ARDEN CLUSTER SYSTEM PLAN

2012/13 - 2014/15





NHS Coventry
NHS Warwickshire

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Appendices

1 Executive Summary

1.1 Cluster Vision

As the Arden Cluster moves into 2012/13 it faces a number of high level strategic challenges:--

Improving outcomes and reducing health inequalities remains the overriding public health objective of the Arden health and social care system with obesity, alcohol abuse and sexual health remaining high priority focus areas in both Coventry and Warwickshire. For Warwickshire, outcomes reveal particular challenges in the areas of cancer, screening and mental health and wellbeing; whilst for Coventry the highest priorities are reducing levels of smoking, teenage pregnancy and HIV.

Delivering best practice in acute care, and meeting national and regional targets and standards, will require a reduction in unacceptable variation in acute care performance and in clinical quality and outcomes between hospitals in Coventry and Warwickshire. An understanding of future demand for acute care, and agreement about the capacity and service configurations needed to deliver it, will also be required.

Achieving consistent provision of high quality integrated primary and community care will be crucial if a radical shift in the way patients are cared for and supported to access the right care in the right place at the right time is to be achieved. The 'right place' means out of hospital wherever possible particularly for patients with long-term conditions and frail older people who currently receive too much of their unplanned care, inappropriately, in a hospital.

The strategic challenge to improve clinical quality and outcomes needs to be seen in the context of a health and social care system facing significant financial pressures. The impact of the current QIPP gap is severe and this Plan will need to deliver QIPP solutions that address the challenges outlined above and deliver a financially sustainable health and social care economy.

Health service changes alone will not address all of the issues identified in this Plan. A successful healthcare system cannot be sustained without strong supportive collaboration with social care. Achieving high quality, sustainable, affordable services in Arden will require the design of an integrated service delivery model through which to deliver the transformed services outlined in this Plan.

All system partners will need to collaborate if individual organisations within the system and the system as a whole are to flourish and achieve maximum potential. Arden's Health and Social Care Chief Executive Officers, Directors, and Clinical Leaders are absolutely confident in the system's ability to deliver the change programmes identified in this Plan and all System Board members have made a commitment to collaborate in its further development and delivery. The Clinical Senate will gain consensus among clinicians about the detailed scope and desired outcomes of the service and system changes proposed in this Plan.

Clinical Commissioning Groups (CCGs) are well on the way to having in place a wide range of transformational change programmes agreed with Providers that will make a real difference to patient care and to the way in which primary, community and hospital services are used in the future. System partners are supporting these efforts by working together to identify change programmes with system wide impact that will, at the same time, support local strategies. The collective vision is to achieve excellence in healthcare and at the heart of this is a commitment to:-

- ensure that very sick and acutely ill people with complex, high dependency needs, get the specialist treatment they need quickly and in the right place
- improve the way services are designed and delivered for people with long-term chronic conditions who are often frail and elderly with a particular emphasis on early identification of risk, early intervention and integrated team working across community nursing and general practice
- look for innovative ways to help people help themselves by exploiting the potential for assistive technology that patients can use, eg, telehealth

- collaborate more effectively across primary, community, acute, mental health, and social care services in the design and delivery of more services to be delivered in a primary/community care setting that wrap around the patient and deliver best outcomes
- commission 'value based healthcare'
- achieve a financially sustainable integrated healthcare service across Coventry and Warwickshire

Arden's high level objectives to deliver this commitment, and designed to achieve transformational change on behalf of the people of Coventry and Warwickshire, are as follows:-

Objectives to Achieve Transformational Change

Leaders in Arden will create a culture and an environment that will:-

continue the drive to promote *healthy living and lifestyle choices*, in particular, through the 'making every contact count' initiative but in all areas of public health. Maximising the gains to be had from working alongside local authority colleagues whose services impact on people's health and well-being

drive up *primary care quality and safety* and support GPs to achieve upper quartile benchmark performance as a minimum in all measures

maximise the potential for *frail older people* to live independently by helping them to self-manage long term conditions where it has not been possible to prevent them; and when older people need intervention, to deliver as much care for them as possible outside of hospital and in a coordinated way by all agencies

promote *well-being in mental health* through the delivery of efficient, excellent, services that provide effective person centred clinical outcomes which ensure an exceptional patient experience is delivered first time and every time

deliver *best practice in acute hospital care* focusing on optimising 24/7 care for the very sick and acutely ill as a first priority

Box 1 – Arden System Objectives

Taken together, these five workstreams make up Arden's transformational change programme. The final scope of the five workstreams, and the processes and milestones for producing an overarching plan to deliver Arden's transformational change programme in its entirety, will be agreed by the end of May 2012. Detailed project plans for all workstreams that have not already started will be signed off by the Arden System Board by the end of October in order that implementation planning is well underway by the time CCGs are authorized in April 2013.

1.2 Achievements in 2011/12

Section 3 summarises notable achievements for the Cluster in 2011. From a service quality perspective the Cluster is particularly proud to have seen a significant reduction in smoking prevalence and achievement against the VTE risk assessments targets. In respect of service performance, CCGs have assumed delegated responsibility for QIPP programmes and have exceeded expectations by over-delivering in some areas including medicines management, reductions in GP referrals to all acute trusts and reductions in activity for procedures of limited clinical value. At a Cluster level, planned cost reductions in continuing healthcare have been achieved as have management cost reductions. More generally, Providers are working closely with the Cluster on QIPP scheme design and delivery; for example, a QIPP Collaboration Work Plan has been agreed between the Cluster and University Hospital Coventry and Warwickshire (UHCW). Arrangements are in place with South Warwickshire Foundation Trust (SWFT) and Coventry and Warwickshire Partnership Trust (CWPT) to take forward joint work on schemes and in North Warwickshire a Partnership Board has been established, involving health and social care partners, to agree and deliver commissioning strategies.

Both Cluster PCTs are forecasting achievement of financial targets in 2011/12, as are all Providers.

COPD – what a service change programme has achieved for 'Jean'

Jean 2010
Jean is 74 years old and has severe COPD. She lives in Coventry with her husband Tom who has diabetes and arthritis. Jean's condition has deteriorated and she has experienced frequent exacerbations, which have resulted in admission to hospital 5 times in the last year. Jean hates being admitted but doesn't feel safe at home. She has also had 3 outpatient appointments at the hospital. Both Jean and Tom find these visits stressful, parking is often difficult and Jean struggles with the walk from the car park to the outpatient department. On each visit Jean saw a different doctor and felt frustrated at having to repeat her medical history. She also gets a little confused about her medications as they have been changed a few times recently by both the hospital doctor and her GP. She finds her new inhaler difficult to use, as it is different to her old one. Like many patients with COPD Jean is anxious and has become increasingly depressed as she increasingly struggles with activities of daily living. Her breathlessness means that she doesn't go out very much these days and worries about being left alone when Tom goes to the shops. Tom is also finding life difficult; he worries about Jean and what to do when she has difficulty breathing. He rarely goes out these days, as he is frightened of leaving her alone for very long. Both Jean and Tom worry about the future and how long they will be able to stay in their home independently with Jean's deteriorating health
Jean 2012
Jean no longer has to visit the hospital as she sees the COPD team at the community clinic. She much prefers this as it is nearer to her home, there is plenty of free parking and she doesn't have to walk far. She has got to know the team really well now as they share her care with her GP. They have given her a self management plan and information booklet and the nurse pointed out some sections which were particularly useful to her. She better understands what an exacerbation is and can now recognise when she is becoming unwell. The doctor also gave her some medicines to keep at home and take if this happens. Although she still has exacerbations she hasn't had to be admitted to hospital as she takes her rescue meds as instructed and lets her GP know. If her GP is concerned about her exacerbation the COPD team will visit her at home and keep an eye on her until she improves. Tom doesn't worry quite as much now and understands more about her breathlessness. The nurses have explained all Jeans medicines to both her and Tom and they are written in her management plan, which she takes to all her appointments with both her GP and the COPD team. They have also shown her how to use her inhalers properly and given her leaflets about the different sorts that she uses so she feels more confident about taking them. Jean has also joined the local patient support group (Breathe Easy) which she and Tom go to once a month, they both enjoy getting out of the house and meeting people with similar conditions, this has helped them to feel less isolated. Jean has just completed the local pulmonary rehabilitation programme and understands that it is OK to get a little breathless when exercising, and last week she managed a walk to the local shop. Jean feels less anxious as she and Tom feel better informed about her condition and supported by the local integrated team.

1.3 Delivery Priorities 2012/13 and Beyond

Whilst this Plan highlights many achievements in 2011/12, the Cluster recognises the need to improve performance in a number of key areas as going into 2012/13. Of major concern is the failure so far to deliver required performance in A&E 4 hour waits, referral to treatment times, ambulance handover times, NHS Healthchecks and access to NHS Dentistry. Unacceptable hospital mortality rates will continue to be a major area for focus next year, as will actions to mitigate the risk of Never Events. Whilst eradicated in most Acute Trusts, there are still breaches of mixed sex accommodation occurring in SWFT and actions are underway to resolve this.

Arden's 5 overarching objectives and associated QIPP programmes will address these areas, as will new governance and performance management arrangements being introduced to reflect the role of CCGs.

1.4 Implementation and Delivery 2012/13 and Beyond

The active engagement of all CCGs and partner organisation clinicians will be vital if the change programmes described in this Plan are to be delivered. The Clinical Senate will promote the development of a clinically led, managerially supported, approach to the planning, delivery and performance management of services and service change programmes. Members of the Clinical Senate have committed to collaborate to establish this necessary delivery culture in Arden.

As in 2011/12 there are significant challenges associated with delivery of this Plan. QIPP programmes will need to address these challenges by significantly reducing acute hospital activity and by establishing a more comprehensive service 'offer' in primary and community care.

The QIPP Programme Management Office function will be strengthened as will performance management of providers by CCGs to ensure contracts are delivered. In parallel, CCGs will work with primary care clinicians to set minimum standards for primary care delivery that will improve primary care quality and reduce unacceptable variation in primary care practice and inappropriate utilisation of secondary care. The vast majority of QIPP schemes will be delegated to CCGs as sub-committees of the Cluster Board. CCGs will be held to account for delivery by the Cluster's Finance and Performance Committee. Oversight of System Plan delivery will be through the System Board.

1.5 Transition and Reform

The Cluster is meeting 2011/12 shared operating model milestones for all transition and reform workstreams (CCGs, CSS, Direct Commissioning), aside from having agreement on the final configuration of CCGs where there may be slight slippage into April 2012 for Coventry and Rugby and Northern Warwickshire. The Cluster is working closely with CCGs on transition plans and does not anticipate any major risks to having CCGs ready to operate in shadow form from April 2012/13. Establishing resilience and mitigating the risks associated with system turbulence is taking a high priority within the Cluster and Section 5 outlines what has been done to maintain effective delivery of day to day commissioning, performance management and service change programmes.

The Arden CSS received positive feedback on its submission for checkpoint 1 in December, receiving a green for leadership and amber in other areas.
It is now proposed to establish the CSS as an arm's length organisation in April 2012 as a subcommittee of the Cluster Board. The Cluster is on track to have an outline business case ready for Checkpoint 2 at the end of March 2012

The transfer of Public Health to Local Authorities is progressing in line with national timescales and the Warwickshire Public Health Department has already relocated to Warwickshire County Council (WCC) offices. Coventry is scheduled to move in Spring 2012.

CWPT is progressing its Foundation Trust application in line with its Tripartite Formal Agreement (TFA) milestones and George Eliot Hospital (GEH) is on track with its milestones to appoint an FT partner. UHCW is in discussion with the Strategic Health Authority (SHA) regarding its TFA milestones.

2 Background and Context

2.1 Arden Healthcare System

2.1.1 Commissioners and Providers

The Arden healthcare system spans the city of Coventry and the county of Warwickshire. The Arden Cluster of PCTs (NHS Coventry and NHS Warwickshire) has a commissioning budget of £1.5bn and serves a registered population of approx 921,553 that stretches from Polesworth in North Warwickshire to Shipston in the South of the county, and borders Worcestershire to the West and Northamptonshire to the East.

There are currently 5/6 groups organised as Clinical Commissioning Groups in Arden with the final configuration expected to be confirmed as 3/4 in time for shadow operation in April 2012. Clinical Commissioning Groups cover 3 relatively distinct localities.

