NHS
Warwickshire North
Clinical Commissioning Group

Our Commitment to Health

COMMISSIONING INTENTIONS

Refresh 2018/19

Quality & Equality First

What are commissioning intentions?

- All CCGs are required to develop and publish commissioning intentions on an annual basis
- Our commissioning intentions outline the actions we will take to **improve health outcomes for our local populations – our "Commitments to Health"**
- They set out the **priorities** for the CCG in line with **national** and **statutory requirements**, set in the context of sustained and **significant financial** and **clinical workforce challenges**
- We have reviewed our progress to date and are now presenting a **refresh of our commitments to health.**

Working together with a local focus

Driven by our values, we are committed to working together and in partnership with others to deliver locally, responding to the health needs and inequalities of our diverse population.

We will build on our progress so far to achieve our strategic priorities:

- Improve health outcomes and reduce health inequalities
- Through effective commissioning, ensure safe, high-quality service for our populations
- Make the best use of our resources
- Build a health system fit for our population
- Promote integration / interdisciplinary working

Our Values

Quality and equality

Valuing each individual

Dignity, respect and compassion - for our patients, carers, population and staff

Working together - improving health and sustainable services

Improving services for the whole community - wasted resources are wasted opportunities for others

National drivers

2017/18 & 2018/19

1. Implement the local **Sustainability Transformation Plan** "Better Health, Better Care, Better Value"
2. **Finance** – making sure we use our money wisely to provide the services people need in an affordable way
3. **Primary Care** – ensure primary care has the right amount of staff to continue to provide services that are high quality, accessible and deliverable at scale
4. Ensure **urgent and emergency care provision** meets required standards
5. **Timely** referral and scheduled care - (incl. maternity services review)
6. **National Cancer Strategy**
7. **Mental Health** – implement the mental health five year forward view for all ages
8. **Learning disabilities** – reduce reliance on avoidable inpatient care and help better support people to live in the community
9. **Improve** the overall quality of health and care.

Aligning with the local health economy

HEALTH AND WELLBEING PRIORITIES

Coventry

- Reduce health and wellbeing inequalities
- Improving the health and wellbeing of individuals with multiple complex needs
- Developing an integrated health and care system to provide help and support to enable people to live their lives well

Warwickshire

- Promoting independence
- Community Resilience
- Integration and working together

BETTER HEALTH, BETTER CARE, BETTER VALUE

- Preventative and proactive care
- Primary Care
- Out of Hospital
- Maternity and Paediatrics
- Urgent Care
- Planned Care
- Mental Health

FIVE YEAR FORWARD VIEW

- Urgent and emergency care
- Primary care
- Cancer
- Mental health
- Integrating care locally
- Funding and efficiency
- Strengthening our workforce
- Patient safety
- Harnessing technology and innovation

