Adult Social Care and Health Overview and Scrutiny Committee

22 November 2017

Agenda

A meeting of the Adult Social Care and Health Overview and Scrutiny Committee will be held at the **SHIRE HALL, WARWICK on Wednesday, 22 November 2017 at 11.00a.m.**

Please note that this meeting will be filmed for live broadcast on the internet. Generally, the public gallery is not filmed, but by entering the meeting room and using the public seating area you are consenting to being filmed. All recording will be undertaken in accordance with the Council's Standing Orders.

The agenda will be: -

1. General

(1) Apologies

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

Members are required to register their disclosable pecuniary interests within 28 days of their election of appointment to the Council. A member attending a meeting where a matter arises in which s/he has a disclosable pecuniary interest must (unless s/he has a dispensation):

- Declare the interest if s/he has not already registered it
- Not participate in any discussion or vote
- Must leave the meeting room until the matter has been dealt with
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests must still be declared in accordance with the Code of Conduct. These should be declared at the commencement of the meeting.

(3) Chair's Announcements

(4) Minutes of previous meetings

To confirm the minutes of the meeting held on 13 September 2017.

2. Public Speaking

Any member of the public who is resident or working in Warwickshire, or who is in receipt of services from the Council, may speak at the meeting for up to three minutes on any matter within the remit of the Committee. This can be in the form of a statement or a question. If you wish to speak please notify Paul Spencer in writing at least two working days before the meeting. You should give your name and address and the subject upon which you wish to speak. Full details of the public speaking scheme are set out in the Council's Standing Orders.

3. Questions to the Portfolio Holders

Up to 30 minutes of the meeting is available for Members of the Committee to put questions to the Portfolio Holders: Councillor Les Caborn (Adult Social Care and Health) and Councillor Jeff Morgan (Children's Services) on any matters relevant to the remit of this Committee.

4. One Organisational Plan 2017-18

To provide the Committee with a quarterly update on progress of the One Organisational Plan 2017-18 at the end of quarter two.

5. Work Programme

This report reviews the recent work the Adult Social Care and Health Overview and Scrutiny Committee and seeks the Committee's views on the proposed forward work programme.

6. Commissioning Intentions

Anna Hargrave of South Warwickshire Clinical Commissioning Group (CCG) and Andrea Green of Warwickshire North and Coventry & Rugby CCGs will provide a report and presentation on their respective commissioning intentions.

7. Any Urgent Items

Agreed by the Chair.

DAVID CARTER
Joint Managing Director

Adult Social Care and Health Overview and Scrutiny Committee Membership

Councillors Mark Cargill, Neil Dirveiks, Clare Golby (Vice Chair), Anne Parry, Dave Parsons, Wallace Redford (Chair), Kate Rolfe, Andy Sargeant, Jill Simpson-Vince and Adrian Warwick.

District and Borough Councillors (5-voting on health matters*) One Member from each district/borough in Warwickshire. Each must be a member of an Overview and Scrutiny Committee of their authority:

North Warwickshire Borough Council:	Councillor Margaret Bell
Nuneaton and Bedworth Borough Council:	Councillor Jill Sheppard
Rugby Borough Council	Councillor Belinda Garcia
Stratford-on-Avon District Council	Councillor Christopher Kettle
Warwick District Council:	Councillor Pamela Redford

Portfolio Holders:- Councillor Les Caborn (Adult Social Care and Health)
Councillor Jeff Morgan (Children's Services)

General Enquiries: Please contact Paul Spencer on 01926 418615
E-mail: paulspencer@warwickshire.gov.uk

* The agenda for this meeting includes item 4 that relates solely to adult social care.

Minutes of the meeting of the
Adult Social Care and Health Overview and Scrutiny Committee
held on 13 September 2017

Present:

Members of the Committee

Councillors Mark Cargill, Neil Dirveiks, Clare Golby (Vice Chair), Anne Parry, Dave Parsons, Wallace Redford (Chair), Kate Rolfe, Dave Shilton, Jill Simpson-Vince and Adrian Warwick.

Other County Councillors

Councillor Les Caborn, Portfolio Holder for Adult Social Care and Health
Councillor Jeff Morgan, Portfolio Holder for Children's Services
Councillor Alan Webb

District/Borough Councillors

Councillor Margaret Bell (North Warwickshire Borough Council)
Councillor Christopher Kettle (Stratford District Council)
Councillor Pamela Redford (Warwick District Council)
Councillor Neil Phillips (Nuneaton & Bedworth Borough Council)

Officers

Chris Lewington, Head of Strategic Commissioning
Dr John Linnane, Director of Public Health
Paula Mawson, Commissioning Lead - Mental Health, Public Health
Nigel Minns, Strategic Director for People Group
Pete Sidgwick, Head of Social Care and Support
Amy Sirrs, Interim Commissioner/Commissioning Support Officer, People Group
Andrew Sjurseth, CAMHS Commissioner
Paul Spencer, Senior Democratic Services Officer
Claire Taylor, Health Improvement Commissioning and Performance Lead, Public Health

Also Present:

Chris Bain, Chief Executive, Healthwatch Warwickshire
Jayne Blacklay, South Warwickshire Foundation Trust
Simon Gilby, Coventry and Warwickshire Partnership Trust

1. General

The Chair welcomed everyone to the meeting.

(1) Apologies for absence

Councillor Andy Sargeant
Councillor Jill Sheppard (Nuneaton & Bedworth Borough Council)
John Dixon, Interim Strategic Director, People Group
Kath Kelly, George Eliot Hospital

(2) Members Declarations of Interests

Councillor Margaret Bell declared a non-pecuniary interest as a member of the Warwickshire Health and Wellbeing Board.

(3) Chair's Announcements

The Chair welcomed Pete Sidgwick who had recently joined the County Council as Head of Social Care and Support. On behalf of the Committee the Chair thanked John Dixon, Interim Strategic Director of the People Group, who would leave the Authority at the end of September.

The Chair gave an update on the arrangements for a Joint Health Overview and Scrutiny Committee with Coventry City Council, to consider the review of Stroke Services. Informal discussions had taken place between the scrutiny chairs of each authority on how the Committee would operate. It was confirmed that the County Council's representatives for this group would be Councillors Mark Cargill, Clare Golby, John Holland, Wallace Redford and Jerry Roodhouse.

(4) Minutes

The minutes of the Adult Social Care and Health Overview and Scrutiny Committee held on 12 July 2017 were agreed as a true record and signed by the Chair, subject to clarification by Councillor Chris Kettle on minute number, 1(4) page 2, that whilst the Oxfordshire Clinical Commissioning Group had met with Stratford District Council, the information provided at that time had proven to be inaccurate.

2. Public Question Time

None.

3. Questions to the Portfolio Holders

None.

4. Dementia - Enhancing Awareness and Understanding across Warwickshire

Claire Taylor, Health Improvement Commissioning and Performance Lead, Public Health gave a presentation to the Committee and spoke to a circulated report. In Warwickshire, it was estimated there were approximately 7,500 people living with dementia and this was likely to rise to over 11,000 people in the next ten years. Raising awareness of dementia, creating dementia friendly communities and supporting people to live well with dementia were key aims of Warwickshire's Living Well with Dementia Strategy (2016-2019).

The presentation, which included a number of short video clips, detailed some of the key achievements made to date, outlined priorities for future work and showed clearly the difficulties for people suffering from dementia and how individuals and communities could help, through raising awareness of the condition. The presentation covered the following areas:

- Setting the context
- What is dementia and common types of dementia
- Warwickshire's Living Well with Dementia Strategy - and refresh for 2016-19

- Raising Awareness and Understanding – and why it is important
- Dementia Friends – there are two million nationally and currently 14,500 in Warwickshire. The presentation showed how people could become a dementia friend
- Dementia Friendly Communities - encouraging local organisations and businesses to become more dementia aware
- Sign up to local Dementia Action Alliance
- Services to support people living with dementia including Dementia Navigator, which is a 'face to face' service and the Warwickshire Living Well with Dementia website
- Reducing the risk of developing dementia - healthy lifestyles can help people to live well with dementia and delay progression of some dementias. Fitter Futures (a physical activity referral scheme) and books on prescription are examples of the initiatives in place.
- The Dementia Pathway

Claire Taylor explained that more detailed sessions could be provided to a future meeting of the Committee or to a member development session, as there were many other aspects to the dementia strategy. A pack of further information would be available after the meeting. She added that by watching the presentation and videos the Committee had all qualified to become dementia friends. She explained the variety of ways in which individuals and organisations could become dementia friends. As community leaders, members were encouraged to approach contacts in their local areas, as this provided a useful introduction for the staff to encourage other people to become dementia friends. Examples were given of the work with organisations such as South Warwickshire Foundation Trust, district and borough councils and at a sixth form college with 200 pupils attending that session. Feedback from users of the Dementia Navigator service was provided. There had been over 5,000 users of the Living Well with Dementia website in the last year.

Members submitted questions and comments on the following areas, with responses being provided as indicated:

- The number of dementia patients requiring acute service care and anticipated growth in such demand. A slide provided information about the dementia pathway, and many patients would need to receive specialist care. It was agreed that more detailed data be provided to the Committee.
- Diagnosis of patients with dementia. Nationally, the target was for 66% of patients to be diagnosed. The current position in Warwickshire was slightly lower at 60%.
- Access to the Fitter Futures programme, which currently required a diagnosis of an eligible condition, and raising awareness with younger people, through groups like the scouts. This was an area where councillors could assist, providing an introduction to their local organisations.
- Providing more education for relatives.
- Making contact with parish councils via the Warwickshire Association of Local Councils.

The Committee members agreed to become dementia friends and a photograph was taken to publicise their support of the initiative. Members also agreed to receive a further update at the March 2018 meeting.

Resolved

That the Committee:

1) Notes the presentation about dementia awareness, the key achievements to date and priorities for future work;

2) Supports and endorses unanimously the suggested actions to raise awareness and understanding of dementia across Warwickshire and particularly in their communities where appropriate. The suggested actions for members to include:

   - Signing up as a Dementia Friend
   - Promoting the Dementia Friends initiative and organising/hosting Dementia Friends Information Sessions where appropriate
   - Encouraging local organisations to get involved with Dementia Friendly Communities/Dementia Action Alliance
   - Visiting Warwickshire's 'Living Well with Dementia' website to enhance knowledge of content and signposting the website to their community
   - Raising awareness of the two key services to support people living with dementia (Dementia Navigators and Dementia website)
   - Promote awareness of ways to reduce the risk of developing dementia
   - Raising awareness that a healthy lifestyle can delay the progression of some dementias and of services available in Warwickshire to support people to live well with dementia (e.g. Books on Prescription - dementia, and physical activity on referral for people with dementia

3) Raises awareness of the above initiatives with fellow councillors; and

4) Agrees to hold a further presentation/development session to cover the additional work being undertaken through Warwickshire's Living Well with Dementia Strategy (2016-2019), the potential areas of focus being timely diagnosis and support in acute/residential housing with care settings.

5. Children and Young People's Emotional Wellbeing and Mental Health Contract

It was reported that Child and Adolescent Mental Health Services (CAMHS) had undergone a competitive dialogue tender process to procure a single, redesigned, children and young people's emotional well-being and mental health service. The Committee received an update from Andrew Sjurseth, CAMHS Commissioner. Previously there were six CAMHS contracts, commissioned independently by clinical commissioning groups (CCGs) and Warwickshire County Council (WCC). Under the new single commissioning arrangement, WCC was the lead commissioner on behalf of the SWCCG, WNCCG and CRCCG and the County Council. This arrangement is underpinned by a legal agreement and includes the pooling of funds.

A summary was given of the competitive dialogue process. Three providers submitted proposals, of which two were invited to enter the competitive dialogue phase, although one later withdrew. Coventry and Warwickshire Partnership Trust (CWPT), in partnership with Coventry and Warwickshire MIND (CW MIND), undertook the competitive dialogue phase before submitting a final tender that was

evaluated, scored and deemed successful. A recommendation to award was approved by WCC and the three CCGs.

The new service commenced on 1st August 2017. This was the start of a significant transformation from the existing service, which would be established throughout a two year implementation period. The contract monitoring was focussed on achieving implementation plan milestones. The redesign process had been based upon co-production principles, involving young people, families, and professionals, with key stakeholders being able to challenge and evaluate the proposals. The stakeholders had expressed positive support for the proposed service, that it reflected the outcomes framework and presented a coherent model. The report outlined the key features of the new service model:

- Increased emphasis on prevention and early intervention
- Focus on building resilience
- Integrated working, especially with schools
- Systemic work with families and child's network
- Increasing the upper age from 18 to 25
- Service with no tiers
- Support for complex and vulnerable children

The new service model was structured around three layers, comprising a central navigation point, community based centres and then a specialist multi-disciplinary mental health team. Within the three layers, the new service contained specific features comprising a dimensions tool, prevention and early help, integration and online provision. The report and accompanying presentation from Andrew Sjurseth detailed how this would work in practice.

The arrangements for governance and contract management were reported with WCC being the lead commissioner. A contract management group has been established to support the monitoring of service performance. For the first two years, this would be by monitoring progress against milestones set out in a service transformation plan. From year three, outcomes would be monitored directly against key performance indicators (KPIs) that were linked to enhanced payments. CWPT would report against the indicators on a quarterly basis. During the initial two years of the new contract, pre-existing KPIs from the old CAMHS contract would be carried forward, including waiting time targets for initial assessment and follow up waits.

The new slogan for the service was 'no door is the wrong door'. This aimed to show the greater flexibility compared to the previous service and it was externally focussed rather than a 'clinic' model. There would be more points of entry to the system with a hub located in each district and borough of Warwickshire, to be run by CWPT. Another element of the revised service was an online questionnaire. Through 27 questions this would provide a personal profile, to enable signposting of people to the correct level of support. The data from such questionnaires would be summarised to provide anonymous information to inform future training and service planning.

Members submitted questions and comments on the following areas, with responses being provided as indicated:

- It was questioned how confident officers were that a timely response would be provided following a referral. Where lower level interventions were needed

there was confidence that there would be a shorter waiting time. The contract monitoring arrangements were explained and these included feedback from families on satisfaction with the service.

- Current waiting times were raised. Simon Gilby, Chief Executive of CWPT advised that the current waiting time was 18 weeks, which was seen as a maximum. Mr Sjurseth added that there could be a further waiting period from the initial assessment to treatment commencing. There were emerging targets from NHS England for people to start receiving treatment within six weeks of the initial assessment.
- Officers confirmed that the focus of this report was on the new service and transitional arrangements, rather than the previous CAMHS service.
- It was noted that the service area spanned the remit of both this Committee and the Children and Young People OSC. It would be helpful to coordinate activity going forward to avoid duplication.
- The maximum age of service recipients had increased from 18 to 25 years and the rationale for this was provided, together with how it would work in practice. There was concern that the additional number of patients may impact on waiting times. Officers explained the previous gap in service for some young people with lower level support needs.
- Clarification was sought on how people would be referred if the summary data was anonymised. The online questionnaire was designed to signpost people to the level of support they needed, but patient consent was always needed before passing on personal data. The anonymised data gave trends, which enabled further training/planning.
- The need to ensure a consistent level of service across Warwickshire was stated. A councillor used data for referrals in North Warwickshire to show current waiting times. As this was the same provider as for the previous contract, members needed confidence that the new contract would deliver improvements. Officers noted the points, reiterating the monitoring arrangements that were in place for the new contract. Reference was made to the national shortage of some specialist staff, the arrangements CWPT had made to address staff shortages and its ongoing focus on both the backlog and new contract requirements.

The Chair suggested that the points raised and any further questions from members be collated and then considered at the next Chair and Party spokesperson meeting. This would be used to shape a further report back to the Committee, which was agreed to be at the January 2018 meeting.

Resolved

1) That the Committee notes the outcome of the Children and Young People's Emotional Wellbeing and Mental Health Service procurement process and the key features and implementation timescales of the new service.

2) That further consideration is given to this area at the next Chair and Party spokesperson meeting and thereafter a further report is presented to the Committee in January 2018.

6. Work Programme Report of the Chair

The Committee gave consideration to its work programme for the coming months. The report included sections on the forward plan of the Cabinet and areas of scrutiny work taking place in each district and borough council in Warwickshire.

The Committee considered arrangements for task and finish group (TFG) work, the proposal being to focus on GP Services and when that review had been completed, Maternity Services. There would be no TFG work on the quality accounts of provider trusts in this year. An update was given on the arrangements for the Joint Health Overview and Scrutiny Committee (JHOSC) with Coventry City Council. The first area for review would be Stroke Services. Clinical commissioning groups (CCGs) were awaiting approval from NHS England to commence public consultation. As part of this, the JHOSC would meet formally to consider and respond to the CCG proposals.

Councillor Kettle referred to the item for the November meeting on the commissioning intentions of CCGs. He asked whether this would include neighbouring CCGs that provided services to some Warwickshire residents. This might prove difficult, as there were several neighbouring CCGs and it had been planned to focus on those serving the Coventry and Warwickshire area. His suggestion would be referred to the Chair and Party Spokesperson meeting for further consideration. Councillor Kettle asked whether a response had been received to the letter from the Committee to the Secretary of State for Health regarding the Oxfordshire STP. A response was still awaited. He then provided a brief verbal update on latest developments in that matter.

Resolved

That the Committee:

1) Approves its work programme for the coming months.

2) Notes the ongoing work in preparation for the Joint Health Overview and Scrutiny Committee with Coventry City Council.

3) Endorses the areas for task and finish group (TFG) work and that member nominations are submitted for participation in the first TFG on GP Services.

7. Any Urgent Items

None.

The Committee rose at 1.15pm

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Chair

Adult Social Care and Health Overview & Scrutiny Committee

22 November 2017

One Organisational Plan Quarterly Progress Report: April - September 2017

Recommendation

That the Overview and Scrutiny Committee:

(i) Considers and comments on the progress of the delivery of the One Organisational Plan 2020 for the quarterly period of April-September 2017 as contained in the report

1. Introduction

1.1. The One Organisational Plan Quarterly Progress Report April -September 2017 was considered and approved by Cabinet on 9th November 2017. It provides Members with a strategic overview of progress of the key elements of the OOP, specifically in relation to performance against key business measures, strategic risks, workforce management, revenue and capital budgets, reserves and savings targets. The report also provides detailed information on the financial aspects at a Business Unit level.

1.2. This report draws on financial and performance information extracted from the Cabinet report and provides Members of this Committee with information relevant to the remit of the Committee.

1.3. The content and style of this report has been revised and will continue to be improved in response to Member feedback and aims to provide:

(i) Contextual information on service objectives in order to enable a better understanding of performance measures, including where appropriate, the key interventions being taken to achieve specific outcomes.
(ii) Quarterly (most up-to date) performance information of the relevant key business measures.
(iii) Improved commentary on key business measures which are not performing well to enable a better understanding of the reasons and the actions being taken to address these.

1.4 This report covers services which are the responsibility of the following business units:

- People Group – Social Care & Support; Strategic Commissioning
- Communities Group- Public Health

2. One Organisational Plan 2020: Strategic Context

2.1 The One Organisational Plan 2020 is the Council's Corporate Plan which sets out the Council's ambitions to make Warwickshire the best it can. This Plan describes the Council's vision for shaping the future of a very different County Council and different

public service provision in Warwickshire by 2020 as it faces the challenge of making further savings of £67 million. The key elements of this Plan are set out below.

2.2 The Council is clear that the reduction in resources does not diminish its ambition for the County and priorities which are:

- Warwickshire's communities and individuals to be supported so they are safe, healthy and independent with priority focused on the most vulnerable.

- Warwickshire's economy to be vibrant and supported by the right jobs, training, skills and infrastructure. We will seek to build our economy by attracting more investment, maximising business opportunities and encouraging job creation.

2.3 To achieve this, we need to ensure our services are more efficient, integrated and that we make best possible use of new technologies and innovation. This means better access and information. We cannot do this alone and we are continuing to look to our residents and partners in the public, private and voluntary communities to open up a new conversation with us to find solutions and different ways of working. This plan sets out the journey we face - and begins to describe how we can work together to make Warwickshire the best it can be for everyone.

2.4 The OOP 2020 Plan also sets out the Council's vision for an integrated health and care model (page 6) which provide the context for the reporting of performance to this Committee.

2.5 The OOP 2020 Plan aims to achieve three high level Outcomes, which are:

Outcome 1: Warwickshire's Communities and Individuals are supported to be safe, healthy and independent

Outcome 2: Warwickshire's economy is vibrant and supported by the right jobs, training and skills.

Outcome 3: Resources and services are targeted effectively and efficiently whether delivered by the local authority, commissioned or in partnership.

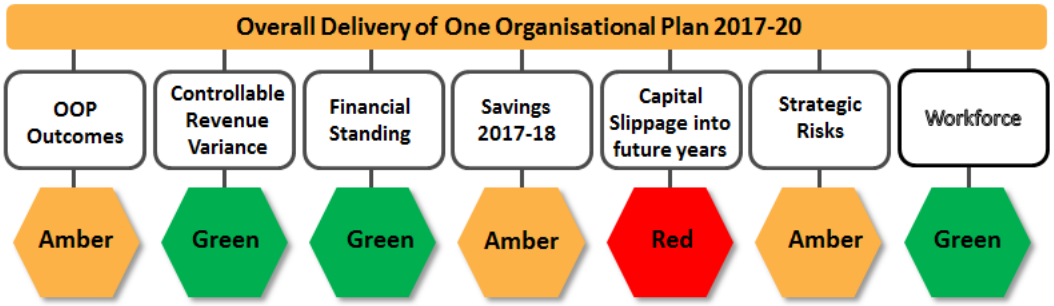
2.6 The achievement of these Outcomes is measured through 83 Key Business Measures (KBMs) which underpin the 3 Outcomes and the progress of all 83 is reported to Cabinet. The 83 KBMs are also reported by one of seven policy/service areas under the relevant OOP Outcome.

