Coventry and Warwickshire
Health and Care Partnership

OUR STRATEGIC FIVE YEAR HEALTH AND CARE PLAN

2019/20 – 2023/24

Coventry and Warwickshire Health and Care Partnership
VERSION – 26TH SEPTEMBER 2019

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EXECUTIVE SUMMARY

Since 2016 when our previous 'Better Health, Better care, Better Value' plan was published, much has happened across Coventry and Warwickshire. We have invested in health and care services, strengthened our partnerships and relationships, and continued to make improvements in care for the one million people we serve.

Our vision is that '***We will do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people at the heart of everything we do.'***

We believe that each of our residents deserves to:

- Lead a **healthy independent and fulfilled life**
- Be part of a **strong community**
- Experience **effective and sustainable health and care services** when they need them.

To achieve this vision and deliver the NHS Long Term Plan (LTP) commitments, additional money will be coming into our system over the next five years. We will use this and our existing resources to respond appropriately to rising demand for health and care services from our growing and ageing population.

Prevention will be at the centre of everything we do. We will invest to promote health and wellbeing. Through a strategic and targeted approach to earlier intervention, we will make it easier for people to lead healthy lives and stay well for longer. The early years are particularly important, and we will work with partners to give every child the best possible start in life.

Our approach to **Population Health** focuses on all of the factors that affect health and their impact on health outcomes. This includes education, affordable and appropriate housing, stable employment, leisure opportunities and a healthy environment. We will build on the work of our Health and Wellbeing Boards and the Year of Wellbeing 2019 to ensure that these determinants are tackled and that associated inequalities are reduced.

The further development of **Primary Care Networks (PCNs) and our Integrated Community/Neighbourhood Teams** are at the heart of our plans. Building on our 'Out of Hospital' programme, these teams will focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment in their own homes when and where they need it. We will also improve the responsiveness of crisis response services and work to achieve closer integration with social care.

Demand for **Urgent and Emergency Care** continues to rise and improving access to appropriate care and early interventions will be critical to meeting and managing demand. Our vision is to simplify our UEC offer and deliver a fully integrated networked response so that the most appropriate care can be given as quickly as possible. We will support patients, their families and carers to do as much as they can for themselves and improve primary care access and pre-hospital urgent care. We will also reduce unnecessary, harmful stays in hospital through increasing same day emergency care and improving timely discharge.

We will deliver a step change in **Mental Health** services by focusing much more on prevention, early intervention and supporting more people to actively participate in their own self-care, wellbeing and recovery. We will ensure timely access to high quality appropriate specialist services when needed, delivered wherever possible in the communities where people live. Improving mental health services for children and young people is a particular priority.

Mental health services will be delivered as locally as possible through our neighbourhood teams, with a commitment to reduce and ultimately remove the need for patients to be treated outside of our area (Out of Area Placements). We will build on our recent improvements to services and support for people with learning disabilities and autism and increase the number of patients cared for locally in their communities.

We will identify more people at risk of **Cancer** earlier and undertake more community-based screening. We will treat cancer patients more quickly in order to improve survival rates and increase the overall experience our patients receive throughout their diagnosis and assessment, their treatment and then living beyond a cancer diagnosis and treatment.

Following extensive engagement with local people, we have commenced a programme to consider how we respond to the changing needs of women, babies, children and young people. Initially, this work will enable staff working in **Maternity and Children's Services** to consider how their services can be most effectively be delivered to improve health outcomes, quality, and patient experience in the context of the existing health inequalities, workforce, estate and financial constraints.

The final phase of our redesign of **Stroke** services will take place over the next 12 months, with implementation of a new agreed model, once public consultation is concluded, evaluated and considered. We are also committed to ensuring other major health conditions such as CVD, diabetes and respiratory disease deliver the LTP commitments.

In order to improve efficiency and value for money, we will implement a number of system-wide **Service Improvement Schemes,** which will look to redesign diagnostic and outpatient services, streamline and modernise radiology and pathology services, improve the productivity of surgical services to reduce waiting times, deliver more care inside the NHS and optimise medicines management. These measures will contribute to us achieving financial sustainability.

We will exploit the opportunities offered by technology (including the introduction of an Integrated Care Record) to support people in managing their own health and care needs in the community. We see our system estate as a key enabler to successful delivery of locally delivered, integrated care and we will work with local authorities to maximise the value of the estate.

To deliver our plan, we have reviewed our system governance arrangements and introduced a new Partnership Board - a mechanism for collaborative action and common decision-making for those issues which are best addressed on a wider scale. The Board is strongly aligned to and heavily influenced by the Health and Wellbeing Boards Concordat and our emerging Strategic Framework. Our Local Authorities are heavily involved in these arrangements.

Within each of our four Places (Coventry, Rugby, Warwickshire North and South Warwickshire), local partnership arrangements are being established that ensure all stakeholders including Local Authorities, voluntary and community groups, NHS commissioners, acute and mental health providers, GPs and other primary care providers and patients and the public have an input into how we progress as a health and care system.

We appreciate the importance of whole system clinical leadership and engagement in delivering our vision. Our Clinical Forum provides clinical advice and expertise to all our workstreams, with clinicians leading our programmes. It ensures the voice and ideas of clinicians, from a range of professions and organisations, lead the development of new clinical models.

Our three CCGs and our Local Authority colleagues are working closely together to consider how they become a leaner and more strategic 'commissioning function'. Our Provider Alliance is working

to share expertise, knowledge and skills and draw on the strength of partners to redesign delivery and develop new models of care.

We recognise the role of Healthwatch, the Voluntary Sector, charities and others in supporting us engage with our communities and citizens to better understand their needs and seek their views. We also acknowledge the critical role of carers and any redesign we consider will be underpinned by a commitment to give people more control over their own health and an ability to co-produce and then fully engage to develop our future plans.

Fundamental to delivering our vision is our workforce. A high priority is to attract, develop and retain a workforce that will be supported and trained to work differently in the future. This requires a profoundly different approach to addressing our challenges and exploiting new ways to utilize the skills staff offer, enabling all to reach their full potential.

This plan outlines our collective ambitions as well as our remaining challenges and how we will overcome them. It also reinforces our commitment and contribution to delivering the NHS Long Term Plan and to ensuring that the additional funding we receive will be invested in the things that matter most, from providing safe and high quality treatment and care to reducing pressure on our staff, investing in new technologies and to adopting a population health approach in order to improve the outcomes for our patients and communities.

1. INTRODUCTION

Since 2016 when our previous 'Better Health, Better care, Better Value' plan was published, much has happened across Coventry and Warwickshire. We have invested in health and care services, strengthened our partnerships and relationships, and begun to make improvements in care for the one million people we serve.

Some of the key achievements that have been delivered since 2016 are:

- We have made a good progress in terms of our **prevention** agenda. The Year of Wellbeing (2019) has proved to be a catalyst for change, galvanizing effort and celebrating and extending existing work on prevention and early intervention, with a specific focus around workplace wellbeing, physical activity and mental wellbeing / social isolation
- With regards our commitment to planning for **population health,** new place-based and asset-based Joint Strategic Needs Assessments (JSNAs) have been rolled out. These underpin emerging work to develop and embed population health management approaches across our system, to enable better understanding of our population and more effectively target interventions to reduce inequalities.
- Good progress has been made with regards **Urgent and Emergency Care** services - on average, there are 6,000 (22.6%) more patients seen across the system within 4 hours each month, compared to 2016; the proportion of patients admitted and discharged on the same day has increased from 29.7% to over 32.4% over the last year; the number of patients in hospital over 21 days has fallen from 7.3% to 5% in the last year; the average length of stay for emergency patients admitted has fallen from 6.1 to 5.1 days; the proportion of patients discharged into nursing homes has fallen from 2.5% of discharges for those over 65 to less than 1%.
- Our **Mental Health** workstream has demonstrated improvement - the Improving Access to Psychological Therapies (IAPT) Service has seen an increase of 996 people between 17/18 and 18/19 and by the end of 19/20 we are forecasting 18,546 people will have accessed this service; our Perinatal Mental Health service saw 4051 women in total since 2018 and by the end of 19/20 it's forecasting it will have seen an additional 1130. Since 2016, the AMHAT services based at University Hospital Coventry and Warwickshire, South Warwickshire Foundation Trust and George Eliot Hospital have supported 13,683 people with acute mental health needs (a 50% increase since service commencement) and the Community Crisis Home Treatment Teams have supported 30,670 people in the community since 2016 an increase by almost 9% over a three-year period.
- With regards to our **Maternity and Paediatric** services there has been a 23% reduction in the number of stillbirths across Coventry and Warwickshire and 17% of women now have access to the same midwife throughout their whole end to end maternity experience.
- A 20% reduction in people with **Learning Disabilities or Autism** in mental health hospitals since March 2016 including a 67% reduction of children in CAMHS Tier 4 beds; 40% fewer adults in secure services due to people being discharged to the community or transitioned to less restrictive hospital environments; and a 16% reduction in people with hospital stays over 5 years; and no admissions to secure services for adults since December 2017

There are also noticeable improvements with regards to the population's health and wellbeing since 2016:

- The smoking prevalence in adults (18+) has reduced from 16.3% to 15.9% across Coventry
- Conceptions to girls aged under 18 has reduced from (rate per 1,000 girls aged 15-17) 26.6 to 22.6 in Coventry and from 18.7 to 17.5 in Warwickshire
- The under 75 mortality rate from cancer considered preventable (age-standardised rate per 1000,000 population) has decreased from 90.1 to 84.9 in Coventry and from 131 to 128 in Warwickshire

- Breastfeeding initiation has increased from 76.4% to 78.3% in Coventry
- A good level of development at age 5 has increased from 65.4% to 67.7% in Coventry and the percentage of pupils achieving a GCSE at grade 9 to 5 in Maths and English has increased from 48.1% to 48.7% in Warwickshire
- The percentage of 16-17 year olds who are not in education, employment or training or whose activity is not known has reduced from 6.8% to 5.4% in Coventry and from 6% to 3.8% in Warwickshire
- Female Healthy Life Expectancy has remained stable at 66.2 years over recent years (compared with a national decline to 63.8 years)
- Those in employment has increased steadily over the last 5 years in Warwickshire which now places it above the national average.

Since 2016, the system has also made significant improvement with regards to ensuring the investment we make in heath and care is more efficient and effective and we can financially sustain the services we provide. Growth in activity and associated costs have been higher than expected. However, between 2016/17 and 2018/19 the system **has reduced our overall system costs by more than £300m** across the NHS organisations. This has been achieved by delivering schemes that focus on removing waste from the system, optimising the use of medicines and reducing the need for high cost, premium rate workforce (agency spend).

We all acknowledge that when we published our previous 'Better Health, Better Care, Better Value' plan, the approach we took wasn't the most beneficial for our system. We have learnt from this experience and this time around have ensured that the plan we have developed is clinically led and locally owned. To achieve this, we have engaged and consulted widely with our patients, our staff, our partners and our communities to ensure that everyone across our system recognises and is bought into what we are trying to achieve.

Working more collaboratively with our partners including NHS organisations, local authorities, primary care, voluntary, community and social enterprise groups, NHSE/I, Healthwatch, the police and the fire services has already unlocked fresh thinking, better integration and more effective service delivery. We will do everything we can to continue this collaborative approach.