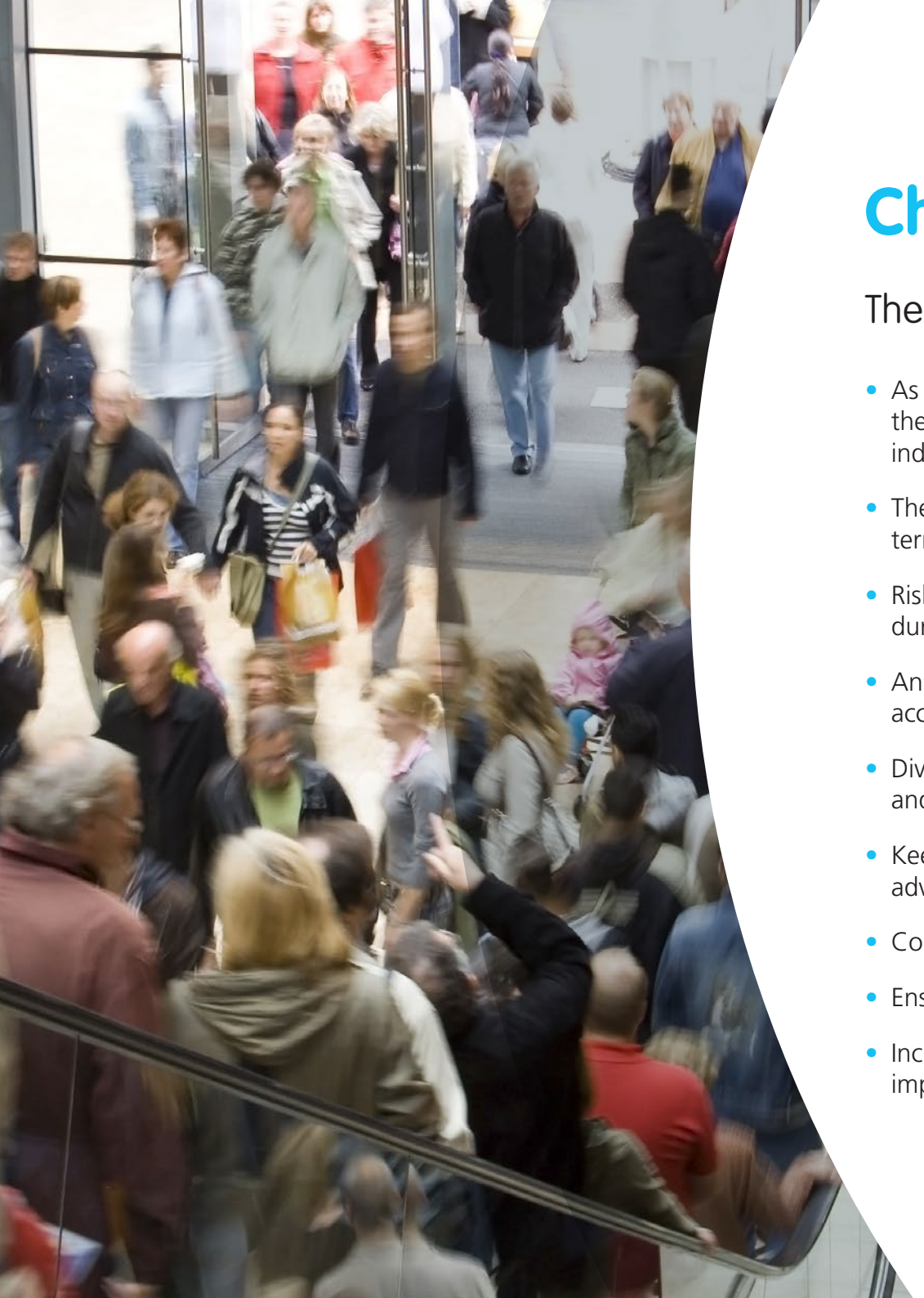
OUR COMMITMENT TO HEALTH

Sustainable Local Health System

- We are committed to **developing strategic** commissioning across Coventry and Warwickshire to deliver **Better Health, Better Care, Better Value**
- We want to be assured of the **sustainability of high quality, clinically safe acute services**, in the light of workforce challenges
- We want to progress **clinical networking between GEH and UHCW.**

The areas we serve –
Nuneaton, Bedworth and north Warwickshire

- We will **tailor system-wide priorities** to optimise health benefits / outcomes **for our local populations**
- We will **commission services** that are delivered around our **diverse neighbourhoods** and **communities**
- We will continue to work with **member practices, clinical leaders, providers, patients and the public** to co-design services to 'fit' local needs.



Challenges and pressures

The NHS locally is facing a range of pressures:

- As we celebrate people living longer, we need to ensure that they have the necessary support to maximise their health and independence
- There has been a rise in the number and complexity of long term conditions
- Risks associated to lifestyle e.g. drug and alcohol misuse, smoking during pregnancy and obesity put pressure on services
- An expectation for an 'always on' NHS and the need to increase access to services (including 7 day services)
- Diverse populations – urban and rural communities who want, need and expect different things
- Keeping up to date with the latest medical & technological advances
- Constrained public resources
- Ensuring there are enough trained staff to deliver the services
- Increased housing developments and population growth and the impact that this has on local NHS.

Health Inequalities - July 2017

Nuneaton and Bedworth

- The health of people in Nuneaton and Bedworth is varied compared with the average across England
- Life expectancy is 7.4 years lower for men and 6.7 years lower for women in the most deprived areas
- About 20% (5,000) of children live in low income families
- 21.5% (289) of children in year 6 of primary school are classified as obese
- The number of hospital stays due to alcohol-related harm among those under 18 years is 19 stays per year and for adults 735 stays
- The number of hospital stays due to self-harm is 320 stays per year
- Estimated levels of adult excess weight are worse than the England average
- The rate of violent crime is worse than average.

21.5%
OBESITY IN CHILDREN

20%
IN LOW INCOME FAMILIES

Local priorities

Priorities in Nuneaton & Bedworth include:

- tackling lifestyle behaviours
- mental health and wellbeing
- sexual health
- smoking in pregnancy

Health Inequalities - July 2017

North Warwickshire

- The health of people in North Warwickshire is varied compared with the average across England
- Life expectancy is not significantly different between the most and least deprived areas of North Warwickshire
- About 15% (1,600) of children live in low income families
- 17.0% (108) of children in year 6 of primary school are classified as obese
- The number of hospital stays due to alcohol-related harm among those under 18 years is 5 stays per year and for adults it's 320 stays
- The number of hospital stays due to self-harm is 104 stays per year
- Estimated levels of adult excess weight are worse than the England average
- The rate of people killed and seriously injured on roads is worse than average.

Local priorities

Priorities in north Warwickshire include:

- tackling lifestyle behaviours
- mental health and wellbeing
- sexual health
- smoking in pregnancy

Commissioning Intentions 2018/19

We face significant financial and workforce challenges across health and social care, which we need to consider when setting our commissioning intentions.

We may need to develop new ways of delivering care to meet patient need, demand and financial constraints.

But most importantly, we need to:

- Put patients needs before organisational needs and make sure the system can continue to deliver
- Provide services that support people to live independently for longer, stay well and recover quickly closer to home, where appropriate and safe to do so
- Commission services that encourage and support patients to be active participants in their own care
- Improve patient outcomes and make the best use of the resources available to us
- Commission in local community settings where it is safe, sustainable and achieves improved outcomes and patient experience
- Provide holistic care co-ordinated around the patient, delivered by multidisciplinary teams working around groups of GP practices.

Commissioning Intentions 2018/19
Our strategic work programmes

We have developed six strategic work programmes:

Primary Care

Our commitment is to enable the delivery of primary care at scale, increase opportunities for practices to work together to deliver resilient sustainable primary care, increase access to seven day services and same-day urgent care.

Out of Hospital Care

Our commitment is for fewer visits to hospital for patients with ongoing conditions and less time in hospital when you do have to stay, supported by more rehabilitation and ongoing support closer to home.

Maternity and Paediatrics

Our commitment is for a Maternity and Paediatrics service delivering safe, kind, family friendly, personalised care with improved outcomes for children, young people and families.

Urgent and Emergency Care

Our commitment is to deliver an integrated urgent and emergency care offer to the public with simple access for patients, delivering consistency of care.

Planned Care

Our commitment is to ensure timely access to expert opinion, investigation and treatment. We will reduce unnecessary visits to hospital for follow up care. Care will be provided in a range of accessible community settings.

Mental Health

Our commitment is to deliver a proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and support individuals and families to manage their mental health and wellbeing condition.