2.7 The 83 KBMs are attributed to the seven policy/service areas as follows:

OOP Outcome 1: Warwickshire's communities and individuals are supported to be safe, healthy and independent	
Policy/service area	**Number of KBM**
Children are safe	11 KBMs
Adult Social Care	6 KBMs
Health & Wellbeing	6 KBMs
Fire & Community Safety	15 KBMs
OOP Outcome 2: Warwickshire's economy is vibrant and supported by the right jobs, training,skills and infrastructure.	
Economy,infrastructure & environment	18 KBMs
Education & Learning	8 KBMs
OOP Outcome 3: WCC makes the best use of available resources.	
Using resources well	19 KBMs

2.8 Each KBM has a target which the relevant service will aim to attain by the year end. Each KBM is rated through a RAG system at each quarter and at year-end. For Quarters 1-3 of the year, the RAG rating is based on a forecast by the service of the likely year-end position. At the year-end, the RAG rating is based on the actual performance attained for most KBMs. A very small number of KBMs do not have confirmed year-end figures until after the Cabinet meeting in July; however these are usually available by the time each Overview & Scrutiny Committee considers the year-end reports. A Green rating indicates that the KBM has attained or exceeded its target; an Amber rating indicates that the target was missed/within a tolerance level, generally of 5% of the target (though a few KBMs have a tolerance level of 2% or none) and a Red rating indicates that the target has not been attained. In exceptional cases, a RAG rating may not be available for a variety of reasons- usually due to the data not being available or a target not having been established.

2.9 The OOP 2020 Plan is assessed in terms of the achievement of: the OOP Outcomes, the key elements of our Medium Term Financial Plan (Revenue Budget, reserves/financial standing, meeting savings target, and use of capital resources), Strategic Risks and Workforce management. Each of these components is assessed through a RAG rating every quarter. At the end of quarter 2, the overall forecast for the delivery of the Authority's Plan is at Amber which is informed by the RAG rating for the components as shown in the chart below. Overall, there is little change from the forecasts at quarter 1.



3.0 OOP Outcomes –Progress on performance for Adult Social Care & Health OSC

3.1 This Committee's remit is:

To review and scrutinise the provision of public services in Warwickshire relating to adult social care services including social care to older people and people with disabilities, policies and services for safeguarding adults and any matter relating to the planning provision and operation of health services for adults and children in Warwickshire.

3.2 For the remit of this committee, we are reporting progress on 12 KBMs which are attributed to the following policy areas:

OOP Outcome 1: Warwickshire's communities and individuals are supported to be safe, healthy and independent	
Policy/service area	**Number of KBM**
Adult Social Care	6 KBMs
Health & Wellbeing	6 KBMs

3.3 Progress on these KBMs is reported below through the Scorecard which draw on the longer term trend data charts within the Scorecard and Quarter 2 data in Annex R.

One Organisational Plan KBM Scorecard 2017/18

Adult Social Care

Commentary

The six measures we have identified as a part of our key business measures are ones which almost all authorities consider and we also report on these as part of our statutory reporting.

These 6 Measures help us understand the numbers entering **care homes (residential & nursing), new customers receiving community support, people buying their own support through direct payment, supporting people after hospital care and supporting people to be as independent as possible. The data and graphs in the tables below show the trend data on these KBMs with the 2017/18 forecasts.**

Admissions to residential & nursing care (under & over age 65+) – The main aim is to reduce inappropriate admissions of people into care homes. Achieving this end is impacted by the complex nature of the person's needs and the availability and the cost of supporting someone in the community. Warwickshire's performance is good in this area, due to a number of community based services but especially Extra Care Housing.

Community Support/care – The aim is to keep overall numbers receiving long term support as low as possible; this KBM has an inverse relationship to care home admissions-i.e. the lower the number of admissions to care homes will most likely mean higher the likely number of people in community support. However, higher is not always better as we still need to ensure that we are only supporting through 'specialist services' people who meet the threshold and that those who don't are supported via 'universal support services'.

Direct payment/people buying their own support

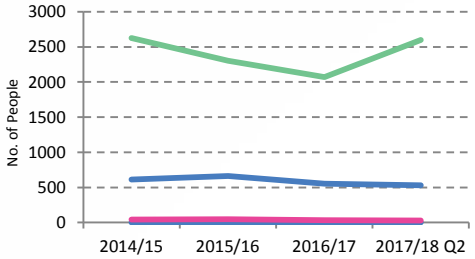
This is a key measure of people being able to express choice and control over their personal budget (their social care financial allocation) with a higher is better drive. There are a number of challenges in relation to this aim and we are trying to reduce the reasons for people not taking this level of control. We are: ensuring that staff are encouraging people to buy their own support, supporting the recruitment of personal assistants, helping people with care needs with money management support and are developing different ways of getting the cash to the customer.

Delayed Discharge/Supporting people after hospital care – This is a local and national driver and remains a challenging area for improvement. Locally, the reasons are due to both delays in assessments being completed and delays in care being sourced. A Countywide Delayed Transfers of Care (DTOC) Project has started to address/improve this. A Hospital Social Care Team Improvement Plan has been developed and additional staff have been employed in hospital social care teams and the re-ablement service to improve social care response to hospital discharges.

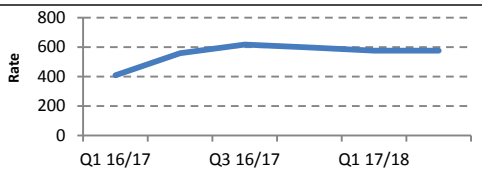
% of customers not needing on going social care/Supporting people to be as independent as possible – Often people with care needs may only need short term support in achieving a better level of independence. Our Re-ablement service is key in delivering this. Our aim is to help as many people eligible for social care as possible through short term Re-ablement services and that we're enabling people to be as independent as possible – not drawing them into our longer term services; and in doing so managing the demand and expenditure for services.

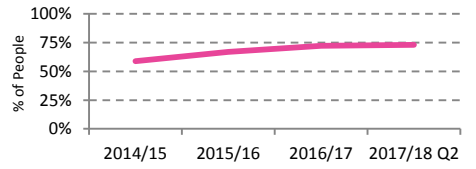
KBM trend data:

Measure	2017/18 Forecast (Target)	2016/17 Actual at Year End	2015/16 Actual at Year End
No. of permanent admissions of older people (65 and over) to residential and nursing care	528 (528)	552	662
No. of permanent admissions to residential and nursing care (18-64)	33 (33)	33	46
No of admissions of 18+ to long term community care	2,600 (2,600)	2,070	2,304

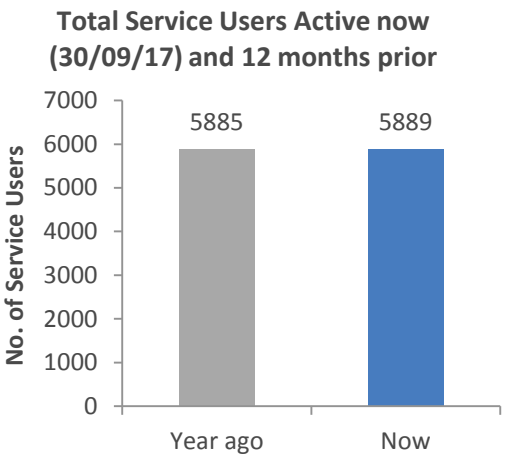


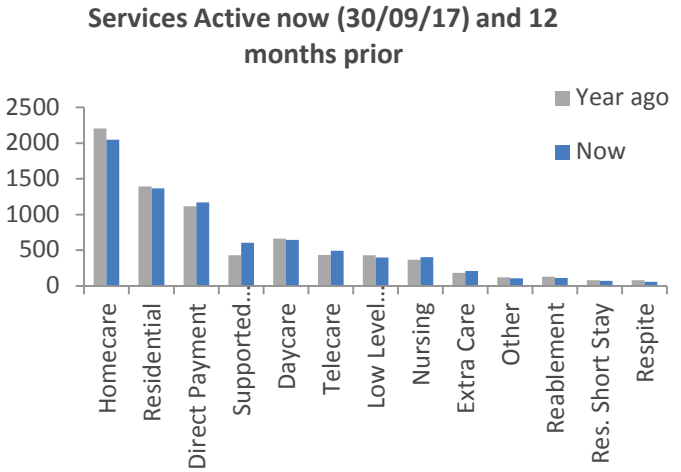
	% of adults receiving direct payment	26.7% (30%)	29.3%	17.3%
	Delayed transfers of care (delayed days) from hospital per 100,000	550 (396)	597	426
	% customers not needing on-going social care 91 days after reablement episode*	75% (75%)	72.3%	67.1%





The KBMs on admissions help to inform us on new customers being admitted into care but do not give a whole picture of the total numbers receiving services as it excludes those already in receipt of services. The two charts below show the total numbers of people receiving a long term service and the types of adult social care services in Warwickshire.





The impact of demand on available is also affected by the length of stay in different types of care by service users. Our data shows that for both residential and nursing care and community services, there are a growing number of service users who have been receiving services for over 5 years. For residential and nursing packages of care, mental Health has the highest average stay of 7 years, followed closely by those with a learning disability at 6.5 years of average stay. For community packages of care, the average length of stay is fairly low with only PDSS and learning disabilities having averages of over 3 years.

How do we compare? Measure	2017/18 Forecast	2016/17 Warks	2016/17 SN*	2016/17 Nat*	2015/16 Warks	2015/16 SN*	2015/16 Nat*
Permanent admissions of older people (aged 65+) to residential & nursing care per 100,000 population		474.2**	n/a	n/a	489.9	652.2	668.8
Admissions to residential care homes per 100,000 population ASCOF 2A - part 1 (aged 18-64)		8.8**	n/a	n/a	11.2	13.1	546.2
No.of admissions to long term community care-per 100,000?	This is not a national Measure and so comparative data is unavailable						

Key: *SN= Statistical Neighbours; * Nat= National average
**-this data is provisional and final figures will be released by Department of Health at the end of October 2017

One Organisational Plan KBM Scorecard 2017/18

Health & Wellbeing

Commentary- There is a significant time lag in data in many of the KBMs; figures reported under specific years often relate to earlier periods.

Teenage conception rates

2017/18 figures are actually for 2015 period. Overall, Warwickshire's rate continues to be below the national rate though there are variations at District/Borough levels. Thus the rates in Stratford-upon Avon and Nuneaton & Bedworth have come down though that in Warwick District & North Warwickshire has increased from previous year. An 'Acting on Teen Pregnancy' group in the north of the County is established to address this. However, the direction of travel for teenage pregnancy and childhood obesity are both moving in the right direction.

Childhood obesity

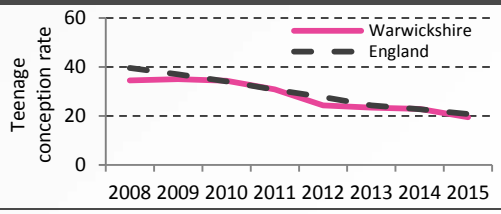
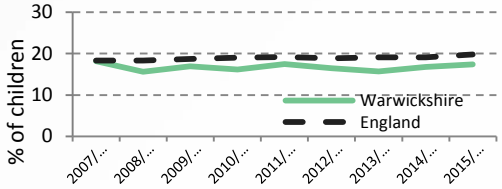
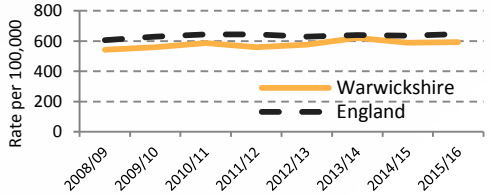
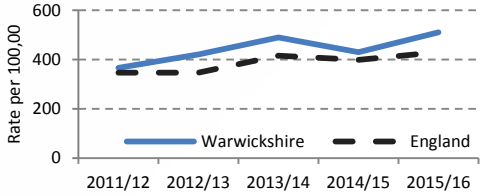
The Warwickshire Fitter Future service aims to address this; referrals are made by other agencies, with results showing a positive improvement for participants through increases in: intake of fruit & vegetables, physical activity and self-esteem score.

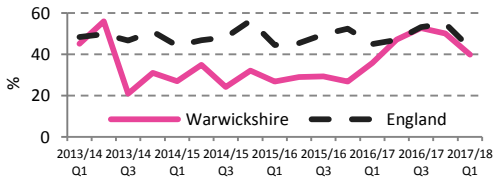
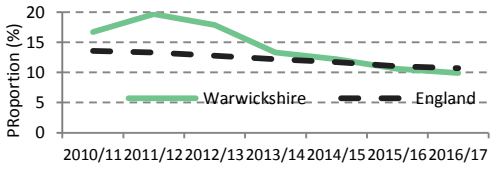
Women smoking in pregnancy

The target for this KBM is set by the Department of Health and is a 0.1% reduction from the previous year's performance for each of the 3 CCGs in Warwickshire. Rates have been declining across all CCGs but the accuracy is affected by the number of unknown (where a midwife has not recorded the woman's status). Additional training of midwives has been implemented on this. Also the implementation of the Risk Perception Intervention, delivered to expectant women at scanning, has led to an increase in referrals to the quit service; this service is an 'opt out' rather than opt in and will improve performance across Warwickshire.

Children & young people hospital admission as a result of self-harm

The School Health & Wellbeing Service is identifying young people who have concerns about self-harm and proactively supporting them. They will be reviewing the data for local hotspots to guide resources and are also embedding an Emotional Health & Wellbeing Lead within the service who will focus on this type of activity in conjunction with CAMHS.

Measure	2017/18 Forecast *(Target)*	2016/17 Actual at Year End	2015/16 Actual at Year End	Trends
Teenage conception rate per 1,000 population *(Warwickshire)*	19.5 *(22.8)*	19.5	22.9	
Percentage (%) children aged 11 years old who are obese	17.4 *(17)*	17.4	16.8	
Alcohol-related hospital admissions per 100,000	625 *(625)*	594	-	
Hospital admissions as a result of self-harm (children and young people 10-24 per 100,000)	510.7 *(510.7)*	-	-	

	Percentage (%) of health check offers taken up (seen) by eligible population each year across all CCGs	40 *(40)*	44	30	
	Percentage (%) smoking at the time of delivery *(Warwickshire)*	The current targets and forecasts are set at a CCG level for this Measure and performance on at this level is reported at Annex R			

How do we compare? It is important to note that comparative data relates to the published time periods for the data and offers a benchmark based on those time periods.

Measure	2017/18 Forecast	2016			2015		
		Warks	WM*	Nat *	Warks	WM*	Nat *
Teenage conception rate per 1,000 population *(Warwickshire)*	19.5	*n/a*	*n/a*	*n/a*	19.5	23.7	20.8
Measure	**2017/18 Forecast**	**2016/17**			**2015/16**		
		Warks	**WM***	**Nat ***	**Warks**	**WM***	**Nat ***
Percentage (%) children aged 11 years old who are obese	17.4	*n/a*	*n/a*	*n/a*	17.4	22.1	19.8
Alcohol-related hospital admissions per 100,000	625	*n/a*	*n/a*	*n/a*	594	728	647
Hospital admissions as a result of self-harm (children and young people 10-24 per 100,000)	510.7	*n/a*	*n/a*	*n/a*	510.7	443.3	430.5
Percentage (%) of health check offers taken up (seen) by eligible population each year across all CCGs	40	50.2	45.9	55	26.9~	46.1~	52.5
Percentage (%) smoking at the time of delivery *(Warwickshire, this relates to financial years, 2016/17 and 2015/16)*	-	9.9	11.8	10.7	10.6	11.9	11

This key relates to the above table only

Key: *WM*= West Midlands; Nat*= National average (England)*

~no significance calculated

	Warwickshire or West Midlands is significantly above/worse than the England average
	Warwickshire or West Midlands is not significantly different to England average
	Warwickshire or West Midlands is significantly below/better than the England average

4. Financial Commentary

4.1 Revenue Budget

4.1.1 The Council has set the following performance threshold in relation to revenue spends: a tolerance has been set of zero over-spend and no more than a 2% underspend. The following table shows the quarter 1 position for the Business Units concerned.

Business Unit	2017/18 Budget £'000	2017/18 Outturn £'000	Revenue Variance £'000	Revenue Variance %	Retained reserve £'000	Financial Standing £'000
SCSS	133,034	132,023	(1,011)	0.76% (Underspent)	(8,319)	(9,330)
SC	13,034	11,480	(1,554)	11.92% (Underspent)	(3,836)	(5,390)
PH	23,721	23,687	(34)	0.14% (Underspent)	(1,049)	(1,083)

SCSS=Social Care & Support Services; SC = Strategic Commissioning; PH= Public Health. All overspends are shown as dark Red, as are any underspends of more than 2% (which are outside of corporate tolerance levels). Underspends of less than 2% are shown as Green. Financial Standing is the level of reserves a business unit is forecast to have at the end of the financial year. Any overdrawn position is shown as Red

4.1.2 The reasons for any over-spends and under-spends of more than 2% are given below

- Strategic Commissioning
  The Business unit is forecasting an under-spend due to staff vacancies and/or planned early delivery of savings.

4.2 Delivery of the Savings Plan

4.2.1 The savings target for the Business Units is shown in the table below:

Business Unit	2017/18 Target £'000	2017/18 Actual at Q2 £'000	2017/18 Forecast Outturn £'000	2017-20 Implementation Status
SCSS	5,343	3,591	4,706	Amber
SC	2,737	2,502	2,737	Green
PH	2,534	1,267	2,534	Amber

- Social Care & Support
  Overall the 2017/18 savings within the business unit do not present an issue to the overall bottom line budget. This is due to other efficiencies achieved and unexpected income from the supplementary iBCF. However, in subsequent financial years this delay in the achievement of efficiencies may start to present a challenge, especially if the 'redesign' doesn't achieve the expected savings, or that increased demand utilises the capacity created. Achieving a reduction in expenditure in transport continues to be an area where there is unlikely to be delivery. This continues to be a cross cutting issue and is the subject of discussion across the service areas.

- Strategic Commissioning
  All relevant restructuring to achieve 17/18 savings are delivered. All Commissioned

Services have been redesigned and delivered e.g. housing related support/advocacy services to achieve savings. Plans are in place to achieve current savings targets for 18/19 and 19/20.

- Public Health
  Savings targets for this year are being supported from reserves on a one-off basis. The Public Health Grant Ring-fence has been extended to 2018/19 which may mean there is a need to reconsider phasing of targets as part of the 2018/19 OOP refresh. An application has been submitted to COLT to support this option.

4.3 Capital Programme

4.3.1 The table below shows the approved capital budget for the business units, any slippage into future years and the reasons for this where applicable.

Service	Approved budget for all current & future years £'000	Slippage from 2017/18 into Future Years (£'000)	Slippage from 2017/18 into Future Years %	Current quarter - new approved funding / schemes (£'000)	All Current and Future Years Forecast (£'000)	Comments
SC&S (Adults)	3,350	(300)	-86%	0	3,350	The slippage of £300k is due to emerging transformation deliverables
SC*	4,886	1	0%	2,062	6,948	Transfer into Strategic Commissioning of Professional Practice & Assurance Project which has also slipped and reduced by £260k
PH	24	0	0%	0	24	

* Capital Funds may not all be related to Adult Social Care activities.

5 Supporting Papers

5.1 A copy of the full report that went to Cabinet on the 9th November 2017 is available via the following link: One Organisational Plan Mid Year Progress Report April 2017- September 2017 and the supporting Business Unit Background Information relevant to the remit of this Committee, which also went to Cabinet on 7th September, is available in each of the Group Rooms.

