge research and innovation that helps us improve everything we do and contribute to the wider health and care system.

Our three refreshed purposes will be used to engage our people, partners, and communities in the new direction we are taking as an organisation. These purposes will determine how our Trust spends its time and focuses its resources and efforts.

Staff stories

Abeesh Panicker, Cardiology Research Nurse has been able to be supported through iCAhRETM – Interdisciplinary Clinical Academic health Research Excellence programme that supports our staff to be the research leaders of the future.

"Going forward my aim is to continue my journey towards a PhD. I am grateful to UHCW and Coventry University for supporting me to complete this programme to the best of my ability and NIHR for their help throughout. Research not only improves patient outcomes and identifies new treatments, but is also a rewarding clinical and academic career which is an option open to all staff within the NHS."

Born in India, **Consultant Smruta Shanbhag** joined UHCW as our Gynaecological Cancer consultant from Glasgow in 2019 where she had been a Consultant for 10 years. She chose to become the lead for Gynaecological cancer as well as Lead for Gynaecology, as Smruta believes that change is driven by clinicians and non-clinicians working together for world class patient care. Her passion for quality of care for her patients and pushing boundaries was seen at first hand on BBC Hospital where she continually sought out any options or treatments that might help her patient Natasha.

"I've been so impressed with the commitment towards trust values, especially those of openness and honesty with patients and colleagues. We feel like a family that strive to work toward a common and highest goal of world class patient care across all services. This is a great place to build a medical career and working as part of a fantastic team of supportive and innovative professionals"

Juliet Starkey joined UHCW in June 1999 as a band two waiting list clerk working part time in her local hospital in Rugby. Twenty-plus years later and continuous progress has seen her become the Group Director of Operations for Trauma and Neuro. Roles along the way have included Orthopaedic Theatre Scheduler, Administration Manager, Ops and Performance Manager and General Manager at Hospital of St Cross, Rugby. Support from the Trust has allowed Juliet to complete the Leading Together programme and an Institute of Line Management course. She is also currently undertaking a Masters of Business Administration. She says they have helped her to develop compassionate leadership and an appreciation for developing the teams she manages.

"I have benefitted from a succession of managers who have supported me in fulfilling my potential,"

4.1 Local integrated care

Our most fundamental purpose is to care for our communities. UHCW is committed to playing an active role in helping people to live happier, healthier lives, as well as providing care for those who are acutely unwell. UHCW will work closely with health and care partners to provide proactive, joined up care to local people – delivered with world-leading quality. A vital part of this will be tackling health inequalities, addressing underlying health factors and reducing variation in our services.

Focus areas	Actions
Integration. Integration puts people rather than organisations at the centre of care. This helps improve the quality of care, outcomes and makes the best use of resources. We will support health and care organisations across our system to deliver joined up services for our communities.	**To integrate care, we will:** • Work with healthcare partners and form multidisciplinary teams to make joint leadership decisions. • Work together to plan how we improve services and share information collaboratively.
Population health. We will work together with partners to design and deliver services that prevent ill health, improve patient outcomes and wellbeing. We are focused on proactive care, and prevention approaches that make a difference to individuals and the population as a whole.	**To improve the health of our population, we will:** • Facilitate data sharing and analysis to develop a clear picture of our population's health needs. • Work with partners to change what we do, to support the health needs of local people better. • Develop a strategy for how we can best utilise our Hospital of St Cross, Rugby site.
Health inequalities. Good health is affected by wider factors such as housing, access to education and employment. With partners, we will take action to address these and ensure our services are accessible to everyone. We will tailor health and care services to meet the needs of deprived communities.	**To overcome health inequalities, we will:** • Work with partners whose roles influence local people's health for example in housing and education. • Look at how we could change services to ensure patients get consistently good quality services which overcome inequalities.

What we want to achieve	Patient experience
For our patients: • Local people should live longer, healthier lives, supported by effective, joined up services. • Improve outcomes by timely support in areas such as diabetes, cancer, smoking and obesity. **For our people** • A sustainable workforce equipped to provide the best care. • Opportunities to work across other organisations, strengthen relationships and gain new skills. • More satisfaction from delivering holistic, joined up care that helps patients to stay well. **For our organisation:** • Leading collaborative work with our partners in integration, population health and health inequality. • Embedding multi-disciplinary teams across services and areas.	**Our patients will:** ✔ Experience responsive and proactive services: where we can to reduce the number of patients getting ill. ✔ Have timely access to the right care, in the right place, at the right time. ✔ Experience holistic care and support that considers their emotional and wellbeing needs. ✔ Have the confidence that wherever care is provided, people will understand and meet their social, emotional, and health needs. ✔ Only need to tell their story once, because our local health and care services are joined up seamlessly around patient needs.