2. OUR VISION

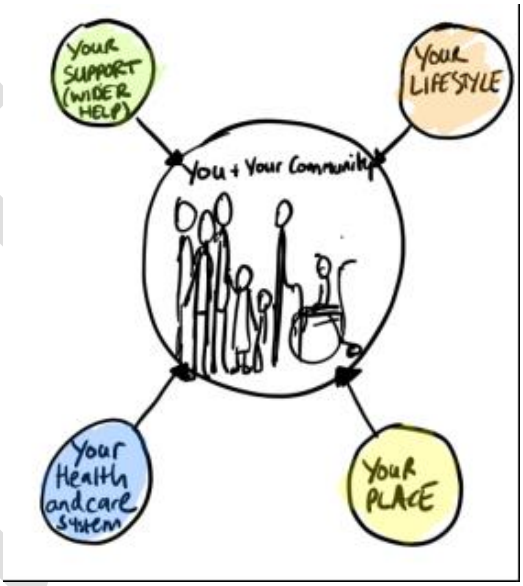
One Health and Care Partnership, Two Health and Wellbeing Boards, Three Outcomes, Four Places

There are a million reasons to be ambitious about living a healthy and fulfilling life in Coventry and Warwickshire. Together, as organisations working to improve health and wellbeing, we share a common vision:

We will *do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people at the heart of everything we do.*

We believe every single one of our one million residents deserves to:

- **Lead a** *healthy, independent and fulfilled life*
- **Be part** *of a strong community*
- **Experience** *effective and sustainable health and care services*



Over the last three years we have been working together on this vision. We now want to use it to change the way we understand population health, prevent illnesses and design services to meet people's often increasingly complex needs over the next 5-10 years.

The NHS Long Term Plan will be a catalyst for change in Coventry and Warwickshire, but we aren't stopping there.
We will look at our health and care services and wider factors that can impact living a heathy, independent and fulfilling life. We will be linking up our Five-Year Plan to both of our refreshed local Health and Wellbeing Strategies.

We have been listening to what local people and our staff have been telling us about what is important to them, and that is now driving a new way of working. Our first important step is the creation of a new Heath and Care Partnership Board, which will meet in public, to oversee the transformation of health and care within Coventry and Warwickshire by building a new relationship between individuals and communities and the services they use.

The Coventry and Warwickshire Health and Care Partnership brings together health and social care services, local authorities, voluntary and community sector organisations and other partners. Our aim is to deliver life-long health and wellbeing benefits for the people of Coventry and Warwickshire. In order to make this happen we are making the following commitments:

- Prevention will be at the centre of everything we do. We are committed to promoting health and wellbeing rather than treating illness. As organisations responsible for public money, we will change where we spend our money to promote health and wellbeing. Through earlier intervention, we're aiming to make it easier for everyone to lead healthy lives and stay well for longer

- Health must not be viewed in isolation. We recognise the importance of education, good work, affordable and appropriate housing, leisure opportunities and a healthy environment to the quality of life of local people. We need to work together to improve the overall health of our population and address inequalities by reducing the health and wellbeing gap that exists between our most deprived and affluent areas

- We all need to do more to look after our own health and wellbeing so that we depend less on our local health and social care services, while knowing they are there when we need

them. Voluntary organisations and community groups play an enormous role in keeping people healthy and independent and we will change how we work with communities to enable community leadership and build capacity. We will do more to support carers too, not only to improve the health of family members they care for, but also their own health and wellbeing

- When people need support from health and social care services, we know that they want accessible, responsive and high-quality services and we will provide them. We will have a focus on making sure that services deliver the right standard of care in a consistent way across Coventry and Warwickshire that builds on best practice and evidence

- We will be honest about the challenges we face. Demands on health care services continue to increase, alongside a shortage of key staff groups and skills to deliver care and financial pressures. While the amount of money we spend in the NHS is going up each year, the cost of services is going up more quickly, so we need to identify ways to deliver the same level of services at a lower cost – for example, through reducing waste and avoiding the duplication of services. We will work together to ensure we are always doing what's right for individuals and make it easier for people to access the right service, the first time

- There will be times when we need to make difficult decisions, but when we do, we will listen to the views of local people and our staff, and we will have transparent processes for making those decisions.

How to get involved

If we are to be successful, we need to put people and communities at the heart of the way we design our new system. We want to start a new conversation that is focused on making sure every individual, every community and every Place is as healthy as they can be.

We will engage with a range of stakeholders to shape the content and direction of our Five-Year Strategic Plan before we publish in mid-November and we will continue to engage on our Health and Wellbeing strategies as we refresh them. Looking ahead we will develop a rolling programme of engagement.

This marks a new way of working – we are at the start of a journey. We want your help to do and shape this.

3. OUR POPULATION NEEDS

3.1 Our approach

New place-based and asset-based Joint Strategic Needs Assessments (JSNAs) are in the process of being rolled out across Coventry and Warwickshire. Both Health and Wellbeing Boards agreed to take a place-based approach to the JSNA, based around 8 family hub geographies in Coventry and 22 geographic areas in Warwickshire. This reflects national policy direction towards population-based health and care systems (based on populations of 30-50k) and has aligned the JSNA approach in our two local authority areas.

Coventry's citywide JSNA profile has recently been updated and in Warwickshire, 8 Place based needs assessments have been completed to date, 6 will be completed by end of September 2019 and a further 6 by end March 2020. The process is being used as a vehicle for engaging and involving local residents, partners and wider stakeholders, to give a more in-depth understanding of the assets and needs of our local communities, and to support programmes and strategies which are founded on building community resilience and shaping service delivery at the locality level.

We are part way through a two-year programme of locality JSNAs, including the development of new data profiling tools in each of the two areas, enabling regular refreshing of data. This place-based approach is providing rich evidence of the needs and assets of local communities to underpin place-based delivery through the Integrated Care System (ICS) and wider population health approaches.

3.2 What do we know about our population needs?

As a system we face a range of challenges, with variation and inequalities evident at Place level:

Overall health: Generally, health in Warwickshire is reported as good compared with the rest of the country. Life expectancy is higher than the national average for both males (79.9 years) and females (83.6 years), compared with 79.6 years for men and 83.1 years for women nationally. By contrast, health in Coventry is below average at 78.3 years for males and 82.4 years for females. People are spending more years in ill-health; in Warwickshire on average 17.5 years for women and 15.8 years for men and is forecast to increase, particularly for males. In Coventry females can expect to live almost a quarter of their lives in poor health (18.9 years) whilst the figure is 15.4 years for males. As people live longer with complex needs, we need to improve how we support people to live independently in their communities for as long as possible, to improve quality of life and ensure services can respond to changing health and care needs.

Population Growth: In the past ten years, Coventry's population has grown by a fifth, making it the second-fastest growing local authority outside of London, with growth particularly high amongst 18-29 year olds. The city's residents are, on average, eight years younger than in England with Coventry's median age being 32 years in 2017 compared to 40 in England. A third of the city's population growth is concentrated in one-tenth of the city, concentrated around the city centre and a few new housing developments elsewhere, which has implications for service planning to ensure fair access. The population is also growing rapidly in some areas of Warwickshire. By 2041 it is projected there will be over 612,000 residents, up 10% more (53,000) from 2016, with the highest increase due in Rugby borough. This population growth is putting pressure on local housing and services. We anticipate that by 2025 in Warwickshire there will be a 4.5% (4,014) **increase in school age children** on 2017, which will increase demand on support services, including school health service, children's social care, and Child and Adolescent Mental Health Service (CAMHS).

Diversity: Coventry and Warwickshire have an increasingly diverse population. In Coventry 33% of the population identified as people from Black and Minority Ethnic (BaME) backgrounds in the 2011 census, with 52% of school children were from BaME backgrounds in the latest school census (up from 38% in 2011). The proportion of BaME groups in Warwickshire in 2011 was 12%, with 20% of school children from BaME backgrounds in the latest school census. In Coventry, Asian Indian forms the biggest BaME group, whilst in Warwickshire the 'White Other' accounts for the largest proportion of BaME groups, largely made up of the European Union accession countries, although Asian Indian accounts for a similar proportion across the county.

Inequalities and deprivation: Whilst Coventry is the 46th most deprived local authority area out of 326 across England (English Indices of Deprivation 2015), Warwickshire is one of the 20% least deprived counties in England. Nevertheless, there are significant variations and inequalities across our area, with deprivation and poor health outcomes experienced in both local authority areas. There are 44 Lower Super Output Areas (LSOAs) in the 10% most deprived nationally in Coventry and Warwickshire; 36 of these are in Coventry, 6 are in Warwickshire North and 2 in Rugby. Preliminary analysis about what drives the life expectancy gap between Coventry and England and within Coventry & Warwickshire suggest the top three conditions are: Circulation, Respiratory and Cancer.

Life expectancy at birth is 7.8 years lower for men and 5.1 years lower for women in the most deprived areas of Warwickshire (Warwickshire North) compared with the least deprived areas. In Coventry, the gap is up to 10 years for males; and 8 years for females. People living in more deprived parts of the city spend a greater proportion of their shorter lives in poor health compared to those living in less deprived parts of the city.

Fuel poverty is an issue across our area, with 15% of all households in Coventry considered to be in fuel poverty (more prevalent than across the West Midlands or England). In Warwickshire there is a higher proportion of people living in fuel poverty compared with other authorities of similar deprivation, with highest levels in Nuneaton, and significant variation across the county.

Employment rates, whilst good or in line with national figures overall are significantly lower in areas of Warwickshire North, and areas of Rugby (Newbold and Brownsover JSNA area), with poorly paid jobs and skills gaps. There are gaps in the employment rate between those with long-term physical health conditions, mental health conditions and learning disabilities compared to the overall employment rate. In Coventry there are inequalities in employment, with residents of White British ethnicity having higher employment rates than amongst residents from BaME backgrounds overall. The city has a notably higher proportion of households in which no working age adult works (17%). There are skills shortages within the local economy, and 10% of the city's working age population have no qualifications at all.

Children and Young People: About 12% of children in Warwickshire (11,400) live in **low- income families** which impacts on their health and wellbeing at an early age, particularly in Warwickshire North (North Warwickshire and Nuneaton and Bedworth). In Coventry one third of households with children are regarded as low-income families. In 2019, 14.9% of Warwickshire pupils and 16.3% of Coventry pupils **have Special Educational Needs support or an Education Health Care Plan (EHCP)**. There are growing concerns regarding **mental health issues and self-harm rates** (10-24 year olds) among young people in Warwickshire. Hospital admissions as a result of self-harm for this age group living in Coventry have declined from a peak in 2013/14 and since 2015/16 have been similar to the national average.

Almost one in three Warwickshire children (31.7%) and 37.8% Coventry children age 10-11 are classified as being either **overweight or very overweight**. The rate of children being admitted to

hospital for **injuries** in Warwickshire is rising and is significantly higher than the national rate. There are also significantly more **hospital admissions for alcohol specific conditions for under 18s** in Warwickshire than the national average (49.6 per 100,000 – the highest in the West Midlands). Coventry is 32.7 (4th highest in West Midlands).

The rate of **under 18 conceptions** has reduced across our area but remains higher than national average in Coventry and higher than other authorities of similar deprivation in Warwickshire. The proportion of **children in care** in Coventry is above the national average. There are also higher levels of children on protection plans or being looked after in care in Warwickshire North and pockets of South Warwickshire.

Older People: We have an **ageing population across** Coventry and Warwickshire. There is a higher proportion of **older people (over 60)** in Warwickshire compared with the rest of the country, particularly in South Warwickshire. By 2041 it is projected that over 85s will increase by 116%, putting increasing pressure on social care, hospital admissions and other services.