How we align to the **five year forward view**

Five year forward view key deliverables 2018/19

Primary Care

Engaging primary care to work within a network of 'hubs', combined populations of 30,000 – 50,000

Enabling practices to share and pool resources and responsibilities

Supporting GP practices to develop a sustainable workforce

Explore opportunities for practices to work together to increase flexible access to seven day services

Out of Hospital Care

Commission and implement a new "lead provider" model of care which will improve the care of frail and vulnerable adults through better coordination of multidisciplinary teams working across groups of practices

Maternity & Paediatrics

Rapid referral protocols in place between professionals and across organisations

Postnatal care - women should have access to their midwife as they require after they have had their baby

Urgent and Emergency Care

Deliver Integrated Urgent Care services with simple access for patients

Standardise Urgent Treatment Centres in line with national standards

Reduce levels of Delayed Transfers of Care from hospital with 85% of assessments undertaken outside hospital setting

Appraisal of a new Stroke Pathway which will deliver the NHS Midlands and East Stroke Service Specifications and the benefits it has delivered

Planned Care

Reduce avoidable demand for elective care – tackling variations in referrals and providing advice first options for primary care

Creation of redesigned and efficient hospital pathways, avoiding duplication and unnecessary hospital visits

Expanding cancer screening uptake – focus on bowel, breast and cervical cancer

Mental Health

Increase access to talking therapies for those presenting with depression and or anxiety from 16.8% to 19%

Children treated via community services, therefore reducing avoidable admissions to inpatient beds

FYFV priorities: **Urgent and emergency care** | **Primary care** | **Cancer** | **Mental health** | **Integrating care locally** | **Funding and efficiency** | **Strengthening our workforce** | **Patient safety** | **Harnessing technology and innovation**

Preventative and Proactive:

Primary Care

Our commitment is to enable the delivery of primary care at scale, increase opportunities for practices to work together to deliver resilient sustainable primary care, increase access to seven day services and same-day urgent care.

Provide more support and education to help patients look after themselves and

REDUCE UNNECESSARY
DOCTORS APPOINTMENTS

REDUCE
WORKLOAD PRESSURE
Hubs spread over 30,000 - 50,000 patients

IMPROVE
Patient experience and reduce unnecessary prescriptions

Make it easier for local health and care organisations to

WORK TOGETHER

Ensure practices aren't **OVERWHELMED** as a result of new housing developments

IMPROVE
access to seven-day services and offer more flexible types of consultation

IMPROVE
dementia diagnosis

Help practices to find the

RIGHT STAFF
to meet demand

COMMISSIONING INTENTIONS

Preventative & Proactive Care: **Primary Care**

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Prevention of Type 2 diabetes	• WN GP's have led improvements in diagnosis and management of diabetes patients • The #onething campaign has been pivotal in raising awareness of the risks and identifying people who are in need of treatment • The #onething campaign has been run in partnership with Warwickshire County Council. - Hundreds of health checks have been carried out as part of the #onething campaign and during Ramadan at the local mosque	• A greater proportion of patients will be diagnosed with diabetes meaning they benefit from earlier detection rates and subsequent treatment and control of condition	• Ongoing monitoring of diabetes diagnosis rates • On-going promotion and utilisation of #onething campaign
Support better management of diabetes in primary care	• Proposals are currently being developed to create an 'insulin initiation in primary care service' • The CCG is exploring the potential benefit and appetite to deliver a community diabetes service	• Increased likelihood that local patients will have their insulin initiation management and general diabetes care in a primary care setting, avoiding the need to be referred into a hospital setting	• Regular monitoring of numbers of patients having their insulin initiated in a primary care setting rather than local hospital
Providing high quality education and self care resources to help support patients with diabetes	• We have secured funding to provide a diabetes education and self care programme for patients, which we have begun to roll out to patients	• A greater proportion of patients will have access to and benefit from the Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND) education programme • Patients will be provided with necessary skills and education to help them manage their own condition, meaning they don't need to go to their GP or hospital as much for their diabetes	• Keep tracking how many people are accessing the DESMOND programme and seeing if there is a decrease in GP and hospital attendances as a result
Supporting GP practices to develop a sustainable workforce and avoid staffing issues	• A GP Forward View group has been established with workforce issues identified as a key priority • We have secured some primary care resilience funding • We are looking into the development of a GP retention scheme • We are assessing the benefits of creating an international recruitment scheme • We are reviewing initiatives such as nurse mentorship and nurse prescribing, to achieve a more sustainable workforce	• Work with our member practices and key partners to understand the current and forecast workforce capacity and pressures • Ensure that the CCG works closely with NHS England and member practices to attract and retain workforce within the local area	• We will proceed with a GP International Recruitment application (November 2017) • Ensure practices benefit from this funding by identifying the key actions necessary to add support to practices experiencing difficulties • We will have a primary care workforce strategy by October 2017, and will deliver the strategy during 2018/19

Preventative & Proactive Care: **Primary Care**

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Develop plans for general practices to work at scale	• The CCG is exploring possibilities for the development of accountable care systems through our work around new models of care for Out of Hospital services and Primary Care Hubs	• Patients will benefit from the sharing of a skilled workforce and exploring possibilities to enhance outreach opportunities	• This is a long-term piece of work that will continue into 2018
Support primary care to improve health in care homes	• We have extended the contract period for current Primary Care enhanced support to care homes	• Patients will see improvements to the quality of care in nursing homes	• This is a long-term piece of work that will continue into 2018

Primary care supports delivery of an End Of Life Improvement Plan	• Primary care in WN are actively involved in the development of an End of Life improvement plan which includes:
	  • Personalised care planning,
	  • Shared records
	  • Evidence and information
	  • Involving and supporting carers
	  • Education and training
	  • 24/7 access to services
		• Patients will benefit from closer partnership working
		• Advanced care planning and better sharing of data between a range of agencies who together deliver support and care to those who are within the last 12 months of life
		• Patients will also benefit from enhanced support in the community to enable them to remain at home where that is their wish
			• Continued monthly meetings of the Palliative Care Network to oversee and deliver the required improvements to the system
			• Commission local palliative care/end of life bed capacity by the end of the 2017/18 financial year

Improving the quality of GP referrals to reduce inappropriate and unwarranted referrals	• Warwickshire North CCG are developing a process for GPs across Warwickshire North to peer review GP referrals in order to ensure all referrals are clinically appropriate	• A greater proportion of patients will not need to be referred into secondary care and might instead have their condition managed by an alternative community based alternative or through self management	• Peer review process will be adopted by WN GP practices from September '17 with regular review points to assess impact going forward