6 Background Papers

None

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Annex R

Adult Social Care

BU	Key Business Measure (KBM)	Aim-is Higher or Lower Better	Mid Year Actual	Year End Forecast	2017-18 Target	Year End Forecast RAG	Comments	Actions to be taken
SCS & SSC	No of permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Lower	289	528	528	Green	On Track, even though we are seeing cost pressures in this area for Older People.	
SCS & SSC	No. of permanent admissions of people to residential and nursing care homes (aged 18-64)	Lower	27	33	33	Green	Transfer of funding from Continuing healthcare (CHC) to social care for people under 65 in residential care continues to remain a risk particularly for people with a Physical Disability	There are a number of specialised accommodation with care units opening in 2017/18 for people under 55 and including people out of county which will offer an alternative solution to people than residential care. Application of Continuing healthcare (CHC) criteria and challenging decisions will continue to be required to ensure numbers of people in residential care do not increase.
SCS & SSC	No. of admissions to long term community care (including both residential and community settings) (all ages 18+).	Lower	2366	2600	2600	Green	On track	
SCS & SSC	Proportion of adults receiving a direct payment ASCOF 1C Part 2A	Higher	26.7	27	30	Red	All customers who are eligible for council funded support are expected to be offered a Direct Payment. This will continue to be offered and evidence recorded in electronic case notes and case file audits.	All customers who are eligible for council funded support will be offered a direct payment. Evidence of this is required in case recording and is one of the measures in the adult case file audit. All new staff have mandatory e-learning on Direct Payments and operational guidance on Direct Payments is being reviewed to streamline current guidance.
SCS & SSC	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) BCF.	Lower	576.5	550	396	Red	Latest available information from the Department of Health (DOH) is July 2017. The local picture reflects the national issues of both health and Social Care delays. Locally DTOC is attributable to both delays in assessments being completed and delays in care being sourced.	A Countywide Delayed Transfers of Care (DTOC) Project has started. The Project Initiation Document details we aim to improve performance during 2017-19. A Hospital Social Care Team Improvement Plan has been developed and additional staff have been employed in hospital social care teams and the reablement service to improve social care response to hospital discharges.
SCS & SSC	% of customers not needing on-going social care 91 days after leaving reablement (all ages).	Higher	81.93	75	75	Green		

SS & SSC = Social Care & Support and Strategic Commissioning

Annex R

Health & Wellbeing

BU	Key Business Measure (KBM)	Aim-is Higher or Lower Better	Mid Year Actual	Year End Forecast	2017-18 Target	Year End Forecast RAG	Comments	Actions to be taken
PH	% smoking at the time of delivery (Warwickshire whole)	Lower				N/A		
PH	Teenage conception rate per 1,000 population (Warwickshire)	Lower	19.5	19.5	22.8	Green	There is an 18 month time lag with this data. The actual figures relate to 2015. 2016 annual data will not be available until April 2018 with the updated release of the Sexual & Reproductive Health Profiles. Warwickshire's rate continues to be below the national teenage pregnancy rate of 20.8 although there is some variation at District/Borough level: the rates in Stratford-on-Avon District and Nuneaton & Bedworth Borough have come down from the previous year, which is good news; the Warwick District rate has increased from the previous year, this is still well below the England rate and therefore, this increase may not be sustained in future years. The North Warwickshire rate has increased from the previous year although, this is still considered to be statistically similar to the national rate.	NB. Target is rate for 2014. The condom distribution programme has now commenced in the North of the County to assist in the reduction of the teenage pregnancy rates, along with the 'Acting on Teenage Pregnancy' group which is looking specifically at this issue. The increases seen in some areas of the county will continue to be closely monitored to understand if a trend emerges.
PH	% children aged 11 who are obese	Lower	17.4	17.4	17	Amber	This actual is the data for 2015/16 - the dataset for 16/17 will be published in November 2017	Increase referrals to Family Weight Management Services (Fitter Futures)
PH	Alcohol related admissions per 100,000 (KBM)	Lower	594	625	625	Green	The data is published annually usually at the end of the financial year, therefore the target is a modelled estimate based on the previous year's data. Quarterly reporting is not possible for this indicator, however, we estimate that the modelled target will be met.	Continued partnership work with groups/teams including Criminal Justice, Social Care, Health etc. The update on Fingertips has indicated a lower actual but the prevalence is increasing. Work with CCGs to agree oversight of Commissioning for Quality and Innovation (CQUIN) in community health this year and acute health environments next year.
PH	Hospital admissions as a result of self-harm - children and young people 10-24 per 100,000	Lower	510.7	510.7	510.7	Green	This data relates to 2015/16. The 2016/17 data will not be released until the Child Health Profiles are updated in March 2018.	The School Health & Wellbeing Service are identifying young people who have concerns about self harm and proactively supporting them. We will be reviewing the data for local hotspots to guide resources. We are also embedding an Emotional Health & Wellbeing Lead within the service who will focus on this type of activity in conjunction with CAMHS.
PH	% health check offers taken up (seen) by eligible population each year across all CCGs	Higher	39.9	40	40	Green	The actual is for Q1. Q2 data is due to be published in December	Q2 data not yet available

PH = Public Health

OOP 2020

Warwickshire: Your Council

Warwickshire County Council One Organisational Plan 2020

Warwickshire County Council

Warwickshire County Council

Introduction

Welcome to Warwickshire County Council's new corporate plan. The One Organisational Plan 2017-20 describes how we will rise to the challenge of making Warwickshire the best it can be.

The journey over the last three years has been challenging - we have delivered the £92 million pounds of savings demanded of us to balance our budgets and we are now faced with making further savings of £67 million.

This means shaping the future of a very different County Council and different public service provision in Warwickshire by 2020. The reduction in resources does not diminish our ambition for the County. We are clear about our priorities - firstly, we want Warwickshire's communities and individuals to be supported so they are safe, healthy and independent with priority focussed on the most vulnerable. Secondly, we want Warwickshire's economy to be vibrant and supported by the right jobs, training, skills and infrastructure. We will seek to build our economy by attracting more investment, maximising business opportunities and encouraging job creation.

To achieve this we need to ensure our services are more efficient, integrated and that we make best possible use of new technologies and innovation. This means better access and information.

We cannot do this alone and we are continuing to look to our residents and partners in the public, private and voluntary communities to open up a new conversation with us to find solutions and different ways of working.

This plan sets out the journey we face - and begins to describe how we can work together to make Warwickshire the best it can be for everyone.

Warwickshire in the future

We know that in delivering our OOP 2020, we will be shaping a very different public service for Warwickshire. We know people will access services in different ways and technology will play a big role in this. This section sets out some of the key drivers and challenges that may impact on the landscape of the County over the next three years and through our understanding of Warwickshire of 2020, we can begin to plan for our future today and deliver our priorities.

Population

By 2020 the estimated population of Warwickshire will be

568,000

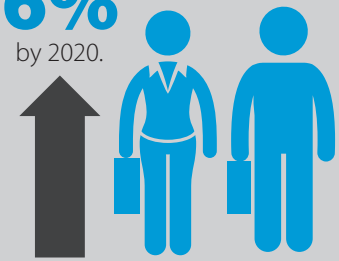
Economy

There will be a continuing focus on the growth of the economy and the importance of business rates.

It is predicted that the number of businesses is likely to increase further in the county and employment growth is expected to increase by

6%

by 2020.



Children & Families

It is estimated that by 2020 there will be

91,054

school age children living and accessing education in Warwickshire a **4%** increase on the 2015 mid year population of 4 to 17 year olds.

By 2020 more than

2,790

vulnerable families and individuals will have been identified and offered support that enables them to achieve greater stability and independence

Community Capacity & Voluntary Sector

Carers, particularly young carers, will continue to play a significant role in delivering aspects of social and personal care.

Some

60,000

carers in Warwickshire

currently provide vital support for their family and/or friends and with a growing population this is expected to increase.

Changing the way we deliver services & access them

The increase in use of **Smart Phones, Tablets** and the improvements in **Broadband speed** and coverage are changing the way people deliver and receive services.

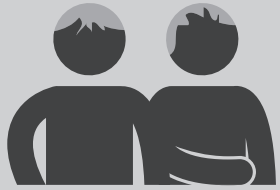
By 2020, Warwickshire residents will contact Warwickshire County Council for information and advice primarily via online tools (e.g. website and email)

Health & Wellbeing (including Adult Social Care & Public Heath)

The demands on adult social care will increase and by 2020 there are predicted to be

2,175

adult Warwickshire residents with a moderate or severe learning disability and 35,465 adult residents with a moderate or serious physical disability.



There is predicted to be a **19%** increase in people aged over 70 years by 2020

By 2020, it is estimated that the number of Warwickshire residents aged 65 and over with a limiting long term illness will be in the region of

59,564

We want to make Warwickshire the best it can be.

Warwickshire's Communities and Individuals are supported to be safe, healthy and independent

- Our communities are independent, resilient and safe
- Vulnerable members of our communities are supported to be independent and safe
- We support and coordinate other organisations to deliver services

Warwickshire's economy is vibrant and supported by the right jobs, training and skills and infrastructure

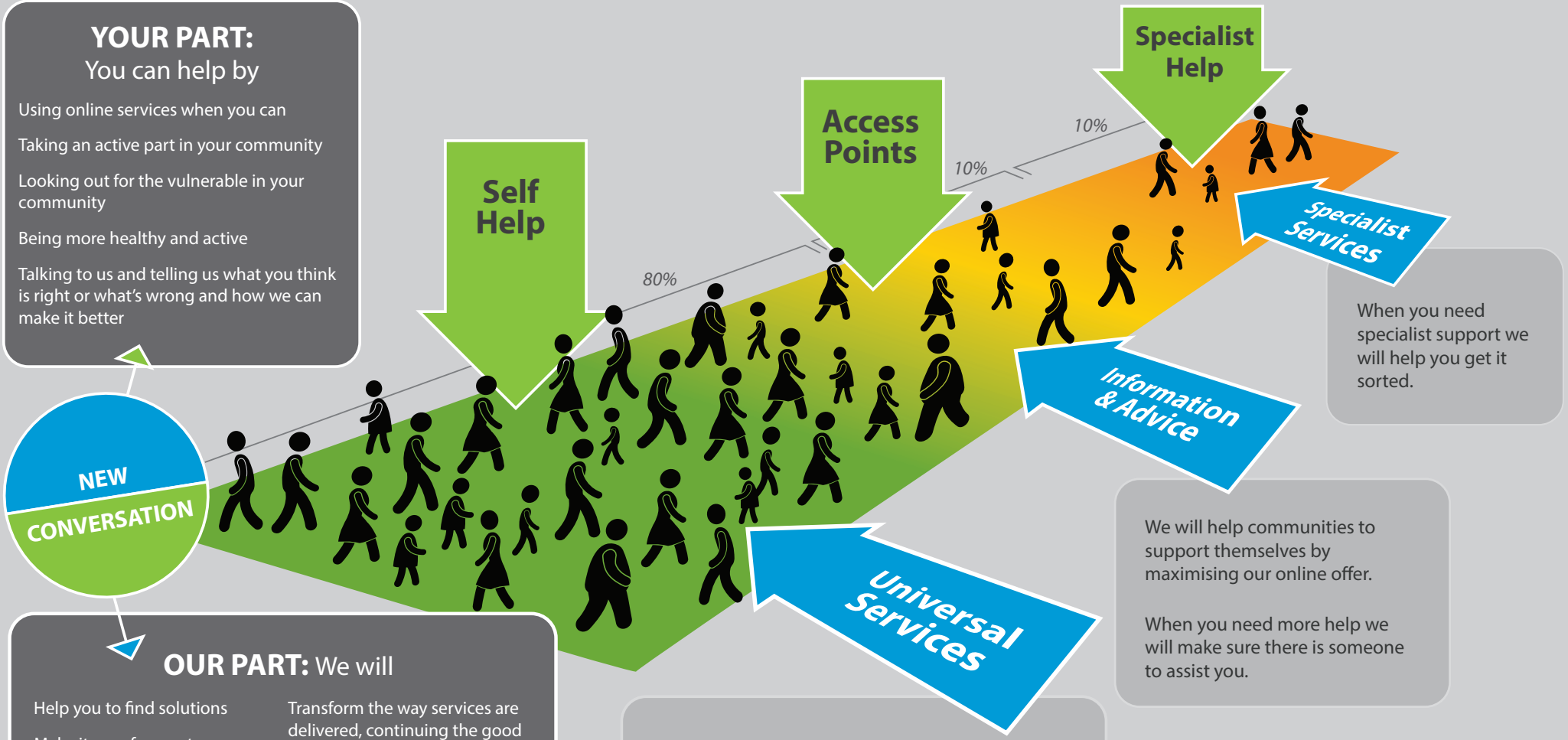
- Children and adults have access to quality learning throughout their lives
- Young people are supported to access apprenticeships and employment
- Warwickshire is an attractive place to do business with a strong local economy and infrastructure
- Our communities and businesses are thriving and prosperous

To make Warwickshire the best it can be and deliver the savings we need to make, we will need to use our resources differently and transform the way we deliver and commission services. The diagrams/frameworks on the following pages set out how we will make the changes we need to make to respond to this challenge.

Making Warwickshire the best it can be: A new conversation

YOUR PART:
You can help by

- Using online services when you can
- Taking an active part in your community
- Looking out for the vulnerable in your community
- Being more healthy and active
- Talking to us and telling us what you think is right or what's wrong and how we can make it better



When you need specialist support we will help you get it sorted.

We will help communities to support themselves by maximising our online offer.

When you need more help we will make sure there is someone to assist you.

We will provide a range of services which are available to all including schools, roads, libraries, fire & rescue.

We will work to increase the ability of individuals and communities to find solutions by developing communities and working with partners including the voluntary sector.

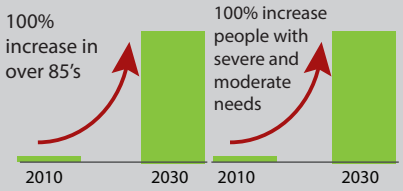
OUR PART: We will

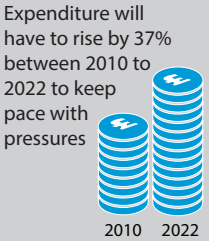
- Help you to find solutions
- Make it easy for you to access services you need
- Maximise the use of digital services
- Listen to your needs
- Build services around individual and community needs
- Transform the way services are delivered, continuing the good work we have started
- Work with partners to make experience between agencies seamless
- Support the economy to make it grow

Towards an integrated health and care model

The case for change

- Increasing demand, reducing supply
- Reducing money in the system
- Complex system to navigate





New model of care

- Enable people to be self sufficient
- Support people to be independent & stay in control
- Use technology & light touch self assessments
- Provide care & support that is proportionate to your needs

Design principles

- Self care
- Build upon existing assets & strengths
- Staff at a more local level
- Keep bureaucracy to a minimum
- Digital first

Behaviours: we will

- Do what we say
- Help people & communities to find their own solutions
- Move with purpose & energy
- Build strong working relationships
- Focus on solutions
- Be the best we can be

Traditional

Transitional

Transformational

New care pathway

Public health campaigns

Info & advice

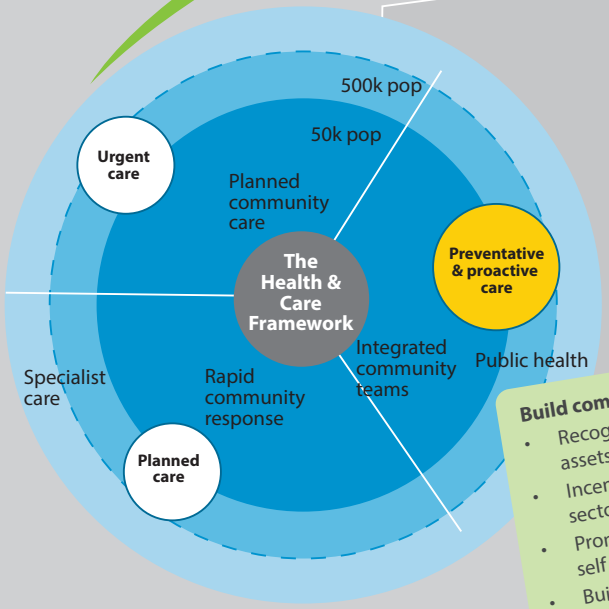
Community assets

Outreaching our social work consultants

Self service

Digital channels

Joint commissioning



Conversation 1 – Front door

- **Starts with a different conversation at the front door – connecting people to local solutions**

80%

Conversation 2 – Local Hubs

- **Takes place in communities where people live – local hubs. With a focus on people's own strengths and assets within their families and communities**

10%

Conversation 3 – Specialist Support Social work consultant/occupational therapists

- **Builds on 1 and 2 if needed**
- **Plan; what needs to change for you and work together to make this happen**

10%

Build community capacity

- Recognise local strengths & assets
- Incentivising voluntary sector & micro enterprises
- Promote health lifestyles & self care
- Build resilient self supporting communities

Front door

- Different conversations
- Improve information & advice offer
- Signpost to hubs & local assets
- Use technology & digital channels

Community based delivery

- Optimise community venues
- Focus on self care & management
- Partners & volunteers a cornerstone
- Social workers will work together with communities & partners

Integrated teams

- Health & Care Teams
  - Co-located
  - Proportionate assessments & reviews
  - Increased use of personal budgets/individual service funds
  - Simple systems & processes
  - Social work professional role strengthened

The outcomes

"I have help to make informed choices"

"I know where to get info about what is going on in my community"

"I have systems in place so that I can get help at an early stage to avoid a crisis"

"I have a network of people who support me – carers, family, friends, community and if needed paid staff"

"I am in control of planning my care & support"

"I have the information and support I need to remain as independent as possible"

"I am supported by people who help me make links to my local community"

"I have a clear line of communication, action and follow up"

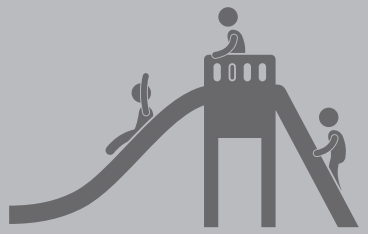
Integrated delivery models

Children and families - a vision for the future

Warwickshire Children

Clear emphasis on
Evidence based interventions
What works at what level
Learning from Priority Families
High quality practice making a difference

Financial context:
Reduced funding
Increasing costs
Increasing volume of need
Cost effectiveness - making every pound count



Easy access to information:
Internet resources, books, libraries, health promotions, leaflets, online video, community led groups, Family Information Service

Universal access to direct advice and guidance:
Schools, GPs, health services, children groups, pharmacies, parenting courses, advice lines, community led groups, emotional wellbeing

Access to direct family support:
Early help single assessment, family support workers

Tier 3: Local problem solving panels
Local multi agency problem solving group focusing on removing barriers and prevention.

Access intensive family support:
Intensive family support, social work

Tier 4: MASH and specialist social worker support
Statutory support provided at acute level of need

Services for children at serious risk of harm:
Foster care or residential, child protection

Tier 2: Single Assessment
One assessment
One plan
Coordinated services

Tier 1: Self help and brokerage
Empowering conversation
Community hubs
Connecting people to local solutions and guided self help

Reduce the time children need in care

Reduce inefficiencies & streamline services

Better outcomes for children

766
Children looked after and
440
Child protection plans

1,800
open child in need plans

1,400
open early help single assessments

Children and young people are at the heart of our practice

Guided self help Communities supporting one another

Working to support at the earliest opportunity

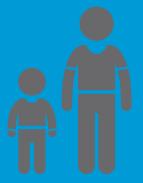
Right Support for the Right issue at the Right time

Services proportionate to need

Reduce the need for looked after children by 25% by 2020

Streamlining the child's journey

In 2014 an estimated 112,262 0-18yrs lived in Warwickshire



The population of children is 28% - 0-5 years 66% - 5-16 years

Over the next 10 years the 3-13 population is estimated to increase by 10%

Developing Community Capacity 2017-2020

Warwickshire County Council, communities, voluntary sector, district and borough councils, health partners and other public service providers work together in the delivery of high quality, cost effective opportunities with an emphasis on supporting people and communities to create their own solutions.

The Case For Change

- Less money into the system
- Increased demand on services
- The need for integrated solutions across sectors
- Under-utilisation of community assets

FOUNDATIONS

Community Engagement

- Promoting healthy and well communities
- Understanding the assets which exist
- Agreeing mutual outcomes with communities
- Empowering conversations
- Increasing participation and utilising community knowledge

Community Development

- Utilising community assets which already exist
- Encouraging communities to recognise and use their own assets
- Developing community –led solutions
- Promoting and encouraging volunteering
- Supporting neighbourhood level activity

Voluntary Sector Transformation

- Self-sustaining organisations
- A broader market of providers
- Supporting micro-enterprise
- Trusted referrals
- Bringing together private sector corporate social responsibility and community work

Community Infrastructure

- Digital access to services
- Universal services accessed through 'hubs'
- Signposting to specialist services
- Supporting flexible and targeted service delivery

Information and Advice

- Easy access to the right information and advice
- Making the interaction between the customer and the council the best it can be
- Directing customers towards self-help
- Ensuring compliance with standards and principles

Digital Services

- Supporting channel shift to digital first
- 'Closing down' other forms of access
- Supporting residents to 'get online'

Principles

- A new relationship with communities
- An asset based approach
- Consistent messages and leadership
- Investing to save

Behaviours: We will

- Do what we say
- Move with purpose and energy
- Focus on solutions
- Build strong working relationships
- Help people communicate and find their own solutions
- Be the best we can be

Transforming the way we work

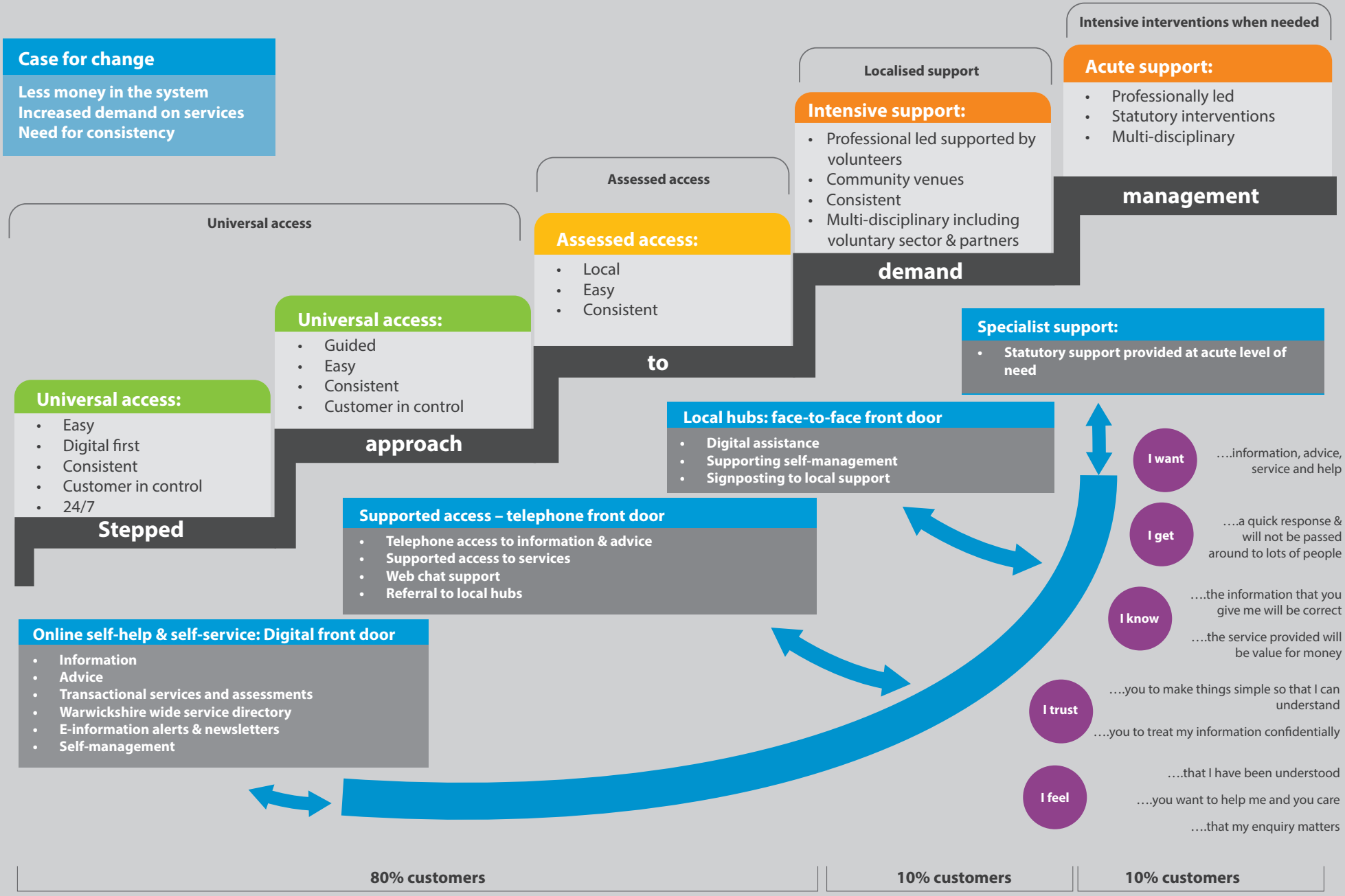
- Raising awareness and usage of the widest range of community assets
- Recognising community assets as enablers and solutions
- Unlocking the potential of emerging community assets
- Making clear and easy links between agencies, community assets and people
- Encouraging people's early participation to protect and promote health and wellbeing outcomes
- Understanding and recognising return on investment

Adult Customer Journey

Children's Customer Journey

Universal Services Customer Journey

Making information and advice freely available



Budget

On 2 February 2017 Warwickshire County Council agreed a medium term financial plan covering the period 2017-2020. This medium term financial plan will underpin the delivery of our One Organisation Plan 2020 and we will continue to review our medium term revenue position during the course of the plan.