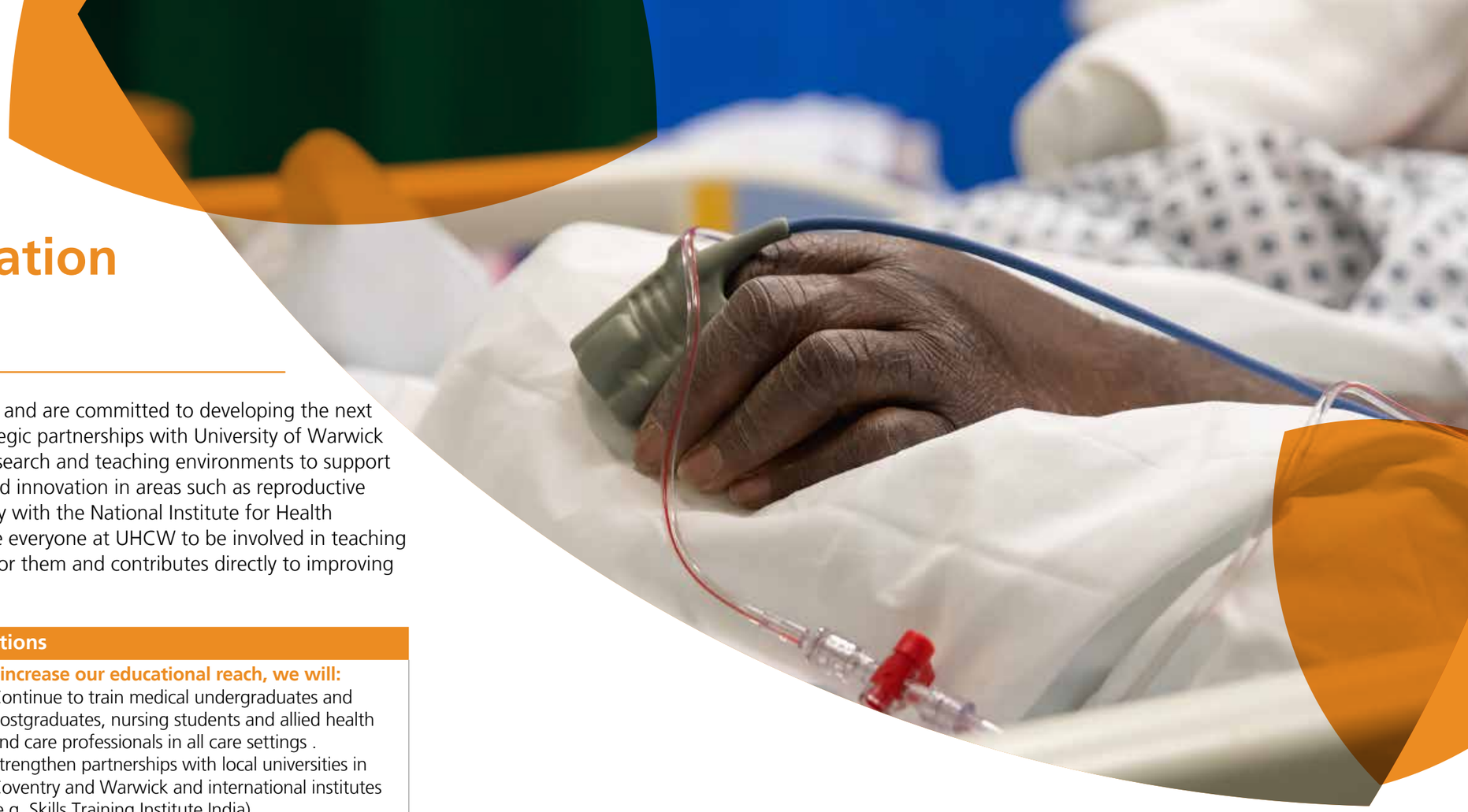
4.2 Regional centre of excellence

Providing regional acute and specialised services is vital for improving care quality and outcomes for a broader patient population. To do this successfully, we need an evidence-based understanding of which services we can offer to patients at a regional level based on excellent treatment outcomes and strong operational performance. We also need to further develop strategic partnerships with other regional acute providers so we can work together to meet the health needs of a broader population across our region.