Improve dementia diagnosis	• A range of actions have been identified for 2017/18 with the aim of increasing diagnosis rates, including :
	  • Asking practices to revisit patient lists and check their accuracy and record keeping
	  • Holding an event for practice managers in September
	  • Attending local community events on dementia to raise awareness and provide information and education, and specifically working with nursing homes
		• More individuals with dementia will receive a definitive diagnosis of dementia and be able to access a range of appropriate post diagnosis support enabling them to live independently for as long as possible	• To focus on residents in the care home population with the aim of identifying and diagnosing dementia
			• To work with primary care on improved identification
			• To continue to promote the Warwickshire County Council 'Living well with dementia' information portal

Preventative & Proactive Care: **Primary Care**

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Consult and work with our member practices on moving to full delegation to commission General Medical Services, giving the CCG the opportunity to take on more responsibility for general practice commissioning	• Warwickshire North CCG have consulted member GP practices in Warwickshire North on the option for moving to delegated authority • Member GP practices voted to remain co-commissioned with NHS England • Warwickshire North CCG intends to consult member GP practices again when the opportunity arises	• Greater opportunity to develop GP Primary Care to reflect the needs of the local population. reflective of demography and availability of local services • Improved access to primary care • Improved quality of care being delivered to patients • Greater local ownership and relationships between CCG and member practices • Greater patient involvement in shaping services • Ensures primary care remains strong for the future	• Implementation from April 2018 subject to member practices voting in favour of moving to delegated commissioning
Improvement of primary care estate – buildings, number of practices, technology available etc	• WNCCG re-established the Warwickshire North Local Estates Forum (LEF) in September 2016 • Hosted by the CCG and attended by provider trust estates leads, as well as WCC and planning leads from NWBC and NBBC. The LEF provides a forum to explore primary care estate opportunities in the context of the wider health economy	• The improvement of primary care estate and the greater use of technology will enhance patient care and experience as facilities will be designed with greater flexibility to accommodate multi-disciplinary teams and an increased online access will make it easier for people to be seen quicker	• Refresh the primary care estates strategy to include new housing and population growth by April 2018 • Continue to progress the projects which are currently under the Estates and Technology Transformation Fund (ETTF) by 2018/19 • Identify, through the Local Estates Forum and wider STP Estates Strategy Group, opportunities for joint working across the estate

Preventative and Proactive:

Out of Hospital Care

Our commitment is for fewer visits to hospital for patients with ongoing conditions and less time in hospital when you do have to stay, supported by more rehabilitation and ongoing support closer to home.

COMMISSIONING INTENTIONS

Recommissioning of residential and nursing home

PLACEMENTS

IMPROVE SUPPORT

for patients nearing the end of their life, and provide support for their family

IMPROVE CARE

and support for the frail and elderly by working more closely across organisations

DEVELOP

local support networks in the community

COMMISSION

hospice-type beds for end of life patients

Ensuring there are

LOCAL SERVICES

in-reach for care homes

DEVELOPMENT

of the Coventry and Warwickshire out of hospital programme in our localities

Preventative & Proactive Care: **Out of Hospital Care**

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Make it easier for patients to know what urgent care services are available and how and when to access them	• We have reviewed current services against national standards to ensure they remain fit for purpose • We have started working with local providers to ensure urgent care services are more closely linked to A&E to help reduce demand and wait times	• A more responsive, joined up service which will be easier to navigate for patients • Patients will receive the right care for their needs in the most appropriate place	• Work will continue in 2017/18 to develop an integrated model of care • We aim to completed integrated service by December 2019
Review commissioning arrangements for enhanced service to nursing homes	• We have consulted with providers and nursing homes to identify what is working well and to explore different models	• Help ensure people in nursing homes only go to hospital when necessary by providing more care at the home	• Agreement of model and approach in 2017/18 • Commission and commence new service in 2018/19
Review commissioning model and investments for hospice bedded care for end of life patients	• We have held initial discussions with stakeholders around redesigning the end of life model of care in Warwickshire North to better suit patient need	• Patients and carers will receive increased level and quality support at end of life • More patients will be able to end their life in their place of choice • Focus on families and carers, and the support they need if they are caring for an individual who is at the end of their life	• The CCG will develop community support ('compassionate communities') for end of life patients
Roll out IT systems across all GP practices to support end of life patients across agencies	• A new electronic palliative care system (CASTLE) is in development	• Patients and carers will receive increased level and quality support at end of life • Patients will only have to tell their story once as their data will follow them	• The electronic system will be introduced across all practices
Commission a sustainable social prescribing model, which enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services, which shows clear benefits and return on investment	• We have worked with the voluntary sector to work towards an integrated sustainable model • A new social prescribing offer is in place in two primary Care hubs	• Patients will be supported to keep healthy and remain independent for longer by accessing an appropriate range community services and support	• Continue with the development of a social prescribing pilot and extended coverage

Maternity and Paediatrics

Our commitment is for a Maternity and Paediatrics service delivering safe, kind, family friendly, personalised care with improved outcomes for children, young people and families.

COMMISSIONING INTENTIONS

REDUCE INFANT MORTALITY

by 50% by 2030

DEVELOP A LOCAL RESPONSE

to the "Better Births" national maternity review

ENSURE

right amount of neonatal cots (level 1 to 3 cots), based on patient need

IMPROVE ACCESS AND MANAGE DEMAND FOR

Occupational therapy | Physiotherapy
Speech and language therapy

INDIVIDUAL EDUCATION, HEALTH AND CARE PLAN (EHCP)

provided for all children with Special Educational Needs and/or Disability (SEND)

Maternity and Paediatrics

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Working together with local commissioners and providers to develop a local response to the "Better Births" National Maternity Review	• Measured our performance locally against the national Better Births recommendations • Established a new "Local Maternity System" which will review and develop better maternity, neonatal and paediatric services by 2020	• Safer, kinder, more family friendly and personalised care • Ensure patients feel more involved in the decisions about their care • Ensure support is centred around a patient's individual needs and circumstances	• Allow patients a choice of provider for antenatal, intrapartum and postnatal care • Provide improved access to a small team of midwives to ensure consistency for mothers and mothers-to-be • Plan for community hubs to provide care closer to where people live