Emergency hospital admissions due to **falls** in older people are higher than average across Coventry and Warwickshire, particularly in Coventry, Rugby, Nuneaton, Warwick and pockets of Stratford-on-Avon District. The under 75 **mortality rate from preventable diseases** and measured health related quality of life (QOL) for older people in Warwickshire are not as good as other authorities of a similar deprivation.

Due to an increasing ageing population the demands on adult social care are likely to increase, particularly where people are less wealthy. Estimates suggest that there will be approximately 32% more people aged 74 or over living in a care home in Warwickshire by 2025, compared to 2017. Nearly 60,000 people (11%) in Warwickshire and an estimated 37,000 people (10%) in Coventry are unpaid **carers**, often caring for people with dementia or cognitive impairment.

Chronic diseases: According to 2011 Census date, 17.7% of Coventry residents and 17.1% of Warwickshire residents live with a long-term health condition or disability. Local analysis indicates that in Coventry an estimated 59,800 residents over 16 years old and 27,300 residents over the age of 65 live with a limiting long-term illness or disability. Chronic diseases, including mental health problems, diabetes, and musculoskeletal disorders, are fastest-rising in people aged over 85. By 2025, the burden of disability will grow as a result of the rising number of people living into old age, rather than an increase in ill-health.

Dementia is the biggest growing cause of disability in Warwickshire and is predicted to increase by 17% in people aged 65 or over in Warwickshire between 2019-2025 (from 8,484 to 9,953). The percentage of adults in Coventry aged 65+ with a recorded diagnosis of dementia is 3.9% (2116 diagnoses) and has remained stable over the last two years. However, we know that we are underdiagnosing dementia and we are working to encourage practices to screen for dementia and improve recording of diagnosis and would similarly expect levels to increase as people live longer.

Loneliness and social isolation: Almost 1 in 3 (31%) of the population aged 65 and over are estimated to be lonely 'some of the time' and 7% 'all of the time or often'. In Warwickshire, this equates to over 43,000 people experiencing some degree of loneliness and social isolation in this age group, and around 19,000 in Coventry. With an ageing population, this issue is likely to increase by 2025. Projections suggest that there will be over 21,000 people aged 65+ living alone in the city by 2025. Loneliness and social isolation are not restricted to the older population. Over 32% of people in Warwickshire live in rural areas, often with poor public transport links, which can make it difficult

to access services (particularly in North Warwickshire), and this rural isolation can affect both young and old.
Mental health: One in four adults will experience a mental health problem in any given year. Estimated prevalence of common mental health disorders amongst 16+ is 14.8% in Warwickshire, and 19.1% (c. 55,300 residents) in Coventry. Depression prevalence and incidence rates are increasing across Coventry and Warwickshire.

Suicide rates in Warwickshire have been significantly higher than the rate in England in recent years, with levels over 10 per 100,000 population since 2010-12. With awareness increasing and changes in underlying risk factors, more adults and young people are likely to present to health services with a mental health need by 2025.

Lifestyle-related diseases: Over half of adults across Coventry and Warwickshire are classified as **overweight or obese,** with figures particularly high in Coventry (64.3%), Warwickshire North and pockets of South Warwickshire. Levels of **physical activity** in adults in Coventry are relatively low and declining. In Warwickshire, physical activity is reported to have increased, but rates are still below average in some areas such as Nuneaton and Bedworth, and only 18% of adults walk to work, below the national average. Fewer adults take up the **NHS Health Check** in Warwickshire than in other areas.

Alcohol-related mortality and health problems are relatively high in Coventry, despite alcohol consumption at city level not being especially high overall. Whilst lower than the national average across Warwickshire, there are issues with alcohol-related harm in the county, with hospital stays on average of 590 per 100,000. In Stratford-upon-Avon premature mortality rates (under 75 years) from liver disease have increased over the last two decades and have moved from below to similar national rates; rates in Rugby and Warwickshire North have been similar to national rates over this time.

Smoking: Between one-in-five and one-in-six Coventry adults smoke, and although **smoking** prevalence is decreasing, deaths caused by smoking are relatively high in the city. Although below the national average and declining, 12.6% of adults in Warwickshire **smoke** and this is higher in some areas such as Nuneaton and Bedworth and among particular population groups such as those with serious mental health conditions.

Sexual health: In Coventry the rate of **STI diagnoses** remains consistently higher than the national and regional average. Rates of diagnosis of chlamydia and HIV late diagnosis are also not as good in Warwickshire as other comparable authorities.

Health protection: Across our area, cancer screening rates for at-risk populations are low. Newborn screening rates in Warwickshire are lower than authorities of similar deprivation, while in Coventry, childhood vaccination rates dropped notably in 2017/18 – this is being investigated. Coventry also has high rates for some communicable diseases, with one of the highest rates of TB and a higher prevalence of diagnosed HIV. These diagnoses are particularly prevalent amongst newly arrived communities and vulnerable groups. The number of older people having **vaccinations for flu** is also below national average and **deaths from communicable diseases** are higher than average (all ages).

Housing and Homelessness: Insecure housing and homelessness is a common issue across our area, often linked to poverty, rental rates, house prices and debt. Drug and alcohol addiction, mental health and family relationship problems can also be factors. The rate of statutory homelessness is higher than the national rate, particularly in Coventry, Warwick and Stratford and areas of Rugby. Coventry has a high level of homelessness, particularly amongst young people and families – at any

one night in 2017/18, between 190 to 250 Coventry families with dependent children spent the night in emergency or temporary accommodation.
Air quality and traffic: Certain parts of our area have poorer air quality than EU and international standards. There are problems with air quality (particularly nitrogen dioxide) in parts of Coventry, and in town centres of Warwick, Leamington, Rugby and Nuneaton. Warwickshire has a **higher rate of people killed and seriously injured on roads** nationally, particularly in North Warwickshire.

Crime: Whilst crime rates are generally lower than average in Warwickshire, there are areas of higher crime in Warwickshire North, Rugby and pockets of South Warwickshire (Leamington and Stratford-upon-Avon), including domestic violence and anti-social behaviour. There has been an increase in violent crime in Coventry, although the increase here has been lower than that of England. Nevertheless, people in the city report feeling increasingly unsafe – with nearly a third of young people saying they feel unsafe in the city.

Our communities: Across Coventry and Warwickshire, local engagement through our place-based JSNAs has highlighted a wealth of voluntary and community activity. There is a growing recognition that health and wellbeing is determined and shaped by the places and communities people live in, and that solutions to addressing and improving health outcomes must also be rooted in local people and communities.

3.3 Our approach to engagement for our Five Year Strategic Plan

Our approach to engagement has been to build on the wide-ranging engagement already undertaken across our system including:

- The development of the Health and Wellbeing Strategies for Coventry and Warwickshire
- The work done to develop local, Place based Joint Strategic Needs assessments (JSNAs)
- CCG engagement relating to key services such as maternity, children centres and planned care
- Engagement on the future of health commissioning and CCG Commissioning Intentions

In addition, Healthwatch Coventry and Healthwatch Warwickshire undertook specific engagement on the priorities in the NHS Long Term Plan, making contact with over 800 people. The insights from which will be used to help inform and shape the future health and care system.

As this approach continues to develop, we will ensure we keep the dialogue open with all stakeholders, staff, Elected Members, patients and the public, voluntary and community sector and partner organisations. This Five Year Strategic Plan is the start of the journey and there will be many more opportunities to influence the delivery of the priorities in the plan moving forward.

We have also engaged with our staff to understand and hear their views about the NHS Long Term Plan and the changes they believe we need to make over the next few years if we are to deliver all the requirements, targets and standards set.

What we have been told so far

Engagement activities undertaken by Healthwatch as well as public/community engagement undertaken by the CCGs and Local Authorities highlights the following six themes as important to our communities:

- You want better access to services
- You want services centered around you

- You want a focus on self-care and prevention
- You want the best quality service
- You want a joined-up service
- You want better communication, advice and guidance

We have considered all of these themes in developing our Five Year Strategic Plan and we will continue to consider them when planning or commissioning new services and/or making changes to existing ones.

During August and September, we conducted a survey with staff working in both the NHS and local authorities. Staff representation across all the organisations was good and most respondents both live and work in the Coventry and Warwickshire area, with a good split of representation from each of our four Places (Coventry, Rugby, South Warwickshire and North Warwickshire). The following was identified:

- Quality of services and joined up care were all highlighted as positives, although often with the caveat of mounting pressures to the system
- Improve access, better IT, funding, communication, collaboration and integration were highlighted as needing to improve, and a greater focus on prevention was also raised
- Most people felt spending the extra investment wisely was the most important factor, closely followed by joined up working and better support for the workforce
- Preventing people from becoming ill, keeping them fit and healthy was more important for the NHS and social care to address than treating people when they become ill
- Choice and control and letting people manage their own health and wellbeing was more important for the NHS and social care to deal with than giving the best possible care and treatment without choice

4. OUR SYSTEM PRIORITIES AND WORKSTREAMS

As a system we are required to deliver the commitments made in the Long Term Plan (LTP) and the detail underpinning each of these commitments can be found in the individual service planning templates. However, there are some unique challenges in Coventry and Warwickshire, and we will therefore prioritise to respond to local need.

We will ensure that **Prevention** is a key priority. The NHS spends around £20bn each year on conditions associated with lifestyle choices such as smoking, alcohol misuse and obesity. If we could reduce our local share of this by 25%, we would **save £6.3m over five years** – we aim to do this by radically changing our approach to prevention by empowering patients and giving them better access to support and advice and investing in early years prevention.

We have struggled to consistently deliver our NHS Constitutional Standards in several areas such as Urgent and Emergency Care, Mental Health (including Out of Area placements) and Cancer. Consequently, these will remain key local priorities until we are able to demonstrate the required improvements.

Urgent and Emergency Care (UEC) - demand for urgent care continues to rise and improving the performance of our urgent care system is one of our key priorities. We have already made progress in reducing hospital urgent admissions, but this is still a challenge. Our vision is to simplify the UEC offer across Coventry and Warwickshire and to fully integrate the response so that the most appropriate care can be given as quickly as possible, as close as is necessary for the immediate need of the patient, whilst supporting patients and their families to do as much as they can for themselves.

The detail of our commitment to deliver the requirements associated with pre-hospital urgent care, same day emergency care and improved, timely discharge can be found in the UEC planning template. This commits to

- providing an acute frailty service for 70hours a week with assessment being within 30 minutes of arrival
- introducing Urgent Treatment Centres (UTCs) by autumn 2020
- increasing the number of people discharged on the same day, through a comprehensive model of Same Day Emergency Care (SDEC)
- aiming to record 100% of patients' activity in A&Es, UTCs and SDEC units via the Emergency Care Data Set (ECDS) by Mar 2020
- operating a Clinical Assessment Service (CAS) as a single point of access for patients, carers and health professionals to support integrated care and improved hospital discharge to reduce the number of people delayed in hospital, particularly over 21 days

As a result of this activity we are looking to reduce pressure on emergency hospital services, to maintain the level of demand for true acute services within the current footprint. That is to use the efficiencies gained, to offset expected unmitigated growth if nothing else was done, and demographic growth pressures continued unchecked.