North Warwickshire and Nuneaton and Bedworth CCGs serve a population of 183,653. 63.1% of North CCG's acute commissioning budget is spent with GEH, the local Acute Provider. The remaining 36.9% is spent largely with Heart of England FT, University Hospital Birmingham FT and University Hospital Leicester NHS Trust

South Warwickshire CCG serves a registered population of 271,512. It spends 68.3% of its acute commissioning budget with its local provider SWFT. The remaining 31.7% is spent largely with Worcester Acute Hospital NHS Trust, Heart of England FT, Oxford Radcliffe NHS Trust

Coventry and Rugby CCGs serve a registered population of 366,775 and 99,613 respectively.

Rugby CCG spends 87.8% of its acute spend with UHCW. The remaining 12.2% is spent largely with University Hospital Birmingham FT, University Hospital Leicester NHS Trust and Birmingham Children's' NHS Trust

Coventry CCG has 87% of its acute spend with UHCW with the balance being spent largely with GEH and SWFT.

Providers have significant inflows of activity from outside the county.

Mental Health and Learning Disability services are provided across Coventry and Warwickshire by one specialist mental health and learning disability provider CWPT. Tertiary mental health services are commissioned from a range of NHS and independent sector providers, primarily outside of Coventry and Warwickshire. Community Services for Coventry are provided by CWPT. Community Services for Rugby, North and South Warwickshire are provided by SWFT. GEH provides specialised community services including county-wide community dental, smoking cessation and TB services, and APMS primary care practices

Of the 4healthcare providers in Arden three are currently applying for Foundation Trust status, CWPT, GEH, UHCW

The Arden Cluster spans 2 local authorities; Warwickshire County Council and Coventry City Council.

Non-NHS provided care services are not equitably distributed across the Cluster. There is no hospice bed provision in the north of Warwickshire (and this is one driver for the higher level of deaths in hospital at GEH).

2.1.2 Health and Well Being Boards

The two Directors of Public Health are fully integrated members of Coventry's and Warwickshire's Health and Wellbeing Boards (HWBB), promoting the active engagement in HWBB business of other Cluster directors whenever needed. The Cluster's CEO is a member of both HWBBs and has taken the opportunity to debate and present on health service strategy. The Cluster will take a lead from HWBBs on how best to ensure that implementation of the change programmes identified in this Plan maximises the gains for the Cluster populations as a whole and supports whole system collaborative working.

Warwickshire's HWBB has been established in shadow form since March 2011, Coventry's will be in shadow form from April 2012. In recognition of the pivotal part that HWBBs will play in shaping future health and social care strategy, and to prepare elected members and officers for their new role, the Cluster has commissionied a comprehensive HWBB development programme with the aim of developing the capacity of both HWBBs to collaborate effectively in delivering health improvement.

Objectives for the programme are:-

- to develop a shared view between the current and potential leaders of all groups, about each other's responsibilities, priorities and lines of accountability; and about the interdependencies between the groups; and how each groups adds value to the system,
- to agree those current and potential priorities that are best addressed by organisations working individually, locally and those that are best addressed by collaboration across the Arden system,
- to agree how strategic planning processes (needs assessment, prioritisation, design and implementation of change, evaluation) can be carried out in a way that supports both local and system-wide activity,
- to agree how the public health resource in the Arden system should be deployed to best support the delivery of system objectives, and
- to understand the development plans for HWBBs and CCGs and to identify any further opportunities for learning and development.

Early priorities for future work programmes have been identified by both Boards and these are outlined in the Public Health Transition Plans. Transition Plans also describe work already underway including how engagement across the health and social care sector will ensure that HWBBs can discharge their strategic funtions in the future.

2.2 Strategic Challenges

2.2.1 Clinical Quality and Outcomes

2.2.1.1 Improving Health Outcomes and Reducing Inequalities

The 2011/12 registered population of Coventry is 366,775 and the resident population is 312,800. There is significant growth in the population of Coventry and this is greater in the registered population than the resident population. The numbers of elderly and children are increasing steadily following a dip in 2006/07. The total number of births in Coventry has increased from 3,634 in 2011 to 4,678 in 2009: an increase of 29%. Almost all of the increase is because of births among mothers who have recently immigrated to the UK.

The population of Warwickshire is circa 550,000. The County's population is projected to reach 634,900 by 2033; an increase of just over 100,000 or 19% from 2008. Migration is seen as one reason for the increase but there is evidence that this is slowing. The rate of growth increases with age, with the oldest age group (those aged 85 and over) projected to almost treble in number by 2033. The growth in the number of people under 16 is also expected, but at a slower rate (around 11% by 2033), slightly below the national rate (12%).

In general, Warwickshire has a relatively affluent population and Coventry a more deprived. However, this obscures the diversity across the population particularly with regard to age profile and ethnicity. The north of Warwickshire is more similar to Coventry than the rest of Warwickshire and both of these areas have higher numbers of ethnic minorities, lifestyle challenges with higher rates of smoking, adult and childhood obesity and high levels of alcohol abuse.

The south of Warwickshire is an older more affluent more homogeneous population. However rates of obesity and prevalence of dementia is rising and there are particular challenges because of frailty and co morbidity in an aging population.

There is a variation of 6 and 7 years in life expectancy respectively for men and women between the North and South of Warwickshire primarily because of earlier age deaths from Cancer and Cardiovascular Disease. This picture is also seen in Coventry because of effects of deprivation, poorer lifestyles and significantly late patient presentation with symptoms.

A review of Public Health outcomes for Coventry shows the need for continued focus on lifestyle risk management: reducing levels of obesity, smoking, alcohol abuse and HIV, sexual health and teenage pregnancy. Life expectancy for both men and women is lower than the regional and national average and sustained efforts need to be made to reduce the gap in left expectancy within the city.

The demands of providing health services to an aging, primarily rural, population present a significant challenge in Warwickshire and the levels of achievement with regards to health outcomes is not in keeping with the overall level of affluence.

2.2.1.2 Acute Hospital Care

CCGs are clear that the primary focus of the Cluster's long-term strategy must be on improving clinical quality and outcomes. CCGs are working closely with Providers to strengthen quality improvement and performance monitoring arrangements as part of routine contract monitoring.

In addition, CCGs are engaging as members of the Clinical Senate and System Board in debates about how best to drive up clinical quality in primary, community and acute care.

Arden's local hospitals developed at a time when most acute care could be provided to an acceptable standard from relatively small sites, with "general" medical and surgical consultants providing the bulk of emergency and elective care. There has been a transformation in acute healthcare over the past twenty years, with increasing complexity in investigation and treatment and the need for greater specialisation. The goal is higher quality, safer care with a wider range of choice and improved experience and outcomes for people and real progress has already been made through reorganizing services for cancer, vascular surgery, stroke, heart disease and major trauma. The Cluster is debating how overall clinical excellence across acute services will be sustained, recognising that it may not be possible or affordable to continue to provide all that is required within the health economy from multiple sites. In particular, the Cluster is considering the optimal way to deliver emergency care for severe acute illness and high risk elective procedures across all hospital sites backed up by improvements in locally integrated care to deliver prevention, diagnosis and long term care in and out of hospital. The aim remains to provide as much locally as is safe, effective and affordable.

Example of the challenges faced in acute care:-

- In Coventry 98% of TIA patients are treated within 24 hours compared with 53% in Warwickshire (despite much work underway to improve stroke pathways)
- The most recent NHS Atlas of Variation (December 2011) shows that observed 30 day mortality rates after colorectal surgery reported in the 2011 National Bowel Cancer Audit vary from 1.2% to 7.3% across the 3 Acute Trusts
- Resection rates for lung cancer as reported in the most recent national Lung Cancer Audit range from 9.1 to 22.3% across the 3 Acute Trusts
- Hospital mortality is also a major concern, in particular at the George Eliot Hospital where a review has now been completed and the Trust is actively implementing the recommendations as part of a comprehensive quality improvement plan.

Acute Trust and PCT Medical Directors are working to develop the clinical engagement and support that will be essential in tackling these, and other, challenges. An agreement in principle has been reached to develop, agree and implement a strategy and plan to deliver sustainable emergency general surgery as the first priority. This strategy and plan will be agreed by the end of October 2012. Work is already in progress to agree a model for sustainable paediatric and maternity services and it is likely that acute adult respiratory care will be the next priority.

There are other clinical quality challenges within the Cluster and these are described in detail in Section 3 below.

Assurance on patient safety and quality will be achieved via:-

- Clinical Quality Review Meetings with Providers
- Technical and Contract Review Meetings
- Use of the SHA's Workforce Assurance Framework Tool for reviewing the impact of workforce changes on the quality and safety of services

2.2.1.3 Primary and Community Care

Strong clinical leadership of CCGs is vital; this has already been secured across most of Arden but remains a challenge in North Warwickshire.

Across many areas CCG leads are already assuming leadership in commissioning and engaging with the agenda for sustainable safety and quality in acute services, however the pace of change required to deliver by 2013 remains demanding. Greater collaboration between primary and secondary care clinicians is already evident, and needs to be extended further to achieve a full, clinically informed, approach to commissioning. The Clinical Senate provides an invaluable forum for discussion, debate, and agreement on shared clinical priorities, and a challenge will be to sustain this through a period of continuing transition.
Early progress is being made in the following areas:

- CCG Development
- Pathway development between secondary and primary care clinicians
- Quality meetings between secondary and Primary care clinicians, which includes involvement in hospital mortality meetings

  A key factor for success of the system plan and the QIPP schemes is primary care quality; however there is significant variation across primary care. For example Blood Pressure control varies from over 90% in some practices down to 50% in others. The challenges therefore are:-

- Remove variability of quality of clinical care between General Practices
- Drive up the overall quality of clinical care provided

This will provide a solid foundation for the next challenge which is the integration of care within the community between, general practice, community services and Local Authorities to ensure that patients are managed within their own residential setting where ever it is clinically appropriate as opposed to the current default of admit to hospital.

Currently there are differing models and providers of community services across Coventry and Warwickshire which do not align fully with primary, secondary and social services. It will be necessary to develop a more coherent approach to support locally integrated care across all these services that improves outcomes for patients and reduces the need for hospitalisation. A fuller understanding of the capacity required in primary and community care to enable the shifts out of acute care will also be needed quickly if Plan milestones are to be achieved.

2.2.1.4 Mental Health

The mental health and well-being challenges in Arden recognise the need to put mental well-being at the core of people's thinking. A programme of public mental health initiatives needs to be continually refreshed to ensure mental well-being is addressed at an earlier stage and that well-being resources are available to the Arden community, reducing the pressure on both primary care and secondary mental health services.

The demographic challenges for Coventry and Warwickshire require responsive commissioning; there is a shift to a younger population and enhancing earlier intervention in Coventry and the need to further develop organic mental health services to meet the growing numbers of older people in Warwickshire.
In a challenging financial climate there is a commitment to keep investment in services, skills and infrastructure local and redistribute resources from high cost placements (in or out of area) to ensure services are shaped to maximise their ability to respond and treat locally, individuals who may have episodes of very challenging behaviour, thus preventing them going out of area.