Ensure women at risk of premature delivery receive the right care in the right place at the right time leading up to the birth of their child	• A pilot pathway is in place to ensure women receive the right care in the right place at the right time
	• The mortality rate per 1,000 live births has been reduced as follows:
	  • Coventry
	  2009/11 – 5.6 per 1000 l 2013/15 – 4.0 per 1000
	  • Rugby:
	  2009/11 – 5.7 per 1000 l 2013/15 – 2.7 per 1000
		• Reduce the number of babies born further from home
		• Improve infant mortality by reducing the number of stillbirths and neonatal deaths in England by 50% by 2030
			• We will continue to evaluate the pilot pathway during 2018/19

Ensure we have the right amount of neonatal cots (level 1 to 3 cots), based on patient need	• Reviewed the recommendations of the West Midlands Neonatal review	• Mothers and babies receive care in the right place at the right time	• Review neonatal cot locations and realign as appropriate • Consider Alliance commissioning arrangements with NHS England
Improve the wellbeing and development of children aged 0-5 years	• Delivered the objectives as outlined in Warwickshire County Council's Smart Start Strategy, aimed at providing children with the best start in life	• Early detection and intervention to reduce any long term health and or developmental issues	• Monitor the progress of all projects and service developments and review ongoing benefits to patients
Achieve national requirements related to Special Educational Needs and or Disability (SEND)	• Children that had a Statement of Special Educational Need are in the process of being transferred to an Education, Health and Care Plan (EHCP)	• All children will have an up to date EHCP that clearly states their needs and outcomes to ensure they receive the best care for their particular needs	• Ensure achievement of all transfer plans in place by March 2018

Maternity and Paediatrics

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Ensure we provide the right children's services across the area by joining up and working more closely with our partner organisations, such as Warwickshire County Council and South Warwickshire CCG	• Coventry and Warwickshire CCGs have agreed to work towards collaborative commissioning arrangements for patients in Warwickshire, including Rugby	• Improved care • Reduced duplication and unnecessary repetition ("tell my story once") to improve patient experience	• Agree the plan to implement phase one of the Collaborative Commissioning approach
Ensure we are spending money wisely on prevention and early intervention	• Planned a review of the following services during 2018/19: - overnight short breaks - community nursing - community paediatric services	• Improving access to the right services, provide earlier identification and intervention of support needs, improve patient outcomes	• Undertake reviews of early intervention and prevention services
Improve services for Looked After Children (LAC) by ensuring we understand their particular needs	• Reviewed services for looked after children through the joint commissioning arrangements with Warwickshire County Council	• Ensure looked after children receive the same level of care and support as others	• Continue to ensure equal access to services
In light of rising demand, ensure we improve access of: • **Occupational therapy** • **Speech and language therapy** • **Physiotherapy**	• Reviewed as part of the joint commissioning arrangements	• Improve access to these services • Better early identification and intervention • Improve patient outcomes • Reduce waiting lists	• Agree and improve the way in which these services are delivered
Work with public health to reduce childhood obesity	• Worked with Fitter Futures programme to increase referrals into the services	• Healthier weight and better lives for children • Prevention of long term conditions	• Identify initiatives to increase referral rates
Helping people better manage long term conditions, such as asthma	• Worked with school nurses to identify opportunities to help prevent and/or manage long term conditions	• Improved outcomes and care • Better access to services	• Prioritise work programme against the range of long term conditions

Urgent and Emergency Care

Our commitment is to deliver an integrated urgent and emergency care offer to the public with simple access for patients, delivering consistency of care

INCREASE

the number of patients and conditions treated in the community and closer to home

PROVIDE BETTER

community based support to help avoid needing to go to hospital

INTEGRATE

and develop rapid response services and support once people are in the urgent and emergency care system

85%

of long-term care assessments outside a hospital setting

Easier for patients and carers to

UNDERSTAND

and access the right type of urgent care service in an emergency

REDUCED

unnecessary reliance on urgent and emergency care services

IMPROVE STROKE SERVICES

across the area to reduce the number of strokes suffered, improve immediate care for those that do have a stroke and provide better support and rehabilitation after a stroke

IMPLEMENT

Urgent Treatment Centres making sure they meet national standards

COMMISSIONING INTENTIONS

Urgent and Emergency Care

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Make it easier for patients to understand and access the right type of urgent care service in an emergency	• Reviewed current services against national standards • Commenced work with providers to realign urgent care services in Coventry to more closely link to A&E to aid overall capacity and demand management	• A more responsive, joined up service which will be easier to navigate for patients • Patients will receive the optimum level of services in the appropriate setting regardless of how they access the service	• Work will continue in 2017/18 to develop an integrated model of care • Completed integrated service by December 2019
Reduced reliance on urgent and emergency care over time, with integrated teams/communities proactively managing people at higher risk	• Supported the Sustainability and Transformation Plan Out of Hospital workstream with a focus on supporting patients (and carers) more proactively in the community • Created three integrated neighbourhood teams with Coventry and Warwickshire Partnership NHS Trust • Implemented a "social prescribing service", which enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services, in Coventry and further development of the Rugby social prescribing offer	• Greater proportion of patients will receive treatment and care in a place that is more convenient for them • There is more support available to help patients to manage conditions themselves	• Continue to develop these new models of care in line with the development of the a new community services across Coventry and Warwickshire
Integrated rapid response and support once people are in the urgent / emergency care system, with better links to urgent social care services	• Completed the development of the Urgent Primary Care Assessment Service in Coventry and Rugby, which looks to prevent unnecessary admissions to hospital for frail & elderly patients • Expanded ambulatory Care pathways in Coventry to prevent admissions to hospital	• More patients will receive treatment and care in a place other than A&E and which is more convenient • There is more support available to help patients to manage conditions themselves • Patients avoid unnecessary admissions to hospital because more suitable care is available and more easily accessible • Services can help prevent hospital admissions and facilitate early discharge, improve patient safety and improve choice by enabling patients to stay in their homes	• Work with providers to increase the number of conditions delivered through a community ambulatory emergency care model • Investigate the development of better ways of delivering care • Exploring options for introducing a community intravenous (IV) service with oversight from UHCW clinicians

Planned Care

Our commitment is to ensure timely access to expert opinion, investigation and treatment. We will reduce unnecessary visits to hospital for follow up care. Care will be provided in a range of accessible community settings.