The plan outlines how we will invest in Warwickshire's future so the economy is vibrant and we can use the proceeds from that to ensure our most vulnerable citizens are safe.

The amount of money we have available to provide services will be in the region of £395 million by 2020. A year by year breakdown is presented in more detail here and includes an annual increase in Council Tax each year of 1.99% plus an extra 2% levy specifically for adult social care.

Overall Predicted Council Revenue Position

	2017/18 £m	2018/19 £m	2019/20 £m
Revenue Support Grant	20	10	-
Business Rates	61	63	65
Other Government Grants[1]	41	44	49
Adult Social Care Levy *(2% year on year increase)*	10	15	20
Council Tax *(1.99% year on year increase)*[2]	247	254	261
Total Revenue Resource	**379**	**386**	**395**

Council tax remains the biggest source of income and the development of the 2017-2020 Plan continues to provide the opportunity to take a longer term approach to setting the level of council tax.

We have identified that over the three years of the plan we must deliver savings of £67 million. The savings have been identified from all areas of activity and will be delivered in a phased manner over the three years.

Inflation

We have allowed for the cost of inflation over the period 2017-20 of £24 million. Funding has been allocated to cover the cost of inflation at a local level to minimise the impact on services.

Spending Pressures

We have allocated £2.5 million a year to respond to expected or new spending pressures that emerge through to 2020 to ensure we have in place a medium term financial plan that is financially resilient.

Capital Resources

We will use our capital resources over the next three years to support an enhanced programme of investment in Warwickshire's future. We will supplement our £20 million annual borrowing by reinvesting the additional funding we receive as a result of growth in delivering a positive and sustainable impact for the people and communities of Warwickshire.

Adult Social Care

We will use all of the additional 2% levy to increase the resources available to deliver adult social care, meeting demographic, statutory and inflationary pressures and delivering a service that supports people shaping their own solutions.

1 Other Government Grants included here are New Homes Bonus, Better Care Fund, Public Health Grant, Education Services Grant and Local Services Grants. Dedicated Schools Grant is excluded.
2 Council Tax figures assume a 0.75% year-on-year increase in tax base in future years
3 Figures may be amended following decisions taken on the Budget in February 2017

Contact:

Performance Business Unit
corporatefinancialplan@warwickshire.gov.uk

February 2017

Item 5

Adult Social Care and Health Overview and Scrutiny Committee

22 November 2017

Work Programme Report of the Chair

Recommendations

That the Committee:

1. Reviews and updates its work programme.

2. Notes the ongoing work in preparation for the Joint Health Overview and Scrutiny Committee with Coventry City Council and the scoping document for the GP Services Task and Finish Group.

3. Approves that a joint task and finish group of Children and Young People OSC and Adult Social Care & Health OSC is established to review the new CAMHs service.

1. Work Programme

The Committee's work programme for 2017/18 is attached at Appendix A for consideration. The programme was discussed by the Chair and Party spokespeople at their meeting on 31 October. A copy of the work programme will be submitted to each meeting for members to review and update, suggesting new topics and reprioritising the programme.

2. Forward Plan of the Cabinet

The Cabinet and Portfolio Holder decisions relevant to the remit of this Committee are listed below. Members are encouraged to seek updates on decisions and identify topics for pre-decision scrutiny. The responsible Portfolio Holders have been invited to the meeting to answer questions from the Committee.

Decision	Description	Date due	Cabinet / PfH
One Organisational Plan Quarterly Progress Report	To report on progress on delivery of the OOP 2020, for the period April-December 2017	25 Jan 2018	Cabinet

Last updated 13 November 2017

3. Forward Plan of Warwickshire District and Borough Councils

Set out below are scheduled reports to be considered by district and borough councils at scrutiny / committee that are relevant to health and wellbeing. Further updates will be sought and co-opted members are invited to expand on these or other areas of planned activity.

Date	Report
North Warwickshire Borough Council	
	In North Warwickshire, the focus on health is provided through two forums, the Warwickshire North Health and Wellbeing Partnership (covering both North Warwickshire and Nuneaton and Bedworth), and the Borough Council's Health and Wellbeing Working Party. Examples of recent work are shown below: Warwickshire North Health and Wellbeing Partnership: • End of Life Care • Addressing Teenage Conceptions – Sustainability of the service • Access to Health Services – Community Transport Initiatives • Services at George Eliot Hospital and its Future Vision • #onething – Focus and sustainability of the service Health and Wellbeing Working Party • The Corporate Health and Wellbeing Action Plan - Delivery • The evolving Strategic Leisure Review – Ensuring that it addresses issues of relevance to the health and wellbeing of the local community • End of Life Care • Addressing Teenage Conceptions - The service afforded to young people in North Warwickshire • Access to Health Services – Community Transport Initiatives • #onething • Fitter Futures and its services in North Warwickshire
Nuneaton and Bedworth Borough Council – Housing Health & Communities Overview and Scrutiny Panel	
2017/18	To be programmed in 2017/18: • Discharge Protocol • Lack of NHS Dental Care • Reduction in Pharmacy Funding • Gambling and its impact on health and wellbeing • Healthwatch Concerns / Priorities
Nov 2017	• Dementia Awareness • HWBB Annual Report 17/18
Mar 2018	• Provision of Hospice Beds in the • Health Performance Report • George Eliot Hospital Update • CAMHS

Rugby Borough Council – Customer and Partnerships Committee	
Date TBC	Mental Health Briefing
Stratford-on-Avon District Council – Overview and Scrutiny Committee	
22 November 2017	HEART progress
24 January 2018	Follow up from Sustainability & Transformation Plan (STP) Lead Prof. Andy Hardy – Focus Prevent Agenda
18 April 2018	• Update from the Oxfordshire CCG • Update from the Bromsgrove and Redditch CCG
Warwick District Council – Health Scrutiny Sub-Committee	
Each meeting	Health and Wellbeing Update
Each meeting	Updates from representative on WCC ASC&H OSC
Date to be set	Care Quality Commission

4.0 Briefing Notes Circulated Since the Last Meeting

4.1 The work programme at Appendix A lists the briefing notes circulated to the Committee. Members may wish to raise questions and to suggest areas for future scrutiny activity, having considered those briefing notes.

5.0 Update on Task and Finish Group Work

5.1 The task and finish group (TFG) on GP Services has commenced. The TFG comprises eight members, including three representatives of district and borough councils, to ensure there is representation for each of the five areas of Warwickshire. By the time of this Committee, the TFG will have met twice, initially on 24 October to discuss the scope of the review and then on 20 November to give final approval to the scope and to conduct the first evidence gathering session. A copy of the final draft scoping document is attached at Appendix B. The aim is to submit the review report for consideration at the March meeting of this Committee.

5.2 The Children and Young People Overview and Scrutiny Committee and this Committee, each received a report at their meetings in September regarding the new Children and Young People's Emotional Well-being and Mental Health Contract. The new contract consolidates the six previous Children and Adults Mental Health Services (CAMHs) into a single commissioning arrangement with WCC acting as lead commissioner.

5.3 The new contract took effect on 1 August and marks the start of a significant transformation from the existing service, over a two year implementation period, with contract monitoring during this time focusing on achieving implementation plan milestones.

5.4 Given that both Committees have expressed an interest in this area and have included this in their work programmes, the Chairs of the Committees have agreed that an appropriate way forward would be for a joint task and finish group to be established, comprising members drawn from both committees, to undertake a review of the new service and report back to a joint meeting of the Committees.

5.5 Proposed terms of reference for the Group are set out in Appendix C.

6.0 Joint Health Overview and Scrutiny Committee

6.1 At its meeting on 18 July 2017, the County Council approved a report and terms of reference for the establishment of a Joint Health Overview and Scrutiny Committee (JHOSC) with Coventry City Council. A copy of that report and terms of reference are available via this link.

6.2 Informal meetings between the Chair and Vice Chair of each authority's Overview and Scrutiny Committees continue, the most recent being held on 23 October. The first area for review by the JHOSC is Stroke Services. There has been a delay in the assurance process which is needed before the public consultation commences. Arrangements are being made to hold the first formal meeting of the JHOSC in January 2018.

Background Papers

None.

	Name	**Contact Information**
Report Author	Paul Spencer	01926 418615 paulspencer@warwickshire.gov.uk
Head of Service	Sarah Duxbury	
Strategic Director	David Carter	
Portfolio Holder	n/a	

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: Councillor Redford

Adult Social Care and Health Overview and Scrutiny Committee
Work Programme 2017/18

Date of meeting	Item	Report detail
Briefing – 22 November	Housing Related Support	Suggested by Councillor Dave Parsons. Invite contributions from district and borough housing officers. What is the position on homelessness? At the Chair and Party Spokes meeting on 22 August this topic was selected as the briefing topic for the meeting on 22 November 2017.
22 November 2017	Integration of Clinical Commissioning Groups and their commissioning intentions	Suggested by Councillor Dave Parsons. How are the three CCGs serving Coventry and Warwickshire Integrating commissioning. This area was also suggested by Healthwatch. Invite all the CCGs to the same meeting to see how their commissioning intentions are integrated. The Chair and Party Spokespeople agreed this should be the single issue item for the November Committee.
22 November 2017	One Organisational Plan 2017-18 Q2 Progress Report	To provide the Committee with a quarterly update on progress of the One Organisational Plan 2020.
24 January 2018	CAMHS	This item was considered in September 2017. The Committee agreed to receive a further update on the CAMHS Service and implementation of the revised contract, taking on board the points raised at the September meeting. This was discussed further at the October Chair and Party spokespeople meeting. A joint task and finish group is to be established to consider the CAMHS service in depth and dependent on timing of its first meeting, the update to the OSC may need to be delayed.
14 March 2018	Dementia Awareness	This item was considered in September 2017. The Committee agreed to hold a further presentation/development session to cover the additional work being undertaken through Warwickshire's Living Well with Dementia Strategy (2016-2019), the potential areas of focus being timely diagnosis and support in acute/residential housing with care settings.
14 March 2018	One Organisational Plan 2017-18 Q3 Progress Report	To provide the Committee with a quarterly update on progress of the One Organisational Plan 2020.
Dates to be confirmed	Reconfiguration of Stroke Services	Suggested by Councillor Margaret Bell. This is the subject of a current engagement exercise and then a formal consultation. A proposal to consider it before decisions are finalised. There are concerns about the assumptions around a reduction in stroke cases. Also suggested by Healthwatch.
	STP – Proactive and Preventative Workstream	Suggested by Councillor Margaret Bell. The Proactive and Preventative work stream of the STP. The suggestion is to find out more: What is happening; what is the plan; how is it to be funded; when will we see results?
	STP – Accountable Care System	Suggested by Healthwatch. The STP is morphing into an Accountable Care System. This item is about how the public will be better engaged in the accountable care system, unlike the process for the STP.

	STP – George Eliot Hospital Campus Model	Suggested by Councillor Clare Golby. To understand how the proposals for the George Eliot Hospital (GEH) Campus Model will fit into other health services for the north of Warwickshire and the implications for residents. Councillor Parsons supported this area, raising concerns about the potential downgrading of services delivered at GEH.
	Patients Transport Service	Suggested by Councillor Margaret Bell. This concerns the voluntary Patient Transport Service. The areas to examine are: is the county covered; how expensive are services for the user; what is happening to their funding sources; how sustainable are they?
	The 111 Service	Suggested by Councillor Margaret Bell. Areas to examine are: How do they refer people to health services; how do they link in with the relevant CCG; how do they know where services are commissioned; also what do they do about patients with no transport who are referred to an Out of Hours Service at, say, the early hours of the morning.
	Provision of GP Surgeries	Suggested by Councillor Pam Redford. A considerable number of new houses are planned across the County. An area for the committee to consider is the need for extra GPs surgeries these homes will require. The review should include the location of these surgeries, particularly in rural areas. Extra housing will not only require extra GP surgeries, but also extra beds in General Hospitals will be needed. With fewer doctors choosing to become GPs this is another area we should be looking at.
	Local Commissioning of Services	Suggested by Councillor Mark Cargill. A pilot scheme has been undertaken in Alcester. ***Needs clarification on the area for scrutiny***
	Reablement and Delayed Transfers of Care	Suggested by Councillor Mark Cargill. A scrutiny area which looks at how to streamline the transfer process, including avoiding hospital admission where possible and links to good quality housing.
	Director of Public Health Suggestions	To support the recommendations highlighted in the Director of Public Health's annual report, which the DPH has a statutory duty to provide. The theme this year is 'Vulnerability' (and its impact on health). This will be taken to the HWBB on 6 September and cascaded following that meeting. To support the JSNA (Joint Strategic Needs Assessment) – The purpose of the JSNA is to analyse the current and future health and wellbeing needs of the local population, to inform the commissioning of health, wellbeing and social care services. The JSNA aims to establish a shared evidence based consensus on the key local priorities across health and social care. From 2017 this moves to a place based approach with five drivers: Health & Wellbeing Strategy Sustainability & Transformation Plan (STP) Out of Hospital Programme GP Five Year Forward Plan Community Hubs County Council Transformation Plans To support the work around suicide prevention, looking at the possible causes of a local increase against national trend.

		To support the work around the dual diagnosis needs assessment – Mental health and substance misuse.
	Coventry and Warwickshire Partnership Trust	Suggested by Healthwatch. There has been a re-inspection of the CWPT by the Care Quality Commission. Invite the Trust to present its progress against the action plan that will flow from the CQC inspection. Suggested area for 4-6 months, so November 2017 or January 2018 meeting.
	Mental Health of Veterans	Suggested by Healthwatch. ***Further detail needed on scope.***
	Meals on Wheels Service	Suggested by Councillor Rolfe. A briefing note to cover the reduction in take up of this service and the current costs of the service. It was agreed by the Chair and Party Spokes (22 August) that a briefing note be provided in the first instance.
	Briefing Session – Proactive Monitoring of the Quality of Care – The 'See, Hear and Act model'	Warwickshire County Council takes a proactive approach to ensuring the quality of the care it commissions through the 'See, Hear and Act' model for quality assurance. There is a dedicated team, Quality Assurance and Improvement, to undertake this work. The See, Hear and Act model includes closely monitoring the ratings providers receive from CQC. An offer from Chris Lewington to host a members seminar on our new model for assuring Quality given the number of new members within the Council.
	Additional Funding for Adult Social Care	At Cabinet on 13 July, members questioned the long term viability of health and social care services across the county. Changes to the domiciliary care commissioning arrangements were discussed. Whilst the situation in Warwickshire is better than in other areas, the private care industry is facing a number of significant challenges, a major one being recruitment. Cabinet suggested that the Overview and Scrutiny Committee be asked to review the fragility/stability of the private care industry and the role of the County Council in ensuring its continuance.

BRIEFING SESSIONS PRIOR TO THE COMMITTEE

Date	Title	Description
12 July 2017	Overview of Strategic Commissioning	Chris Lewington provided an overview of the work of Strategic Commissioning.
13 September 2017	Out of Hospital Programme	A significant and positive step forward on the Out of Hospital Programme. It is felt members need to be sighted and engaged in this development. This session would include representatives of the clinical commissioning groups.
22 November 2017	Housing Related Support	Hugh Gaster, Housing Related Support Officer to lead on this. A briefing beforehand to remind of recent history and the briefing session to bring up to date with current position / developments.
24 January 2018	Proposal from Chair and Party Spokes Meeting - Direct Payments	An initial briefing note on direct payments would be useful, ahead of the January session.
14 March 2018	Proposal from Chair and Party Spokes Meeting - 0-5 year olds and / or Paediatric and Maternity Services	Discussed at the October Chair and Party Spokes Meeting. Needs clarity on content.

BRIEFING NOTES

Date Requested	Date Received	Title of Briefing	Organisation/Officer responsible
31/10/17		Update on progress with reducing delayed transfers of care	Chris Lewington
-	01/11/17	Healthwatch England Publication – Readmission to Hospital	Paul Spencer
-	31/10/17	LGA Publication – Adult Social Care Funding	Paul Spencer
12/07/17	07/09/17	Dementia – Enhancing Awareness and Understanding Across Warwickshire	Claire Taylor
12/07/17	05/09/17	Summary of the CAMHS Redesign Process	Andrew Sjurseth
-	20/07/17	Healthwatch Report into Warwickshire Mental Health Services	Chis Bain
01/03/17	23/03/17	Maternity Briefing Note	
-	16/01/17	NHS Dental provision in Stratford	
14/09/16	14/2/17	End of Life Care	Amy Sirrs
14/09/16	14/2/17	Public Health: Monitoring Performance and Outcomes	Paul Kingswell
-	23/11/16	Patient Transport Services	
14/09/16	31/10/16	Timetable for the Health Visiting Service tendering process	Director of Public Health (Kate Sahota)
-	31/10/16	Member visit to WMASS Coventry Hub	Paul Spencer, Democratic Services
14/09/16	15/11/16	Hospital discharge planning arrangements. A briefing note to explain the discharge arrangements for each of the hospital sites in Coventry and Warwickshire.	Head of Social Care and Support
13/07/16	25/08/16	Urgent Care & Walk in Centre, George Eliot Hospital	Andrea Green, Warwickshire North CCG
13/07/16	10/10/16	Falls Prevention trip hazards and condition of footways – data on claims	Head of Transport and Economy

TASK AND FINISH GROUPS

ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	TIMESCALE	FURTHER INFORMATION
GP Services	The Committee agreed this TFG area at its meeting on 15 September. Membership: Councillors Margaret Bell, Keith Kondakor, Anne Parry, Dave Parsons, Pam Redford, Jerry Roodhouse, Jill Simpson-Vince.	Aim to report back to ASC&H in January 2018.	Member nominations received including some from district and borough councils to provide representation for all five areas of the County. The scoping of the review took place on 24 October and its next meeting is scheduled for 22 November.
Joint Health Overview and Scrutiny Committee	This is the first of the joint committees, working with Coventry City Council to focus on Stroke Services.	To be confirmed	
Maternity and Paediatric Services	The Committee agreed this TFG area at its meeting on 15 September. The detailed scoping of this area is still to be determined.	Review starts after completion of the GP Services TFG.	
Quality Accounts 2016/17. Paul Spencer and Coventry City Council / Healthwatch	QA Groups for each of the 5 Trusts to work with the Trusts on quality accounts over the year.	June 2016 – completed	Follows the format used for 2015/16, with WCC leading on the TFGs for George Eliot Hospital, West Midlands Ambulance Service and South Warwickshire Foundation Trust. Coventry City Council and Healthwatch Coventry to lead on the reviews for UHCW and CWPT.
Quality Accounts 2015/16, Paul Spencer and Coventry City Council / Healthwatch	QA Groups set up for each of the 5 Trusts to work with the Trusts on quality accounts over the year.	June 2016 – completed	The reviews are complete. This year, WCC led on the TFGs for George Eliot Hospital, West Midlands Ambulance Service and South Warwickshire Foundation Trust. Coventry City Council and Healthwatch Coventry led on the reviews for UHCW and CWPT.
Select Committee to look at Winter Pressures	The Committee held a select committee to look at the winter pressures for 2014/15. A follow up report was provided on actions progressed.	2 October 2015 - completed	An update was requested at the meeting on 2nd December 2015, to the Committee on 2 March 2016.
Quality Accounts 2014/15, Ann Mawdsley/Sally Baxter	QA Groups set up for each of the 5 Trusts to work with the Trusts on quality accounts over the year	May 2015 - completed	

Scoping Document

Review Topic (Name of review)	GP Services Task and Finish Group
TFG Committee Members	Councillors Margaret Bell, Keith Kondakor, Penny-Anne O'Donnell (SDC), Anne Parry, Dave Parsons, Pam Redford (WDC), Jerry Roodhouse and Jill Simpson-Vince.
Co-option of District and Borough members (where relevant)	District and borough council representation has been sought to ensure local input from each of the five areas of Warwickshire. Councillors Penny O'Donnell (SDC) and Pam Redford (WDC) appointed. Councillor Margaret Bell represents both WCC and NWBC.
Key Officers / Departments	John Linnane (Director of Public Health), Emily Fernandez and Gemma McKinnon (Public Health)
Lead Democratic Services Officer	Paul Spencer
Relevant Portfolio Holder(s)	Councillor Les Caborn, Portfolio Holder for Adult Social Care and Health
Relevant Corporate Ambitions	The Health and Wellbeing of all in Warwickshire is protected
Type of Review	Task and Finish Group (TFG)
Timescales	Complete review and report to the March 2018 Adult Social Care and Health Overview and Scrutiny Committee
Rationale (Key issues and/or reason for doing the review)	Identifying the problems that exist now and those anticipated in the future, including the aging population, increasing demands on health services, at the same time as decreasing GP numbers.
Objectives of Review (Specify exactly what the review should achieve)	To gain an understanding of service demand and levels of pressure on GPs. Identifying the potential areas to reduce these pressures and particularly areas where the County Council has an influence, including the Health and Wellbeing Strategy and CCG strategies. An education role to reduce wasted/unnecessary GP appointments and directing people other services including pharmacies or NHS helplines, where these are appropriate.