Focus areas	Actions
Develop our strengths. We deliver a number of regional specialist services that we are proud of and wish to build on. To make strategic decisions about which services we deliver for our region in the future, we need to establish clear evidence for our capacity and ability to achieve outstanding outcomes.	**To develop our strengths, we will:** • Analyse our patient outcomes and operational performance for high performing specialties, and benchmark against other NHS trusts to help us deliver the best outcomes for patients. • We will model the demand and identify gaps to meet the needs of patients to inform our developing services for the future, wherever they need to be. • Collaborate with regional partners to embed hub and spoke models for selected specialties.
Meet a broader population's needs. UHCW is in a unique position to serve multiple geographies at system and regional level. By understanding the needs across these areas and through partnerships, we have the potential to deliver even more specialised care across the Midlands.	**To meet a broader population's needs, we will:** • Conduct analysis to understand which populations depend on our services. • Establish regional agreements that set out which services each organisation will lead on. • Collaborate closely with primary care networks to streamline referrals.

What we want to achieve	Patient experience
For our patients: • Local and regional patients will have consistently excellent health outcomes. • Patients with highly complex conditions will achieve the best possible outcomes from treatment. **For our people we will provide opportunities:** • To develop in specialised areas and build a career with us and our partners. • To work with regional partners and different communities of patients. **For our organisation:** • Attract and retain the best talent to build a culture of excellence. • Improved productivity and operational performance. • Be a regional leader that recognises partners'. strengths and learns from them, to support our service improvement.	**Our patients will have:** ✔ Timely access to the best specialised treatment. ✔ Seamless, joined up services that maintain excellent communication with their closest health and care organisations. ✔ More appropriate choice in where and how they receive care, including in satellite outpatient settings close to their homes and virtually where appropriate. ✔ Dedicated support for families and visitors. ✔ Interactions and processes that are clear, straightforward, and instil confidence in our ability to deliver excellent care.

4.3 Research, innovation and training



We are one of the country's largest teaching hospitals and are committed to developing the next generation of health and care professionals. Our strategic partnerships with University of Warwick and Coventry University enable us to have the best research and teaching environments to support our staff. We are involved in cutting-edge research and innovation in areas such as reproductive health and human metabolism, and collaborate closely with the National Institute for Health Research (NIHR) to deliver this. We want to encourage everyone at UHCW to be involved in teaching and research at scale and in a way that makes sense for them and contributes directly to improving patient outcomes.

Focus areas	Actions
Expand our educational reach. Alongside our core teaching activities for students and trainees, we will play a greater role in training health and care professionals in all settings. We will enhance our learning offering to students, and invest in providing this education to a wider audience abroad.	**To increase our educational reach, we will:** • Continue to train medical undergraduates and postgraduates, nursing students and allied health and care professionals in all care settings . • Strengthen partnerships with local universities in Coventry and Warwick and international institutes (e.g. Skills Training Institute India). • Invest in digital virtual learning.
Develop a learning health system. A learning health system continuously analyses data which is collected as part of routine care to monitor outcomes, identify improvements in care, and implement changes. Our UHCWi improvement methodology enables us to do this through embedding a culture of continuous learning and improvement. We will use this approach to help us drive innovation forward in our organisation, and across our local system.	**To develop a learning health system, we will:** • Continue to embed our UHCWi methodology and share learning from this across our system. • Provide ongoing learning opportunities for all our people, focused on using data to generate evidence-based improvements.
Broaden and develop research areas. Much of our current research is in clinical areas connected to our strongest specialties and through our pioneering Centre for Care Excellence (CCE). Our CCE will help us champion clinical academic careers and leadership development in nursing and Allied Health Professions. We will continue to advance in this, while broadening our research to include areas such as quality improvement, innovation, and organisational design.	**To broaden and develop research areas, we will:** • Promote research excellence for all staff. • Develop institutes of excellence, in line with our emerging R&D strategy. • Become a Biomedical Research Centre (BRC). • Increase awareness by publishing papers, attending conferences, and applying for awards.