REDUCE AVOIDABLE

demand for elective care – tackling unwarranted variations and providing "advice first" options for primary care

EXPANDING CANCER SCREENING

uptake, with a focus on bowel, breast and cervical cancers

Ensure hospital services are

EFFICIENT

avoid duplication and reduce unnecessary hospital visits

ENSURE TIMELY REFERRAL

and access to planned care services

COMMISSIONING INTENTIONS

Planned Care

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Provision of care in convenient community locations	• The CCG has well developed plans in place to create a Community Dermatology , Atrial Fibrillation Service and community Audiology service • An integrated Musculoskeletal (MSK) service has been introduced to prevent patients from unnecessary hospital visits	• A greater range of services delivered closer to patients homes. Reduced travel times, no parking costs , increased convenience for the local population	• Ensure delivery of these new services within 17/18 financial year
Reducing unnecessary hospital outpatient attendances	• Workshops have been planned with University Hospital Coventry & Warwickshire NHS Trust and George Eliot Hospital NHS Trust to help reduce avoidable outpatient follow up attendances • Workshops undertaken with Ear, Nose and Throat (ENT) and Trauma & Orthopaedics (T&O) specialists • Future workshops arranged with ophthalmology, general surgery, and dermatology	• Reduction in unnecessary patient visits to hospital • Reduced travel and car parking charges for patients • Improved patient satisfaction	• Work with clinical specialists for each department to reduce unnecessary follow-up care during 17/18 financial year
Ensure commissioning policies are reviewed and aligned across both CCGs	• A number of policies have been developed, revised and implemented via the Arden policy group to promote a consistent commissioning approach across Coventry & Warwickshire	• Ensures equity of access for patients and a consistent approach to policy development across the Coventry & Warwickshire footprint	• A planned programme of review during the 2017/18 financial year and beyond is in place
Explore "advice first" opportunities for GPs	Warwickshire North CCG has commissioned a telephone advice and guidance system called Consultant Connect. This will enable: • local GPs to call a team of local specialty consultants to seek appropriate advice. • This service will launch in Warwickshire North in the middle of September in four specialties initially - Urology, Cardiology, Gynaecology and Diabetes	• Potential for significant reduction in unnecessary hospital visits • Consultant Connect system encourages GPs and Consultants to have conversation re: management plans with patient present and at the centre of the decision making process	• Four specialties to be live on the system by end September 2017 • Additional four specialties to be added to the system by 31st March 2018
To ensure social prescribing model is meeting the needs of our communities	• We have invested money into a social prescribing model, which enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services, during 2017/18	• The social prescribing model will support people with a wide range of social, emotional or practical needs, and many schemes are focussed on improving mental health and physical well-being	• We will be evaluating the model to ensure that it provides benefits to patients and reduces unnecessary workload for primary care by April 2018

Planned Care

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Work with our Local Authority partners to progress the implementation of the Carers Strategies which were refreshed during 2016/17	• New Carer's strategy launched for patients in Warwickshire, including Rugby • New county-wide carers service commissioned by WCC commenced 1st June • CCG is represented on the Warwickshire Carer's Strategy Board and working to support partner organisations	• Ensure those acting as carers for family members or friends are given the right support • Provide wellbeing checks to carers	• The CCG will continue to promote the new service as far and wide as possible e.g through GP practices, pharmacists, hospices and a range of voluntary sector organisations
Continue to support Public Health in their efforts to achieve healthier lifestyles	• We have worked with Warwickshire County Council to provide physical activity and weight management support for children and adults	• A greater proportion of patients will be supported to achieve a healthier lifestyle	• CCG will continue to promote weight management services • The programme will be evaluated at the end of the 2017/18 financial year
Engage with our local communities to explore how to improve cancer screening uptake	• Focused on bowel, breast and cervical screening uptake • Scheduled training sessions in Coventry during July with support from Cancer Research UK	• A greater proportion of patients will receive screening opportunities, resulting in earlier detection of cancer and increasing survival rates	• Targeted health promotion and awareness activities covering bowel, breast and cervical cancers will continue
Provide quicker access to cancer diagnostics and specialist care and that are compliant with national quality standards	• A demand and capacity assessment in relation to diagnostics has been undertaken by the Coventry & Warwickshire Cancer Board	• A greater proportion of patients will now benefit from speedy access to a range of diagnostic investigations, reducing waiting times and improving patient outcomes	• Waiting times and access to diagnostic services will be monitored by the CCG on a routine monthly basis
Deliver a year-on-year improvement in the one year survival rate; maximise involvement in survivorship programmes	• Actively worked with primary care to support GPs in improving the consistency and quality of referrals for cancer treatment • Worked with a range of providers to ensure that screening uptake for bowel related conditions improves	• A greater proportion of patients will survive and learn to manage bowel related conditions	• On-going monitoring and review of programme and on-going monitoring of survivor rates

Planned Care

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Ensure all elements of the recovery package are commissioned (holistic needs assessment, care plan, pain management, review by GP)	• The CCG has implemented the Living With and Beyond Cancer (LWBC) programme • The LWBC will incorporate delivery of "Stratified Follow Up" (SFU) pathways in breast, bowel and prostate cancer and delivery of the recovery package to all cancer patients	• A greater proportion of patients will receive treatment and care in a place that suits them with a greater emphasis on provision of support to help patients and carers to manage conditions themselves	• We will focus attention on agreeing an approach for collecting data on long-term quality of life for cancer patients
Improve ability for GPs to refer electronically	• The CCG is responding to the national target - 100% of all GP referrals by October 2018 to be made electronically	• Patients empowered to make appointments themselves with a provider of their choice at a time and date convenient to themselves • Greater utilisation will also result in reduced waiting times for local patients	• Working group created involving reps from primary, secondary care and Local Medical Committee (LMC) to drive forward greater utilisation rates in advance of national milestone in October 2018

Mental Health

Our commitment is to deliver a proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and support individuals and families to manage their mental health and wellbeing condition.