In 2017/18 we spent nearly £13million more that the lowest 5 of 10 similar CCGs on non-elective activity in the top 10 spend programme areas. Nearly £9million of this is related to 3 programme areas (neurology, trauma & injury and genitourinary) and the majority of this is related to frailty. If we can halve the current trend of growth in A&E attendances and hospital admissions, we could **save £12.65m over five years** – we aim to do this by investing in primary care, self-help and same day emergency care.

Linked to this we will also prioritise how we improve the way we manage our frail patients. Many frail older people remain in hospital longer than they need to due to a lack of step down support which often leads to a further deterioration in their mobility and independence. If we reduce our 'stranded' patient numbers by 40% we will **save £14m over five years** and we will achieve this by implementing a system-wide best practice frailty model.

Mental Health has also been chosen as a key priority in order to continue our work on the MH5YFV and take forward the LTP ambitions.

For children and young people, we are focusing on our tier 3.5 service development and working with partner Mental Health Trusts across the west midlands to develop a New Care Model for delivery of tier 4 services. This work is particularly focused on the needs of children with mental health problems and autism. For other specialist CAMHS services we continue to embed our pathways approach and strengthen the earliest parts of the pathway within primary care. We are a trailblazer site for working with schools and are committed to driving this initiative at pace.

For adults, between now and 2023/24 we will continue the work to deliver the MH5YFV targets with emphasis on out of area placements, including the strengthening of CRHTT and MH Liaison to Acute hospitals, expanding services for those requiring early intervention in psychosis and access to psychological therapies through IAPT and improving the uptake of alcohol care services. Reducing the need for patients to be managed outside of our area offers a potential **saving of £2m over five years** and we will work hard to realise as much of this saving as possible. We will scope the mental health community pathways and strengthen primary care mental health through collaborative work with emerging PCNs, including improving the rate of annual health checks undertaken across the system.

Our local challenge, evidenced through a review of mental health services, is that people are too often accessing specialist care when a more local community approach would deliver better outcomes and experiences. We will seek to do this by focusing on a step change in prevention, early intervention and supporting more people to actively participate in their own self-care, wellbeing and recovery; whilst ensuring timely access to high quality appropriate specialist services when needed, delivered wherever possible, in the communities where people live. Aligned to this principle, services will be delivered as locally and in as integrated a way as possible through our Places.

In responding to a more strategic approach and greater provider collaboration, opportunities will be explored with the national new care models programme (including adult eating disorders and CAMHS Tier 4), with the devolvement of mental health specialised commissioning to providers and CWPT will continue to work actively as a member of the mental health alliance for excellence, resilience, innovation and training (MERIT) programme.

Cancer remains a system priority both in terms of delivery of the existing constitutional standards but also in terms of the new requirements in the LTP. We are fully committed to ensuring faster/earlier diagnosis through enhanced screening programmes and increased/improved diagnostic capacity as well as embracing and implementing innovation, ensuring we offer the most safe and precise treatment available. After treatment patients are offered a follow-up pathway that suits their needs and enables them to get rapid access to the clinical support they need, if they feel their cancer has recurred.

Primary Care and Integrated Community Care - building on our Out of Hospital model along with the exciting introduction of Primary Care Networks (PCNs), the system has made a commitment to ensure that the ongoing development of PCNs remains a system priority for the foreseeable future. We will look to develop fourteen Place Based Team ('PBTs') aligned to the PCNs within each Place

and bring together health and social care professionals to co-ordinate, lead and align services to meet the needs of their patient population.

The PCNs will allow us to accelerate the partnerships that have formed between general practice, hospital teams, social care, hospices and the Out of Hospital Collaborative to develop person centred integrated services for our most vulnerable patients. Focusing on Frailty, end of life and other long term conditions the PCNs and PBTs will take a proactive, multidisciplinary approach to supporting people remain independent in their usual place of residence for as long as is possible. This new way of working will be facilitated through significant investment in workforce, IT and estate.

There are also several key service transformation programmes that have been identified as priorities for the next 18 months.

Population Health - building on the Kings Fund model of Population Health and our pilot relating to Children and Young People (CYP) in crisis as 'proof of concept' for future PHM model/approach, we are committed to developing this approach at pace in order to change the way we prioritise investment, commission services and deliver treatment and care to our population. As part of our approach to population health we want to hold ourselves to account for the impact of our plans and strategies and demonstrate progress and are developing a strategic outcomes framework to achieve this.

Stroke services - having been through a significant planning phase to develop a proposal to redesign Stroke service across Coventry and Warwickshire, we will now move into the implementation phase and deliver the improvements we have planned for, once public consultation is concluded, evaluated and considered. The proposed model would see the expansion of rehabilitation services across the STP and the centralisation of all stroke admissions, to ensure that all of our population has access to inpatient care in a hyper-acute stroke unit and community-based specialist rehabilitation services when they need them. We are making a significant investment to improve access to address the current gaps and remove the inequities in current local services.

Maternity and Paediatric services– a key work stream within the Local Maternity Services (LMS) Plan 'Choice and Personalisation' has a longer term, more strategic, objective to define the future clinical model for maternity and neonatal services across Coventry and Warwickshire to ensure an integrated care pathway. This programme, following completed extensive engagement, will enable front line staff working in maternity and paediatrics to consider how services can be most effectively be delivered to improve the health outcomes, quality, and experience of services in the context of the existing health inequalities, workforce, estate and financial constraints.

Our Service Improvement Schemes – in order to improve efficiency and value for money, we have agreed several system-wide programme of work that will reduce overall cost across the system:

- **Musculo-skeletal (MSK)services-** identified as a system priority in the Clinical Strategy in 2018, this transformation offers the opportunity to reduce/remove unwarranted variation across the system, ensure evidence-based intervention rates are in line with the national average, ensure that the capacity to treat MSK services across the system is the most efficient it can be and deliver significant cost savings.

  In 2017/18, we spent nearly **£7.75illion** more that the lowest 5 of 10 similar CCGs on MSK elective activity. This higher spend is in Coventry & Rugby and South Warwickshire. We have developed plans to improve our pathways and realise as much of these cost savings as possible.

- **Diagnostics –** the system acknowledges that there is huge opportunity to redesign the way diagnostic services are delivered across the system. Addressing workforce challenges as well as reducing duplication and variation and cost reduction are three of the key outputs from this workstream.

  The 2017 2nd Atlas of Variation in NHS Diagnostic Services demonstrated large variation in diagnostic tests across the country with opportunities that need exploring around MRI activity, non-obstetric ultrasound activity, DEXA scanning, gastroscopy procedures, endoscopic ultrasound procedures, audiology assessments, diagnostic sleep studies and urodynamic (pressures and flows) tests – where one or more Place had significantly higher rates than England.

- **Medicines Optimisation and Pharmacy Integration -** The Medicines Optimisation and Pharmacy Integration workstream has been identified as a key system priority due to its interaction across other workstreams and the potential for significant savings across the System (see more detail under enabling workstreams below).

  In 2017/18, we spend over £7million more than the lowest 5 of 10 similar CCGs on prescribing in the top 10 spend programme areas. We have explored this variation and we believe some of this spend is warranted i.e. higher spend is leading to better outcomes. However, we still believe up to **£3m could be released.**

- **Premium workforce costs –** we appreciate that any money spent on premium cost workforce, (agency and locum staff) brings not only a potential impact to the quality of care offered to patients but also increased cost to the system. As such, we will introduce a phased programme to reduce this spend over the next five years, resulting in a potential cost saving to the system of **£11.5m over five years** with a further undefined savings expected at Phase 2 (reducing the overall substantive system workforce costs)

Schemes that deliver short term savings have already been implemented. Therefore, the schemes above will reduce costs over a longer time period.

5. RESPONDING TO THE NHS LONG TERM PLAN

In addition to our local priorities, we are also fully committed to delivering the other requirements highlighted in the Long Term Plan (LTP). Our clinicians have been critical to planning and agreeing our delivery models that achieve success. Clinical work-streams or Expert Advisory Groups (EAGs) have developed both the approach and a more detailed plan for each of the relevant clinical chapters with formal sign off being undertaken by the Clinical Forum. Clinical engagement will continue to be undertaken across the system to ensure that all delivery co-dependencies and enablers are understood and highlighted, ready for development of operational plans in the new year.

We recognise that we need significant transformation at every level to become an Integrated Care System (ICS). To achieve this, Clinical Leadership is critical and needs to be central to all we do. Shifting to a population health model rather than a reactive and transactional care model is essential and clinicians will drive this shift. Our new system governance arrangements ensure that Clinical Leadership and engagement is well embedded at both System and Place.

Our Clinical Forum provides clinical leadership, advice and challenge for the work of the Partnership in meeting our ambitions. It provides clinical advice and expertise to all our workstreams, with clinicians leading programmes of work. It ensures that the voice and ideas of clinicians, from across the range of clinical professions and organisations, are the number one driving influence in the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

At Place, Transformation Boards are established with clinicians from local health and care sectors, working together to redesign care pathways in line with the Partnership Board strategy and agreed Place priorities. Representatives from the Place arrangements link in to the Clinical Forum to ensure that there is continuous alignment with what is delivered at Place and what is delivered at System and that learning is shared.

5.1 Out of hospital care

Out of hospital care has been a key priority across Coventry and Warwickshire for some time with the successful introduction of the Out of Hospital (OoH) service in late 2017. The clinical model for this service aligns closely with the model described in the NHS Long Term Plan and builds on the following principles and focused particularly on supporting the top 15% of the population identified as having complex needs:

- Proactive and preventative care tailored around the needs of the individual
- Empowering patients/local people to support each other and themselves in their health and care,
- Multi-disciplinary health care professionals working together and taking accountability for improving the health and care outcomes of populations.

As our model evolves, the OoH community teams will expand their role to include things such as increasing the diagnosis and improving the care we provide to people with dementia, both at home, in hospital or in care homes. They will also develop their role in relation to population health management, using a Frailty Index to identify patients and patient groups for targeted care, prevention and gaps in service to improve patient outcomes. A key enabler will be digital technology, and the teams will look to utilise home-based monitoring equipment to predict and prevent potential hospital admissions.

As the building blocks of the emerging new model of OoH care, eighteen Primary Care Networks (PCNs) (127 GP practices) have formed in Coventry and Warwickshire. Supporting the development of the PCNs has and will remain a key priority and we are fully committed to meeting the new funding guarantees for primary and community care. Our focus will, in part, be on ensuring that they are positioned to successfully deliver the nationally mandated requirements, including the seven new Network services. Recognising the key role that the PCN Clinical Directors will play not only in the success of the networks themselves but also as the voices of general practice at Place level, we will offer them support to develop in their new roles.

As PCNs mature, Practice Based Teams will evolve within each Place and bring together health and social care professionals to co-ordinate, lead and align services to meet the needs of their patient population. These Multi-Disciplinary Teams will be supported by a risk stratification tool which will identify patients most at risk, allowing services to put in place preventative interventions. The MDTs also work closely with patients, relatives and carers, to give them more control over the co-ordination of their own care.

Enhancing support to people living in care homes is an improvement priority for the Coventry and Warwickshire Frailty Improving Value Group. We will roll out the Enhance Health in Care Homes model across all care homes as staffing and funding grows and ensure stronger links between PCNs and their local care homes, with all care homes supported by a consistent team of healthcare professionals, including named general practice support. As part of this, we will ensure that individuals are supported to have good oral health, stay well hydrated and well-nourished and that they are supported by therapists and other professionals in rehabilitating when they have been unwell.

5.2 Personalised care

Across the system there is recognition of the opportunities that increased personalisation brings, particularly as an enabler to delivering better health outcomes across our local population. In order to achieve these benefits, we will continue to work in collaboration with partners to transform the nature of our commissioning and service delivery arrangements.

