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

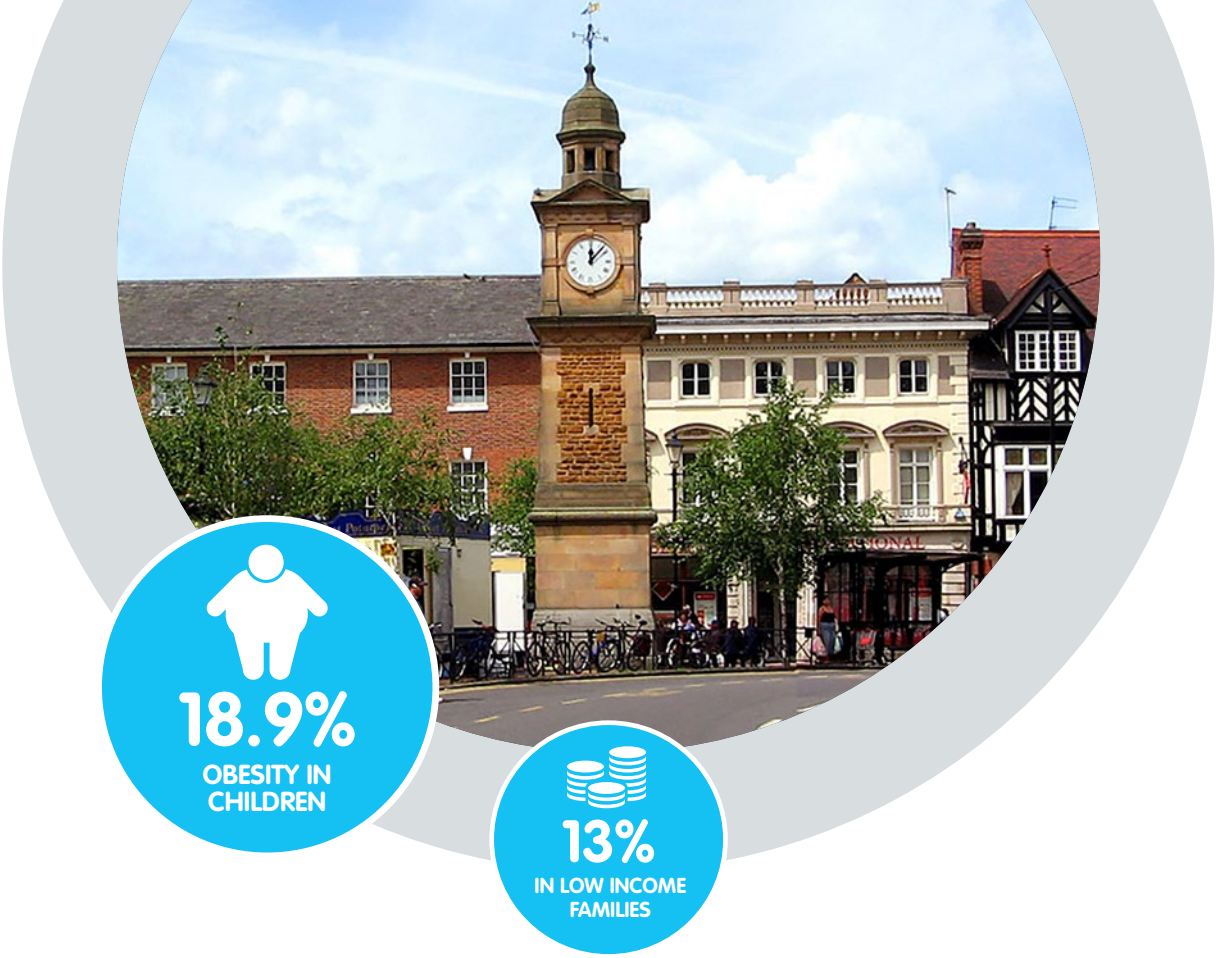
Reducing inequalities across the city by:

- 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

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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

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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.