EMBED

suicide prevention strategy and reduce rates by 10% against the 2016/17 baseline

IMPLEMENT

the local CAMHS transformation plan

INCREASE

access to talking therapies for depression and/or anxiety to 19% during 2018/19

Treat children through community services to reduce

AVOIDABLE ADMISSIONS TO INPATIENT BEDS

IMPROVE

care for people with learning disabilities

INCREASE

access to annual health checks, 75% uptake by 2020

IMPLEMENT

all age neurology development pathway for adults with suspected autism and/or ADHD

EARLIER ACCESS

and interventions, crisis aversion and reduced demand for specialist care

COMMISSIONING INTENTIONS

Mental Health

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Implementing a new Child and Adolescent Mental Health Service (CAMHS) and deliver a range of transformational priorities such as a reduction in waiting times, acute liaison team, early interventions in schools and a community eating disorder service	• New services commissioned for: patients with eating disorders • New pathway for autism assessment developed • Referral to treatment for emergency, urgent and routine appointments in 16/17 between 98-100%	• Earlier access and interventions • Improved crisis aversion • Reduced unnecessary demand for specialist care by ensuring more appropriate care is available and easy to access	• Reduce avoidable placements to in-patient beds • Ensure a highly-skilled workforce can meet demand • Local Transformation Plans to be annually refreshed • Ongoing monitoring of transformation priorities
Review mental health crisis response and self-harm (i.e. provision of services that support crisis care as per the Mental Health Crisis Concordat)	• Reviewed the Crisis Concordat work to ensure that our services are up to date and fit for purpose	• Improved and increased access to a more responsive crisis service	• The Crisis Concordat plan will be updated with a named CCG lead
Implement an all age neurology developmental pathway for adults with suspected ASD and/or ADHD	• Adult diagnostic pathway and support launched in February 2017. Work will continue to create the all-age pathway	• Patients with suspected Autistic Spectrum Disorder and/or ADHD are diagnosed locally and given the right support for their individual needs	• Staff are recruited and in post, undertaking assessments alongside the provision of specialist post-diagnostic support
Continue transforming care for people with learning disabilities – phase 2 (repatriation of patients out of area and/or in NHSE commissioned beds)	• Established a Transforming Care board to deliver a new model of care • Created a register of patients in a hospital bed or a risk of admission • Jointly commissioned new community services to support patients with learning disabilities or autism to avoid hospital admission	• Delivery of patient centred care closer to home to reduce avoidable admissions	• A reduction across the Transforming Care Partnership footprint of 24 beds from 61 to 37 by March 2018 across CCG and NHSE • Working closely with our provider to redesign services

Mental Health

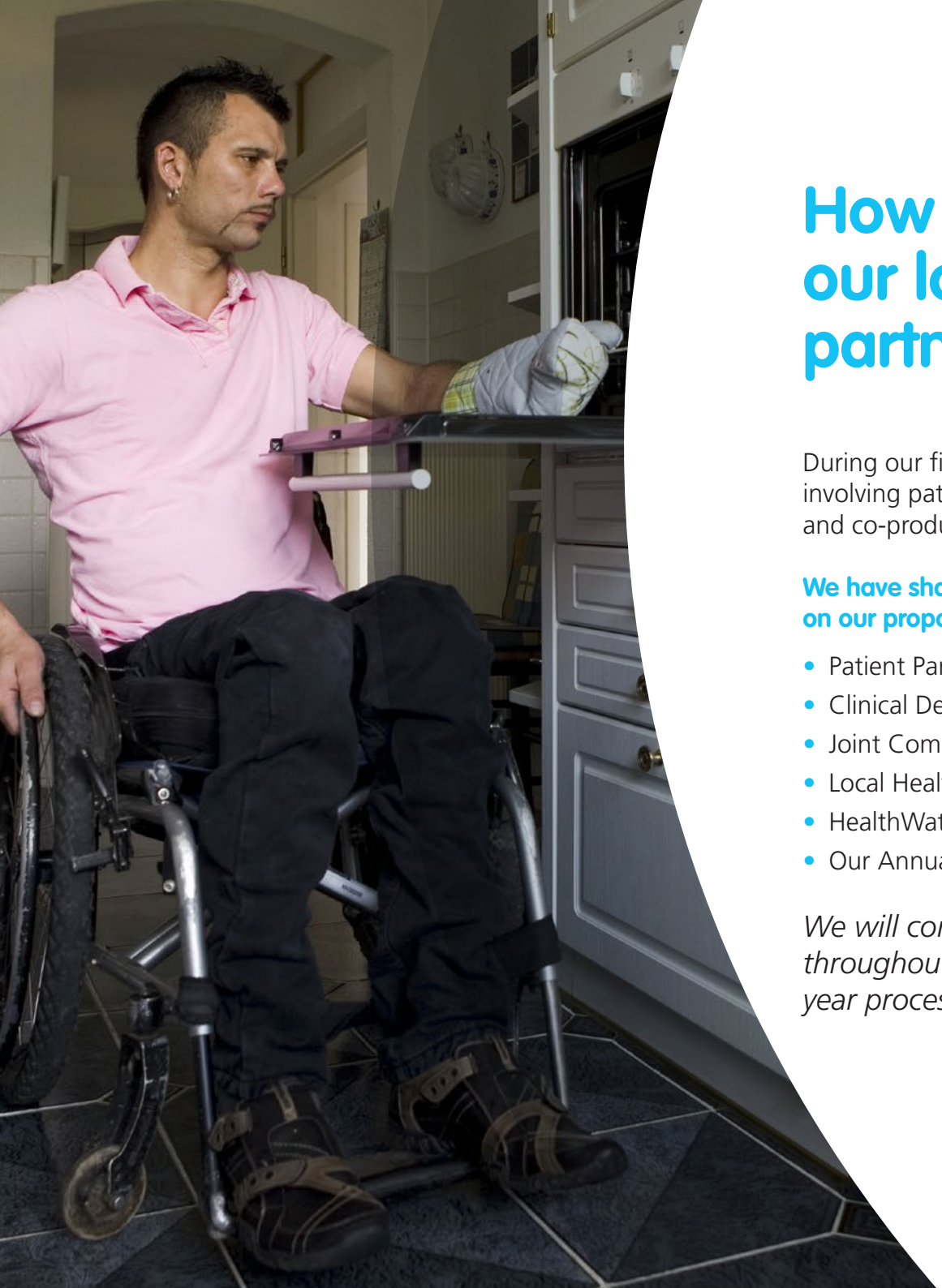
COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Improved referral and access criteria for services – focusing on respite, rehabilitation and specialisations	• An ongoing programme of work has been developed to review all the mental health service specifications	• Improved patient experience, clinical outcomes and access to services	• Review current specifications to ensure transformation of services is contractually documented
Continue to implement our local mental health Commissioning for Quality and Innovation (CQUINs) to improve case management and acute mental health admission avoidance	• Local CQUINs have demonstrated a reduction in readmissions	• Reduction in avoidable mental health admissions • Improvement in the use of care coordinators • Improved discharge planning for patients	• Continue previous CQUIN initiative • Provide better, targeted, more appropriate support to frequent attendees at A&E
Review the options for a joint commissioning approach to learning disability with Warwickshire County Council as the lead partner	• Local CCGs have agreed to work to a collaborative commissioning arrangement	• Care is based around individual patient needs for Rugby patients with learning disability	• Work collaboratively with our local provider to understand current activity and how best to use available resources
Improving access to Child and Adolescent Mental Health Service (CAMHS) services	• Awarded a new contract to deliver a new model for emotional wellbeing service in Warwickshire (Rugby young people) • Improved early identification of needs and closer working with schools to improve access to the CAMHS services	• Earlier access to intervention from a range of multidisciplinary teams (MDT)	• Contractual and governance arrangements to be agreed • Begin the two-year implementation phase • Develop a positive outcome based commissioning model
Embed the Suicide Prevention Strategy and reduce suicide rates by 10% against the 2016/17 levels	• Implementation of a local multi-agency strategy for suicide prevention • Begun working towards “Zero Suicides” across Coventry and Warwickshire	• Raise awareness of support available to those contemplating suicide • Reduce levels of suicide	• Look at prevention strategies targeting high-risk groups and high-risk locations to work towards reducing suicide levels