Scope of the Topic (What is specifically to be included/excluded)	<u>Include - There are four main themes</u> 1. Primary Care profile in Warwickshire to include resources, demand, outcomes, quality: • Consideration of the GP Five Year Forward View: https://www.england.nhs.uk/gp/gpfv/ • Mapping of services. Examine current GP service capacity and future capacity based on predicted population growth. Use waiting times for non-urgent appointments and the availability of emergency appointments as indicators. • Establishing a baseline of what constitutes 'good practice', which could include co-located services, alternative models of service delivery, out of hospital commissioning and from this learning, to share the good practice with others. • Qualitative research on comparative demands for health services. • Review recent CQC and Healthwatch data for Warwickshire GP practices. 2. Primary Care Estate • Seek information on the CCG 'estates', their adequacy for the next 10 years and additional planned provision of medical centres and GP practices, being mindful of the 'other work being undertaken' section below. • Travel distance to the GP and the proportion of patients who aren't registered with a GP. 3. Response to population changes and local plans • Patient migration. This will include the implications of older people housing developments and the costs of providing medical services for those with complex/greater medical needs**.** • Explore with CCGs how they interact with the planning process to secure financial contributions for health services from new developments and the 'triggers' for release of funds. 4. Community Resilience and Social Prescribing • Examine how the One Organisational Plan contributes to social prescribing, the sustainability of the voluntary sector and the increasing reliance on this sector. It is important to focus on the areas where the County Council has most influence, also avoiding duplication of work as there is a planned review of community resilience due to be scoped shortly. <u>Does not include</u> • Patient experience, screening services, health checks and self-harm are outside the review's scope.

How will the public be involved? (See Public Engagement Toolkit / Flowchart)	• Ask Healthwatch Warwickshire to contribute as the patient voice and given the extensive work on GP 'enter and view' visits. • Invite representatives of the Patient Participation Group Chairs' forum. • Review CQC patient surveys.
What site visits will be undertaken?	No site visits are planned.
How will our partners be involved? (consultation with relevant stakeholders, District / Borough reps)	• Involvement of the three clinical commissioning groups, Healthwatch Warwickshire and the Patient Participation Group Chairs. Also, meet with the local medical committee (GP representatives) and the local pharmaceutical committee
How will the scrutiny achieve value for money for the Council / Council Tax payers?	• Provide evidence, conclusions and recommendations for consideration and implementation both within the County Council and by its partners. • Explore the synergies that can be achieved from partnership working.
What primary / new evidence is needed for the scrutiny? (What information needs to be identified / is not already available?)	The following people be invited to contribute: • The three clinical commissioning groups, Healthwatch Warwickshire and the Patient Participation Group Chairs. • Kushal Birla - the County Council's lead officer on social prescribing. • Paul Tolley, CAVA - the voluntary sector perspective on social prescribing • The local medical committee (GP representatives) and the local pharmaceutical committee • Mark Ryder, Chair of the County Infrastructure Group
What secondary / existing information will be needed? (i.e. risk register, background information, performance indicators, complaints, existing reports, legislation, central government information and reports)	• General Practice Five Year Forward View Document. • CCG briefing and overview of the key work programmes • Director of Public Health to pull together a GP data pack of key information, with patient numbers per GP and patient profiles, working with the Observatory and others, the data pack to be disaggregated for each district/borough area, **if possible** • Links to web sources including the CQC inspection reports and Healthwatch 'enter and view' visits to GP surgeries. • Data on CCG estates and an infrastructure spreadsheet.

Indicators of Success – (What factors would tell you what a good review should look like? What are the potential outcomes of the review e.g. service improvements, policy change, etc?)	• The review should conclude with a report containing a series of recommendations to the Overview and Scrutiny Committee, Cabinet and partners outside the County Council. This may identify further areas for consideration as subsequent reviews.
Other Work Being Undertaken (What other work is currently being undertaken in relation to this topic, and any appropriate timescales and deadlines for that work)	There is a range of work being undertaken around GP service planning: • All three CCGs as commissioners of primary care have undertaken an utilisation exercise to understand the capacity within the current estate. This also factors in planned housing growth to highlight how existing estate would manage growth. • From these plans the CCGs produced strategic estates plans which identify any potentially estate opportunities and constraints across the locality. These also factored in the emerging STP work and GPFV • Alongside these strategic plans the CCGs host regular Local Estates Forums (LEF) with a range of health and local authority partners to discuss health infrastructure on a locality by locality. It is here that discussions around S106 requests, responses to planning applications and general estate updates are given. • These groups feed into the wider STP Estates Strategy Group which is where discussions aligning to any estate plans are held and where governance dictates that any new plans and/or disposals have to go through the group to be approved. • For SWCCG the GP practices attend on a rotating basis, dependant on the locality focus and this is where main engagement takes places and opportunities for CCG, providers and GPs to have an open discussion • For WNCCG each project has a smaller team and within the engagement with GPs takes place.

Children and Adolescent Mental Health Services Joint Task and Finish Group
Terms of Reference

Purpose	To review the new Children and Young People's Emotional Well-being and Mental Health Service, in particular the implementation period. The review should cover: • the objectives of the new contract • the performance monitoring arrangements • the achievements/outcomes
Membership	**7** councillors (5 Conservative; 1 Labour, 1 Liberal Democrat) To be drawn from the Children and Young People OSC and the Adult Social Care and Health OSC.
Timescale	To report to a joint meeting of the Children and Young People OSC and Adult Social Care & Health OSC in June 2018.

Report to:	Warwickshire Adult Social Care and Health Overview and Scrutiny Committee
Date:	22 November 2017
By:	Anna Hargrave, Chief Transformation Officer *NHS South Warwickshire Clinical Commissioning Group* Andrea Green, Accountable Officer/Matt Gilks, Director of Commissioning *NHS Coventry and Rugby Clinical Commissioning Group* *NHS Warwickshire North Clinical Commissioning Group*
Title:	CCG Commissioning Intentions 2018-19 – Context and Development Process
Purpose:	To provide an update to the Committee regarding the broader context for the development of the Clinical Commissioning Groups' commissioning intentions for 2018-19 and to outline the process undertaken to develop the commissioning intentions documents.

Recommendation/s

The Committee is asked:

1. To note the wider context for the development of the Coventry and Warwickshire Clinical Commissioning Groups' (CCGs) commissioning intentions for 2018-19;
2. To note the process undertaken to develop the commissioning intentions; and
3. To provide any comments or feedback in relation to the content of the report.

1. Context/Background Information

Clinical Commissioning Groups

1.1. The three Coventry and Warwickshire Clinical Commissioning Groups (NHS Coventry and Rugby CCG, NHS South Warwickshire CCG and NHS Warwickshire North CCG) are clinically-led statutory NHS bodies responsible for the commissioning (planning, buying and monitoring) of most healthcare services for the people of Warwickshire. The CCGs operate within a financial budget set by the Department of Health.

1.2. Commissioning, in summary, is about "*getting the best possible health outcomes for the local population. This involves assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc. It is an ongoing process. CCGs must constantly respond and adapt to changing local circumstances. They are responsible for the health of their entire population, and measured by how much they improve outcomes".*[1]

NHS Five Year Forward View (2014)

1.3. In October 2014 NHS England published the *NHS Five Year Forward View* (5YFV).[2] This key policy document sets the context within which all subsequent local plans (as identified in section 2 below) have been developed. The 5YFV articulates a clear vision of the future, in which greater emphasis is placed on prevention, integration of services (in other words, organisations, both commissioner and provider, within local health and care systems working together to meet the needs of and deliver the best care for patients) and putting patients and communities in control of their health. The 5YFV sets out a vision and collective view of how the NHS needs to change, what change might look like and how to achieve it.

[1] https://www.nhscc.org/ccgs/

[2] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

1.4. The 5YFV identifies different approaches that local areas can take to deliver the vision set out in the document – these so-called 'new models care' are being tested and refined through national pilot (vanguard) sites.[3] Although the new models of care offer a *'blueprint'* that local areas may choose to adopt, this is not mandatory. In driving transformation at a local level, system leaders must, however, remain focused on addressing three *'gaps'* described in the 5YFV:

- ***The health and wellbeing gap*** – describes the gap in health outcomes and how it will be addressed through a greater focus on prevention. This includes not only addressing lifestyle related issues, such as smoking, diet and alcohol, but also the wider determinants of health which are the 'causes of the causes', including early years, education, the built environment and employment.

- ***The care and quality gap*** – describes the quality and scope of services provided, with the solutions focused on developing different care models, using technology and addressing variations in quality. This focus in particular provides the CCGs with significant opportunities to improve provision of healthcare in Warwickshire, looking at tackling the variation in quality indicators within CCG geographies and in comparison to other areas in England and inequities in quality across the county.

- ***The funding and efficiency gap*** – which is described in two parts. The first is a shortfall in funding to the NHS as a whole, which is part of a national challenge made clear in the 5YFV. The second part is to continue to identify productivity gains and cost efficiencies within services. Closer working between organisations is highlighted as a key opportunity to create efficiencies (by reducing duplicated activities, sharing infrastructure, developing a shared workforce, etc.).

1.5. From a focus on the triple gap emerges a *'triple aim'*, which forms the golden thread between all of the local plans described in section 2 and the delivery of which will be the ultimate marker of our success as organisations:

Delivering the Forward View: NHS planning guidance 2016/17-2020/21 (2015)

1.6. December 2015 saw the publication of the national planning guidance *Delivering the Forward View*.[4] As in previous years, the guidance established the 'rules' for local strategic planning, articulating the national priorities that local plans should address and confirming the financial assumptions and business rules that plans were required to build out from. The document also introduced the concept of Sustainability and Transformation Plans (STPs) – system wide plans developed jointly by local health and care commissioner and provider organisations to accelerate implementation of the vision in the 5YFV.

[3] https://www.england.nhs.uk/ourwork/new-care-models/vanguards/
[4] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

1.7. The three CCGs sit within the Coventry and Warwickshire STP footprint. There is a strong history of partnership working at both a strategic and operational level between the CCGs, the two local authorities and the four NHS main provider organisations that make up the footprint. To date, the process of developing and implementing the local STP plan *Better Health, Better Care, Better Value* has offered an opportunity to strengthen local relationships further and to reach clear decisions on the actions required to design and deliver transformative solutions. Many of these solutions address priorities and challenges that have already been recognised in strategic plans at individual organisation level. The *Better Health, Better Care, Better Value* plan acknowledges that momentum must as a minimum be maintained, and wherever possible accelerated, on transformation projects that have come out of existing strategic plans and are now incorporated within the STP (for example, over the last 12-18 months delivery of the Out of Hospital transformation programme has been a key area of focus for the STP partners).[5]

1.8. In common with other STPs nationally, the *Better Health, Better Care, Better Value* plan is characterised by a number of key themes (see **Appendix A**), which are also reflected in the other local plans described in section 2.

2. Local Strategic Plans

Strategic Plans

2.1. The CCGs' Strategic Plans articulate our vision and values as organisations, describing the overall ambition and longer term outcomes that we have set for ourselves.[6] As noted above, the plans incorporate the key themes that are now recognised as characteristic of the higher geographic level STPs; thus reflecting the extent to which STPs exist as drivers of established priorities (all targeted toward delivering the 5YFV triple aim).

2.2. While, as outlined in section 1, being shaped by national policy direction, for CCGs the strategic planning process commences with assessment and understanding of local need. The Strategic Plans set out our understanding of the health challenges facing our populations and the specific initiatives that we are putting in place to tackle them. Keys sources in relation to understanding local challenges in terms of both health and social care need are the Warwickshire Joint Strategic Needs Assessment (JSNA) and the Warwickshire Health and Wellbeing Strategy. Many of the CCGs' work programmes directly address the Health and Wellbeing Strategy priorities. The latest Health and Wellbeing Board (H&WB) annual review outlines the contributions that the CCGs have made in relation to the H&WB priorities.[7]

Operational Plans

2.3. All CCGs are required by NHS England to develop Operational Plans on a cyclical basis.[8] The Operational Plans are developed out from the Strategic Plans and set the work programme for the CCG for a defined time period (either 1 or 2 years) within the Strategic Plan period. The overall programme described in the Operational Plans must, as a fundamental, enable a CCG to meet its statutory duties and to make progress towards delivering its strategic aims.[9]

2.4. It is not the purpose of the Operational Plan to detail all of the services that we commission as CCGs and how they will be delivered; instead the document outlines our strategic programmes, how our priorities link to national policy, what delivery work streams will help us to achieve our priorities, how we will measure performance and what risks we face in delivering the plan.

[5] http://www.southwarwickshireccg.nhs.uk/mediafile/3fa50e24-80bd-4127-8466-6e5ff982f95f
[6] http://www.southwarwickshireccg.nhs.uk/mf.ashx?ID=68ef044f-565f-4ae8-8f44-d6206bf85a3d; http://www.coventryrugbyccg.nhs.uk/mf.ashx?ID=59d85a54-2a27-41ea-b32e-a3500f7c03bc; http://www.warwickshirenorthccg.nhs.uk/mf.ashx?ID=11722529-9758-4ef4-9005-e0b3d0cb35a0.
[7] https://democratic.warwickshire.gov.uk/cmis5/CalendarofMeetings/tabid/128/ctl/ViewMeetingPublic/mid/645/Meeting/3889/Committee/494/Default.aspx
[8] http://www.southwarwickshireccg.nhs.uk/mf.ashx?ID=2bbc89e2-304c-4871-a561-f77df1f4fe3b
[9] https://www.gov.uk/government/news/functions-of-clinical-commissioning-groups

2.5. The Operational Plan has four key audiences:-

- It provides assurance to the CCG Governing Body that the organisation will deliver its statutory duties and that the organisation's work programmes reflect the direction of travel the Governing Body has set (through its endorsement of the Strategic Plan);
- It gives assurance to NHS England that the CCG has plans in place to meet its statutory duties and to deliver other core performance standards set out in the NHS Constitution e.g. the referral to treatment waiting time target;
- It communicates and confirms to teams within the CCG the expected work programmes and outcomes to be achieved over the plan period, and sets a clear framework for monitoring progress;
- It communicates to our population the CCG's work programme and (through the identified metrics of success) helps members of the public to understand what changes they can expect to see through delivery of the plan.

2.6. In very simple terms the development of the Operational Plan provides an opportunity for the CCGs to ask the question 'are we still doing the right thing?'. In answering this question, the CCGs will consider a range of sources of evidence to ensure that our efforts are being directed towards areas where the most value will be achieved – this includes the outputs of engagement with our Member Practices, populations and other key stakeholders. **Appendix B** contains a non-exhaustive list of other possible sources of external evidence.

2.7. The answer to the question must also take into account national policy and guidance. The *NHS Operational Planning and Contracting Guidance 2017 – 2019* describes nine 'must do' priorities which all CCG Operational Plans were required to address.[10] Unsurprisingly, in the context outlined in section 1, a key feature of the guidance was a focus on cross-system working – speaking to this point our Operational Plans recognise that we will not succeed in delivering the triple aim if we continue to commission and provide services in the way that we have done previously. Change will need to be driven by effective collaboration between organisations on both the commissioner and provider side.

2.8. A number of other plans sit in support of the Operational Plan. For example, one of the 'must do' priorities for 2017-2019 was for all CCGs to develop a plan which responds to the April 2016 publication of the *General Practice Forward View*.[11] The CCGs' General Practice Forward View plans set out how we will work with our own Member Practices to develop and implement a 'new model' of primary care, which offers benefits for both practices and patients. As **Appendix A** highlights 'redesigning primary care' is a major area of focus for all STP footprints.

3. Commissioning Intentions

3.1. The process of developing commissioning intentions is one of the more technical actions within the wider strategic planning process described in sections 1 and 2 above, with all CCGs required to develop and publish commissioning intentions on an annual basis.

3.2. Developed firmly in the context of the Strategic and Operational Plans, the commissioning intentions identify how the CCG intends to translate its strategic aims into the commissioning of services, with a key audience being the major local provider organisations. The commissioning intentions enable our major providers to understand how our strategic vision impacts contracts and, specifically, what will continue in the existing contracts and what changes will be implemented.

[10] https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf
[11] https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

3.3. Again, and as outlined in paragraph 2.6. above, the process of developing the commissioning intentions offers the CCG an opportunity to pause and take stock. This year the publication of another key national policy document the *Next Steps on the NHS Five Year Forward View* coincided with the start of the development process. This document identifies a number of key deliverables that NHS organisations must address through their planning. Ensuring that the development of the 2018-19 commissioning intentions took account of these deliverables was a priority for all of the CCGs.

3.4. In summary, the key functions of the commissioning intentions documents are:

- To notify our providers as to what services the CCGs intend to commission for the following year;
- To provide an overview of our priorities for the coming financial year in line with national and statutory requirements set out in sections 1 and 2 above;
- To drive improved health outcomes for our local populations; and
- To transform the design and delivery of care, within the resources available.

3.5. The work to develop commissioning intentions happens with an agreed timetable (see **Appendix C**) geared to accommodate a period of engagement and to enable the commissioning intentions to be delivered to the CCGs' providers by the end of September each year (the timing of delivery acknowledges the requirement in the NHS Standard Contract to provide 6 months' notice of any proposed significant changes to services).

3.6. **Appendix C** highlights the range of engagement activity which takes places as part of the development of the commissioning intentions. The commissioning intentions documents provide a constructive basis for engagement between the CCGs and our Member Practices, stakeholder partners, patients and the wide public, with the insights gained through this engagement used to shape the priorities within the documents.

3.7. A set of 'contracting intentions' are developed to sit alongside the commissioning intentions. The contracting intentions are highly technical in nature and address both performance and quality aspects of the commissioned services.

3.8. The CCGs' September 2017 reports and presentations to the Warwickshire Health and Wellbeing Board provide a detailed overview of the content of the 2018-19 commissioning intentions.[12] The commissioning intentions are presented to the Health and Wellbeing Board each year for the Board's endorsement.

4. Recommendation/s

4.1. The Committee is asked:

- To note the wider context for the development of the Coventry and Warwickshire Clinical Commissioning Groups' commissioning intentions for 2018-19;
- To note the process undertaken to develop the commissioning intentions; and
- To provide any comments or feedback in relation to the content of the report.

END OF REPORT

[12] https://democratic.warwickshire.gov.uk/cmis5/CalendarofMeetings/tabid/128/ctl/ViewMeetingPublic/mid/645/Meeting/4158/Committee/494/Default.aspx

APPENDIX A

Sustainability and transformation plans (STPs) explained
The King's Fund, February 2017
https://www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained

APPENDIX B

1. Commissioning for Value Packs – RightCare

NHS RightCare is a national NHS England supported programme, the overarching aim of which is to help to increase the value which a population receives from the resources spent on their healthcare. The programme supports CCGs to:

- Make the best use of their resources – by tackling over use and underuse of resources.
- Understand their performance – by identifying variation between demographically similar populations so they can adopt and implement optimal care pathways more efficiently and effectively.
- Focus on areas of greatest opportunity – by identifying priority programmes which offer the best opportunities to improve healthcare for people and ensuring taxpayer money goes as far as possible.
- Identify tried and tested evidence based processes to make sustainable improvements to reduce unwarranted variation.

Further information can be found at: https://www.england.nhs.uk/rightcare/products/.

2. Health Investment Network

The Health Investment Network has been established to help commissioners "improve their ability to achieve the best health outcomes from every pound invested". The website provides access to the knowledge and tools which can support CCGs' health investment and disinvestment decisions

Further information can be found at: http://www.networks.nhs.uk/nhs-networks/health-investment-network.

3. The Spend and Outcome Factsheet and Tool (SPOT)

The Spend and Outcome Tool (SPOT) has been developed by the Association of Public Health Observatories. The profile supports understanding of the overall relationship between spend and outcomes in relation to identified categories, by highlighting areas of significant variance which are likely to require more in-depth analysis. SPOT includes a large number of measures of spend and outcomes from several different frameworks. A number of different benchmarks are used to provide a range of peer comparisons.

Further information can be found at: http://www.yhpho.org.uk/resource/view.aspx?RID=49488.