2.3 System Challenges

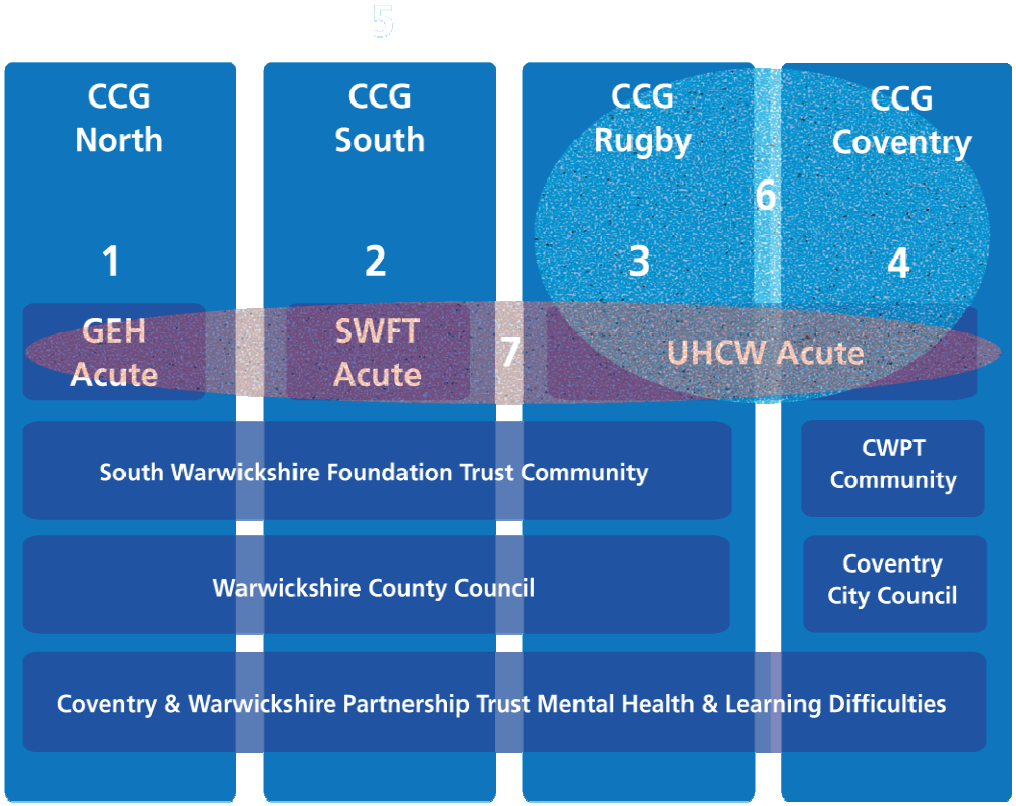
Central to successful delivery of improved clinical quality and better outcomes will be health service organisations and teams configured to maximize the potential to achieve these aims. This presents the main challenge for the Arden system; the need to design and deliver a service change programme that:-

- delivers the right shape of acute and community services for the future,
- is underpinned by a collaborative approach to the delivery of public health, primary, community, mental health and social care services, that
- wraps around the patient in a way that improves patients' life expectancy and life chances, improves access and patient experience, maximizes outcomes, delivers higher quality and better value care
- enables the achievement of foundation trust status for CWPT, GEH and UHCW

The drivers behind the service change programme are:-

- the need to deliver sustainable acute services for the future
- a rising older people population, where upwards of 50% of unplanned admissions to hospital are in the over 75 age group
- a greater number of people living for longer and with disabling long-term conditions that can be better managed in the community if planned and delivered in a collaboration between providers
- rising demand for acute care that can only be met if inappropriate activity in hospitals is shifted to free acute capacity

Arden Cluster - Systems within a System



Achieving System Collaboration

The Arden system is, in practice, a number of systems within a system. The system 'map' is shown in Figure1 to the left. Within local systems there is a very significant amount of work already underway designing and delivering service change programmes. This effort is having an impact, for example, in the number of bed reductions it has been possible to achieve as a result of new ways of delivering intermediate care. The challenge now is to exploit the potential for bigger gains as a result of upscaling benefits from local initiatives across the whole of Coventry and Warwickshire where the evidence shows this will have the right impact.

The commitment to collaborate entered into by all System Board members will ensure that Plans deliver against all local priorities in addition to exploiting the potential to maximize gains for the system as a whole (for example, in the way risk stratification, virtual wards and assistive technology is adopted at scale for system wide impact).

2.4 Financial Challenges

The system comprises two PCTs with significantly differing recent financial histories. On the basis of the latest allocation formula application, Warwickshire is some £13m below its target allocation position and Coventry £18m above. There is no gain to be had in the short term from any allocation pace of change which sets out to address the imbalance, as across the health economy Warwickshire would gain and Coventry would lose. Indications are that the pace of change for the next Comprehensive Spending Review (CSR) is likely to continue to be zero. However, the policy relating to the setting of CCG level allocations has not yet been announced and this may have some more localised impact if set above zero.

In addition to this there is a fair shares dynamic within Warwickshire, the values of which vary quite significantly depending on which formula or toolkit version is applied to the comparator calculation. What is clear is that under those current scenarios, which determine fair application of resource, more than fair resources are applied to the south and Rugby and less than fair resources to the north of the county. This is a continuation of the trend set by the allocations of the three former, pre-2006, Warwickshire PCTs, though it should be noted that the impact of the change to the allocation formula in 2011/12 had a significant impact on the level of target resources determined for areas of significant health inequalities (increased), relative to those with low levels. Demographics show that the south has a high level of very elderly population, whilst the north has a younger, more deprived population. Whilst the impact of this in formula terms is to move target resources towards the north (as health inequalities elements have the heavier impact within the formula), the current picture is exacerbated by more voluminous community service infrastructure in the south and Rugby. Of the three Warwickshire areas, each reaches into a separate acute, thought there is no evidence to suggest that acute access is at inappropriate levels within any area.

NHS Warwickshire has delivered its revenue plan for the last 6 years since its creation in 2006/07 by the re-merger of the three former smaller PCTs (north, south and Rugby), however has struggled to do so and has had very high savings/QIPP targets in each of those years. This has placed many challenges on the system in terms of year-on-year productivity, efficiency and referral management requirements, coupled with significant pathway efficiency drivers and stringent contracting processes. Coventry emerged from a similar scenario into a healthier financial position in 2007, though its position of being over its allocation target factors in to future financial plans in terms of the potential decline of resources in the period beyond the current CSR.

For 2012/13 and the medium term, the impact of the current QIPP gap is severe and the financial outlook is that the economy cannot afford its current configuration of services. This is a key driver for change, alongside that of quality dimension. In the longer term the total resource within the economy is unlikely to shift significantly and therefore it is of paramount importance that the economy together brokers the solution, long term, to providing services within the affordable envelope.

2.5 Social Care Challenges

2.5.1 Coventry City Council

Children's and Adults Social Care is showing a balanced financial position in 2011/12 with an underlying pressure of £1.7m within adult services, and £5.2m within children's services, which is being managed using existing resources, including transfers from health to support social care. The most significant pressure on Adult Social Care budgets is in Community Purchasing which is the cost of external packages of care across all service user groups, and the most significant pressure for children's services is in the costs of supporting historically growing numbers of looked after children. Whilst numbers of older people supported remains fairly static at this time, their care needs are increasing. In addition to this a further £0.8m of care packages relating to young people transferring into adults social care has taken place this year. People are also now living longer and spending a greater length of time requiring social care services, across all areas of provision.

The additional social care and health funding via the PCT, including reablement and winter pressure funding, provides some resources to help manage this position. However, as elements of this funding are one off or time limited, this adds further complexity to balancing costs against resources. Both adults' and

children's services are being reviewed as part of a council wide significant redesign and modernisation programme, the abc programme, focussing on personalisation, quality, and best use of available resources. Running in parallel to the changing financial environment and the significant level of policy change/uncertainty across the health and social care economy with the passage of the current health and social care bill, is a social care white paper due to out in April 2012. Because of the continually changing resource availability and activity across the health economy, Children's and Adults Social Care is seeking ways to manage these pressures whilst meeting the population's care needs.

2.5.2 Warwickshire County Council

The current pattern of long term care services for older people cannot be sustained given the reduction in resources available in the future. A Warwickshire County Council transformation programme has designed and delivered major change which has resulted in externalised care service provision (ie, home care and residential care (with a process for day care being completed in 2012/13)), removed subsidies from those who can afford to pay, and rigorously applied 'Fair Access to Care' criteria to target those in greatest need (ie, those with substantial or critical needs). An additional significant achievement has been the adoption of a policy that ensures all services secured maximise independence for service users. This has been the focus of the funding transferred to the County Council under Section 256, which has secured additional reablement home care (65% of those using the service do not require further care), community equipment and telecare and extra care housing replacing residential care.

In Warwickshire, savings required are £19m on a controllable adult social care budget of £113m to be achieved over the 3 year period 2011/12-2013/14, of which £14m will be delivered in the first 2 years. Children, Young People and Families services are required to save £26m in this period, including the loss of £9m of specific grants. Section 256 funding has offset some of this reduction, and allowed investment in the reablement services that transform revenue commitments. In 2012/13 the budget set by the Council confirms a dependency on Section 256 funding to continue this drive to achieve 'reablement and recovery'.

3 Review of Delivery - 2011/12

3.1 Quality Achievements

During 2011/12 the Cluster has delivered, or made improvements, in the following areas:-

Target/Standard	Position as at December 2011
VTE Risk Assessments	All Providers are achieving the target of 90% of patients having had a VTE risk assessment; UHCW has maintained its performance for over a year.
Diabetic Retinopathy Screening	Full compliance is being achieved for both PCTs in respect of access rates (although a recent review of the screening service has revealed some shortfalls to be addressed).
Smoking Quitters	Prevalence of smoking in NHSC has reduced from 29% to 24% in the past 2 years. At the end of December there were 2335 smoking quitters in Warwickshire against a target of 2178. Sept, Oct and Nov data shows NHSW as being close to the monthly target. NHSC continues to meet its target.

These successes were achieved as a result of dialogue with Providers through formal clinical quality review and contract performance meetings. Significant new investment in Any Qualified Provider contracts has introduced new Smoking Quitter service provision into Coventry with financial incentives available for achieving successful quit rates.

3.2 Service Performance

2011/12 has been a challenging year for Arden given a QIPP target of £116m and the turbulence associated with creation of the Cluster and CCGs. Notable successes:-

3.2.1 Commissioner QIPP Programme

The majority of QIPP schemes are delegated to CCGs to drive delivery in 2011/12 and notable successes are:-

- Medicines management in primary care – where both PCTs are set to over-deliver on their planned targets for 2011/12 through the close working relationship of CCG prescribing leads with the medicines management team and local GPs
- New GP Out-patient Referrals – CCG led schemes, including the Referral Support Service (a GP peer-review scheme) in Coventry and a 'live data' IT system and practice-level targets in Warwickshire, have resulted in the planned reduction of GP referrals at all Acute Trusts
- Procedures of Limited Clinical Value – CCGs have led delivery of planned reductions in both Coventry and Warwickshire through enhanced GP peer review and prior approval against a revised Cluster-wide commissioning policy
- Reductions in emergency admissions for patients with long-term conditions, where many Coventry GP practices have reduced activity levels as a result of their improvements to the quality of care in a general practice and as a direct result of support, training and alignment of initiatives for long-term condition management (although activity has not reduced to planned levels as confirmed in 3.2.2 below).

At a Cluster level key areas of success include:-

- Continuing Healthcare, where both PCTs are set to achieve their planned cost reductions as a result of enhanced processes of assessment and review and better procurement and contract management.
- Management Cost Reductions, where both PCTs will achieve their planned management cost reductions for 2011/12 through robust vacancy control and streamlining of functions across the Cluster as the two PCTs have come together.

Successful QIPP delivery has been driven by strong clinical engagement and commissioner control. QIPP schemes that have relied on greater multi-organisation/multi-agency engagement have proved more difficult to implement, as demonstrated by the poor performance of many of the unscheduled care QIPPs schemes. This is a key learning point for the Cluster moving into 2012/13 where, as part of contract negotiations, CCGs are seeking to agree 'win-win' QIPPs with Providers to drive efficiency savings for both commissioners and Providers.

Appendix 1 gives an overview of QIPP delivery in 2011/12 and the learning points where schemes have not delivered.

3.2.2 Provider QIPP Programme

During 2011/12 Providers have supported system-wide QIPP delivery and delivered internal cost improvement (CIP) targets in excess of the national 4% requirement. Both are expected to continue over the next 3 years. The following sections provide an overview of both QIPP and CIP delivery in 2011/12. See Appendix 2 for further details and for performance against plans for all Providers.

University Hospitals Coventry and Warwickshire

UHCW has £4m of QIPP schemes included in the 2011/12 contract with NHS Coventry and NHS Warwickshire. The risk for some of these schemes is solely with UHCW; for others it is shared jointly with the commissioner.

In addition to these schemes, the 2011/12 contract includes a commitment that UHCW will agree with commissioners additional QIPP schemes to the value of £2.66m, to be established by 31 March in order that full year effect savings are achieved in 2012/13.

The 2011/12 QIPP contract agreement has been included in negotiations for QIPP schemes in the 2012/13 contract.

UHCW has agreed a 'QIPP Collaboration Work Plan' with the Cluster which is being used to progress 2011/12 schemes and to develop schemes for 2012/13 and beyond.

In addition to the above, UHCW is managing the impact of commissioner QIPPs, including, for planned care, i) the reduction of referrals and reduced hospital activity from the agreement with commissioners of an enhanced Low Priority Procedures Policy in the 2011/12 contract and ii) the implementation by commissioners of referral management processes for elective planned care.

Commissioner QIPP schemes aimed at reducing non-elective activity at UHCW have not had the impact anticipated. Reductions in A&E attendances and emergency admissions have not reduced to planned levels. UHCW and GP commissioners are agreeing schemes that will have impact early in 2012/13, as well as medium term schemes for the future, with the aim of reducing activity to 2008/09 baseline levels.
UHCW has a 2011/12 CIP of £28 million (5.9% of turnover).