Mental Health

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Commission additional psychological therapies, integrated with physical health	• Ensure a highly-skilled, confident workforce with the right capacity and skill mix with access to ongoing training in new competencies for long-term conditions • Increased, improved and expanded access to psychological therapies i.e. reaching new patient cohorts such as those in Black Asian Minority Ethnic (BAME) communities	• 15% (increasing to 16.8% by Q4 2017/18) of people with common mental health conditions access psychological therapies • 50% of people who access treatments achieve recovery	• Provision of employment advisors to help people find and stay in work • Explore opportunities around new digital therapies • Test, design and implement integrated pathways for Improving Access to Psychological Therapies (IAPT) and long-term conditions (LTCs) focusing on diabetes, asthma and chronic obstructive pulmonary disease (COPD) • 16.8% (increasing to 19% by Q4 2018/19) of people with common mental health conditions access psychological therapies
Ensure we have services in place to deliver national early intervention in psychosis standards and increase access to individual placement support	• Progress towards National Institute for Health and Care Excellence (NICE) compliance standards	• 53% of people with first episode of psychosis starting treatment with a NICE-recommended package of care within 2 weeks of referral	• Working with the service to review and benchmark staffing capacity and capability to ensure we have the right staff with the right skills • Embedding specialist employment support to help people find and stay in work
Increase access to annual health checks, progressing towards 75% uptake by 2020	• New standards are being monitored as part of the Service Development Improvement Plan	• Patients to have improved awareness of and access to annual health checks and reviews	• Raise awareness of annual health checks to increase uptake as part of the five year plan
Continue to develop the community-based Assessment & Treatment service that is providing an alternative to in-patient admission for people with learning difficulties in crisis	• Community Intensive Support team developed and currently being reviewed to ensure it is provided improved outcomes	• Ensure patients with behavioural challenges are supported to remain in the community, where it is appropriate and safe to do so	• Undertake service redesign with local provider to increase impact of the service to prevent avoidable admissions

Mental Health

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Providers to improve transparency on service costs, performance, and activity	• New performance indicators have been developed for inclusion in the Mental Health contract	• Better understanding of the numbers of patients seen, timescales and areas for improvement, as well as how money is being spent to improve services	• Monthly monitoring of indicators to identify areas requiring support, investigation or investment
Embed effective and timely primary care mental health support across our hubs	• Active Case managements is focusing on input to the four GP hubs	• Timely access to first line intervention services promoting emotional resilience	• Mental health worker attendance at multidisciplinary hub meetings



How we have engaged with our local population and partners

During our first six months, we have collated the insights gained through involving patients, public and other key stakeholders in collective action and co-production to drive delivery.

We have shared our progress to date and sought stakeholder feedback on our proposed next step actions for each CCG:

- Patient Participation Group Chairs Forum - WNCCG
- Clinical Development Group / Executive Group
- Joint Commissioning Committee
- Local Health and Wellbeing Boards
- HealthWatch
- Our Annual General Meetings.

We will continue to engage throughout the two year process.

We will continue to engage with our local population

Building on our ongoing engagement with stakeholders, patients and the public, we will undertake further engagement and targeted dialogue to encourage our local populations to provide feedback against our proposals. We will use this feedback to check that our priorities will deliver the best health, best care and best value.

We will use a range of methods available to receive feedback from our local population and stakeholders.

These will include:

- Online surveys
- Social media
- Face to face meetings with specific groups
- Any service changes will include engagement and where appropriate consultation; we will also require providers to seek service user feedback to evaluate and influence service delivery and service provision.

We will continue to involve patients and the public to help guide and inform the implementation of commissioning intentions, and to assess the impact and patient benefits delivered for our local populations.