4. NHS Digital Website

The NHS Digital website holds a wide range of key data and information, for example:

- *Compendium of Population Health Indicators*
  A wide-ranging collection of over 1,000 indicators designed to provide a comprehensive overview of population health at a national, regional and local level.
- *Quality Outcomes Framework (QOF) Data*
  QOF was introduced as part of the national General Medical Services (GMS) contract on 1 April 2004. The Framework rewards GP practices for the provision of quality care and helps standardise improvement in the delivery of primary medical care services. QOF prevalence data records the proportions of registered patients living with identified health conditions. The data identifies which conditions are the most prevalent and which exhibit the greatest changes year on year.
- *Social Care*
  This collection captures the main findings for each measure in the Adult Social Care Outcomes Framework (ASCOF). The ASCOF provides councils with robust information that enables them to monitor the success of local interventions in improving outcomes, and to identify their priorities for making improvements.

Further information can be found at: https://digital.nhs.uk/home.

5. Contract Performance Data

The CCG Operational Plans describe the systematic processes which are in place relating to the management of each CCG's contract portfolio (from both a contractual performance and quality perspective). Reviews of data and information assist CCGs to conclude actions to be taken to

improve services and, in turn, health outcomes for their populations. Where performance is not in line with national or other appropriate benchmarks, the CCG will investigate the reasons for variation and formulate responses, as appropriate. This may trigger different action depending upon the circumstances, for example:

- Calling upon local enablers, including contractual management levers (e.g. clauses, performance notices, service specification reviews), clinically led debate with providers/other key commissioners to discuss potential issues and propose resolution; or
- Improvement proposals for existing services; or
- Business cases to commission new services or to propose re-procurement of existing services; or
- Disinvestment from an intervention or service.

Commissioning Intentions Development Process

JUNE	JULY	AUGUST	SEPTEMBER
Review context for new commissioning intentions	Develop draft commissioning intentions	Document design & engagement.	Governance
Engagement with other Coventry and Warwickshire CCGs			
ACTIVITIES			
• Review strategic context & population needs; • Review commissioning intentions from previous year; • Start to identify priority areas for current year.	• Identify long list of statements aligned to priority areas and strategic cornerstones. • Refine long list.	• Seek input from key stakeholders; • Design document with support from CSU Communications Team; • Commence period of wider public engagement.	• Review outputs of engagement; • Update draft document; • Present document to Health and Wellbeing Board; • Progress document through CCG internal governance.
METHODS			
• Document review (local and national); • Review of existing feedback mechanisms.	• Seek input from CCG senior management team, wider staff team and project leads; • Workshop as part of CCG Team meeting; • Workshop as part of Public and Patient Participation Group meeting.	• Stakeholder meetings; • Share document via usual engagement channels; CCG website, CCG social media, etc.	• Attendance at relevant meeting forums. • Production of reports and briefings.
OUTPUTS			
• Updated understanding of strategic context; • Progress against prior year commissioning intentions documented.	• Draft commissioning intentions statements produced; • Records of the output of engagement events completed.	• Draft commissioning intentions document; • Engagement report.	• Draft document endorsed by Health and Wellbeing Board; • Final document approved by CCG Members' Council; • Final document published by end of September.

Information Sources and References

How does the NHS in England work?, October 2017 (Video)
https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work

Section 1
NHS Five Year Forward View, October 2014
https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Simon Stevens on the NHS Five Year Forward View, January 2015 (Video)
https://www.kingsfund.org.uk/audio-video/simon-stevens-nhs-five-year-forward-view

New Care Models Vanguards
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Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21, December 2015
https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

Section 2
Coventry and Warwickshire Clinical Commissioning Groups' Strategic Plan 2014-2019
http://www.coventryrugbyccg.nhs.uk/mf.ashx?ID=59d85a54-2a27-41ea-b32e-a3500f7c03bc

NHS South Warwickshire CCG 2016-2020 Strategic Plan
http://www.southwarwickshireccg.nhs.uk/mf.ashx?ID=68ef044f-565f-4ae8-8f44-d6206bf85a3d

NHS South Warwickshire CCG Operational Plan 2017-2019
http://www.southwarwickshireccg.nhs.uk/mf.ashx?ID=2bbc89e2-304c-4871-a561-f77df1f4fe3b

The Functions of Clinical Commissioning Groups, June 2012
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NHS Operational Planning and Contracting Guidance 2017-2019, September 2016
https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

General Practice Forward View, April 2016
https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Section 3
Next Steps on the NHS Five Year Forward View, March 2017
https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

NHS
Coventry and Rugby
Clinical Commissioning Group

Our Commitment to Health

COMMISSIONING INTENTIONS

Refresh 2018/19

Working together to improve our local NHS

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

Caring

We will ensure our population receives access to a choice of local services which are safe and patient-centred.

Resourceful

Our resources will be used effectively and efficiently by investing in services that deliver quality and best value for money.

Collaborative

We will be responsive and listen and work with the community, practices and partner organisations.

Community focused

We will focus on health and wellbeing, preventing ill health and reducing health inequalities.

Great place to work

We will enable and empower our workforce and members to be the best they can.

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 – Coventry and Rugby

- 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

Coventry

- The health of people in Coventry is generally lower than the average across England
- Life expectancy is 9.4 years lower for men and 9.6 years lower for women in the most deprived areas of Coventry
- About 25% (16,500) of children live in low income families
- 23.1% (848) of children in year 6 of primary school are classified as obese
- Levels of teenage pregnancy, GCSE attainment and smoking at time of delivery are worse than the average across England
- The number of hospital stays due to alcohol-related harm, smoking related deaths and sexually transmitted disease is worse than the average across England.

23.1%
OBESITY IN CHILDREN

LOWER THAN AVERAGE HEALTH

Local priorities

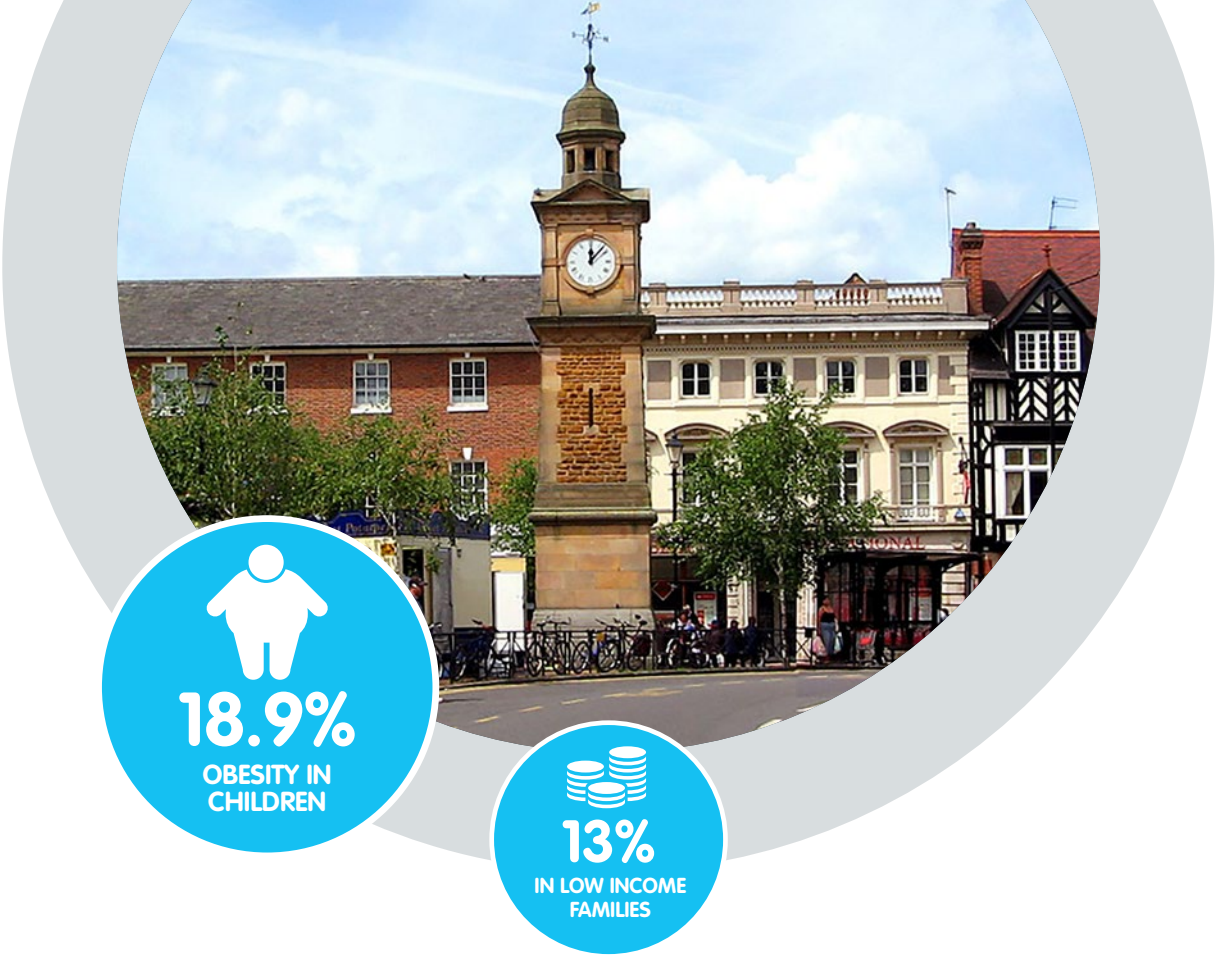
Reducing inequalities across the city by:

- improving the health and wellbeing of individuals with multiple complex needs
- ensuring that our health and care system is integrated and enables people to live their lives well.

Health Inequalities -
July 2017

Rugby

- The health of people in Rugby is varied compared with the England average
- Life expectancy is 5.5 years lower for men and 4.9 years lower for women in the most deprived areas of Rugby
- About 13% (2,600) of children live in low income families
- 18.9% (214) of children in year 6 of primary school are classified as obese
- The number of hospital stays due to alcohol specific issues among those under 18 years old is 10 stays per year; for adults it's 682 stays per year
- The number hospital stays due to self-harm is 213 stays per year
- The number of people killed and seriously injured on roads is worse than average.



Local priorities

Reducing inequalities across the Rugby by:

- improving healthy lifestyle behaviours reducing obesity
- improving physical activity, healthy eating, mental health & wellbeing support, including dementia, and drugs & alcohol misuse.

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
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 of 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) • We will proceed with a GP Resilience Funding application in order to secure central funding to support practices in greatest need and to address and support urgent issues should they arise • We will have a primary care workforce strategy by October 2017, and will deliver the strategy during 2018/19
Improve access to flexible, seven day services and same-day urgent care by helping practices work together	• We have been involved in the development of a recently approved Out of Hospital commissioning model will support integrated working and seven day week service developments	• Rugby practices are able to offer their patients improved access to GP services through the Coventry and Rugby GP Alliance. • The Alliance will deliver GP appointments to patients from all/any practice within the CCG outside of normal working hours with some availability at the weekend to offer patients more choice of appointment time and location	• This is a long-term piece of work that will continue into 2018
Help practices form strong networks and work collaboratively to deliver their services "at scale"	• We are working with member practices and the Local Medical Committee to develop GP "clusters" and have been successful in joining the Primary Care Home Program, supporting work around new models of care for out of hospital services and primary care hubs	• Patients will benefit from a wider range of skilled staff and better access to a range of services	• 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

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
Develop multidisciplinary teams working across groups of practices to support the care delivered to frail and vulnerable adults	As part of the STP workstream for Out of Hospital we have: • Engaged with patients, the public and stakeholders • Developed a new model of care and identified key benefits for patients • Awarded contracts for the new model of care	The new model will help to: • Prevent ill health and improve the quality of life for people with long term conditions • Effectively manage long term conditions such as diabetes, heart disease, stroke • Identify people at risk of ill health or hospital admission who are 'frail' • Avoid hospital admissions for at risk patients with increasing frailty • Better coordinate the care of people with complex problems and support them to live independently for longer • Better coordinate the care of people with complex problems via joined up hospital and community services	• Agree and sign off new contracts – October 2017 • Implement new model of care – October 2017 onwards • New contract commences – April 2018
Implement a revised approach to the commissioning of residential and nursing home placements	• Commenced a process to re-commission residential and nursing home placements • An integrated health and social care approach to approach to quality monitoring and improvement • Implementation of infection control support for managing outbreaks of infections such as norovirus • Joint accreditation of care homes for best practice	• More flexible and responsive service to clients will be available for residential and nursing home placements which will more accurately reflect the needs of clients • Sustained reduction in pressure ulcers in the community • Reduction in admissions to hospital for norovirus	• Commissioning Process to be completed during 2017/18
Commission enhanced, dedicated in-reach services to care homes	• Included in the new service model for Out of Hospital Services	• Support to individuals in nursing homes to prevent unnecessary admissions to hospital	• Agreement of model and approach to be employed locally by April 2018 • Implementation of new service during 2018/19

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 (Rugby children)	• 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
Help children, young people and families better cope with challenges by developing the "early help" offer in partnership with Coventry City Council	• Working with Coventry City Council to establish 8 family hubs	• Early help and support for children and families, reducing avoidable demand on specialist services	• Put the new service in place and regularly check progress
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 both Coventry City Council and 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

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

Urgent and Emergency Care

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Provide better, clearer and easier-to-access alternatives to A&E to help patients receive the best care for their need when it isn't a life-threatening emergency	• Improved signposting and local working with the NHS 111 service to ensure all services can be booked directly from NHS 111	• 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 to manage conditions themselves • Providing Nursing Home staff access to clinical support via NHS 111	• Services will be directly bookable in 2018/19
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	• Undertaken pre-consultation engagement with public, patient groups, local authorities and other key stakeholders • Used engagement feedback to develop a clinically viable proposal that provides the services people need	• Improved access to specialist services in a "hyper acute" stroke unit • Localised rehabilitation services • Improved anticoagulation for AF patients • Reduction in mortality rates as a result of strokes • Help people continue to live independently, where it is safe to do so, following a stroke	• Work with NHS England to assure the new proposals • Develop an implementation plan • Consult with patients, the public and other stakeholders on an agreed plan

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
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
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
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

Planned Care

COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Continue to support Public Health in their efforts to achieve healthier lifestyles	• For Rugby Patients, 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
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

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

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:

- Clinical Development Group / Executive Group
- Primary Care 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 mobilise and deliver our intentions, assess the impact and outcomes and ensure that there are no unintended adverse impacts. 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.

NHS

South Warwickshire

Clinical Commissioning Group

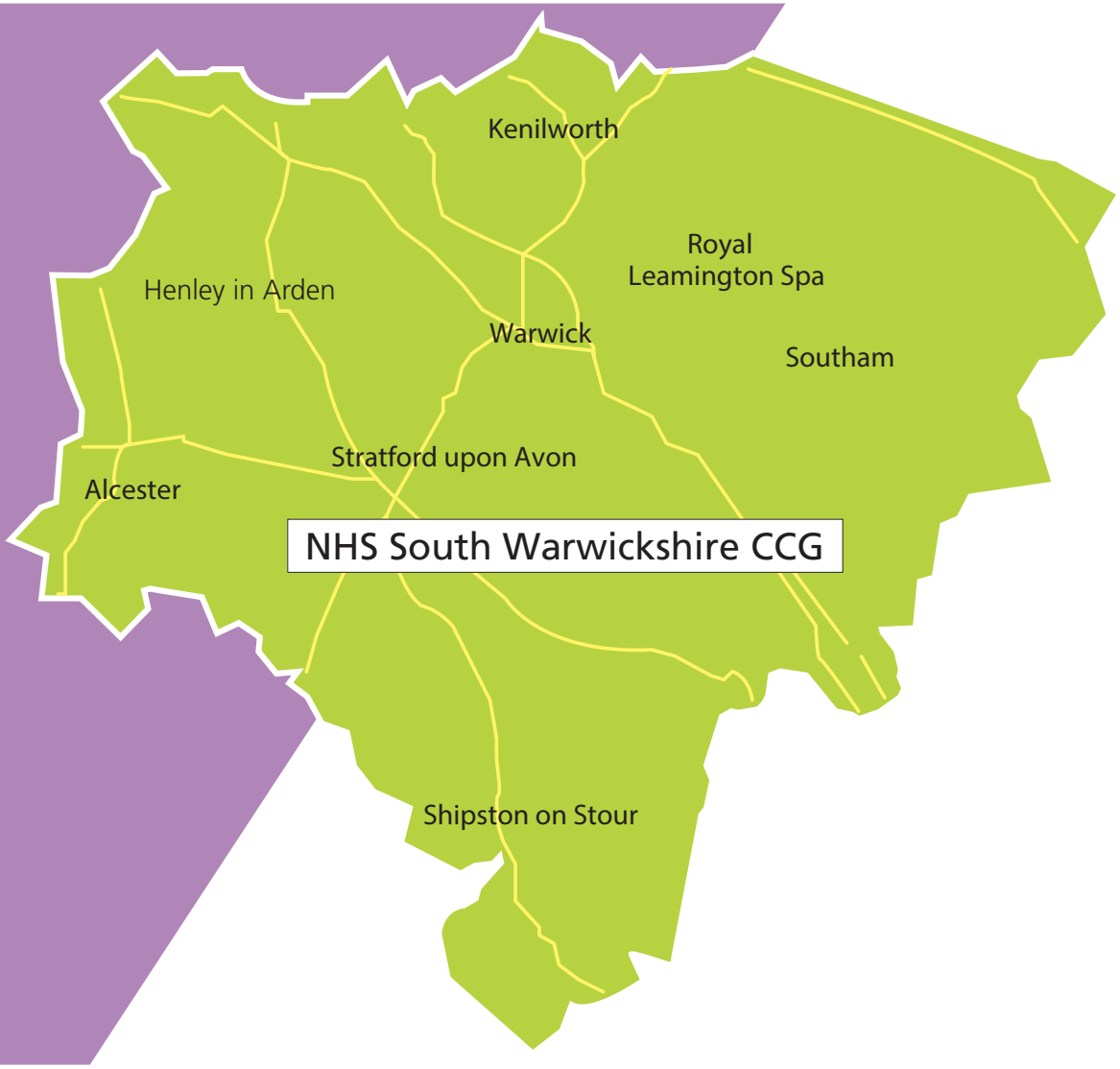
Commissioning Intentions 2018-2019

better healthcare for everyone

Translating our 2020 vision into reality

2018-19 sees NHS South Warwickshire Clinical Commissioning Group (the CCG) move into year three of our five-year strategic plan, *Translating our 2020 vision into reality.*

Building on the foundations delivered through our previous strategy. The plan sets out an ambition to deliver more integrated and personalised services to our population in order to improve the experience and health of the nearly 282,000 people who we, as a CGG, are responsible for.



In May 2017, the CCG's Governing Body took time to reflect on the work that has been done over the last 12 months to progress our strategic plan. Much has been achieved but, as in previous years, we recognise that much more work will be required to deliver the transformational change that we want to see.

Increasingly, this will see us working in collaboration with our partners across the Coventry and Warwickshire health and care system (two other CCGs, two Local Authorities, local District Councils and the four main NHS providers) to identify and realise opportunities which benefit the system as a whole and to address the structural, cultural and professional barriers to delivering truly person-centred care. As partners, we will hold ourselves collectively to account for delivering the necessary transformation of services and for getting the most out of each pound spent on health and social care within Coventry and Warwickshire. If we are successful, the impact of this work will be to deliver the CCG's 2020 vision; better healthcare for everyone. As we explain in our 2 Year Operational Plan, this vision is directly aligned with the triple aim that NHS England set for the NHS as a whole in 2014 in the *NHS Five Year Forward View (5YFV)*:

Along with our partners, we recognise that delivering the transformation required to make our system a truly integrated one, in which every patient's experience of care is seamless, will require sustained effort over the coming three years. The change will be driven by effective collaboration between organisations, cultural shifts within the workforce and building more effective relationships with the people who receive health and care services. Those familiar with NHS England's *Next Steps on the NHS Five Year Forward View* may recognise these as some of the features of developing 'accountable care'. Locally we are at a very early stage of thinking about accountable care, recognising it, primarily as a collective effort that will unite organisations across Coventry and Warwickshire and bind us to a common set of goals which will benefit our population and the overall health and care system. We expect to take forward local discussions about and progress our thinking on accountable care during 2018-19. In line with our recently published Communications and Engagement Strategy, listening to and involving patients, the public, our Member GP Practices and our staff will be one of our guiding principles as we undertake this work.

Context

In this document we set out our priorities for 2018-19. The document should be read in conjunction with both our own Strategic and 2 Year Operational Plans and the Coventry and Warwickshire *Better Health, Better Care, Better Value Plan*. Together these documents explain in detail the local and national context in which the CCG will be working in 2018-19.

The CCG, of course, does not work in isolation and both existing local strategies and plans, national policy requirements and the publication of the *Next Steps on the NHS Five Year Forward View* have shaped our latest commissioning intentions. The *Next Steps* recaps the progress that has been made to date to deliver the change described in the *NHS Five Year Forward View* and goes on to identify the key improvements that must be made this year (2017-18) and next year (2018-19) in order to maintain momentum.

In this document, we take the opportunity to review how our commissioning intentions align to both the national priorities identified through the *Next Steps* and the priorities established through the Warwickshire Joint Strategic Needs Assessment (JSNA). By drawing on both 'hard' data (i.e. statistics) and 'soft data' (i.e. the views of local people and service data), the JSNA - which is produced under the direction of the Warwickshire Health and Wellbeing Board - highlights who Warwickshire's priority groups are in relation to health and social care need and exists as a shared, evidence-based consensus on the key local priorities across health and social care.

As we explain in our 2 Year Operational Plan, the CCG's plan to deliver our 2020 strategic vision is built around four key cornerstones.

Our Plan...

The 2016-2020 Strategic Plan is specific to our CCG and sets out how we are going to deliver this transformation within our locality. The Plan is built around four cornerstones.

Our Aims...