George Eliot Hospital

Cluster QIPP schemes affecting GEH total £8.3m for 2011/12. The Trust estimates that £2.0m of savings have been made with schemes totalling £1.1m in progress. The remaining £5.2m of schemes, principally referral management and admission avoidance schemes, are not viewed by the Trust as having made any significant progress in savings.

The community emergency response team (CERT) is in place and has been effective in improving discharges, but not in admissions avoidance. This is evidenced by the reduction in the time that patients with delayed transfers of care (DTOC) have remained in hospital, even though the level of DTOCs has continued to be higher than the target. The benefit in terms of reducing excess bed days has not been assessed. CERT will be carried forward as an initiative into 2012/13. Admissions have considerably over-performed planned levels compared with the Leicestershire trend where a large reduction has been experienced.

GEH has a 2011/12 CIP target of £11.2m (10%) and has identified £9.0m against it (80%).

South Warwickshire Foundation Trust

SWFT has a 2011/12 CIP of £6.2 million (3.1% of m10 forecast turnover) and currently expects to deliver 92% of that plan (£5.7 million) in 2011/12. The CIPs that have not been delivered have been offset by additional income earned through increased levels of activity and by generating some non-recurrent savings during 2011/12 which have been translated into recurrent CIPs for 2012/13.

In respect of 2012/13 QIPPS, the figures contained in the Systems Plan relating to SWFT are recognised from contract negotiations and discussions are on-going to achieve higher QIPP targets given the current position in contract negotiations. These increased QIPP schemes are currently subject to a process of assurance and will need to be supported by more detailed project plans. SWFT intends to support delivery of the QIPPs agreed.

Coventry and Warwickshire Partnership Trust

In 2011/12 CWPT has supported delivery of commissioner QIPPs through joint work on reducing and repatriating out of area placements. This scheme has been incentivised through the use of CQUIN monies, which pay for an out of area assessment and case management team that monitors client care packages, enabling step-down to local services as soon as is clinically appropriate. This scheme will be built upon in 2012/13.

3.2.3 Workforce Performance

A Cluster Workforce plan was submitted to the Strategic Health Authority (SHA) in July 2011 following quality assurance to ensure that Provider plans matched commissioning intentions and was within the financial envelope available. The Plan described key delivery areas for workforce in the current year. The Cluster has worked in close collaboration with all Providers to present a clear narrative describing workforce performance against plan for 2011/12. The outcome of those discussions has been quality assured by finance and workforce colleagues, supported by the SHA's workforce lead. Appendix 3 summarises 2011/12 performance against each of the Key Lines of Enquiry covered within the workforce domain.

In respect of each Provider's workforce plans, establishments and skill mix, the Cluster is assured that taken together, in the main, these will deliver safe quality care. However, the Cluster is seeking further assurance and action plans from UHCW that demonstrate that midwife to birth staffing ratios, and skillmix which includes the correct number of trained nurses, is in place. The same assurance is being sought from GEH. Assurance is being sought from CWPT that staffing establishments are appropriate on care of the elderly wards and the Cluster is working with SWFT to ensure that paediatric nurses are assigned and competent to work as part of the A&E team.

During the year, the Cluster's Workforce Stakeholder Board has funded the following projects:-

Staff 'Invest in You' Programme
Provide Workforce Development Programme – capacity and capability building aimed at middle manager
Dementia training (aimed at supporting staff in an acute environment to better care for patients with dementia)
VITAL (introduction of soft ware that provides online training for nursing staff, eg, for outpatient nurses re-entering ward duties)

Priorities for 2012/13 are:-

- to support the development of bands 1-4 and apprenticeships,
- to train for new to management managers incorporating leadership,
- to support providers to manage workforce planning and development more appropriately, and
- meeting infrastructure needs, for example: robust personal development planning, appraisal, training needs analysis, staff engagement.

In respect of the impact on workforce of the change programmes outlined in this System Plan, CCGs and providers will work together to agree impacts as part of detailed project planning and in light of agreements about implementation phasing reached during the current contract negotiations.

The Cluster will support CCGs and providers to build workforce capacity and capability through use of the SHA's Workforce Modelling and Quality Assurance Tools. In doing this, the Cluster will ensure that workforce plans align to standards identified in the new National Education Outcomes Framework. This framework places obligations on providers to take responsibility for their training and education budgets and a key focus for the Cluster will be on ensuring that appropriate collaborative arrangements are in place to ensure the delivery of a coherent system wide workforce agenda.

Providers will be asked to monitor and comment on specific highlighted challenges; some ongoing from last year's plans; some new initiatives from the Department of Health. For example:

- High level recommendations for action arising from the Cluster's workforce plan submitted in July 2011 as summarised in Appendix 4
- The Health Visitor trajectory over the next three years as below: This has been calculated on attrition rates, 80% job uptake, leavers and turnover.

Health Visitor Numbers and Escalation combined Across Arden Cluster				
FTE	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Increases per year	26	28	20.1	0
Final Planned position	113.3	139.3	167.3	**187.4**
This demonstrates a total increase of 74.1FTE over the period which is in line with out combined target for increase				

- Infrastructure in place to support staff performance, ie, PDP and appraisal training needs analysis, staff survey action implementation, emerging recommendations arising from the Francis Report into Mid Staffordshire
- Provider plans to deliver the "Make Every Contact Count" agenda
- How staff are being trained to reach zero level pressure sore targets

The workforce agenda is reflected in the Cluster's Equality Delivery System Action Plan.

Appendix 5 summarises the specific measures that will be the subject of review at quarterly meetings between Cluster based human resources, medical and nursing colleagues.

Fluctuations in staff groups during 2011/12 and anticipated changes in 2012/13

Coventry & Warwickshire Partnership Trust does deliver a full range of community services for Coventry. Warwickshire Community services staff in Arden is now employed in Acute Trusts. Providers are reporting a reduction in 2012/13 of 412.41 wte. More work will be done to understand in detail which services this reduction relates to. Significant shifts of activity are anticipated to flow from the acute sector into the community in line with the frail older people transformation programmes being delivered, and detailed planning is underway to ensure that capacity is available in the community to cope with this shift.

The table below summarises workforce changes:-

Aggregated FULL-TIME EQUIVALENT PERMANENT STAFF IN POST across UHCW,GEH,CWPT,SWFT	**31 March 2012 Baseline**	**31 March 2013 Baseline**	**Differential**
Post TCS	**FTE**	**FTE**	**FTE**
Medical and Dental	**1,518**	**1,516**	-2.09
All registered nursing, midwifery & health visiting staff	**4,859**	**4,768**	-91.38
All Scientific, Therapeutic and Technical Staff	**1,830**	**1,754**	-76.00
Support to clinical staff	**3,736**	**3,604**	-132.60
NHS infrastructure support (managers and estates)	**2,643**	**2,533**	-110.35
All Staff in Post excluding Bank staff, Locums and Agency staff (FTE)	**14,587**	**14,174**	-412.41

3.3 Activity and Financial Performance

Coventry and Warwickshire PCTs are forecasting achievement of financial targets in 2011/12. Both PCTs are not without challenge; however the risk is low for NHS Coventry but high for NHS Warwickshire. This is in the context of significant QIPP (£41m) savings as part of those 2011-12 plans. Both PCTs are focused on mitigating these risks and forecasts remain to deliver financial control totals in both PCTs.

SWFT and CWPT are reporting forecasts that are at plan and no issues of financial risk have been identified. The remaining trusts, UHCW and GEH are also forecasting delivery of their financial plans, but have experienced significant pressure in doing this.

The pressures faced by GEH in 11/12 relate to a large extent from reduced activity from Leicester County and Rutland where the Trust has not benefited either from emergency marginal threshold relief or strategic change reserve allocations to compensate for the loss**.**

3.4 Performance Priorities 2012/13

Whilst this Plan highlights many achievements in 2011/12, the Cluster recognises the need to improve performance in a number of key areas.

Of major concern for the Cluster is the failure so far to achieve the required performance in A&E 4 hour waits, referral to treatment times and ambulance handover times in particular. Unacceptable hospital mortality rates will continue to be a major area for focus next year, as will actions to mitigate the risk of Never Events. NHS Healthchecks and access to NHS Dentistry also require continuing significant attention. Whilst eradicated in most Acute Trusts in Arden, there are still breaches of mixed sex accommodation occurring in SWFT.

The Arden Cluster CEO is supporting CCG Chairs and Chief Operating Officers to establish robust plans to deal with all poor performing areas by meeting personally with provider CEOs to agree remedial actions. Appendix 6 contains a very detailed summary of the actions being taken to address these areas and all other performance priority areas for 2012/13.

3.4.1 Tackling Poor Performance

Detailed Recovery Trajectories for Performance are set out in Appendix 7.

Unscheduled care QIPP plans implemented in 2011/12 had some, but insufficient, impact on A&E performance largely because they were focused too much on early supported discharge and not enough on admission prevention or, in the case of the latter, because they were slow to be implemented because of delays in recruitment or difficulties in changing clinical pathways and behaviours.

QIPP Plans for 2012/13 reflect the learning from last year. They focus to a greater extent than was the case in 2011/12 on new schemes designed to reduce demand on acute emergency services and on improving unscheduled care pathways and performance. The introduction of the QOF Quality and Productivity Indicators for A&E provide an opportunity for Cluster and CCG leadership to work together to incentivise general practices to make a valuable contribution to A&E performance.

The Cluster is introducing new governance and performance management arrangements to reflect the new accountabilities of CCGs. The Finance and Performance sub-committee of the Board is holding CCGs to account for their performance management of key performance targets and QIPP delivery, and provides assurance on delivery to the Cluster Board.

More detailed and sophisticated performance management reports for CCGs at GP practice level are being developed.

The national contract will be fully utilised to lever improvements in performance by Providers. Trajectories for 2012/13 are being reviewed as part of contract negotiations which are being led by the CCGs with clinician input. CCGs are also taking the lead in contract performance and clinical quality review (CQR) meetings with providers.

4 Priorities for 2012/13 (National, Regional, Local)

4.1 National Priorities

The Operating Framework sets out the national priorities for 2012/13. Action plans to address these priorities are outlined below:-

4.1.1 Dementia and Care of Older People

Measure	Current position and further actions	Deadline
Commissioners should ensure that providers are compliant with relevant NICE quality standards and ensure information is published in providers' quality accounts	The NICE Quality Standards are reviewed as part of the West Midlands Quality Review Service (WNQRS) and action plans are in place to address any deficits. These action plans are monitored through the CQR Part of all contracts to be compliant with NICE To communicate the need to publish these in Quality Accounts to providers	End March 2012
Commissioners should work with GP practices to secure ongoing improvements in the quality of general practice and community services so that patients only go into hospital if that will secure the best clinical outcome • Increase in number of GPs undertaking shared care for dementia patients. • Increase in numbers being referred to Memory Assessment Services • Review of numbers on dementia registers • Implementation of CRHT for organic patients (phasing to be determined)	MH GP leads are working on: • dementia task and finish group to support role out of shared care and shared care prescribing • review and redefinition of pathway for memory assessment services • peer support for improved diagnosis • shifting dementia services to a community model based on Crisis Resolution Home Treatment (Warwickshire initially with review and roll out to Coventry over the next five years) • support of third sector and wider community for those diagnosed and needing community support. (in partnership with LA)	12/13 Roll out within 5 years
Ensuring participation in and publication of national clinical audits that relate to services for older people	All providers took part in the National Dementia Clinical Audit for the Royal College. The Clinical Audit Programme is reviewed at CQR meetings. When audits for calls for participants are requested this is circulated to all Providers.	End March 2012
Initiatives to reduce inappropriate antipsychotic prescribing for people with dementia to improve quality of life with a view to achieving overall a two-thirds reduction in the use of antipsychotic medicines	'Reduction of Inappropriate Use of Antipsychotic Medication in people with Dementia' resource pack was developed and approved by Coventry and Warwickshire Area Prescribing Committee in September 2010 Use and implementation of this publication will be followed up. This will include: Newsletter to primary care; Distribution of comparative prescribing data; Use of QOF Med6 to drive change	30 April 2012