We will develop and train our local workforce to support this shift towards an increasingly partnership-based approach, planning with people rather than for them and by 2023/24 we plan to deliver the six standards of the Universal Comprehensive Model of Personalised. Our current position reflects some positive work in relation to Personal Health Budgets and Social Prescribing with the wider adoption of the Comprehensive Model in preparation and planning stage. Our intentions are:

- **Social prescribing and community-based support -** social prescribing link workers (SPLW) will support people to receive more personalised care that address their holistic needs, recognising the interface between health-related clinical issues and wider determinants of health. Primary Care Networks will be fully funded to cover the cost of Social Prescribing Link Workers (SPLWs) from 1st July 2019. Based in GP practices, SPLWs will facilitate the navigation through the wider community to support people to identify and access wider societal support to help address their individual needs and tackle cause rather than effect.
- **Shared decision making -** We will use the national Shared Decision Making, Self-Assessment Checklist, once published to assess our starting point for Shared Decision Making and as a basis for an action plan which will focus on: supportive systems and processes, trained teams, commissioned services and prepared public. Over the next 5 years we will use the self-assessment checklist, develop and implement action plans across our key pathways. We will

start this work in MSK as we are aware there are a lot of national resources and support available to enable improvements.

- **Enabling choice -** CCGs are required to self-assess their position against the minimum standards of the Choice Planning and Improvement Guide 2016 by NHS England and NHS Improvement. Choice is offered through eRS, which is used by all our GPs and is promoted through the local Public and Patient Participation Group (PPPG) which includes a member of each existing practice-level Patient Reference Group. Group members feed back to their own practice groups to promote choice, and patients can also access the choice page on CCG websites. GPs are also robustly engaged with eRS through CCG/GP meetings, Protected Learning Time and the GP Newsletter. Managing choice with providers is undertaken through regular contract management meetings, and there are processes in place to support patients requesting alternative provider as required. We will also work to optimize our pathways in our NHS providers to encourage our providers to be patient's preferred choice and to repatriate activity back to our Health and Care Partnership.
- **Personalised care and support planning -** People with long term physical and mental health conditions have person centred support plans in place. All existing assessment, planning, decision-making and review pathways and processes have been mapped and a person-centred approach rolled out. Workforce training requirements will be reviewed to ensure that a skilled workforce can deliver person centred support plans.
- **Supported self-management -** People will be supported to identify community-based support options and to identify individual assets that enable them to self-manage their health care. This may include the development of education/health coaching and peer support options
- **Personal health budgets (PHB) and integrated personal budgets -** PHBs are routinely available for CHC eligible patients across the system; implementation of Personal Wheelchair Budgets is also underway. We will continue to review, develop and expand the local PHB offer to maximise opportunities for patients to meet their outcomes through PHBs.

5.3 Digitally-enabled primary and outpatient care

We will continue to develop digital-first primary care with some of our GPs already offering digitally enabled consultations. We will support primary care to develop this further so that every one of our patients has the right to choose this and other digital options. This will be supported by national developments e.g. framework for digital suppliers, adjustments to GP payment formulae and review of GP regulations and terms and conditions.

We will reduce face to face outpatients by 30% by 2023. We are implementing 4 key projects to support delivery of this requirement to address these redesign opportunities:

- Demand Management Schemes: GP Referral Support and Management Schemes, Referral avoidance services (E-Referral Advice and Guidance; Consultant Connect; Capacity Alerts) Triage and Treatment services (MSK, Ophthalmology, Dermatology)
- Primary and Community based Treatment Services: First Contact Practitioners, MDTs working in PCNs
- Follow-Up Transformation: No requirement for follow up (No FU) for minor conditions; Patient initiated follow up (PIFU), Virtual follow up (VFU), Telehealth by phone or Skype, Nurse led follow up (NL) where a consultant is not warrantedDigital Solutions (Remote monitoring; Telehealth; Video consultations).

5.4 Increasing Focus on Population Health

Building on our systems model, we have now committed to use the King's Fund model of population health (taken from their Vision for Population Health, November 2018) as our approach to improving the health and wellbeing of people in Coventry and Warwickshire. We are using the model to develop our understanding of how all parts of the system contribute to health and wellbeing, and the roles that each organisation play and how they relate to each other.

As part of this approach, we want to hold ourselves to account for the impact of our collective plans and strategies and demonstrate progress against our priorities. We are developing a strategic outcomes framework in consultation with stakeholders and local communities. Our starting point is the high-level ambitions and outcomes outlined in our Place Forum/Health and Wellbeing Boards Concordat (our shared agreement that outlines what we will achieve together and how we will work collectively to achieve it), which we are building into our population health model.

We recognise that shifting to more preventative care requires more intelligent predictive modelling of population characteristics and risk, so actions can be better targeted to improve outcomes. Information and intelligence systems need to become smarter at identifying patients who are amenable to prevention and treatment actions and using wider determinants to understand health and wellness.

Our strategic outcomes framework will complement the core narrative and articulate in measurable terms what success will look like in implementing this new approach to deliver our three strategic outcomes:

- Our population will lead healthy, independent and fulfilled lives
- Our population will be part of a strong community
- Our population will experience effective and sustainable health and care service

5.5 Prevention and Health Inequalities

Prevention is becoming embedded across the Partnership, with primary, secondary and tertiary prevention approaches already being taken forward in many of our system workstreams, e.g. the Out of Hospital (OOH) and Mental Health workstreams have a clear prevention focus at all levels. Our prevention approach comprises action on the wider determinants of health - the social, economic or environmental factors affecting health, such as housing, employment, education, or parks and green spaces – particularly championed in Coventry, which is a Marmot City. As part of our upscaling prevention activity, we have piloted new approaches to building community capacity and resilience, through funded projects with voluntary and community sector partners. Evaluation has been shared with system leaders to inform future activity.

A key aspect of our approach to prevention has been a commitment by our two Health and Wellbeing Boards (working jointly) to deliver a Year of Wellbeing in 2019 across Coventry and Warwickshire, to promote population and community health and wellbeing. This initiative is being used as a catalyst for change at both an organisational and community level, to galvanise effort and celebrate and extend existing work on prevention and early intervention. At an organisational level, it is being used to prompt culture change by encouraging partners from across the health and care system to champion and take ownership of the prevention agenda. At a community level, existing preventative activity is being promoted to increase its reach and impact, with a general campaign using positive language to encourage our communities to make one positive change.

For reasons both of fairness and of overall outcomes improvement, we plan to take a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care. We have identified Circulation, Respiratory and Cancer as the top three conditions driving our health inequalities. Our Population Health and Preventative Care working group will support our CVD, Respiratory and Cancer groups to: understand these health inequalities, engage with the relevant communities, implement interventions to address inequalities and monitor and evaluate the impact. This will be supported by the RightCare PCN Focus Packs and nationally developing dashboards.

In contributing to the ambition of an extra five years life expectancy by 2035, our staff are committed to utilising every contact they make with patients, carers and the public, to promote prevention activities and opportunities to improve health. Details of the activities we intend to undertake with regards to smoking, obesity, alcohol, air pollution and antimicrobial resistance are highlighted in our Prevention and Inequalities planning template.

5.6 Further progress on care quality and outcomes

A strong start in life for children and young people

Our activities to achieve a strong start in life for children and young people currently sit in several disparate work programmes and are overseen by various working groups/ programme boards across our system. Each of these workstreams are aware of the requirements and are developing plans and agreeing new service models to ensure delivery of the targets set out in the Long Term Plan. Detail of how each group will deliver the LTP targets is found in the following separate planning templates:

- Maternity and Neonatal Services
- Children and young people's mental health services
- Learning Disability and autism
- Children and young people with cancer
- Redesigning other health services for children and young people

In the short term, ambitions will be reviewed by these working groups/ programme boards and where needed new actions added to their work plans. In the longer term, we will develop Children and Young People's Transformation Programme and Programme Board – the timing of this will depend on the development of the national transformation programme. Together with the Maternity Transformation Programme and the Local Maternity System Board - this will work in a matrix way with the other working groups/ programme boards to enable achievement of the long-term plan ambitions.

Better care for major health conditions

Over the last 2 years, we have been developing working groups and work programmes for the major health conditions (Diabetes, Cancer, Mental Health, Stroke, CVD, Respiratory, Frailty).
More recently we have reviewed our clinical leadership and relaunched our Clinical Forum with a new system clinical lead (chair of clinical forum) and further emphasised clinical leadership in our governance structure. Our existing groups are being formalised as sub-groups of our Clinical Forum with a clinical lead and SRO leading each workstream.

The Long Term Plan ambitions have been reviewed by these working groups/ programme boards and where necessary new actions have been added to their work plans as highlighted in the relevant planning templates. These show how they will achieve the following key targets:

Cancer	• Roll out of Rapid Diagnostic Centres from 2019 • Introduce faster diagnosis standard so patients receive diagnosis within 28 days by 2020 • HPV primary screening for cervical cancer by 2020 • Offer personalised care to all appropriate cancer patients by 2021 • Extend lung health checks model by 2022 • Deliver stratified follow-up for people worried about recurrent cancer by 2023 • Diagnose 75% of cancers at stage 1 or 2 by 2028
Cardiovascular disease	• We will improve community first response and defibrillator networks • Deliver cardiac rehabilitation to at least 85% of those eligible by 2028
Stroke Care	• Introduce improved post-hospital rehabilitation model by 2020 • Deliver ten-fold increase in the number of our patients who receive a thrombectomy after a stroke by 2022 • Deliver thrombolysis to all appropriate patients by 2025
Diabetes	• Introduce more preventative activity • Expand provision of structured education to newly diagnosed patients • Introduce self-management support tools • Ensure all pregnant women are offered continuous glucose monitoring by 2021 • Ensure more people achieve the recommended diabetes treatment targets in primary care • Provide access to MDT footcare teams and inpatient diabetes inpatient specialist nursing teams
Respiratory disease	• Reduce the variation in quality of spirometry testing to increase diagnosis • More primary care staff trained to provide specialist input • Expand pulmonary rehabilitation, including use of digital technology and self-management tools • Optimise medication through medication reviews and patient education • Introduce risk scoring for deteriorating/vulnerable patients
Adult Mental Health services	• Integrated primary and community mental health care in place by 2023/24 • Increase in access to NICE-approved IAPT services by 2023/24 • Increased alternatives for people in crisis in place including NHS 111 by 2023/24 • Improved ambulance service response (vehicles and staff) to people experiencing mental health crisis by 2023/24 • Liaison services in place in all acute hospital A&E departments, with 70% delivered 24 hours a day by 2023/24
Short waits for planned care	• Roll out the use of Musculosketal (MSK) First Contact Practioners by 2023/24 • Extend access to online support for MSK patients • Reduce Face to face outpatient attendances by 30% by 2023/24

We are taking a pathway approach to better care for major health conditions. There are common components to these pathways which are independent priorities in the NHS Long Term Plan and there are sections addressing these as part of the individual service planning templates. This approach to planning along with our developing approach to matrix working ensures that actions that contribute to more than one workstream are jointly owned and supported.

5.7 NHS staff will get the backing they need

Workforce is seen as a key enabler to providing the stepped change required in delivering the Long Term Plan (LTP) and is therefore a critical priority for the system. The leadership for this resides with the Local Workforce Action Board (LWAB) with a clear line of sight to the Programme Delivery Group and on to the Partnership Executive Group (PEG). Membership includes NHS providers, education and local authority representation along with primary care. The work of the LWAB, underpinned by the 2017-2021 Workforce Strategy, set out a vision to support the system's ambition to transition to an Integrated Care System.