By identifying the 'Four Cornerstones' of the 2020 Plan – Out of Hospital Care, Personalisation, Specialist Provision and Delivering Today – we can group together enabling programmes that collectively can deliver real changes in outcomes for patients.

OUT OF HOSPITAL

To **Prevent** negative lifestyle choices

To **Innovate** the provider market

To **Respond** 24/7 in a coordinated way

Ensuring that people have a positive experience of care and support

INSPIRE

Enhancing the quality of life for people with long term conditions

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

BETTER HEA
FOR EVERY

To ensure people feel supported to manage their condition

Preventing people from dying prematurely

To **Support** a personalised approach

Improving responsiveness across health and social care to personal needs

To **Align** resources to deliver better care

To **Transform** commissioning arrangements for vulnerable groups

PERSONALISATION

INSIGHT

SPECIALIST PROVISION

To increase Confidence of service users

To Accelerate integrated working

To increase the proportion of stroke patients reporting an improvement in activity/lifestyle

To Centralise expertise to improve outcomes

ALTHCARE ONE

Helping people to recover from episodes of ill health or following injury

To improve outcomes from planned treatments

INTEGRATE

Treating and caring for people in a safe environment and protecting them from avoidable harm

People know what choices are available to them locally and feel they have had their voices heard

The CCG remains assured by NHSE and balances planning for tomorrow with delivering for today, whilst improving the health outcomes for the people of south Warwickshire

To Listen to the patients and the public

To Assure quality and performance

To Drive the best outcomes for our population

INVOLVE

DELIVERING TODAY

Our Vision...

Our vision for commissioning of healthcare for the people of south Warwickshire is to build relationships with patients and our communities to improve health, transform care and make the best use of our resources.

Our Values...

Our seven core values - Committed, Listening, Innovative, Empowering, Responsible, Collaborative and Equitable - will continue to guide us and underpin our relationships and interactions with our partners and stakeholders.

Commissioning Intentions

1
Out of Hospital

Out of Hospital

This cornerstone of the strategic plan includes the projects which will improve primary care and community resilience and reduce the demand on acute hospital care. Projects in this area include integration between health and social care and the delivery of different contractual models to improve outcomes. Increasingly, over the coming years we will look at the way in which we contract with provider organisations, specifically identifying the type of contracts and the ways of awarding contracts that will facilitate collaboration and deliver the outcomes that are important to our population.

Our focus in 2018-19 will remain in part on the Coventry and Warwickshire Out of Hospital Programme. The Programme is a significant component of our strategic plan which puts an effective out of hospital system at the centre of the future south Warwickshire care system – getting the Out of Hospital Programme right will lay the foundations for the wider system transformation envisaged in the plan. In July 2017, our Governing Body agreed that the south Warwickshire component of the Programme will be taken forward by developing a lead provider contract with South Warwickshire NHS Foundation Trust (SWFT). We will work closely with SWFT during 2018-19 to support the roll-out of the Programme, including the implementation of the underpinning clinical model. In addition, a large part of our focus will remain on primary care – making sure that general practice in south Warwickshire is sustainable for the future and able to work effectively in a more integrated system.

The work that we will be doing is set out in our plan *Transforming General Practice Together*, which was developed as a response to NHS England's *General Practice Forward View*. The plan will provide the mechanism to connect services within the wider out of hospital environment to our GP practices, enabling GPs to more easily access the support of other professionals in meeting the needs of their patients.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Make prevention the job of everyone	Develop and implement a new approach to delivering preventative services in general practice.	 Primary Care	 Long-Term Conditions	Monitor the performance of our GP Member Practices participating in the CCG's Fit for Frailty programme against identified Key Performance Indicators relating to Module 1 (Prevention and Early Intervention). Complete 12 month evaluation of the Fit for Frailty Programme and formulate recommendations for future commissioning model/s. Explore greater use of navigators/digital technology to support patients to navigate the health and care system. Work with our Coventry and Warwickshire partners to explore other opportunities to incentivise prevention and early intervention through primary care.	Fit for Frailty evaluation report. Increase in people being referred to lifestyle services from primary care. Increase in people self-referring to lifestyle services. Increased uptake of universal screening/immunisation programmes in south Warwickshire. Coventry and Warwickshire Prevention and Early Intervention Plan, and aligned Local Delivery Plan.
	Continue to work with our partners to develop new approaches that support people to self-care, including through the use of innovative technology solutions.	 Harnessing Technology & Innovation	 Long-Term Conditions	Roll out telehealth programme to identified patients living with one or more of the following long- term conditions: diabetes, heart failure and chronic obstructive pulmonary disease (COPD). Require our providers to give front line staff appropriate education, training and support to ensure preventative approaches are embedded in all interactions.	Evaluation report on telehealth programme. Evaluation report capturing the impact and outcome of preventative and early intervention approaches. Greater self-care management by patients with long-term conditions. Patients self-report benefits including improved confidence and emotional well-being. Practices report that they have benefitted from the roll out of the telehealth programme. A reduced number of emergency admissions for patients living with the identified long-term conditions.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Make prevention the job of everyone	Review local social prescribing pilot schemes and look to commission a sustainable social prescribing model.	 Primary Care	 Physical Wellbeing	Evaluate south Warwickshire General Practice social prescribing model pilot programmes in partnership with Public Health and formulate recommendations for future commissioning model/s.	An evaluation report on social prescribing, including recommendations. A business case, including recommendations for future commissioning. Sustainable social prescribing model implemented. Improved patient experience through lower numbers of GP appointments needed.
	Implement the National Diabetes Prevention programme along with our Coventry & Warwickshire System partners, supported by the central NHS England team.	Integrating Care Locally	 Long-Term Conditions	Roll-out of the national diabetes prevention programme following a procurement process.	Implementation of the national programme aligning and enhancing the current local pathways (Fitter Futures and the diabetes Telehealth project).
	Continue to work with our partners, through the Warwickshire Cares Better Together programme, including the third sector, to identify opportunities to build and strengthen community capacity and resilience.			Identify opportunities to strengthen and build community capacity and resilience through continued participation in the Warwickshire Third and Public Sector Partnership Group. Develop and roll-out locality level asset maps aligned with the GP practice locality boundaries. Work with our Coventry & Warwickshire System partners to explore other opportunities to build community capacity and resilience.	On-going participation in the Warwickshire Third and Public Sector Partnership Group. Locality level asset maps.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Make prevention the job of everyone	Support the Warwickshire Health Protection Strategy 2017-2021			Develop an action plan to address the 3 key areas identified by Public Health Warwickshire: air quality, screening and immunisations and excess winter deaths/ fuel poverty. Focus on the identified areas in the CCG's public facing communications (newsletter, etc.).	Improvement in the 3 key areas identified by Public Health Warwickshire: air quality; screening and immunisations and excess winter deaths/fuel poverty. Regular reporting to the Clinical Quality and Governance Committee.
Commission person-centred outcomes for our most complex group of people	Develop a process to monitor the performance of the new Out of Hospital contract against the outcomes framework developed in collaboration with providers, stakeholder clinicians, patients, carers and the wider public.	 Urgent & Emergency Care  Primary Care	 Long-Term Conditions	Mobilise new contract. Implement actions from the End Of Life Improvement Plan.	A new contract in place for out of hospital services. Regular reporting to the Performance Committee and Governing Body which captures the outcomes of on-going contract monitoring. An implementation plan for delivery of the End of Life Improvement Plan (as part of the Out of Hospital transformation plan).

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Commission person-centred outcomes for our most complex group of people	Work with the Out of Hospital collaborative to develop a full end-to-end frailty pathway covering prevention through to end of life.		Physical Wellbeing	Development of an integrated pathway covering primary care and out of hospital services.	Care closer to home, less hospital admissions and unnecessary interventions. Improved patient outcomes and patient experience. Delivery of person-centred care to support patients at the end of their lives.
	Evaluate the impact of enhancing pharmacy support to residential homes.	Urgent & Emergency Care	Physical Wellbeing	Evaluate the pilot support scheme in 7 residential care homes. Consider future commissioning options.	An evaluation report identifying the outcomes of the pilot project. A business case, including recommendations for future commissioning.
Make sure that primary care maintains its status as the lynchpin of care delivery in south Warwickshire	Evaluate options to redesign current methods of resourcing general practice over and above the core General Medical Services (GMS) contract, aligning the incentives that we apply to general practice with those applied to the wider system and vice versa.	Primary Care		Engage with Member Practices to develop options. Engage with our population to understand what they want and expect from primary care both now and in the future.	An independent report that enables us to understand the key requirements of primary care from the perspective of our Member Practices and population. A clearly defined service offer from local practices to their populations.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Make sure that primary care maintains its status as the lynchpin of care delivery in south Warwickshire	Work with Member Practices to redesign the delivery of services through increased collaborative working. The development of this model will enable resources to be wrapped around groups of practices and create a foundation for delivering 'primary care at scale'.	 Primary Care	 Physical Wellbeing	Use the outcomes of the public and workforce engagement exercise completed in 2016/17 to define critical success factors for future primary care models. Work with Member Practices to develop the collaborative working arrangements between practices.	Leadership capacity within each locality that is working with South Warwickshire Foundation Trust on the implementation of the Out of Hospital clinical model.
	Seek to improve uptake of 'enhanced' service offers (locally commissioned services and national enhanced services) by our Member Practices.	 Primary Care	 Long-Term Conditions	Engage with our Member Practices to understand barriers to uptake. Develop an action plan based on the outcomes of this engagement.	An action plan that identifies barriers and actions that we will take to overcome these. Improved uptake of 'enhanced' service offers.
	Consider whether to commission a primary care-led dementia diagnosis and care management service based on evaluation of the pilot implemented in December 2016.	 Primary Care	 Mental Wellbeing	Monitor the pilot service commenced in 2016/17. Complete 12-month evaluation of the pilot project. The Coventry and Warwickshire Partnership Trust (CWPT) Memory Assessment Service will be required to provide support and advice to GP practices participating in the pilot.	An evaluation report on the pilot service, including the impact on dementia diagnosis rates. A business case, including recommendations for future commissioning. Any variations required to the contract with CWPT are identified and implemented. Shared learning locally and across the wider Coventry and Warwickshire footprint. Improved understanding of the service requirements of people diagnosed with dementia and their carers.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Make sure that primary care maintains its status as the lynchpin of care delivery in south Warwickshire	Evaluate the Primary Care Mental Health Service (active monitoring) pilot project which begins August 2017.	 Mental Health	 Mental Wellbeing	Complete evaluation of the pilot project following the year-long pilot. Explore options for future commissioning of mental health support services within GP surgeries.	An evaluation report identifying the outcomes of the pilot project. A business case, including recommendations for future commissioning.
	Work with our Member Practices to deliver a Primary Care Estates Strategy which builds on the existing Outline Strategy.	 Primary Care		Further develop Outline Primary Care Estates Strategy produced in 2016/17 to include full options appraisal for each locality, leading to the production of an agreed plan to secure the physical capacity required to meet future demand. Completed relevant engagement (stakeholder and public) to inform options appraisal process. Progress schemes (new development and improvement) that have reached business case stage and have confirmed approval for 2018/19. Engage with Member Practices to evaluate opportunities to develop 'shared space' within individual localities (e.g. shared back office space). Continue to engage with Warwick and Stratford-on-Avon District Councils to secure Section 106 contributions from developers and in relation to the local introduction of the Community Infrastructure Levy. Collaborative working with NHS England (West Midlands) to support the progress of new build schemes prioritised for funding through the Estates and Technology Transformation Fund (ETTF).	Full Primary Care Estates Strategy finalised, including agreed plans at locality level. New premises development completed in Central locality (Hastings House). New premises development completed in Warwick locality (Prior Medical Centre/Cape Road Surgery). Contributions (secured via Section 106 Planning Obligations or the Community Infrastructure Levy) are passed from the District Councils to the CCG to support projects identified in the Primary Care Estates Strategy.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Make sure that primary care maintains its status as the lynchpin of care delivery in south Warwickshire	Develop and refine our plan *Transforming General Practice Together* in response to engagement with our Member Practices, patients and the wider public and other key stakeholders.	Primary Care	Long-Term Conditions Mental Wellbeing	Progress the Strategy through the relevant approval/assurance process.	Regular reporting to the Primary Care Committee and Governing Body in relation to the implementation of the Strategy.
	Extend access to general practice services in line with the requirements of the *General Practice Forward View* by commissioning a new extended access service which meets the 7 core requirements specified by NHS England.	Primary Care	Physical Wellbeing	Progress project plan established in 2017/18 to implement new extended access service in 2018/19. Programme Board to maintain oversight of the project plan.	Our population has access to evening and weekend GP appointments by March 2019.
	Continue to work with our Member Practices to respond to opportunities flowing from the sustainability and transformation programme outlined in the *General Practice Forward View* (e.g. General Practice Resilience Programme).	Primary Care		Identify potential support requirements via engagement with practices, soft intelligence and the systematic approach described in the CCG's *Primary Medical Care Quality and Performance Framework.* Maintain engagement with the Local Medical Committee (LMC) via regular quarterly meetings. Maintain engagement with the NHS England (West Midlands) Primary Care Team via the local GP Transformation Board.	Practices that would benefit from support are identified at an early stage. Support requests are successful in securing funding.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Make sure that primary care maintains its status as the lynchpin of care delivery in south Warwickshire	Work with our Member Practices to increase uptake of GP online services, thereby enabling patients to take more control of their own health.	Harnessing Technology & Innovation	Physical Wellbeing	Ensure practices are aware of the support and resources available to them. Maintain links with the NHS England Patient Online Programme Team and work with them to promote support and resources available to practices. Enforce relevant contractual requirements in the General Medical Services (GMS) contract.	On-going contract monitoring. On-going liaison with the NHS England Patient Online Programme Team.
	Develop and deliver an agreed GP IT Strategy and work with our Member Practices to enable general practice to make greater use of technology in order to enhance patient care and experience, and release capacity.	Harnessing Technology & Innovation		Roll out IP telephony to our Member Practices. Progress work-streams identified in the Local Digital Roadmap. Work with our Member Practices to respond to opportunities flowing from the Online Consultation Systems stream of the General Practice Development Programme (publication of rules and specification awaited).	IP telephony rolled out to 35/35 practices. Practices report that they have benefitted from the roll out of IP telephony. Funding allocation for Online Consultation Systems invested in line with the requirements of the scheme.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Make sure that primary care maintains its status as the lynchpin of care delivery in south Warwickshire	Continue to develop and work with our Member Practices to progress local implementation of the Releasing Time for Care Programme in order to support general practice sustainability and release capacity. Our intention is for all practices to be engaged with the programme in order to accelerate the 10 high impact changes to release time for care.	 Primary Care		Work with the South Warwickshire GP Federation and the NHS England Sustainable Improvement Team to deliver the Programme locally.	Streamlining of general practice administration to free up clinician time. Better signposting to other services as appropriate to support appropriate care and management.
	Develop and commence implementation of a Coventry & Warwickshire Primary Care workforce strategy with appropriate local variation and actions.	Integrating Care Locally		Produce a primary care workforce strategy in collaboration with key partners (Member Practices, Local Medical Council, Health Education England, the South Warwickshire GP Federation) with the support of the Coventry and Warwickshire Local Workforce Action Board (LWAB).	Primary care workforce strategy finalised and implementation commenced. Regular reporting to the Primary Care Committee and Governing Body in relation to the implementation of the Strategy.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Join up parts of the urgent care system that need to respond to our population 24/7	Roll out Electronic Palliative Care Coordination Systems (EPaCCS) across all Member Practices to support timely information sharing between primary care, the Out of Hours service and NHS 111.	 Harnessing Technology & Innovation		Develop and implement roll out plan, including education and training for practices.	System launched across all Member Practices. Monitoring of uptake and usage on-going.
	Contribute to the implementation of the West Midlands Urgent and Emergency Care Network.	 Urgent & Emergency Care		Develop a local action plan aligned to the vision of the West Midlands Urgent and Emergency Care Network and which addresses the need to effectively join-up providers. As part of the development of this plan, identify gaps in terms of being able to offer an urgent response to our population.	Local action plan agreed. Monitoring of delivery against the action plan is on-going.

2
Personalisation

Personalisation

This cornerstone of the strategic plan focuses on the provision of care for people with the most complex needs in our community – groups such as children, people with learning disabilities and long-term mental health conditions. Our strategic plan recognises that many of these people would be better served by shared resources across partner organisations and, where appropriate, with access to personalised care.

Our focus in 2018-19 will be on working with Warwickshire County Council to build on the collaborative arrangements established in 2016-17 in relation to the commissioning of services for children and young people. Through the delivery of our Transforming Care Programme, we will continue to work with partners across Coventry, Warwickshire and Solihull to design and commission services that enable children and adults with a learning disability and/or autism to live safely with support in their communities and prevent unnecessary admissions to hospital. At the same time through joint working with the two other Coventry and Warwickshire CCGs, we will maintain momentum on the delivery of our work programme developed in response to the *Five Year Forward View for Mental Health.*

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Make sure we have the systems and processes to provide Personal Health Budgets (PHBs)	Ensure that people included in the CCG offer for a PHB (people who are eligible for NHS Continuing Healthcare, children who are eligible for continuing care and individuals who have complex needs as a result of their Learning Disability) who want to achieve a personalised approach with a PHB are able to do so.	 Mental Health	 Mental Wellbeing	On-going audit and monitoring of implemented PHBs. Work with Providers to respond to the requirements of the national roll-out of PHBs.	Raised visibility of PHBs via regular internal reporting.
Give our population the best start in life by using our collective resources most effectively	Monitor the performance of the new Children and Young People's Emotional Wellbeing and Mental Health service contract against the outcomes framework developed in collaboration with providers, stakeholder clinicians, patients, carers and the wider public.	 Mental Health	 Mental Wellbeing	Work with providers to support the delivery of the new Emotional Wellbeing and Mental Health service for 0-25s. On-going monitoring and evaluation of the new service.	Regular reporting to the Performance Committee and Governing Body which captures the outcomes of on-going contract monitoring.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Give our population the best start in life by using our collective resources most effectively	Ensure robust arrangements are in place to understand the needs of, and deliver high quality services to Children Looked After (CLA).		 Vulnerable Young People	On-going monitoring of relevant providers to provide assurance that CLA receive well co-ordinated care that meets their needs.	Regular reporting through the CCG's governance structures.
	Develop the governance and commissioning infrastructure required to establish a new Children's Integrated Commissioning Unit (CICU), which will bring together teams from across the Local Authority and 3 local CCGs (South Warwickshire, Warwickshire North and Coventry and Rugby).	Integrating Care Locally	 Vulnerable Young People	Develop the governance and commissioning infrastructure required for the new Children's Integrated Commissioning Unit (CICU). CICU to develop a plan to integrate 0-25s services to address transition within universal services and drive personalisation.	Secure aligned budgets between commissioners through a formal process (i.e. Section 75 agreement). Governance structure is agreed and in place. Regular reporting on the activities of the CICU through the CCG's governance structures. Integration plan in place.
	Work with Public Health Warwickshire to take forward actions related to the Perinatal Mental Health agenda.	 Mental Health	 Mental Wellbeing	Contribute and support development and delivery of the action plan.	Integrated approach to perinatal mental health. Improved access to advice and support for new parents.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Change our commissioning arrangements for mental health and learning disability services to allow a personalised approach	Support the joint commissioner for learning disabilities to deliver the agreed commissioning strategy.	 Mental Health	 Mental Wellbeing	Work with Member Practices and providers to implement the Coventry and Warwickshire-wide action plan.	Increased numbers of people with learning disabilities identified and included on the General Practice learning disabilities 'health check' registers. Increased % of people with learning disabilities have an annual health check from their GP practice and receive an associated care plan.
	Continue transforming care for people with learning disabilities and/or autism by implementing *Transforming Care for People with Learning Disabilities,* the joint plan developed through the Arden and Solihull Transforming Care Partnership.	 Mental Health	 Mental Wellbeing	On-going monitoring of progress against the plan. Continue to repatriate patients who are placed in other areas and/or in NHS England commissioned inpatient beds back to south Warwickshire, in line with their wishes and treatment pathways.	Regular reporting through the CCG's governance structures. A reduction in the number of people in inpatient beds in accordance with agreed trajectories.
	Work in collaboration with Warwickshire County Council and other partners to deliver an updated Autism Strategy.	 Mental Health	 Mental Wellbeing	Attend and support the Autism Partnership Board.	Updated Autism Strategy.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Change our commissioning arrangements for mental health and learning disability services to allow a personalised approach	Evaluate options for the development of an all age neuro developmental pathway to support the diagnosis of people with autism and attention deficit hyperactivity disorder (ADHD).	 Mental Health	 Mental Wellbeing	Further development of an all age pathway across Coventry and Warwickshire following evaluation of the adult pathway.	Evaluation of the adult pathway and decision on an all age pathway.
Work to transform the environment to empower patients	Deliver the 2017-2020 Carers Strategy in partnership with Warwickshire County Council.		 Carers	Attend and support the Carers Strategy Delivery Board in order to deliver the identified actions. Review of respite and short breaks services across health and social care.	Improved service and support for carers.
	Seek to improve the experience of individuals going through the NHS Continuing Healthcare (CHC) process.		 Long-Term Conditions	Review processes in association with the new 'embedded' CHC team.	Positive feedback and reduced volume of complaints.
	Work in partnership with colleagues on the Mental Health Commissioning Group to deliver in full the agreed actions from the Mental Health Commissioning Group work plan in order to deliver the *Five Year Forward View for Mental Health* for all ages.	 Mental Health	 Mental Wellbeing	Progress the actions on the revised mental health crisis care concordat. Work with providers to review the service specifications for community and acute mental health care. Review of the secure care pathways including rehabilitation. On-going monitoring of progress against plan.	Regular reporting through the CCG's governance structures. Clearer roles and responsibilities within mental health services.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Work to transform the environment to empower patients	Continue to roll out the three year Increased Access to Psychological Therapies (IAPT) programme to support the population of south Warwickshire with long-term conditions.	 Mental Health	 Mental Wellbeing	Implement the programme in partnership with local partners and deliver a new service that meets the needs of people with long-term conditions.	Patients diagnosed with respiratory conditions and diabetes will be offered psychological support following their diagnosis.
	Deliver actions identified in the Warwickshire Suicide Prevention Strategy 2016-20.	 Mental Health	 Mental Wellbeing	Work collaboratively with partners to implement the Warwickshire Suicide Prevention Strategy and associated action plan. Collaborate with Public Health Warwickshire to commission suicide awareness training for front-line workers e.g. GPs. Participate in local and national suicide prevention events and disseminate through the local health and social care system. Review every death from suicide reported as a serious incident using a robust root-cause analysis approach.	Regular reporting through the CCG's governance structures.
	Improve the quality of end of life care.	 Primary Care		Implementation of RESPECT forms and use of the CASTLE register for end of life care. End of life will form part of the frailty pathway as developed via the Out of Hospital design board.	More people dying in their place of choice.