Improving diagnosis rates, particularly in the areas with the lowest current performance 11/12 data as baseline, re-evaluate with 2012/13	Peer support for improved diagnosis using QOF registers and confirm and challenge through CCG is now established	11/12 data as baseline, re-evaluate with 2012/13
The continued drive to eliminate mixed sex accommodation (the Cluster has a zero tolerance approach)	Performance notice has been issued to SWFT SW CCG is working with SWFT through urgent care QIPPs to reduce admissions and LOS to get occupancy down to 92% to eliminate MSA breaches	End March 2012
The use of inappropriate emergency admission rates as a performance measure for national reporting	Definition of inappropriate emergency admissions to be agreed Cohort of patients to be agreed	End March 2012
Non-payment for emergency readmissions within 30 days of discharge following an elective admission	Non-payment for emergency admissions following elective admissions within 2012/13 contracts to be agreed with acute providers	End March 2012
PCT Clusters should ensure that all providers have a systematic approach to improving dignity in care for patients, to giving staff appropriate training and to incorporating learning from the experience of patients and carers into their work	This is a part of all providers quality schedules and is monitored through the CQR	End March 2012
PCTs are asked to work with their local authorities and publish dementia plans which set out locally the progress they were making on the National Dementia Strategy, including any local or national CQUIN goals Completion of Dementia Plan with clear milestones, monitoring and governance arrangements	Warwickshire has a comprehensive multi-agency dementia plan which was agreed in 2011. There is an overarching Dementia Board with clinical commissioning and Public Health representation which is overseeing progress. The Warwickshire Board has made links with Coventry City Council colleagues in order to look at integrating approaches and creating an Arden Board	End March 2012
PCTs are required to assess the impact of service changes on their populations	An EIA will be carried out on the Dementia Strategy to inform this work stream	End March 2012

4.1.2 Carers

Measure	Current position and further actions	Deadline
Following a joint assessment of local needs, which should be published with plans, PCT clusters need to agree policies, plans and budgets with local authorities and voluntary groups to support carers, where possible using direct payments or personal budgets	Current policies cover the provision of support through DPs but not personal budgets (mental health personal budgets have been the priority to date). Joint contracting with AGE UK and Crossroads is delivered between NHSW and WCC for carers support in dementia and hospital discharge. This area has additional benefits to be explored. JSNA will be completed Whole cluster plan will be collated to consider the impact of movements of LA resource on the Market	May 2012 May-August 2012 April 2013 Sept 2012
Plans should be in line with the Carers Strategy	Joint Carers strategies will be checked for compliance in these areas. Carers Strategy will be corrected if non-compliant	April 2012 August 2012
To be explicitly agreed and signed off by both local authorities and PCT clusters		August 2012
Identify the financial contribution made to support carers by both local authorities and PCT clusters and that any transfer of funds from the NHS to local authorities is through a section 256 agreement	2011/12 £637k S256 cash transfer from NHSW to WCC Additional funds applied and need to be assigned correctly	May 2012
Identify how much of the total is being spent on carers' breaks	See above Additions of new carer night and day sit services in palliative care will be collated	
Identify an indicative number of breaks that should be available within that funding	End total for S256 transfer will be collated palliative care and dementia care services numbers will be added	March 2012
Be published on the PCT or PCT cluster's website by 30 September 2012 at the latest	Above actions will take place and strategy will be signed off at August board.	September 2012.
The impact of all commissioning decisions on carers should be considered	Every EIA has a section on carers	On going

4.1.3 Military and Veterans' Health

Measure	Current position and further actions	Deadline
SHAs should maintain and develop their Armed Forces Networks to ensure the principles of the Armed Forces Network Covenant are met for the armed forces, their families and veterans	For SHA Cluster action.	
The Ministry of Defence/NHS Transition Protocol for those who have been seriously injured in the course of their duty should be	The Cluster is committed to upholding the MoD/NHS Transition Protocol for military and veteran's health. It will support the implementation of the Murrison Report to improve access to mental health services by veterans	End March 2012

implemented, meeting veterans' prosthetic needs and ensuring improvement in mental health services for veterans		
NHS employers should be supportive towards those staff who volunteer for reserve duties	In place across Cluster. Many Cluster staff have volunteered for reserve duties and have been supported to do so by their employer organisation	On-going

4.1.4 Health Visitors and Family Nurse Partnerships

Measure	Current position and further actions	Deadline
SHA and PCT Clusters should work together to deliver the number of health visitors required as part of the Government commitment to increase the number by 4,200 by April 2015	The increase in health visitors by 2015 is 98.6 wte. Effective communication will ensure that the number of student placements commissioned by the SHA have access to train within the Arden Cluster if that is their preferred choice. Training for other Clusters will be offered in line with increased capacity An SHA funded project manager is being recruited to drive forward the implementation of the new service model and workforce	2015 2012 – 2013
Commissioners should ensure that new health visitors coming through the expanded training pipeline are effectively supported and deployed	The number of Community Practice Teachers is being increased to enable an increased number of student placements year on year and the provision of 1:1 support for newly appointed health visitors. A peer mentorship programme and action learning sets have been developed. Priority deployment will be in line with areas of greatest deprivation and need	2012 – 2015
The increased number of health visitors will ensure improved support for families through the delivery of the Healthy Child Programme and the Family Nurse Partnership programme	Service specifications have been developed in line with the requirements of the Healthy Child Programme (HCP) 2009, and key performance indicators are monitored quarterly. In Warwickshire over 50% of the health visiting teams are co-located within Children's Centres and the health visitors' caseloads are organised geographically. The HCP Board in Coventry is driving the redesign of the Health Visiting service to enable progress towards meeting the requirements of HCP. The full delivery of HCP across the Cluster is reliant on the expansion of the HV and FNP services by 2015	2012 - 2015
PCT clusters are expected to maintain existing delivery and continue expansion of the Family Nurse Partnership programme in line with the commitment to double capacity to 13,000 places by April 2015, to improve outcomes for the most vulnerable first time teenage mothers and their children	The FNP programme in Coventry is increasing by 3 wte during 2012. A further 11 wte Family Nurses will be required across the Cluster to meet all identified needs in line with the current population. This additional workforce will be developed in line with the health visitor expansion to be delivered by 2015. Project management arrangements are in place to ensure the national objectives are achieved prior to transfer to Public Health or CCGs	2012 – 2015

4.2 SHA Cluster Ambitions

4.2.1 Eliminating Avoidable Grade 2, 3 and 4 Pressure Ulcers

Avoidable pressure ulcers are a key indicator of the quality of nursing care. Elimination of Grade 2, 3 and 4 pressure ulcers is being taken as an outcome measure for nursing care which includes: hydration, nutrition, pressure area management and individualised care for patients in acute and community providers.

Patients developing pressure ulcers face longer lengths of stay in hospital with the associated heightened risk of acquiring a healthcare acquired infection plus a reduction in their ability to return rapidly to their pre-hospital state, resulting in either a prolonged period of reablement or a long term residential care placement.

Delivery of this ambition is well aligned to local strategic priorities and QIPP schemes which are aimed at minimising lengths of stay in hospital and returning patients to reablement/rehabilitation services in the community as soon as possible in order to reduce the volume of long term residential care placements. Trajectories are being worked up with CQUIN schemes currently to deliver this objective.

The aim is to achieve zero reported avoidable Grade 2, Grade 3 and Grade 4 pressure ulcers by March 2013.

Measure	Current position and further actions	Deadline
Zero reported avoidable grade 2, 3, 4 pressure ulcers	Base line data collected	March 2012
Zero reported avoidable grade 2,3,4 pressure ulcers	CQUIN in place to reward practices	March 2012
Zero reported avoidable grade 2,3,4 pressure ulcers	Education programs rolled out, including to LAs	June 2012
Zero reported avoidable grade 2,3,4 pressure ulcers	System wide recording and reporting agreed	June 2012
25% reduction on March 2012 baseline	Average over Q1	June 2012
50% reduction on March 2012 baseline	Average over Q2	September 2012
75% reduction on March 2012 baseline	Average over Q3	December 2012
100% reduction on March 2012 baseline	Nil cases by Q4	March 2013

4.2.2 Making Every Contact Count Through Systematic Healthy Lifestyle Advice Delivered Through Frontline Staff

This ambition aims to ensure that when appropriate, and whenever possible, NHS staff support people to make positive changes to their life to improve health and well-being. Staff will do this by using consistent and simple lifestyle advice combined with appropriate signposting to lifestyle services.

Linked to the local strategic priority of addressing obesity, smoking, drug and alcohol consumption, and sexually transmitted diseases and teenage pregnancy, this ambition supports and aligns with local preventative QIPPs.

Measure	Current position and further actions	Deadline
PCT clusters need to have systematic plans in place to deliver the SHA's ambition to Make Every Contact Count (MECC). This will require the delivery of MECC to be more systematic and for it to be delivered on an industrial scale in NHS organisations in the first instance	Existing activities to deliver MECC will continue across Coventry and Warwickshire Health and Social Care as previously agreed Provisional plans will be drawn up to support delivery of the revised MECC requirements and the resources required to support delivery in 2012/13 will be estimated. This will require the active engagement of CCGs and Trust boards, with champions identified A detailed plan to identify the additional action required to meet the SHA ambition to deliver MECC by NHS organisations across the cluster will be completed (guidance anticipated March 2012) A training plan will be drawn up together with a specification for additional training to be commissioned to meet the ambition. This will include meeting monitoring and evaluation criteria and other stipulations anticipated in the guidance Training of frontline staff to commence	Ongoing March 2012 May 2012 June 2012 August 2012

4.2.3 Significantly Improve Quality and Safety in Primary Care

Primary medical care is the cornerstone of the NHS, providing the majority of patient contacts. Access, coordination and continuity are the key offers of effective and efficient services. However, quality and safety can be variable and there is currently no defining set of measures for quality in primary care.

Reducing variation in quality to improve overall quality in primary is a key strategic local priority and crucial in supporting overall system transformation. This will be done through:

- Robust and consistent monitoring of relevant metrics through an agreed monitoring system
- Strengthened medical appraisal that will use these metrics to support the quality agenda
- Board reporting on primary care performance based on these metrics that will provide assurance
- Clear links into the Primary Care educational system to ensure that skills and knowledge are appropriate for the proposed changes
- Close working relationships with CCGs to ensure sufficient peer review and mentorship to improve performance

The Cluster will focus on the SHA's 4 specific objectives and will work with the SHA to maximise the effectiveness of a standard benchmarking tool.

Measure	Current position and further actions	Deadline
Develop emerging clinical commissioning groups to undertake quality assessments of their practices, and to support quality improvement	Quality benchmarking tool will be agreed for use across the Cluster CCGs will peer review practices falling short of required standards and offer support and education	On-going
Significantly reduce the prescribing of	CCG prescribing leads will work with CSS Prescribing Advisers to identify outlier	On-going

quinolones and cephalosporins, broad spectrum antibiotics associated with C Difficile	practices through benchmarking and offer advice and guidance to bring rates down	
Improve management of patients taking the anti-coagulant Warfarin	Through work on long term condition management GPs will be encouraged to work to best practice guidelines and will be monitored on this through the benchmarking tool	On-going
Ensure patients receive the best quality of care for managing their diabetes	Through work on long term condition management, GPs will be encouraged to work to best practice guidelines for management of Diabetes in primary care, working closely with Specialist Diabetes Teams	On-going
	The Cluster's Equality Delivery System has sections on improved patient experience; the EDS will be strengthened to reflect the primary care quality and safety agenda and targets will be created for improving primary care as part of EDS Action Plan	

4.2.4 Ensuring Radically Strengthened Partnership Between the NHS and Local Government

The Arden System recognises the need to work closely with the Local Authority in order to deliver system-wide transformation, and Local Authority leads are well represented on the System Board and Clinical Senate alongside CCG, Cluster and Provider leads. Specific components of work with the respective Local Authorities include:

Measure	Current position and further actions	Deadline
Support CCG development to embrace partnerships with local Government including via membership of H&WBB, Local Strategic Partnerships and Local Health Resilience Partnerships	CCGs are members of the HWBB and participate in the production of the JSNA and in establishing commissioning priorities. Membership of local strategic partnerships is developing and CCG membership of LHRF and future LHRP is being arranged	April 2012 and ongoing
Establish policies and systems to deliver integrated commissioning, including appropriate joint governance finance and performance monitoring	Joint commissioning arrangements already exist for a number of public health programmes including sexual health, mental health and drug and alcohol services. Strong collaborative working is in place for mental health, learning disabilities, older people's and children's services commissioning. Governance and priorities will be reviewed further during 2012/13 as CCGs take over leadership of this agenda	February 2012 and ongoing
Establish Task and Finish Groups to determine KPIs/KLOEs with representation from Local Government networks, CCG chief officers, PCT Clusters, DsPH and Patient Voice Leads	Joint work on KPIs takes place for established joint commissioning. Further work will be undertaken to extend this to cover all programmes of work including commissioning priorities identified by the JSNA and HWBBs	February 2012 and ongoing

4.2.5 Create a Revolution in Patient and Customer Experience

4.2.5.1 Foundation Stone for the Patient Revolution

The Cluster has a strong track record of embedding patient and public involvement in its work which will act as the foundation stone for the Patient Revolution. Work on the Patient Revolution will build on this previous experience and will aim to continue the process of ensuring that patients are at heart of every decision being made.