Where we are:

A governance review has been undertaken with all stakeholders and although there is a degree of development and maturity to be reached, the core principles for delivery are agreed:

- Respond to system wide workforce priorities
- Optimise use of funding from the C&W pound
- Respond and deliver themes of the NHS People Plan
- Collate, analyse and utilise workforce data from across the system
- Support the development of workforce planning expertise across the sytem

To support delivery of these principles, the LWAB has now formed four constituent sub groups focussed on key areas of delivery - recruitment and retention; leadership and organisational development; workforce planning and education and development.

We continue to develop connectivity, building on local relationships, to deliver against key workforce challenges, and opportunities. We also recognise that some workforce action needs to happen at national/regional level, alongside local action at organisational, PCN and place levels.

What we are currently doing aligned to the themes of The Interim People Plan

The LWAB and representative organisations are fully committed to the NHS People Plan and both collaboratively and as individual organisations are aligning activity to those themes. Some of these activities are identified in the table below:

Making the NHS the best place to work	**Improving NHS leadership culture**
• Scope/develop a system wide recruitment campaign, to live, learn and work within Coventry & Warwickshire. • Develop and extend health and wellbeing initiatives to support our staff • Facilitate system rotational posts, particularly in supporting the growth and retention of mental health nursing roles and of AHP's • Support greater integration and awareness of primary, community and inpatient services amongst the workforce	• Deliver local programmes enabling GPs/Practice Managers to learn alongside senior clinicians/non-clinical staff • Deliver a BAME Leadership programme with a further cohort in 2019 • System-wide reverse mentoring programme for our diverse workforce • Scope system leadership skills/behaviours • Leadership programmes in place in all NHS providers • Develop a leadership offer to support staff who work in integrated teams • Produce system-wide induction video
Addressing urgent workforce shortages	**Delivering 21st century care**
• Develop nursing associate role • Staff retention rate/Sickness absence discussed and aligned to local metrics for realistic achievement, with consideration of staff retention	• Develop Assistant Practitioner roles in inpatient and community teams and integration of care navigator roles and social prescribing • Operate a local apprenticeship hub, maximizing efficiency relating to

• Utilise best practice across the system to release greater time to care • Promote flexible working options to assist recruitment and retention • Develop and pilot new roles across disciplines, including medical, therapies e.g. physician assistants	procurement of apprenticeships • Deliver a range of activities to promote health careers in disadvantaged communities • Review organisational sign up to initiatives such as 'Stepping into Health' a Local University project aimed at 'Male Career Changers into Healthcare.'
Developing a new operating model for workforce	
• Work collaboratively within the Integrated Care System (ICS) • Align occupational coding across organisations to ensure consistency in data reporting • Establish a more robust/holistic approach to workforce planning so that we have a system wide understanding of workforce demand and supply trajectories, making best use of data • Ensure workforce information in digital platforms is used to maximise workforce productivity.	

What we still need to do:
We still need to undertake work to ensure our workforce is fit for the future and that we maximise their potential to deliver the LTP. With regards to **partnerships** we will work collaboratively to ensure our workforce plans are reflective and consistent with the system clinical strategies that deliver LTP commitments. We will develop greater connectivity to our partner voluntary and charitable organisations including the further development of volunteering and we will develop a support offer for our newly emerging PCN's and Place-based teams. Where there are specific workforce shortages, we will establish system shared development programmes for all organisations , e.g. Sonography. We are also committed to stabilising the current general practice workforce, putting in place the a more robust approach to GP workforce planning, developing Primary Care networks and investing in the development of the wider primary care workforce

With regards to **valuing and supporting our people**, we will agree system staff well-being and workforce metric measures and interventions and monitor/utilise them as a 'temperature check' of how staff are feeling. We will develop strong system leaders, ready to take ownership, do things differently and take individual and collective responsibility. We plan to agree workforce diversity measures for our leadership team and wider workforce and ensure system compliance with the new Workforce Disability Equality Standard. We are keen to increase alignment with the digital and estates enabling workstreams and upskill our workforce to maximise the effective use of technology.

We acknowledge that, as a system, we need to **streamline our processes,** join up how we operate consistently and drive 'value for money.' We will develop a system-wide response to international recruitment, particularly for the nursing workforce. We will establish one collaborative bank across the system, we will develop a route for Nursing Associates to become registered nurses, maximising the use of the apprenticeship levy and we will lead the work to eliminate premium rate staff costs, wherever possible.

System wide workforce metrics are being developed to support us focus our action and measure outcomes. Current NHS data is shown below for ease of reference:

	UHCW	GEH	SWFT	CWPT
Total Headcount - as at 31st August 2019)	9013	2446	4856	3625
Total WTE - as at 31st August 2019)	7900.25	2079.94	4032.65	3142.88
Sickness Absence % - as at end of July 2019	4.69%	4.32%	4.79%	5.76%
Vacancy % - as at end of July	13.02%	9.7	5.8%	13.40%

6.0 BUILDING A SUSTAINABLE PARTNERSHIP

6.1 Our Partnership Governance arrangements

Our approach to collaboration begins in each of the 18 neighbourhoods/PCNs which make up Coventry and Warwickshire, with our 127 GP practices working together, with community, mental health, social care service and voluntary sector teams, to offer integrated health and care services for populations of 30-50,000 people. These integrated services are focused on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it. We see these as critical building blocks within a mature ICS and PCNs will be key partners in identifying possible Place- based opportunities for increased out-of-hospital models of care well as horizontal efficiencies (shared clinical workforce, collective back-office functions).

Neighbourhood teams sit within each of our four local Places (Coventry, Rugby, South Warwickshire and Warwickshire North). These places are the primary units for partnerships between NHS services, local authorities, the voluntary sector, charities and community groups, which work together to agree how to improve people's health and improve the quality of their health and care services. The focus for these partnerships is increasingly to move away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment.

These place-based partnerships, overseen by the Coventry and Warwickshire Health and Care Partnership Board, are key to achieving the ambitious improvements we want to make. However, we recognise that there are also clear benefits in working together across a wider footprint and that local plans need to be complemented with a common vision and shared plan for Coventry and Warwickshire as a whole. We apply three tests to determine when to work at this level:

1. to achieve a critical mass beyond local population level to achieve the best outcomes;
2. to share best practice and reduce variation; and
3. to achieve better outcomes for people overall by tackling 'difficult issues' (i.e. complex, intractable problems).

6.2 Our Health and Care Partnership Board

Building on the Coventry and Warwickshire Place Forum, a system-wide Partnership Board has been established to provide us with a mechanism for collaborative action and common decision-making for those issues which are best tackled on a wider scale. This is strongly aligned to and heavily influenced by the Health and Wellbeing Boards Concordat and our emerging Strategic Framework. It meets four times a year in public and is chaired on a rotational basis by either Health and Well Being Board Chairs or by the NHS Independent Chair.

6.3 The Partnership Executive Group (PEG)

The Partnership Executive Group (PEG) is one of the delivery committees of the Partnership Board and includes each statutory organisation. It is responsible for overseeing delivery of the Five Year Plan and building leadership and collective responsibility for our shared system objectives. The PEG also includes attendance from the System Clinical Lead, the System Finance Lead and the System Transformation Director and NHSE/I representation.

The Programme Delivery Group (PDG) reports to the PEG on a monthly basis. This will be the vehicle by which the PEG and ultimately the Partnership Board oversee and monitor the deliverables identified in this Five Year Strategic Plan.

6.4 Our Journey to becoming and ICS

Consistent with the NHS Long Term Plan, we are working toward being a mature ICS by 2021. A full self-assessment against the recently updated NHS ICS Maturity Matrix was undertaken in July 2019. This allowed us to identify key areas of strength as well as areas requiring further focus going forward.

As a system we are performing well regards System Leadership, Partnerships and Change Capability, and Coherent and Defined Populations with work already undertaken on leadership, developing the system architecture and governance, and ensuring there are coherent and defined populations at System, Place and Neighbourhood.

Whilst some progress has been made against elements of System Architecture and Strong Financial Management and Planning, Integrated Care Models and Track record of Delivery, further work is required and challenges remain, particularly with regards to financial management, delivery of some of the constitutional standards and demonstrating transformational delivery.

Following our self-assessment, we updated our ICS Roadmap with the key milestones required to achieve mature ICS status including a single 'Strategic Commissioning' function and a commitment to move to four Integrated Care Partnerships (ICPs). Our ICS roadmap is overseen by the Partnership Executive Group and reported against to the Partnership Board.

6.5 Our System Enabling workstreams

Estates

The estates workstream has been a key enabler in driving the development of Place Based estates strategies linked to clinical priorities. Key personnel from each organisation at Place have been brought together to develop a programme that will ensure the infrastructure is able to respond to the unique and changing demands of each Place whilst making best use of existing and fixed assets. This has driven the prioritisation of schemes that offer system benefits to several partners at once, rather than individual organisations. A clear governance structure is in place to link the enabling workstreams (estates, medicines optimisation and digital) with clinical, workforce workstreams and Place.

The approach we have taken is underpinned by the following:

- Development of plans underpinned by clinical assumptions/priorities linked to the NHS Long Term Plan (LTP)
- Bottom up plans at 4 Places – Coventry, Rugby, South Warwickshire and Warwickshire North
- Include all key partners – primary care, secondary care, community care, mental health, Local Authorities
- Deliver as much care as possible closest to patients/communities – a 4-tiered facilities approach at neighbourhood, community hub, DGH and Tertiary/Specialist centre level
- Ensure sustainability for all service redesign/reconfiguration - workforce, facilities, financial
- Consolidate and centralise complex services to improve quality and safety, maximise workforce efficiency and make services sustainable
- Enhance the use of mobile/agile working and system consolidation of non-clinical services

All partners have existing estates strategies (including a single Primary Care Strategy) and continue to update and refresh these in line with the system clinical priorities and the development of local priorities at Place. Significant progress has been made with partners coming together to support

delivery of system priorities and overcome organisational constraints. The approach to developing the required estates infrastructure at Place has fostered system level thinking which has then changed and shaped individual organisational estates strategies. These plans not only respond to system clinical priorities but unlock several benefits for several organizations at any one time.

The Estates Strategy Group has increased its membership, to ensure all organisations are represented at the monthly meetings. An implementation plan/workplan is utilised to monitor and manage progress of actions/schemes with a risk register in place to identify/mitigate and manage risk across the system. Key estates workstreams are in place to support the implementation and delivery of the strategy around Capital Developments, Efficiencies, Primary Care and Disposals.

Work has now commenced to consider the entire estates workforce with a view to sharing resource and working more flexibly with all the workforce, particularly where specialist, technical knowledge/expertise is required, or workforce is scarce.

The System Estates Strategy has been refreshed with future schemes identified ready for prioritisation in the late Autumn.

Medicines Optimisation and Pharmacy Integration

Medicines Optimisation has a major influence on delivering better health outcomes for individual patients and improving the health at a population level particularly with regards to reducing inappropriate prescribing and ensuring patient safety across care pathways. For this reason, Medicines Optimisation is part of the LTP, NHS 10 Point Efficiency Plan in the NHS Next Steps on the Five Year Forward View and Lord Carter's review on productivity in NHS Acute Hospitals.