What we want to achieve	Patient experience
For our patients: • Improved care quality and better treatment outcomes. **For our people:** • Continuous learning, development, and leadership opportunities for all. • Opportunities to innovate and experiment in a supportive environment. • Increased satisfaction from delivering successful, cutting-edge treatments for patients. **For our organisation:** • Strong national and international reputation for teaching, research, and innovation. • Increased ability to attract students and professionals in all health and care disciplines. • Greater ability to attract investment for continued research and innovation.	**Our patients will benefit from:** ✓ Access to clinical trials and experimental treatments that may not be available elsewhere. ✓ Continual improvement in the quality of services and care experiences. ✓ Care from highly motivated professionals who strive to deliver the best treatment. ✓ Digital and technological innovations that will streamline care interactions. ✓ Feeling involved in every aspect of what we do, and know that their voice influences our services and the way we deliver care. ✓ Additional education resources.

5 Enablers

Our ability to deliver outstanding care is dependent on how we **improve quality, support our people, invest in digital technology and data insights, and promote a sustainable future.** These cross-cutting enabling strategies relate to our three interconnected purposes of local integrated care, being a regional centre of excellence and research, training and innovation.

5.1 Quality

The primary purpose of the NHS, and everyone working within it, is to provide a high quality service, free at the point of delivery to everyone who needs it. As such, achieving high quality care is the foundation to everything we do. However, achieving this standard is not an easy task; quality is a moving target. Continuous improvement in quality means that what is considered an acceptable quality today may not be acceptable next year. Our Quality Strategy therefore outlines a journey towards providing exceptional safe, clinically effective care experienced through a way in which our patients wish to be cared for. To meet these ambitions we will focus on a number of key themes:

Embedding a culture of Continuous Quality Improvement: Utilising the UHCW improvement system (UHCWi being a system of tools and techniques based on lean principles and continuous improvement), we will continue to focus on a culture within UHCW that enables clinicians to work at their best and to have in place arrangements for systematic learning, measuring and monitoring quality at all levels (within and outside of the hospital setting), whilst having capacity for innovation and improvement.

Making a real difference to clinical outcomes for our population - Our long term aim is to achieve the best and most equitable clinical outcomes for the population we serve and this will require us to not only focus on how we improve the quality of our core services, but thinking beyond our hospital walls, will require us to explore the quality of care at a pathway level across acute, community and primary care settings.

Improve the experience of patients and their families who use our services: To ensure that patients continue to be right at the heart of all we do, we need to build upon and spread what our patients and carers value. To achieve our commitment to deliver exceptional care, we will involve and use the experiences of our patients, carers and other advocates to shape the provision of our services.

5.2 Our People

Our people define UHCW and are vital to the care we deliver and the outcomes we achieve for patients. Our Organisational Development, Workforce & Innovation Strategy is to be redeveloped and will include a People Strategy – to **transform our culture, and make UHCW a great place to work** remains relevant.

We have focused on two areas:

- **People** – supporting staff on every step of their journey to reach their potential and deliver the best patient care. This involves enabling continuous learning, development and progression, flexible working, and proactively supporting their health and wellbeing. We are a values- based organisation, committed to attracting and retaining the best people who reflect our communities.
- **Culture** - creating an environment where staff feel empowered and supported to make decisions and deliver change. This involves embedding a culture of coaching, learning and inclusivity where equality and diversity (including of skills, knowledge and experience) are celebrated. It is underpinned by our UHCWi improvement system.

As we deliver, we will focus on supporting our people in the following ways:

Local integrated care	Regional centre of excellence	Research, innovation and training
✓ Explore flexible workforce models, including shared roles and cross-organisational multidisciplinary teams. ✓ Help increase people's skills, e.g. in population health analytics.	✓ Support health and care professionals to deepen their expertise in our regional services. ✓ Empower people to build relationships at a regional level.	✓ Embed teaching and learning opportunities for all our staff. ✓ Recruit nationally and internationally to support UHCW's long term sustainability.

5.3 Digital

Digital technology and advancements in the way we use data to help us plan services more effectively, will inform how we deliver healthcare in the future.