3 Specialist Provision

This cornerstone of the strategic plan looks at delivery models for acute specialties. Echoing the *NHS Five Year Forward View* it recognises that that in some services where there is a strong relationship between the number of patients and the quality of care – such as stroke, specialised surgery, some cancer and other specialist services - there is a compelling argument for greater concentration of care in specialist centres.

Our focus in 2018-19 will be on kick-starting elements of our strategic plan that have been prioritised by the Coventry and Warwickshire Better Health, Better Care, Better Value partnership. This means that we will be bringing some of our local projects forward in order to benefit from a system-wide approach.

Across many of the work programmes being progressed under this cornerstone, we will be looking at how we can streamline service delivery, simplifying and standardising pathways to ensure people are supported in the right place, at the right time and as quickly as possible.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Ensure that our population knows what choices are available to them and that they have the information available to make those choices	Ensure that our population has access to up to date information to enable them to make informed choices about their care and treatment.			Ensure GPs and other referrers have access to relevant information to help and support patients to make choices. Increase utilisation of NHS e-Referral Service (e-RS). Work with GPs/referrers who are low users of e-RS to understand barriers and develop action plans to increase utilisation. Co-produce information to support choice with the CCG's Public and Patient Participation Group (PPPG). Undertake an engagement exercise with patients on an identified care pathway to test whether patients fully understood the choices available to them before entering that pathway and whether their expectations as to how treatment will benefit them are well-informed. Ensure choice is considered for new models of care for all client groups.	% increase in utilisation of NHS e-Referral service. Action plans in place for GPs/ referrers who are low users of e-RS. Systems and processes in place that promote and measure awareness of choice. Co-produced information available to our population. On-going monitoring of providers. Engagement exercise completed.
	Work in partnership with Warwickshire County Council and South Warwickshire Foundation Trust to ensure patients are discharged from hospital in a timely manner.		Long-Term Conditions	Ensure 85% of Continuing Health Care (CHC) assessments take place out of the hospital setting. Enhanced performance management of CHC key performance indicators. Implement the High Impact Change Model for reducing Delayed Transfer of Care (DTOCs).	Targets achieved in relation to CHC assessments. Reduction in DTOCs. Project Plan.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Encourage our providers to develop new partnerships and ways of working in order for them to adapt to the changing landscape, within the context of Coventry & Warwickshire *Better Health, Better Care, Better Value Plan*	Continue to work with system partners to develop a new Coventry and Warwickshire clinical model for Maternity and Paediatric services.		 Physical Wellbeing	Review the National Maternity Review's 'Better Births: Improving outcomes of maternity services in England' and work with local partners to identify gaps and implement a range of actions in response. Work with service users and providers to develop a clinical model.	Public and patient engagement on future commissioning arrangements.
	Increase specialist mental health care in Accident and Emergency (A&E).	 Urgent & Emergency Care	 Physical Wellbeing	Continue to review the current service and identify requirements.	An appropriate level of service to address identified need.
	Continue to develop the Diabetes Clinical Network (DCN) with key stakeholders across south Warwickshire.	Integrating Care Locally	 Long-Term Conditions	Review and refine the year 1 work plan for the DCN with the key partners: GPs, practice nurses, South Warwickshire Foundation Trust, Diabetes UK, patient representatives, dieticians, podiatrist/and digital Retinopathy services. Deliver new and enhanced services to improve structured education and foot care, whilst testing new approaches in technologies - including telehealth - to support people with complex type 1 diabetes and pre-diabetics.	Options appraisal for future commissioning arrangements completed.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Encourage our providers to develop new partnerships and ways of working in order for them to adapt to the changing landscape, within the context of Coventry & Warwickshire *Better Health, Better Care, Better Value Plan*	Work in partnership with the Coventry and Warwickshire Cancer Group to drive delivery of the National Cancer Strategy and recommendations from the cancer task force (through aligning commissioning responsibilities across the cancer pathway and enabling collaborative working across providers).	 Cancer	 Long-Term Conditions	There will be a specific focus on: • Prevention - increasing focus on screening programmes • Early Diagnosis – enhancing primary care development through a Cancer Education Network, and reviewing diagnostic capacity across the Coventry & Warwickshire System footprint • Improved care pathways and patient experience - to reduce waiting times across the whole pathway from primary care through to end of treatment, this will include supporting direct diagnostics from Primary Care to condense the patient pathway • Living with and beyond cancer-supporting the delivery of the living with and beyond cancer programme.	Higher cancer prevention rates from better screening initiatives. Reduction in diagnosis time for patients diagnosed with cancer. Reduction in patient waiting times for the whole cancer pathway. More support for patients with cancer and those recovering from cancer.
	Review and update our *Systematic Approach to Quality* document to reflect quality and safety priorities in light of the *NHS Five Year Forward View* and other national guidance.			CCG quality team focus reflects new priorities.	Reduced variation in provision of primary and community services including Continuing Health Care (CHC).
Specify the outcomes we want for key elective specialities to support providers to deliver the right level of care and best outcomes	Implement an integrated Musculoskeletal (MSK) service across Coventry and Warwickshire.		 Physical Wellbeing	Expansion of the south Warwickshire service. Explore options for wider geographical scope. Develop an action plan that delivers improvements in the short, medium and long term.	MSK triage assessment and treatment service in place in south Warwickshire.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Specify the outcomes we want for key elective specialities to support providers to deliver the right level of care and best outcomes	Be part of a Coventry and Warwickshire-wide approach to the review of other planned care pathways.			Undertake relevant stakeholder and the public engagement to support this work. Develop an action plan that delivers improvements in the short, medium and long term.	Work plans developed, with regular reporting in place.
Centralise services where there is evidence that will provide better clinical outcomes for our population	Commission improved Coventry and Warwickshire-wide stroke services to meet the outcomes outlined in the Midlands and East regional stroke service specification.	Integrating Care Locally	 Physical Wellbeing	Undertake relevant stakeholder and the public engagement to support this work. Progress through NHS England assurance process and obtain approval to proceed. Providers will need to be able to respond and deliver the agreed service specification. Implement new service model. Monitor the new contract in line with the agreed outcomes framework.	New service model in place by May 2018. Regular reporting to the Performance Committee and Governing Body which captures the outcomes of on-going contract monitoring. Improved stroke outcomes as reflected in agreed business case.

4 Delivering Today

This cornerstone of the strategic plan sets out the regular activities that are required to provide assurance to both our own Governing Body and NHS England that we are functioning effectively as an organisation and delivering our various statutory duties.

Our focus in 2018-19 will remain on achieving and improving performance standards against the standards in the *NHS Constitution*. Driving improved quality, whether that be clinically or experientially, will continue to be a priority and is central to the proposed outcomes focused contracting approach described under cornerstone 1. Finally, we will need to ensure that we deliver a balanced in-year financial position and meet NHS England's financial planning requirements.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Continue to seek the views of, listen to and drive our relationship with patients, partners and communities	Proactively engage with stakeholders and enable people to contribute to shaping future health services commissioned by the CCG.			Work with the CCG's Public and Patient Participation and Gateway Groups. Actively engage with minority community groups. Actively promote and recruit Health Champions. Work with key partners to share information. Report feedback to public meetings of the CCG.	Information will be publicly available showing how feedback supports changes to services. Increased numbers of Health Champions. Coordinated approach to public engagement across all health and social care. An increase in reported satisfaction in the CCG Annual 360° Stakeholder Survey. An increase in use of our communications channels e.g. the CCG website.
	Develop a culture that promotes open communication and engagement with patients and the public.			Ensure the organisation's vision and values, statutory requirements and aspiration for public engagement are known by every member of staff. Deliver proactive and reactive media relations. Ensure all project managers are aware of expectations regarding communication and engagement and are suitably trained to deliver them. Project plans describe stakeholder engagement.	Staff will be empowered and have the tools to deliver high quality commissioning for the benefit of local people. Staff will know the vision, aims and priorities of the CCG and be able to articulate these and how their work relates to them. There will be an improved balance in media coverage in local media. Regular engagement activities such as 'Have Your Say Day'.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Continue to seek the views of, listen to and drive our relationship with patients, partners and communities	Strengthen our relationship with our Practices in order to ensure that we act as partners in the delivery of our plan, *Transforming General Practice Together.*	 Primary Care		Provide opportunities for GPs to influence commissioning and the provision of services through Member Council meetings. Promote clinical involvement in commissioning. Maintain and develop the website. Develop feedback mechanisms for issues and concerns raised by GPs and other stakeholders. Ensure staff briefings are focused on key topics and there are opportunities for feedback.	Member Practices are informed, engaged and involved in the work of their CCG and this is reflected in the feedback in the CCG Annual 360° Stakeholder Survey. GPs and their teams will be actively involved in service redesign and the clinical leads will be known. Member Practices will know the vision, aims and priorities of their CCG and be involved in implementing the strategic plan.
Continue to develop the people, processes and reporting that we have in place to oversee the quality of the services delivered to the population of south Warwickshire and drive continuous improvement in terms of patient safety, clinical effectiveness and patient experience	Continue to manage all of our provider contracts in order to ensure delivery of local and national performance and quality standards across all contracts.			On-going performance management of provider contracts. Regular reporting which captures the outcomes of on-going monitoring. On-going monitoring of patient and GP feedback on services. On-going monitoring of the use of staffing resources in order to ensure safe, sustainable and productive services. On-going monitoring of any Care Quality Commission (CQC) action plans. Review of the CCG's Systematic Approach to Quality.	Regular reporting to the CCG's Performance Committee and the Governing Body.

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Continue to develop the people, processes and reporting that we have in place to oversee the quality of the services delivered to the population of south Warwickshire and drive continuous improvement in terms of patient safety, clinical effectiveness and patient experience	Continue to be an active member of the Coventry and Warwickshire Accident and Emergency Delivery Board, the Scheduled Care Board and other joint programmes within the Coventry & Warwickshire system.	 Urgent & Emergency Care		Local implementation of the national Accident and Emergency Improvement Plan. Delivery of the agreed trajectories for the five mandated improvement initiatives: Streaming at the front door – to ambulatory and primary care. NHS 111 – Increasing the number of calls transferred for clinical advice. Ambulances – Dispatch on Disposition and code review pilots; Health Education England increasing workforce. Improved flow – 'must do's' that each trust should implement to enhance patient flow. Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models.	Shorter wait times at A&E. Reduction in Delayed Transfers of Care (DTOCs).

We will	2018-19	Next Steps on 5YFV	JSNA Theme	2018-19 Requirements	2018-19 Deliverables; what can you expect to see?
Provide the financial stability and contractual flexibility to deliver the CCG strategy	Continue to deliver financial balance in line with our financial strategy for the period 2017-2019 in order to allow sustainable transformational change to happen.	 Funding & Efficiency		Maintain positive relationships with our partners and providers and seize on opportunities to work in partnership to deliver effective and efficient change to the healthcare system and improve health outcomes for the population of south Warwickshire.	Financial balance. Strategic deliverables achieved. Regular reporting to the Executive Team, Primary Care Committee, Performance Committee and Governing Body.
	Deliver projects identified within the CCG's Quality, Innovation, Productivity and Prevention (QIPP) programme, achieving identified milestones in line with individual project plans.	 Funding & Efficiency		On-going management of the CCG's QIPP programme. Maintain regular reporting in line with agreed governance processes.	QIPP projects successfully implemented leading to delivery of QIPP target. Regular monitoring of implemented schemes to evidence outcomes.
Embrace the technology changes required to improve our efficiency and patient experience	Develop an IT strategy in collaboration with partners and providers to address the priorities identified in the Local Digital Roadmap.	 Harnessing Technology & Innovation		Update the GP IT strategy to enable the *Transforming General Practice Together* plan to be underpinned by sound infrastructure and to support the delivery of the enhanced care record between primary care and community services as part of the Out of Hospital programme. Implement the Universal Capabilities Delivery Plan, which will track progress in 10 key areas identified by NHS England.	GP IT Strategy. Improved functionality of GP IT.

If you have any further queries, please contact the CCG via the contact details listed at the end of this document.

Reference Documents

NHS Five Year Forward View
https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Next Steps on the NHS Five Year Forward View
https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

General Practice Forward View
https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

The Five Year Forward View for Mental Health
https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

NHS Operational Planning and Contracting Guidance 2017-2019
https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

NHS South Warwickshire CCG Strategic Plan 2016-2020; Translating our 2020 vision into reality
http://www.southwarwickshireccg.nhs.uk/About-Us/Publications-and-Policies/Strategic-Plan-2016-2020

NHS South Warwickshire CCG Operational Plan for 2017/18 and 2018/19
http://www.southwarwickshireccg.nhs.uk/About-Us/Publications-and-Policies/2-Year-Plan

better healthcare for everyone

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NHS
South Warwickshire
Clinical Commissioning Group

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

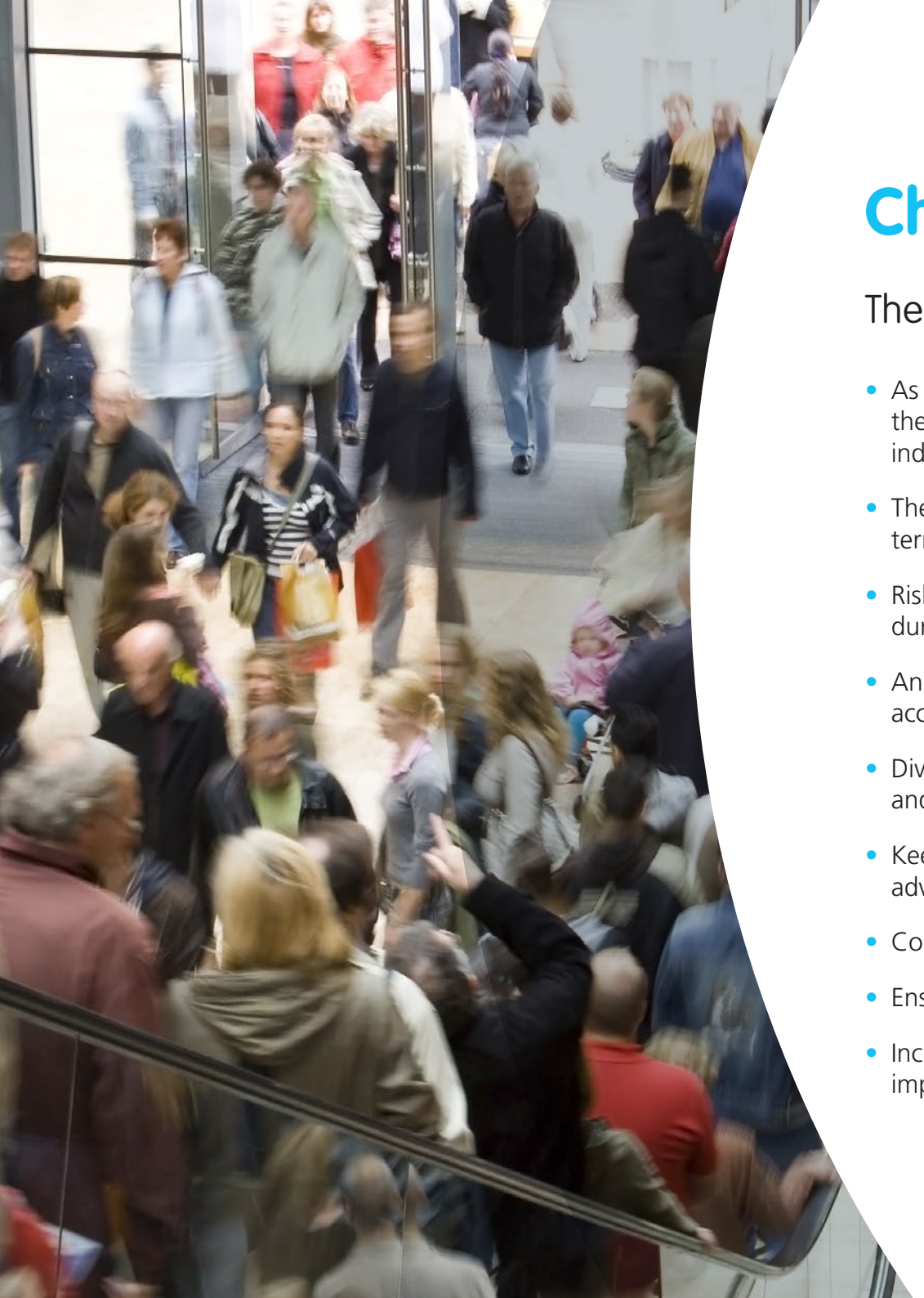
OUR COMMITMENT TO HEALTH

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

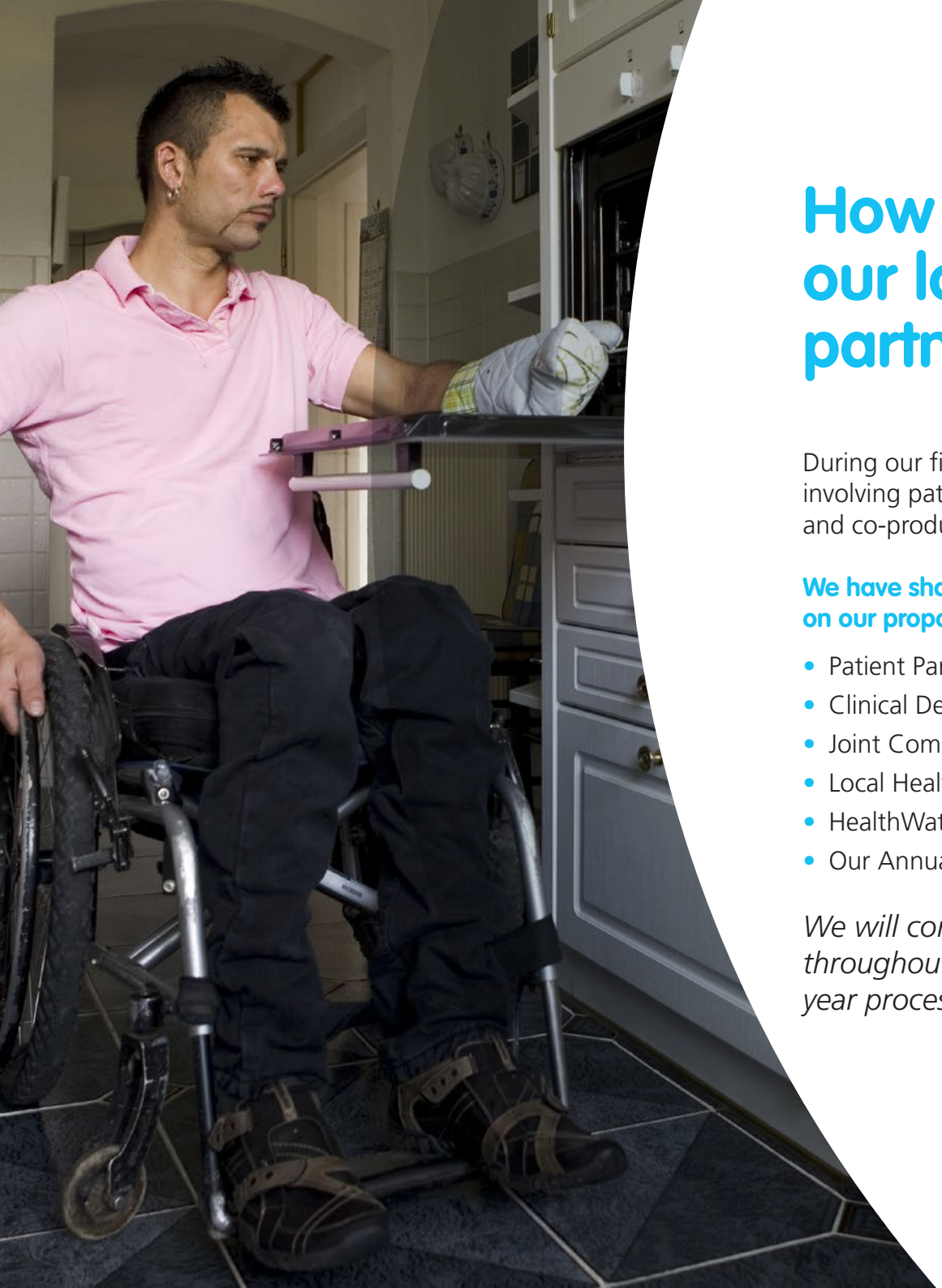
COMMITMENT	WHAT WE HAVE DONE	PATIENT IMPACT	NEXT STEPS
Improved referral and access criteria for services – focusing on respite, rehabilitation and specialisations	• An ongoing programme of work has been developed to review all the mental health service specifications	• Improved patient experience, clinical 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.