The Medicines Optimisation and Pharmacy Integration workstream has been identified as a key system priority due to its interaction across other workstreams and the potential for significant savings across the System. Our approach:

- Plan underpinned by clinical assumptions/priorities linked to the NHS LTP
- Bottom up plans at 4 Places – Coventry, Rugby, South Warwickshire and Warwickshire North
- Establish bottom up shared learning – individual focus for each Place which can then be shared up at System and cascaded down to all other Place groups
- Include all key stakeholders – primary care, secondary care, community care, LPC, APC, GP Alliance, CSU, PHE, Healthwatch etc
- Ensure sustainability for all service redesign/reconfiguration

The Medicines Optimisation and Pharmacy Integration Steering Group (MOPISG) has increased its membership, to ensure all aspects of the system are represented at monthly meetings. This group will become Medicines Optimisation and Pharmacy Integration Programme Board with representation from each Place. Utilising RightCare data, financial and statistical analysis, the workstream will focus on areas whereby the most system efficiencies can be made. An implementation plan/workplan is utilised to monitor and manage progress of actions/schemes with a risk register in place to identify/mitigate and manage risk across the system.

A System Lead for Medicines Optimisation and Pharmacy Integration post has been approved by the PEG and will be implemented to provide dedicated capacity. This role will be pivotal for the system-wide oversight and driving the programme across multiple organisations.

At Place, activity is driven and monitored through the Medicines Optimisation and Pharmacy Integration Place Groups. These report up into the Place Executive Committees as well as the

Medicines Optimisation and Pharmacy Integration Board. Each Place currently has three identified in-year priorities to focus on with sub-categories forming part of the workstreams.

Digital

The Digital workstream is a critical enabler in supporting our system deliver the NHS Long Term Plan (LTP). Key personnel from every organisation across the system have been brought together to develop a programme that will ensure the infrastructure is able to respond to the unique and changing demands of Place and System whilst also making best use of existing systems. The sharing of knowledge and where possible standardisation of IT systems will achieve a more efficient way of working, reduce duplication and provide the potential for any future system wide integration requirements. This has driven the prioritisation of schemes that offer system benefits to several partners at once, rather than individual organisations.

The approach we have taken is underpinned by the following:

- Development of a Digital Strategy underpinned by clinical assumptions/priorities linked to the NHS Long Term Plan
- Planning undertaken at Place and System and then aligned to maximise opportunities
- Include all key partners – primary care, secondary care, community care, mental health, Local Authorities
- Deliver as much care as possible closest to patients/communities utilising digital technology such as video consultations etc. This will support Place based working and allow other enabling workstreams, such as the estates workstream to deliver their requirements
- Using technology and digital system integration, support organisations to consolidate and centralise complex services to improve quality and safety, maximise workforce efficiency and make services sustainable
- Enhance the use of mobile/agile working and system consolidation of non-clinical services.

The Digital Transformation Board (DTB) has a wide representation with input from all organisations across the System as well as Place and external groups such as the LMC, Ambulance Service, NHSE/D, Information Governance (IG) and Chief Clinical Information Officer (CCIO) etc. A workplan is utilised to monitor and manage progress of actions/schemes with a risk register in place to identify/mitigate and manage risk across the system. The Digital Strategy is currently being refreshed with future activities identified ready for prioritisation by late November.

At Place, activity is driven and monitored by the individual Place Digital Leads who report up into the Place Executives, and the DTB.

Empowering people - this plan acknowledges the transformation in relationships between the population and the clinical and care communities. Records will no longer be fixed to organisations or clinicians but in the future there will be a joint collection and curation approach across all stakeholders using new tools such as apps and wearables.

As part of the Integrated Care Record (ICR) programme a Patient Portal will allow patients access to a summary of their care record including appointment. This will become a Personal Health Record (PHR) which will hold care plans and allow patients to contribute to their health record through the integration with health apps and wearable devices. By 2023 the Summary Care Record (SCR) functionality will be moved to the local shared health and care record systems and be able to send reminders and alerts directly to the patient.

Supporting health and care professionals- all staff need to be equipped with the skills to work in a digital environment and the interim NHS People Plan addresses the need for an increase in the technical skills of the NHS workforce for both specialist and non-specialist staff. The DTB will work with the Local Workforce Action Board (LWAB) to ensure that an integrated approach to staff digital skill development is taken.

Supporting Clinical Care - the ICR will make a significant impact on the delivery of clinical care by allowing clinicians to access a single source of data from across care providers, be that acute, community, mental health, social or primary care. Other partners may be added in the future.

Subject to local prioritisation, other specific areas where digital approaches will improve clinical care are a single Cancer IT system, an integrated Digital pathology network and a single pharmacy solution for all Providers.

Improving population health - as part of the ICR programme a Population Health Management (PHM) tool for data analytics will be procured and implemented. Through risk stratification and predictive modelling it will support System level strategic planning and proactive healthcare management at the Locality / Primary Care Network (PCN) level.

Improving clinical efficiency and safety - provider Digital Maturity will take the greatest step forward in the next 2-3 years as all three acute providers either will or might replace their EPRs. This will deliver ePrescribing to all areas which will improve safety and a more modern EPR solution that will improve general efficiency. Demand and capacity modelling tools will be developed to assist System flow for patients.

Research

Coventry and Warwickshire Health and Care Partnership is committed to a focus on innovation to drive outcomes across health and social care. There is currently variance across the system in terms of innovation maturity, but we are seeking to build a culture of innovation across all partner organisations and embed innovation into all workstreams, so it's 'everyone's business.'

All NHS Coventry and Warwickshire hospitals are research active, partaking in clinical trials with dedicated research departments. Providers work together as a West Midlands South region, potentially exploring a shared clinical trial matching platform. There are good working relationships and partnerships with both Coventry University, and Warwick University and Medical School.

The AHSN network provides an interface between industry, academia and the NHS and the AHSN Implementation Lead provides 'on the ground' capacity to continue developing links with industry and academia. The role is also involved in the NHSE Test Beds, proactively identify potential opportunities for pace of test beds adoption and implementation. Utilising the Innovation Technology Tariff, Innovation Technology Payment and Accelerated Access Collaborative, the AHSN Implementation lead supports system implementation.

Each Provider has a dedicated research department working on health research recruitment. This will ultimately be supported with the development of the integrated health record, and associated population health management work. As a genomics ambassador, UHCW is a leading centre for genomics, one of 18 regional Trusts who come together to form the West Midlands *Genomic* Medicine Centre.

The West Midlands south region operates a Membership Innovation Council which continues to foster a culture of partnership and collaboration with members from across Coventry and Warwickshire and Hereford and Worcester systems coming together to share best practice. All providers in the region also have access to the services of MidTech who provide commercialisation and intellectual property advice and the AHSN Implementation Lead ensures system awareness.

Coventry and Warwickshire host a clinical Entrepreneur, a research midwife based at UHCW. We are also proposing an Innovation, Quality Improvement and Research workstream to increase the sharing of learning across all providers.

6.6 Place

Within each of our four Places (Coventry, Rugby, Warwickshire North and South Warwickshire), local partnership arrangements are being established that bring together our Councils, voluntary and community groups, NHS commissioners, acute and mental health providers, GPs and other primary care providers. Although early days, it is intended that these Place partnerships begin to take responsibility for the cost and quality of health and social care for their populations as well as their well-being through increased prevention. Each of the four Places are developing their own arrangements to deliver the ambitions set out in the NHS Long Term Plan.

These new ways of working reflect local priorities and relationships, but all provide a greater focus on population health management, integration between providers of services around the individual's needs, and a emphasis on care provided much closer to where people live; in primary and community settings. The model also builds on existing partnership working by bringing those commissioning and providing services into an even stronger alignment.

The extent and scope of these arrangements is a matter for local determination, but they typically include elements of shared commissioning, integrated service redesign and delivery, aligned or pooled investment and joint decision making. Other key members of these partnerships include:

- voluntary and community sector organisations and groups
- housing associations
- other primary care providers such as community pharmacy, dentists, optometrists
- independent health and care providers including care homes and hospices.

A more detailed overview of each of the Place arrangements is shown in Annex 1.

6.7 The role of the Strategic Commissioner

During 2019/20 the CCGs have begun to consider how they work together differently in the context of the NHS Long Term Plan's conclusion that CCGs will, in the future, become '*leaner, more strategic organisations'*. In May 2019, the Governing Body of each CCG considered a report which set out different options to create a 'single commissioner' for Coventry and Warwickshire. Engagement with and decisions of the three CCGs' GP memberships will conclude in November 2019. Following on from this, transitioning to more joint working will likely be an area of focus for the CCGs in 2020/21.

Whatever organisational form the CCGs ultimately take, the approach to commissioning must change. Going forward, we have agreed that we will use the same methodology and approach as the Out of Hospital (OoH) outcome-based contract for the following areas; maternity and paediatrics, mental health and potentially planned care. In the longer term, it is intended that Integrated Provider

Contracts will provide the mechanism for these functions ('delivery/place commissioning' functions) transferring this from the strategic commissioner.

As commissioners acting within the same system, CCGs and Local Authorities will maintain close engagement throughout this plan period to ensure a 'true' Strategic Commissioning function is created. The Coventry and Warwickshire Collaborative Commissioning Board ('the CCB'), which draws representation from three CCGs, Coventry City Council and Warwickshire County Council, will continue to have a critical role in ensuring continued alignment in commissioning arrangements between health and social care, as well as in developing the conditions for commissioning integrated and preventative services.

The CCGs' commissioning intentions for 2020/21 were published at the end of September 2019 and identify several priorities that the CCGs will focus on during the year to develop both strategic and delivery/Place commissioning.

6.8 Our Provider Alliance

The Provider Alliance was formed in September 2018 with health and care providers from across Coventry & Warwickshire committing to work together to share expertise, knowledge and skills and draw on the strength of the collective to work in partnership to redesign delivery and develop new models of care.

The alliance comprises NHS providers and the two local authorities plus Primary Care. Their main objectives are:

- Respond to the system need to redesign end to end pathways and determine the most appropriate partnerships to undertake this (System, Pan-System or Place)
- Influence and shape the strategic commissioning development pipeline
- Oversee the assessment of risks and opportunities associated with each pathway redesign
- Determine the most effective form for the management of the end-to-end pathways e.g. prime contractor, prime provider or alliance and influence the commissioning of these forms
- Develop the governance principles and structures that will enable and drive the collaborative efforts between providers and commissioners and identification of the resources to do it
- Develop a delivery roadmap for each opportunity, identifying the required capability and capacity to deliver
- To provide a forum to share best practice.

As the strategic commissioning function develops, the provider alliance will need to build capacity to respond to the pipeline of outcome-based contracts as well as work with partners in place. Initial meetings focused on the establishment of the alliance, agreed ways of working and the scope of the work programme.

It is recognised that there are clinical relationships and co-dependencies for which it is anticipated the Clinical Forum or Clinical Groups at Place will be the most appropriate groups to critically appraise the proposals for new models of care through a clinical lens.

In July 2019 the MCYP Programme started Phase 2 of the Maternity and Paediatrics workstream that will be undertaken during 19/20 into 20/21. Phase two will enable front line staff working in maternity and paediatrics to consider how services can be most effectively be delivered to improve the health outcomes, quality, and experience of services in the context of the existing health inequalities, workforce, estate and financial constraints. The Provider Alliance is a key vehicle for the provider collaboration throughout the process.