Our Digital Strategy sets out five principles for transforming the way we enable and deliver care, notably focussing on:

- **Patients:** Patient led care through Digital Empowerment
- **Population health:** Digitally supporting Integrated Care and Population Health across the system
- **Staff:** Provide outstanding experience for all staff using digital technology
- **Quality:** Enhance Patient care through an integrated Electronic Patient Record solution
- **Value:** Drive standardised efficient processes through the use of innovative technology including AI and automation

Local integrated care	Regional centre of excellence	Research, innovation and training
✓ Implement an integrated Electronic Patient Record (potentially system wide) that allows seamless access to patient health information for all clinicians. ✓ Enable integrated digital pathways with full secure data sharing between clinicians and social care. ✓ Enable patients to take control of their own healthcare with digital access to their records, remote monitoring and self-care tools. ✓ Minimise inequalities by supporting our population to optimize digital and health literacy.	✓ Improve the way information flows for more specialist services. ✓ Use technology to support relationships with regional acute and primary care providers for data sharing. ✓ Deliver solutions that enable care closer to people's home. ✓ Support our people to deliver care remotely where appropriate. ✓ Optimise the ICT infrastructure to maximise effectiveness of digital solutions and staff workflows.	✓ Maximise and improve the use of technology to delivery benefits and standards of care and patient outcomes. ✓ Use technology to expand our educational reach, for example streaming robotic surgery to students across the world. ✓ Maximise use of data and AI to enable world leading research. ✓ Invest in innovative technology and systems to be a leader in healthcare. ✓ Enhance our staff experience by investing in digital skills.

We will be investing in an outstanding, secure and resilient infrastructure (including cyber security), and processes that are easy for staff and patients.

5.4 A Sustainable Future - clinical, environmental, and financial

Building a sustainable future for our Trust involves a holistic consideration of clinical, environmental, and financial factors. We are a major 'anchor' organisation, part of the long term fabric of Coventry and Warwickshire. We must play a positive and sustainable contribution to the local economy as well as influencing health and well being of individuals and communities.

Our 2018 Finance Strategy sets out how we are prioritising reducing costs by removing unnecessary processes and maximising value in service delivery. This will also include a clear plan to address future capital investment needs for responsive services that offer the best outcomes for patients. As we move to being part of a formalised integrated care system, we will consider **financial sustainability on a wider scale** – NHS England and Improvement will assess the combined financial performance of health and care organisations in Coventry and Warwickshire. We will need to consider environmental sustainability at both organisational and system levels. Building on our membership of the Coventry and Warwickshire Anchor Alliance, we will continue our joint work around minimising the impact we have. Ensuring we achieve our net zero carbon commitment by 2045 as we develop our refreshed strategy. We will also consider how our ambitions can contribute to **clinical sustainability**:

Local integrated care	Regional centre of excellence	Research, innovation and training
✓ Focus on collaboration, integrating services, and proactively managing the health of our communities will help us be more clinically sustainable. ✓ Optimise the skill mix across our people by innovative approaches e.g. role substitution and skills enhancement.	✓ Collaborate with partners to organise certain services at a regional level will contribute to our clinical sustainability. More specialised services require a critical mass of patients and health and care professionals to be viable, and are best delivered across a wider geography.	✓ Train the next generation of health and care professions. ✓ critical research areas means we are contributing to the local and national sustainability of health services.

6 Your Views

Thank you for reading our draft organisational strategy for 2022-30. We hope you like what you have heard and we encourage you to let us know your views to help inform in our work. This is our future together.

We have a quick online survey for you to offer your feedback. This should take no more than five minutes to complete. Additional information is also available in our special video outlining why we are so much more than a hospital.

Take our survey

View our video

We will publish our final strategy in April 2022 including a summary of feedback we have received.

If you have any queries about this strategy please email **Strategy@uhcw.nhs.uk**

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 4th April 2022**

From: Kirston Nelson, Chief Partnerships Officer

Title: Coventry and Warwickshire Place Forum Update

1 Purpose

1.1 This paper updates the Health and Wellbeing Board on the outcomes of Coventry and Warwickshire Place Forum meeting held on the 9 March 2022.

2 Recommendations

The Health and Wellbeing Board is asked to:

1. Note the contents of the report and the next steps and actions resulting from the Coventry and Warwickshire Place Forum meeting held on 9 March 2022; and
2. Endorse the proposed arrangements for the 'Place Forum' going forward (section 5).

3 Coventry and Warwickshire Place Forum meeting, 9 March

3.1 An online development session for Coventry and Warwickshire Place Forum (the two Health and Wellbeing Boards) was held, with around 40 members attending. The meeting was chaired by the Health and Wellbeing Board chairs, Cllr Margaret Bell and Cllr Kamran Caan, and facilitated by Nigel Minns (WCC) and Kirston Nelson (CCC).