Over the past year, the Arden Board has invited patients, service users and carers to attend Board meetings to share their experiences of using health services. The initiative has been extremely positive. Patients share views about how services could be improved; communication and staff attitude are common themes raised. Issues raised are reflected in Provider contracts, quality specifications and performance indicators where appropriate.

Pilot work undertaken in 2010 to embed engagement into all decision making, by taking to the local population about how health service funds should be spent, is also being built upon. For example, a computerised 'Wheel of fortune' has previously been used to develop understanding of the costs of various clinical procedures and of the appropriate conditions to present to A&E with. Local communities have also been asked for ideas about how best to get key health service messages across in local areas. All sections of the population are involved; people with learning disabilities, mental health issues, children and young people's groups, as well as meetings with large cross sections of the community. A video of the approach taken for the pilot, including the initial planning sessions with commissioners, was made for the Department of Health and evaluation showed that this innovative way of talking to local people about difficult decision making was a good way to educate people about commissioning intentions.

Arden's membership also provides a strong basis for patient and public involvement. There are 4000 active members across Warwickshire and 2500 'Join the Conversation Champions' in Coventry. These membership groups are used to test ideas, obtain valuable information for research purposes and in the development of commissioning plans.

4.2.5.2 Strategic Approach

Board-level leadership is key to the Patient Revolution becoming a reality and Director Leadership of this agenda is provided by Fay Baillie, Director of Nursing, Non-Executive Director leadership is provided by Janet Smith.

The Cluster is working with the NHS Institute and 'In Health Associates', on behalf of the Department of Health, to refresh the 'engagement cycle' approach to involving patients and local people at every stage of the commissioning cycle. A template drawn up by the Arden Public and Patient Involvement Team for capturing user experience feedback and for recording actions taken, is held up as a good example of how to document and conduct engagement activities and is be made available nationally. This new approach will be adopted by Providers and CCGs.

Arden's CCGs are committed to embedding a robust approach to using patient feedback. For example, South Warwickshire CCG has recruited a lay Chair to its Authorisation Board. The CCG's 'No decision about me, without me' PPI working group is chaired by a GP and it has a number of local patients on it that are helping the CCG to embed engagement into all areas of the emerging organisation. The 'engagement cycle' framework is being used and the aims of the Patient Revolution are central to the approach.

4.2.5.3 The Friends and Family Test

The Cluster recognises that there are many ways to benchmark patient engagement and experience data, but that there is no systematic approach to identifying the actions that have been taken to improve the patient experience. The 'Family and Friends Test' will be adopted in Arden as a simple indicator of the 'net promoter' to measure the success or otherwise of local patient experience improvement activities. The use of a standardised net promoter question will allow CCGs to judge the relative performance of Providers

.

There will be a patient experience CQUIN for each Acute Provider using the Patient Revolution net promoter question and methodology. Regionally mandated sample size and reporting will be adopted from the 1st April 2012. The aim will be to improve Acute Provider scores by 10 points over the year, or for Providers to be in the top quartile of performance.

The 'Friends and Family Test' will be embedded into non-Acute Provider patient surveys from 1st April 2012. The Cluster will adopt the standardised approach to implementing the net promoter question in non-acute settings when the Regional approach has been confirmed.

4.2.5.4 Revolution into Action

The Cluster's Creating a Patient Led Revolution Action Plan, outlined in Appendix 8, will deliver a transformation across the '3 Cs' that define the 'Patient Revolution' through:

- **Driving greater co-production between patients and professionals**
  An example of this for Arden is the embedding of patient representatives in the work of CCGs. For North Warwickshire CCG this involves a patient representative sitting on the CCG Board.
- **Delivering greater community participation between the public and the service**
  An example of this is the strengthening of public engagement work with the local population ahead of the major service reconfigurations planned this year including: paediatrics and maternity and dementia services
- **Improving the customer experience of patients and carers**
  An example of this is ensuring that Providers not only monitor patient experience through the net promoter, but that they use the data from the test to improve patient experience

4.2.5.5 Utilization of Real Time Data

CQUIN indicators for 2012/13 will measure the extent to which Acute Providers

- have real time systems in place to monitor the patient experience,
- demonstrate improvements in patient experience using the net promoter score,
- demonstrate clear commitment from Board to ward to improve patient experience.

By the end of 2012/13, CWPT will have developed real-time and non-real time systems to monitor patient experience in specific areas of community services, eg, clinical assessment services; within 48 hours of discharge; long-term conditions; at the point a patient is ready to 'step down'; diabetic patients under the care of District Nurses; during on-going care. Patient experience stories will be collected and acted upon to inform service development and redesign. CWPT will be able to demonstrate improvements in patient experience within the specified areas, using a range of methods including the 'net promoter score', and to evidence clear commitment from Board to 'clinic/practitioner' to improve patient experience. There will be mechanisms in place to share the patient experience themes with all staff, so that lessons can be learnt and good practice shared across all services.

4.2.5.6 Improving Quality and Safety in Primary Care and Contribute Towards the Elimination of Grade 2, 3 and 4 Pressure Ulcers.

Cluster activities to eliminate avoidable grade 2, 3 and 4 pressure ulcers by December 2012 include a rigorous system to monitor pressure ulcer numbers and track reductions.

Serious Incident Management and Monitoring
There will be standardised Cluster wide systems management of all grade 3 & 4 pressure ulcers serious incidents involving:

- a review process to check all grade 3 & 4 pressure ulcer Root Cause Analyses (RCA) to classify into 'avoidable' and 'unavoidable' categories, with contributory factors
- discussion of grade 3 & 4 pressure ulcers at monthly Cluster wide Patient Safety and Quality Group meetings
- monthly review and monitoring of grade 2, 3 & 4 pressure ulcers at Clinical Quality Review meetings with Providers
- quarterly review by the Quality Safety and Governance Committee
- quarterly review by the Cluster wide Serious Incident Forum

Safety Thermometer
The National NHS Safety Thermometer (ST) has been adopted by all Arden Providers with base line data collected on the 15th February as part of the national roll out. To support data collection Providers have been incentivised through a CQUIN scheme. The elimination of grade 2, 3 & 4 avoidable pressure ulcers is a contractual requirement for 2012/13.

Communications
The Arden Cluster Communications Plan includes tracking of pressure ulcers through:-

- weekly communications conference calls
- quarterly Communication Team meetings

In addition, there will be a Cluster wide launch event to establish and promote use of care bundles, ulcer prevention, treatment of established ulcers and audit mechanisms.

Forward Planning

- With the establishment of the Intensive Support Team, the Director of Nursing with a visiting team of experts and peers will review practice and give advice on how pressure ulcer prevalence can be reduced
- A set of protocols and care bundles covering skin assessment, ulcer prevention and the treatment of established ulcers, including a set of audit measures, will be disseminated via a cluster wide launch events and reports provided on a monthly basis

Research
The Cluster is currently engaging in a research study to expand the knowledge base relating to patient safety and organisational culture within health care settings. This includes:

- A baseline assessment of the current position relating to learning following Serious Incidents (SIs)
- Identification of all SI RCAs investigation reports received in the last two years from all Providers
  - Cross matching against National Framework and categorising by incident type in order to identify most frequently occurring incidents
  - Identification of key themes, trends and lessons learnt

- Development of a questionnaire (using semi structured interview) to identify dissemination mechanisms or strategies currently being used by Providers to cascade significant learning following SI investigations
- Use of the Cluster Wide Serious Incident Forum to establish a Provider governance focus group to better understand the implementation of learning following SIs

The Arden System recognises that putting patients and the population at the heart of planning and monitoring health services is critical to achieving a transformation in the way patients experience those services.

Recent patient surveys highlight areas where patient experience of some services at CWPT and GEH is poor. Both Trusts have implemented a number of changes to bring about improvement. Action plans are resolving identified issues and use is also being made of bedside reporting and NHS Choices.

Measure	Current position and further actions	Deadline
Patient outcome measures improved from base line	Set out vision to Board Gain baseline survey from members	May 2012
Patient stories demonstrate change in customer care experience	Review results	July 2012
Patient choice report reduced dissatisfaction	Develop marketing material to energise and start the revolution	Sept 2012
	Targets will be created for improving patient experience as part of the Cluster's Equality Delivery System Action Plan	

5 Transition and Reform

Plans are well developed in the Cluster to exploit the opportunities presented by the introduction of the health reforms. The Cluster will use these opportunities to:-

- liberate CCGs to shape, with key stakeholders, the way services are designed and delivered to local populations,
- strengthen dialogue with local authorities about the way in which the public health of the population can improve as a result of the gains to be made from public health departments sitting alongside other local authority departments whose services are instrumental in improving the health and well-being of the population,
- influence, through HWBBs, the way in which the whole system works together to shape future strategy,
- embed more strongly the patient voice at the centre of all that is done,
- ensure that as the new system architecture matures, this System Plan is shaped with partners such as to leave a strong legacy of commitment and ambition for others to take forward.

In doing all of this, it is recognised that these are extremely difficult and challenging times. Cluster staff are being required to deliver the day job and to shape innovative and challenging service transformational change in partnership with CCG and Provider colleagues in the face of uncertainty about the future. Building in resilience is a key priority for the Cluster:-

- Chief Operating Officers were appointed to CCGs in June 2011
- The majority of the Cluster's commissioning and other support staff have been moved into the Commissioning Support Service
- CCGs have published commissioning intentions for 201/13 and are leading contract negotiations with providers. CCGs have taken on lead commissioner roles on behalf of other CCGs
- Roles have been redefined to achieve greater efficiency and effectiveness from the staff remaining in the Cluster. Providing support to CCGs in the way they would wish remains a challenge however in the face of too few staff to allocate to individual CCGs
- Comprehensive Public Health Transition Plans are in place. The Warwickshire Public Health Department has already moved to Warwickshire County Council offices. The Coventry Public Health Department is set to move into Coventry City Council (Chief Executive's Department) in early April
- Briefings and other support for staff have been strengthened in order to ensure that staff feel well supported over the transition period
- A Clinical Senate and a System Board are established, comprising members from all NHS and LA partner organisations, for the purposes of providing clinical and whole system perspective and leadership during the transition and beyond

5.1 Cluster Development

The Arden Cluster was formed in April 2011 with a new Chief Executive and a single Executive Team (Primary Care Medical Director; Acute Medical Director; Director of Nursing; Director of Finance; Director of Delivery; Director of Commissioning Development; Transformation Programme Director; Director of Governance Systems and Two Directors of Public Health).

In November 2011 a single Cluster Board was established to discharge the respective statutory functions of the constituent PCT Boards.

The Arden Cluster has been rapidly re-structuring to maximise and retain scarce, skilled commissioning staff. The Cluster will achieve its running cost savings targets for 2011/12.

The Board recognises the importance of maintaining a focus on inclusion over the transition period and is utilising individual coaching provided through the NHS Leadership Council to support Board member understanding of the impact of decision making on equality, diversity and inclusion.

5.2 Commissioning Development

A Programme Management approach is being adopted to take forward plans for the new commissioning architecture. This approach will:

- maintain the integrity of the system as a whole;
- provide assurance that emerging organisations can maintain the level of performance that is required in order to deliver "Business as Usual";
- ensure that the transition to the new commissioning architecture is managed in an efficient and coordinated way; and
- ensure that locally defined benefits are delivered.

Within the Cluster projects have been established to:

- establish CCGs that will be fit for authorisation;
- develop Commissioning Support Services;
- manage the transition of Primary and Family Health Service Commissioning to the NHS Commissioning Board;
- manage the transition of Public Health departments to Local Authorities (including the requirement of commissioning support to this function);
- continue the development of Joint Commissioning with the Local Authority; and
- manage the transition of the existing cluster as it moves into its new role and organisational form.

5.2.1 Any Qualified Provider

Following publication of implementation packs for Adult Hearing and Podiatry on NHS Supply 2 Health in December 2011, and confirmation of the outline specification for Wheelchair Services earlier in January 2012, work is underway at a local and regional level to deliver this agenda.