6.9 Partnership working

Many of the key partnership arrangements have already been mentioned and detailed in this document such as PCNs, our four Places, Commissioners and the Provider Alliance. However, our relationship with our Local Authority (LA) colleague goes from strength to strength and is one of the most important relationships in delivering our approach to Population Health.

We recognise that the Voluntary Sector organisations are also important partners in our system and have the potential to support us deliver the requirements of the LTP, if we enable them. Alignment with the voluntary and community sector ('VCS') is delivered through multiple channels including the Place based partnerships, the local Working Together Boards (as part of the OoH Transformation Programme) and the Practice Based Teams. We will build on these existing relationships to ensure that the VCS is enabled to contribute to the overarching outcomes that our Partnership is seeking to achieve for the benefit of all communities in Coventry and Warwickshire.

6.10 Our future approach to Engagement

As identified in the New Local Government Network (NLGN)report 'Community Commissioning – Shaping Public Services through People Power,' a radically different relationship between citizen and the state is required for the public service to deliver its preventative agenda. The report argues, community commissioning results in numerous benefits for both people and Places with evidence available that individual wellbeing, community cohesion as well as policy effectiveness all improve based on greater participation among citizens. This ultimately means handing power and resource, that is currently held by public sector institutions, over to communities.

The commissioning of public services is one of the most important functions of the public sector but also one that is deeply embedded within institutions. Community Commissioning makes a convincing case for why the process needs to be led by citizens and service users not public sector professionals. Importantly, it also explains in detail how this shift is happening in practice.

Although at the very start of this journey, our future model of engagement will be rooted in true integration and meaningful collaboration within every neighbourhood and we are committed to make the changes required to transfer this powerbase. Our approach will be underpinned by the following principles:

- Change is done with and not too people. Building on the work already undertaken by our Local Authorities, we want to continue to develop a relationship between public services, people, communities and businesses that enable shared decision making, democratic accountability and voice, genuine co-production and the joint delivery of services
- We will adopt an asset-based approach that recognises and builds on what individuals, families and our communities can achieve rather than focus on what they lack
- We will encourage behavior change in communities that build independence and support people to be in control
- Wellbeing, prevention and early assessment and intervention will become bigger priorities
- A Place-based approach will redefine services and put people, families and the communities at the centre
- We will continue to develop an approach that supports the development of new investments and resourcing models, enabling more collaboration with a wide range of organisations and communities of all sizes, e.g. the voluntary sector and charities
- We will be honest and transparent with our public about what can and can't be achieved, and why, even if this sometimes means having difficult conversations. This will help manage the expectations of our population.

We also acknowledge that the community and voluntary sector do fantastic work to support our population, especially those who might struggle to access services and feel their voice is lost or seldom heard. We will work with and support these organisations to make sure as many people as possible have a say in the future to ensure that our services are fit for purpose and reflect the needs of our entire population.

6.11 Our approach to Quality

In line with our Partnership's system-wide vision, we are committed to improve the quality and outcomes for users of health and care services across Coventry and Warwickshire. We will seek to achieve this through a standardised approach to quality assurance at both System and Place levels. Partnership working, reducing unwarranted variation, reducing avoidable harm and improving the personalised patient experience will all contribute to achieving this approach.

As commissioning and provider organisations, we aim to address the 'quality gap' by transitioning from our established approach to quality to one where commissioners and providers across the system work better together to maximise the impact that can be achieved through quality assurance and quality improvement activities.

Our approach to quality, forms one aspect of the broader system strategy to improve health outcomes. Historically there have been three areas that NHS Commissioner's monitor - patient safety, patient experience and clinical outcomes. The Strategic Commissioner will move away from this approach to one which establishes and monitors outcomes-based contracts. Quality monitoring becomes critical as the delivery of clinical outcomes drives payment rather than activity. Each lead provider will take responsibility/accountability for contractual quality monitoring of sub-contractors.

Our future clinical outcomes approach will form the basis of a new system wide quality dashboard which will operate at both System and Place level. System level will focus on the monitoring of outcomes and Place level will focus on the delivery of specific KPIs that underpin delivery of these outcomes. Monitoring at Place level will need to be statistically sophisticated and robust enough to account for normal statistical variation and statistical special cause variation, which requires further work. This approach recognises that getting collective, accurate and detailed reporting is fundamental to achieving these aims.

There will be clear system governance processes in place with the strategic commissioner having oversight of the clinical outcomes dashboard. The lead providers in the Integrated Care Partnerships (ICPs) will develop their own Clinical Governance Committees and will monitor the KPI dashboards of their own contract and their sub-contractors. The governance will include the process of escalation and de-escalation of concerns at a system level, strategic level and place-based level, based on a risk-rated approach. A new Integrated Care System Quality Surveillance Group will have oversight of those red-rated risks, ensuring effective management of these, but also ensuring the dissemination of best practice between lead providers across the ICS.

7. Finance, Activity and Workforce Assumptions

7.1 Finance Assumptions

In 2018/19 the system out-turned at an aggregated position of £14.7m deficit from our control total; this contained £36.7m of sustainability and recovery funds. The reported efficiency within this position amounted to nearly £100m representing a reported year on year aggregate efficiency of circa. £300m since 2016; however, we acknowledge that this has been underpinned by a significant volume of non-recurrent and provider productivity.

The system workstreams have largely allowed cost containment against rising demand rather than remove costs. The system has committed to a financial plan that shows year on year improvement in the underlying financial position, with year four and five starting to show a reversal of the trend.

In 2019/20 two significant contracts changed to reflect the commitment to improve the "system £". This has refocused the discussions from that of transactional contracting to wider conversation of pathway improvement. The programmes for Place underpin the delivery, with future operating models for MSK, frailty and mental health.

Alongside this, is the workforce plan. Organisationally, a significant impact has been made on the agency spend reducing by over £14m from 2016/17; however, there are still areas of shortage and the ability to provide the workforce to support transformational change is still a challenge. This provides a focus on the innovative use of workforce in the system work programme.

Moving forward the system is committed to the implementation of Aligned Incentive Contracts (AICs) and is currently working through both the financial strategy and associated risk share that will help to manage risk across the system.

During 2019/20 a system capital allocation was issued against which providers were asked to manage their programmes. This presented the system with a number of challenges due to its mixture of foundation and NHS trusts; however, providers came together to agree a common methodology and an agreed spend within the envelope allocated.

The STP had total allocations of £1.356bn for 2018/19 and had an adverse variance to planned control totals of £26.18m at the year end. George Eliot and UHCW posted deficits for 2018/19 as they have over recent years. SWFT has consistently delivered surpluses over the past decade and CWPT have delivered another small surplus in line with the planned control total.

Combined NHS underlying system financial position at the beginning of 2019/20 is a deficit £101m.

	Coventry & Rugby £000's	Warwickshire North £000's	South Warwickshire £000's
Underlying Position - Surplus/(Deficit)	(54,246)	(29,384)	(18,018)

Finance Principles

In order confirm our desire to work together to deliver an improved financial picture, several principals have been agreed. The 8 agreed principals are listed below:

1.	We all agree to collaborate under the principle of "one system, one budget" and to make decisions based on the best use of NHS resources. We will work towards wider public sector resource utilisation.
2.	We all agree to promote an unrelenting focus on eliminating waste whilst maintaining, if not improving, quality.
3.	We all accept the need for expenditure within a given ICS footprint to be contained within the available resources (within our control) to commissioners in the ICS.
4.	We all agree to deliver an improved year on year collective financial position.
5.	We all agree to share information openly in order to inform collective decision making.
6.	We all agree to actively support demand management initiatives (as modelled in the system-wide demand and capacity plan) intended to keep actual aggregate year on year growth as close to zero as possible.
7.	We all agree to facilitate the sharing of patient information between organisations (within IG rules) to support the delivery of proactive and preventative care, including demand management.
8.	We will collaborate and facilitate the redistribution of resources to ensure that patient needs can be addressed in the most cost-effective care setting.

One of the agreed financial principals aims to contain expenditure within the available resources allocated to commissioners in the system. Dealing with demand in a different way will be key in reducing and containing the cost of delivering clinical services, another agreed financial principal.

Productivity and Efficiency

The total efficiency required by the system is £119.4m for 2019/20; £51.7m for commissioners and £67.7m for providers. The system recognises that attempting to deliver savings in a traditional manner will not deliver the scale of savings required and therefore a different approach is needed.

Focus on Cost

With the commissioner letting contracts for each of the 4 places for a (largely) fixed sum, the focus will need to move away from income to the cost base of delivering services. Multi-year contracts provide certainty of income to providers while incentivising innovation. Integrated Care providers will need to work differently to respond to the demands with modest year on year growth in contract values.

The cost base for NHS providers is generally in two parts; workforce and estate. Provider workforce costs tend to increase in response to demand from patients for services whether planned care or urgent care.
Managing demand for services give the opportunity to;

- add costs - where providers must engage additional clinical workforce over establishment and therefore incurs premium costs, and;
- reduce costs – where demand can recurrently be dealt with in a different way;

Capital

Given the ongoing constricted position on capital nationally it is essential that the system makes the most efficient use of estates. The estates strategy focuses on both utilisation and the potential for capital receipts. Future planning intends to draw on the experience used in the 19/20 response to

the system capital allocation to ensure an equitable approach to future development and back log maintenance.

PFI

Increasing costs of some PFI buildings have not covered by inflationary tariff uplifts in recent times. Overall estates usage could have an impact on making sure the right blend of services are delivered on the right sites to give the best operational fit for each site. Going forward we need to maximise the amount of specialised services delivered on the UHCW site, and currently the provision of specialised services is being reviewed across the system.

7.2 Activity Assumptions

Activity plans have been based on the application of demographic, non-demographic growth, based on current activity rates, and planned service changes. The activity plans are responsive to both System and Place based needs, and support the delivery of the Long Term Plan requirements including reducing face to face outpatient attendances, increasing same day emergency care and increasing planned care to ensure that patients receive timely and effective care.

7.3 Workforce Assumptions

Assumptions across the Coventry and Warwickshire system are based on the following core principles:

- the overall workforce numbers and cost will not increase however there will be a continued focus on the redesign of job roles ensuring generic skills are recognised and optimised
- Spend on agency staffing will continue to reduce and a truly flexible workforce established with the ability to flex supply and demand in a more efficient and effective way
- System wide working will improve with rotational posts and services ensuring previous organisational boundaries are removed allowing staff and services to be directed to areas of most need.

7.4 Key risks to delivery and mitigating actions

As a system, we have identified five key areas of risk associated with our ability to deliver this plan over the next five years. These are:

- Financial sustainability in the short to medium term
- Building a workforce that is fit for the future
- Having the right information/evidence to inform effective decision making for our population
- Capacity of clinicians within the system to engage in the programme of activities required
- Maintaining positive system relationships through times of change and challenge

Having identified these risks, we intend to work up a detailed system risk register, describing each risk in more detail and aligning mitigating actions for each risk by the mid-November submission. We will then manage risk through the Programme Delivery Board and the Finance Advisory Board, reporting on a monthly basis to the Partnership Executive Group.

8 Conclusion

Or Five Year Strategic Plan reaffirms our commitments to realising our ambitions and delivering both local priorities and those set out in the Long Term Plan. It provides a reflection on what we have achieved, but also an honest view of the challenges that lay ahead of us and our responsibility to address them.

Our collaboration is underpinned by a governance structure that continues to evolve and there is a commitment from all partners to work together to implement solutions that will improve the health outcomes and well-being of our population.