3.2 This was the last meeting of the Place Forum in its current guise, pending the new statutory governance arrangements to be established for the Integrated Care System. It was an opportunity to reflect on the Place Forum journey to date and share proposals for future arrangements. It was noted that the Place Forum – which has been meeting since December 2017 – has laid the groundwork for the new statutory Integrated Care Partnership.

3.3 A number of presentations were shared and discussed, as outlined below.

3.3.1 ICS update – Statutory Integrated Care Partnership: An update on progress in the transition to a statutory ICS and proposed governance arrangements, including recommendations for the new Integrated Care Partnership reflecting feedback from the previous meeting of the Place Forum and its role in developing an Integrated Care Strategy for the ICS.

3.3.2 Health and social care integration – joining up care for people, places and populations: Reflections on this recently published White Paper on health and social care integration at place level, and its implications for Coventry and Warwickshire. The scope of White Paper covers proposals on: shared outcomes; leadership, accountability and finance; digital and data; and the health and care workforce and carers.

3.3.3 System Health Inequalities Plan: An update on progress with the 5 year strategic inequalities plan for the ICS that is a requirement of NHS England. Feedback from the separate Health and Wellbeing Boards on early proposals is addressed in the latest iteration of the plan. The plan has a particular health and care system focus, in the context of wider system action around the population health model. A draft plan must be submitted to NHSEI by the end of March, with final submission by end of April.

3.3.4 Digital Transformation Strategy: A presentation on the draft ICS strategy for data and digital transformation, which is currently subject to consultation. Coventry and Warwickshire is working with NHSX as a national trailblazer for creation of a system-wide digital strategy. Members discussed the value of integrated data in generating actionable insights and the opportunities to improve population health through joined up data and digital healthcare delivery. Concerns around digital inclusion and implications for the workforce were shared.

3.3.5 Healthy Communities Together programme update: A partnership between Grapevine Coventry and Warwickshire, CWPT and Coventry City Council, is one of 4 partnerships to be funded through this national programme (led by The King's Fund and the National Lottery Community Fund). The programme is about tackling health inequalities through changing the way services and communities connect in order to give people the best chance of getting and staying well. It is testing a new model of collaboration, centred on the lived experience of an individual.

3.3.6 Developing our ICB Community Engagement Strategy: NHSEI requires the ICS to have an overarching framework in place to support engagement activities and show how we will involve and empower people and communities. This is core to the ICS vision of "putting people at the heart of everything we do". Members discussed the importance of listening to communities if we are to shift to meeting need instead of responding to demand. A proposal to establish an ICS-wide Involvement Network with a wide range of partners was welcomed.

3.3.7 Suicide Prevention Strategy consultation: The presentation shared learning from work across Coventry and Warwickshire as part of the national suicide prevention programme, as well as plans for a joint strategy, delivery plan and partnership arrangements to take this work forward. A proposed vision and high level approach to the strategy were shared, with consultation details to be shared in due course.

4 Key actions

4.1 The following actions were proposed for partners:

- Share feedback on proposals and engage in further development of ICS at system and place
- Commit to ongoing engagement and participation in the renewed 'Place Forum'
- Champion and support embedding the Inequalities System Plan in your organisation and partnerships

- Support and champion the system approach to involving and engaging individuals and communities across Coventry and Warwickshire
- Respond to consultation on and promote the Digital Transformation Strategy
- Share feedback on proposals for developing the Coventry and Warwickshire Suicide Prevention Strategy and take opportunities to support suicide prevention activity across and within system partners.

5 Proposals for future of Place Forum

5.1 Further to discussion at a private development session of the Place Forum in November, specific proposals were made regarding the future of the Place Forum in the context of the new statutory Integrated Care Partnership, to be in place from July 2022. These include:

- Name proposal: C&W Integrated Health & Wellbeing Forum
- Purpose of Forum: advisory role for the ICS and to reflect community voice from across C&W
- Initial membership: Health and Wellbeing Boards (and Exec); ICP members; Care Collaborative and Place reps
- Meeting frequency: 3 times per year

5.2 Feedback was invited on these proposals, and the Board is asked to endorse these arrangements, subject to further development over time.

6 Next steps

6.1 It is proposed that the statutory Integrated Care Partnership (ICP) will be established and meet in shadow form in May 2022, beginning with early work on the Integrated Care Strategy.

6.2 Once the membership of the ICP is confirmed, the first meeting of the newly established C&W Integrated Health and Wellbeing Forum will be arranged for June / July 2022.

6.3 The Integrated Care Strategy must be approved by the ICP by December 2022.

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Appendices
None