The Cluster is working with other Clusters across the region on specifications to be taken forward, paying attention to identification and management of risks associated with unwinding existing contractual arrangements, eg, notice periods and variation clauses.

This has resulted in combined submissions across local Clusters with shared 2012/13 implementation priorities and in engagement with national Qualification Centre Activity. A local Cluster Implementation Plan is currently being reviewed by the SHA. Contractual values and volumes for priority areas have been aggregated to support collaborative procurement which is being taken forward by HCS.

5.2.2 Clinical Commissioning Groups

The Cluster started the year with 6 clinical commissioning groups. Following national guidance on CCG Authorisation, pre-authorisation risk assessments have been carried out by the SHA. Of the proposed CCGs, only 1 (South Warwickshire) meets all the criteria for authorisation. Rugby and Coventry need to address the specific challenges of size and member engagement respectively to progress, whilst Nuneaton and Bedworth and North Warwickshire need to address issues of geography (member practices) and size (in the case of Nuneaton and Bedworth).

Rugby and Coventry are currently discussing the potential to form a single Coventry/Rugby CCG configured in support of UHCW/St Cross patient flows. Consultation with member practices is expected to conclude by mid-March to enable operation in 2012/13 on a single CCG basis. Both Local Authorities have indicated informally that they would support this configuration.

Given the difficulties in achieving a suitable configuration in Northern Warwickshire, there is ongoing work within the Cluster with SHA involvement in order to agree a configuration for the north of the County by the end of March 2012 at the very latest. This includes: sourcing external mediation/facilitation; LMC involvement; and potential input by the National Director of Commissioning Development. Whilst pre-authorisation risk assessments will not be repeated, both groups of GPs are clear that their current configuration does not support authorisation and that they are now potentially putting their authorisation timetable at risk.

During 2011/12 South Warwickshire, Coventry, Rugby and North Warwickshire CCGs were established as formal sub-committees of the Cluster Board and have taken on formal delegated responsibilities from November 2011 for:

- 2011/12 contract management
- 2012/13 contract negotiations
- 2011/12 QIPP delivery (selected schemes)
- 2012/13 QIPP planning and delivery – all schemes except those relating purely to Direct Commissioning activities (e.g. primary care contracting).

With respect to contract negotiations, the 4 provider contracts have been delegated to CCGs (as lead commissioners) as follows:

- South Warwickshire CCG — South Warwickshire FT (acute and community services)
- Rugby CCG — Coventry and Warwickshire PT (mental health and learning disability services)
- North Warwickshire CCG — George Eliot Hospital Trust
- Coventry CCG — UHCW and CWPT (community services)

Once successfully negotiated by the lead commissioner, working in collaboration with associates, all contracts will be broken down to CCG level (activity and finance) to reflect the split of agreed QIPP plans at a CCG level. In-year performance monitoring will occur at CCG as well as PCT level.

A Delegation Pathway, Assurance Framework and revised Scheme of Delegation were approved by the Cluster Board in November 2011 to support further development and delivery of activities by the CCGs. From the 1st April 2012 CCGs will assume delegated responsibility for all the commissioning functions they will be responsible for from 1st April 2013. An updated Scheme of Delegation reflecting the delegation of all appropriate budgets to CCGs will be taken to the March 2011 Board meeting in preparation for this. CCGs are held formally to account for their delivery against the Assurance Framework through the Cluster's Finance and Performance Committee

Once established in authorisable form CCGs will continue their journey with a focus on Development Plans (based upon the results of their self-assessments) and on Delivery Plans, the latter being the vehicle for local implementation by CCGs of the System Plan. Progress with implementation will be monitored through CCG sub-committees with their development driving individual CCG thinking on Do/Share/Buy options. CCGs have confirmed that they wish to aim for full authorisation by April 2013 and a Cluster-wide transition plan for CCG development has been established to ensure all CCGs are able to achieve this goal. Agreement has recently been reached on an internal process to enable the appointment of interim managerial Accountable Officers (or lead managers), as appropriate with the aim of having people in post by April 2012.

In respect of Shared Operating Model milestones for 2011/12, the position at the end of December 2011 was as follows:-

Milestone	Progress
July 2011 Clusters will ensure that 90% of practices are in CCG pathfinders	Achieved
August 2011 By August Clusters will have begun ensuring that a clear percentage of budgets are delegated to CCG pathfinders	Achieved.
October 2011 All CCG pathfinders to have completed self-diagnostic or equivalent	Achieved
October 2011 Clusters will have ensured that a clear percentage of budgets are delegated to CCG pathfinders, with a trajectory for future delegation	Achieved. Delegation pathway and Assurance Framework agreed with CCGs – approved by November PCT Cluster Board
October 2011 All practices to be within an emerging viable CCG	Partially achieved (Northern Warwickshire configuration issue)
December 2011 Clusters to have agreed with prospective CCGs their do/share/buy options and their commissioning support arrangements	Initial discussion held by deadline. Detailed discussions will continue in February and March 2012 given configuration risk issues in parts of the Cluster and the need to work through the role of the Arden 'Federation' of CCGs

5.2.3 Commissioning Support

The Arden Commissioning Support Service (CSS) was established in September 2011 comprising the vast majority of Cluster staff, other than those whose destination has either been defined as the National Commissioning Board or Local Authorities. A prospectus has been produced for the CSS and discussions have taken place with CCGs in respect of 'Make/Share/Buy'. It is anticipated that the first pass of the make/share/buy decisions from CCGs will be completed by the middle of February from which CCGs will specify the functions required from the CSS. Further iterations will be undertaken in March and April in order to refine the CSS functions and as clarity on 'share' and the national footprint for some functions is provided. During 2011/12 the CCGs have used the CSS for all commissioning support whilst they focus on developing their organisations; this position is likely to change however with the assignment of staff to CCGs between April and October but all CCGs have confirmed an ongoing commitment to the CSS. Discussions have been held with a neighbouring Cluster regarding opportunities to deliver some functions on a larger footprint and these are likely to be business intelligence and HR. The Operating Framework for 2012/13 milestones suggests the Make/Share/Buy work will need to be completed by the end of January 2012. In practice, given the outstanding issues in relation to CCG configuration, this timescale is likely to slip in the Arden Cluster to the end February

The Arden CSS received positive feedback on its submission for checkpoint 1 in December, receiving a green for leadership and amber in other areas.
It is now proposed to establish the CSS as an arm's length organisation in April 2012 as a subcommittee of the Cluster Board.

Work is also underway to produce an outline business case for Checkpoint 2 at the end of March 2012. The Business Case will include an initial consideration of the shortlisted options for future organisational form. It is anticipated that the CSS will be hosted by the NCB for a short period.

In summary, in respect of Shared Operating Model milestones for 2011/12, the position at the end of December was as follows:-

Milestone	Progress
June 2011 Clusters to have completed business review stocktake of commissioning support	Achieved
September 2011 Clusters to begin Phase II of commissioning support review	Achieved
October 2011 Clusters to have supported agreed Right to Request proposals to become successful establishments	No requests received

5.2.4 Direct Commissioning

The Cluster's two Primary Care contracting teams came together under the leadership of the Director of Commissioning Development in April 2011, the FHS functions of Registration and Screening having historically been provided on a cross-Cluster basis. Progress has been made against milestones in the Shared Operating Model for 2011-12 as follows:-

Milestone	Progress
September 2011 Clusters to have identified staff currently involved in directly commissioning primary care, specialised, prison health and military services	Achieved
September 2011 Clusters to input into the development of a single approach to primary care contract performance for delivery by April 2012	Achieved
September 2011 Clusters to have identified how they provide the services described in the draft national FHS schedule and the staff involved in this work. They should have established how they are linked into the national work and from this how they are moving to standardising their services across the Cluster to that described in the draft national specification. It is envisage that by December 2011 to have achieved standardisation within the Cluster, and have clear plans for rationalisation, where appropriate	Achieved as appropriate based on the information available nationally
December 2011 Clusters to have completed cataloguing existing contracts for primary care, prison and custodial health and offender health according to a national template setting out the broad contents of the contracts and their state of readiness for handover to the NHSCB. In addition, Clusters to have completed a cataloguing of primary care premises according to a national template to ensure that the NHSCB has a robust record of the current primary care estate	Contract cataloguing submission made December 2011.As a result, the Cluster has a detailed understanding of the work to be undertaken to ensure all primary care contracts will be ready for transition to the NHSCB Guidance is awaited on the cataloguing of primary care estate

A management re-structure has occurred at the tier below director level to create two Associate Heads of Primary Care, focusing on GP and Optometrist, and Dental and Pharmaceutical contractors respectively (plus other associated roles). The remainder of the staff within primary care contracting have been aligned across Coventry and Warwickshire to form a single team, working to consistent policies and procedures. No further re-structuring will occur until further national guidance emerges. It is fully understood that members of staff undertaking direct commissioning functions are eligible to transfer to the NHS Commissioning Board (ie, those working in primary care). Further work may be required, as further guidance emerges, to determine the appropriate transfer destination of those staff undertaking primary care quality or primary care information roles.

Work has commenced via the Arden Registration and Screening function on a full review of practice-registered lists. Registration and screening staff are working closely with general practices to ensure any identified anomalies are rectified by March 2013. The 'clean-up' of registered lists is an on-going process to ensure 'ghost patients' are regularly identified and removed.

The Milestone Tracker is attached at Appendix 9

5.2.5 Arrangements with Local Authorities for Public Health

Transition plans have been agreed with Local Authorities in respect of the transfer of Public Health functions. They were signed off by the Cluster Board in November 2011. See Appendices 10 and 11

The Coventry transition plan for the Public Health transfer consists of 4 key stages:

Stage 1 – Assessment	September-November 2011
Stage 2 – Design	November- February 2012
Stage 3 – Construction	February- June 2012
Stage 4 – Implementation	July-December 2012

Detailed work programmes are being overseen in the following areas: Health Protection, Health Improvement, Population Health (including the core offer) and the Wider Determinants of Health. In addition, there are underpinning workstreams on Finance, Human Resources, Accommodation, Data and Information.

Within Warwickshire the transition plan for Public Health is being overseen by a Health Transition Strategic Group, chaired by the Deputy Leader and Portfolio Holder for Health for the Council. There are 6 key strands:

1 Finance
2 HR and workforce development
3 Information Management and Technology
4 Accommodation
5 Communications
6 Cross Cutting Issues.

HWBBs for Coventry and Warwickshire will be operating in shadow form April 2012 with wide-ranging membership, including CCG Chairs. Coventry City Council has agreed that the Director of Public Health will report directly into the Chief Executive; Warwickshire County Council is not, as yet, of the same view. This is being pursued by the Cluster Board given the importance of this role within the Health and Social Care system.

The Cluster continues to support the development of HealthWatch with both local authorities, working closely with Coventry and Warwickshire LINks to ensure the patient's voice is heard. The Cluster is fully supportive of the local LINks' place at the HWBBs. The Cluster is also working with LINk to support them in providing representation in key health economy workstreams and in pieces of work undertaken by the CCGs. At each Cluster Board meeting, a patient joins the Board to tell their story, giving the Board a unique insight into their experience and providing them with the opportunity to ask questions and receive patient views direct.

5.3 Provider Development

Arden has 1 Foundation Trust and 3 in the pipeline. SWFT was authorised in March 2010.

UHCW is currently in discussion with the SHA about a new trajectory and TFA timeline.

GEH's TFA was signed off in September 2011. The trust is leading a process to identify a partner in order to achieve foundation trust status. Its Foundation Trust preparation project, '*Securing A Sustainable Future'*, is working to the following milestones:-

Full Business Case	Nov 2012
Contractual Agreement	Dec 2012
Implement	Apr 2013

CWPT is the most advanced in the pipeline. Its TFA was signed off in May 2011and the Trust will be in the consultation phase from 21 November 2011. The expected authorisation date is January 2013 and CWPT is currently on track with its TFA milestones.

Coventry and Warwickshire PCTs' community services were successfully transferred to CWPT and SWFT on 1st April 2011. Maximising the potential of these transfers to support transformation of services is now a key strategic priority for the Arden system.

Should any TFA slip or should any Provider face a real risk of not attaining FT status, the Cluster will agree with the SHA an appropriate course of action in partnership with Provider CEOs.

5.3.1 Impact of Commissioning Plans on TFA proposals

The following change proposals require consideration within TFA proposals:-

- Service change proposals will transfer a significant proportion of unplanned hospital activity (largely for frail older people) into the community, in Coventry the Coventry & Warwickshire Partnership Trust as lead community provider for Coventry, will play a significant role in the delivery of pathways outside of the hospital. An early analysis suggests that the hospital with the biggest potential to shift activity is UHCW, with upwards of 2500 fces potentially suitable for community based care. There is similar potential but on a smaller scale at the other 2 Acute Trusts. The analysis is, however, being subject to further scrutiny at the time of writing this Plan. This shift presents opportunities for Acute Trusts, on the one hand, to free up capacity for more appropriate activity and, on the other, to support delivery of pathways outside of hospital. It is estimated that acute bed requirements as a result of the frail older people programme will reduce by between 150 and 200 by the end of the Plan period, although further analysis of the data is required before this can be confirmed. Further analysis is being undertaken with the support of the SHA to forward project acute demand and capacity requirements. By the end of May planning assumptions will have been tested and agreed with Acute Trust, community care and primary care clinicians.

- The Cluster and provider Medical Directors are jointly developing terms of reference for a programme of work designed to deliver sustainable acute specialties for the future. The Clinical Senate has accepted that there needs to be a reconfiguration of some specialties along network lines and that there is a need to look closely at the case for centralizing some elements of emergency general surgery, at the most appropriate hospital.

- There is a commitment to maintaining 3 viable Acute Trusts in Arden and this work will consider proposals for how services could best be configured between hospitals in order that each remains viable and plays to its strength in the future.

- The review of paediatric services in North Warwickshire will impact on the range of paediatric, and possibly maternity, services provided on the GEH site. Currently, proposals to develop a network arrangement between GEH and SWFT are being reviewed by the Royal College of Paediatrics and Child Health (RC). The view of the RC is expected to be confirmed by the middle of March. If proposals are recommended then the extent of service transfer will be limited to paediatric inpatients (from GEH to UHCW). If they are not and, as a result, the Cluster's Medical and Nursing Directors are unable to recommend proposals to the cluster Board, all obstetrics services will need to move. In these circumstances, GEH has confirmed that out of hours gynaecology will also move. Local access to some form of paediatric assessment service, plus obstetric outpatients will remain at GEH. The major risk around this for UHCW is the need to assure relevant stakeholders that it can cope with this extra activity and there are infrastructure implications; these issues are covered in the Paediatric and Maternity Business Case. From an income perspective, there is agreement among CEOs that a local tariff for paediatrics will be agreed in order that neither Trust loses financially as a result of the transfer of paediatrics.

- Service change proposals affecting CWPT are fully understood and agreed.

5.4 Arrangements with Local Authorities

Both PCTs have historically had joint or lead commissioning relationships with their respective Local Authorities. During the next 12 months, with strong CCG engagement, there will be a comprehensive review of these arrangements. Arrangements will be changed where appropriate to ensure fit for purpose, well governed arrangements that will underpin the delivery of transformation across the System and effective use of S256 in support of this.

Given the number of CCGs within the Cluster it is envisaged that lead CCG commissioning arrangements may well apply in respect of this work.

There is also dialogue with the Local Authority in respect of commissioning support arrangements.

6 Financial Analysis and Activity Projections

6.1 Financial Year 2011/12

The Cluster is forecasting delivery of its control total surplus of £6m and all other statutory financial duties for the year.

The 2011/12 system plan identified a Cluster QIPP requirement for the year (net of investment) of £63m. This position was based on an assessment of the anticipated commissioning expenditure requirements and the need to comply with Operating Framework guidance, specifically around setting aside 2% of resources non recurrently to achieve system change.

The scale of this challenge could, however, only be achieved by means of a substantial transformation programme implemented over a longer timescale. In recognition of this, it was agreed that the in year QIPP target be reduced and by means of deploying the 'notional' strategic change reserve (SCR). As a result, the Cluster's QIPP target for the year was revised to £42.9m.

Against this revised QIPP target of £42.9m the Cluster is forecast to deliver £34.1m (80%); this is illustrated in Table 1. The underachievement in 11/12 of £8.8m has been incorporated within the planning assumptions for 2012/13 and is part of the QIPP challenge for the new financial year.

Table 1: 2011-12 Cluster Commissioner Savings Summary

2011/12	Gross Savings Requirement per 11/12 system plan	Targeted SCR deployment	QIPP Net Savings Plan	QIPP Forecast Outturn Savings	QIPP Plan Variance Fav / (Adv)
	£m	£m	£m	£m	£m
Coventry	13.1		13.1	14.4	1.3
Warwickshire	49.9	20.1	29.8	19.8	(10.0)
Cluster Total	**63.0**	**20.1**	**42.9**	**34.2**	**(8.7)**

6.2 Financial Year 2012/13 to 2014/15

2012/13 financial plans were refreshed to take account of changes in resource, activity and cost assumptions and underperformance against the 2011/12 QIPP programme. Table 2 below illustrates the revised plans:-

Table 2: Refreshed medium term financial plan summary

Cluster Medium Term Plan	2011/12 Forecast £m	2012/13 Plan £m	2013/14 Plan £m	2014/15 Plan £m
Resource	1446	1469	1490	1508
Expenditure	(1440)	(1463)	(1486)	(1505)
Planned Surplus	6	6	4	3
CIP/QIPP within the above:				
Commissioner	34	63	14	0
NHS Providers (tariff efficiency)	28	48	38	38
Total QIPP & Tariff efficiency	**62**	**111**	**53**	**38**

2012/13

The commissioner QIPP requirement for 2012/13 is £63m and on the basis of the programmes identified and of further programmes in the development pipeline, these savings are achievable on a recurrent basis; details of the transformation programme underway are set out in this document. To enable this to take place the Cluster is required to support transformation by means of its strategic change reserve. In deploying this reserve the Cluster anticipates the in year savings programme for 2012/13 to be £38m (as described within the Clusters triangulation toolkit).

It is however fully recognised that the scale of the QIPP challenge is significant in 2012/13 and work will continue throughout the year to identify further savings opportunities to mitigate against any delays or non delivery of planned QIPPs and to contribute towards the development of the 2013/14 programme.

In addition to the commissioner QIPPs, the financial plan also includes savings in 2012/13 of £48m associated with tariff deflation applied to NHS provider contracts.

2013/14 to 2014/15

Delivery of the full year effect of the planned 2012/13 QIPP programme will put the Cluster in a strong position going forward and the scale of the QIPP challenge thus reduces significantly in future years (subject to there being no significant changes in resource growth assumptions).

Comparison with last year's system plan

The development of the 2012/13 QIPP programme remains broadly in line with last year's system plan in terms of themes e.g. frail older people, reductions in hospital admissions and repatriation of out of area mental health clients. This year's plan therefore represents a refresh of plans, reflecting necessary changes in assumptions, rather than a significant overhaul of them.

Table 3 below compares this years' refreshed plan with last year's plan and, as can be seen, over the period of the spending review the cumulative challenge remains broadly the same:-

Table 3: Comparison of cumulative QIPP requirement within refreshed plan with last year's system plan requirements

	10/11	11/12	12/13	13/14	14/15	Total
	£m	£m	£m	£m	£m	£m
5 Yr System Plan	6	69	93	113	122	403
Refreshed Plan	6	40	103	117	126	392

6.3 Provider Performance

Arden Trusts are forecasting that they will breakeven/deliver their financial plans in 2011/12, however 2 of the 4, UHCW and GEH have experienced significant pressure in doing this. Tables 4 and 5 below show; (a) the Arden contract values for 2011/12 and (b) the 2011/12 financial plan and the CIP values for 2011/12 and 2012/13.

Table 4: Provider Performance 2011/12

	Arden Annual Contract £m	**Forecast Year End Under/(Over) performance £m**
University Hospitals Coventry and Warwickshire NHS Trust	286.3	(4.6)
George Eliot Hospital NHS Trust	78.8	(2.9)
South Warwickshire Foundation NHS Trust	167.0	(2.9)
Coventry and Warwickshire Partnership NHS Trust	116.5	0.0
Cluster Total	**648.6**	**(10.4)**

Table 5: Provider CIP/QIPP Plans 2011/12

	2011/12 Plan £m	**2011/12 FOT +surplus / (-) deficit £m**	**2011/12 QIPP/CIP £m**	**2011/12 FOT QIPP/CIP £m**	**2012/13 QIPP/CIP Rec Plan £m**	**%**
Arden Cluster	1,470	6.00	45.7	32.6	**63.0**	***4.3***
University Hospitals Coventry and Warwickshire NHS Trust	456	1.22	28.0	20.0	**43.0**	***9.0***
George Eliot Hospital Trust	109	0.01	11.2	9.4	**6.8**	***5.9***
South Warwickshire Foundation NHS Trust	194	2.97	6.2	6.2	**10.0**	***4.9***
Coventry and Warwickshire Partnership NHS Trust	203	3.58	8.0	8.0	**10.2**	***5.1***
Total			**99.1**	**84.2**	**133.0**	

Table 6: Provider CIP Plans as Percentage of Costs

	2011/12	2012/13	2013/14	2014/15
Main Provider CIP %	%	%	%	%
SWFT	3	5	4	4
GEH	8	6	4	4
UHCW	4	9	4	4
CWPT	4	5	4	4

Table 6 above shows Provider CIPs as a percentage of Provider costs. This reflects the total challenge to Providers of meeting the provider efficiency requirement (4%), unfunded cost pressures, commissioner QIPP schemes offset by any new investments.

6.4 Contract Negotiations 2012/13

Contract negotiations are being led by CCG Chairs and Chief Operating Officers. Work is being progressed in order to ensure that all contracts are signed by the March deadline. Contract documentation will be in line with the requirements contained in the Midlands and East Contracting Assurance Framework.

The position in relation to each provider is as follows:-

6.4.1 Coventry and Warwickshire Partnership Trust

For the Coventry Community Services element of the contract financial positions are largely aligned. Areas additional to service lines (eg, HIV drugs and Palliative Care home support) are expected to be finalised by 14th March. For the Mental Health element of the contract, negotiations are focussed on gaining agreement to the inclusion of QIPP schemes to close the financial gap. Mental Health negotiations acknowledge the move to implementation of Payment by Results.

CQUIN schemes are currently being finalised. They include the following local schemes in addition to national/regional elements:

For mental health:

- Mental Health Liaison (coordinated with schemes for acute providers to progress local integrated working)
- Primary Care 'Liaison'

For community services

- Reducing emergency attendances and admissions through:
  - case-management of patients identified through risk stratification
  - the use of Telehealth
- Integrated Team working contributing to reduced emergency admissions

6.4.2 University Hospitals Coventry and Warwickshire

The Cluster is confident of resolving remaining differences in financial positions. A risk share agreement is in development for delivery of QIPP plans. This will limit the financial risk to both parties, set out responsibilities for QIPP delivery and pave the way for agreement on finance and activity plans within the contract. Key Performance Indicators, CQUINs and QIPP plans have all been agreed at a high level and work is continuing to ensure that the detail can be agreed in time for contract sign off.

6.4.3 George Eliot Hospital

A financial gap remains to be closed and the Cluster is confident of closing it through the identification of further QIPP schemes for delivery in 2012/13. A risk share agreement is in development for delivery of QIPP plans. This will limit the financial risk to both parties, set out responsibilities for QIPP delivery and pave the way for agreement on finance and activity plans within the contract. Work is on-going to agree Key Performance Indicators and CQUINs to ensure that the detail can be agreed in time for contract sign off.

6.4.4 South Warwickshire Foundation Trust

An 'in principle' agreement has been reached in respect of activity and finance for both acute and community contracts. Key Performance Indicators, CQUINs and QIPP plans have been agreed at a high-level and the detail is now being worked through for inclusion in contract documentation. The contract will include a risk sharing agreement.

6.4.5 General

Non-recurrent strategic change monies will be used non-recurrently within contracts to support delivery of recurrent QIPP schemes.

7 Quality Innovation Productivity and Prevention Programmes

Arden's commitment to improve the health and well being of the people of Coventry and Warwickshire, and the high level strategic objectives to deliver that commitment, are set out in Section 1 of this Plan. Set out below is a description of the work programmes that will be pursued to deliver the strategic objectives, early priorities for action and milestones up to March 2015.

7.1 Healthy Living and Lifestyle Choices

The public's health is the Cluster's priority, where wellness and tackling health inequalities will be central to all that is done. Public Health will work collaboratively with all on outcomes that will reduce the preventable causes of ill-health, by using the least intrusive approaches necessary to achieve the desired effect, and will focus on enabling and guiding people towards positive life choices wherever possible.

Public Health will:

- treat the public's health as a priority. Sustaining growth and wellbeing depend on good health. Wellness will be central to all that is done – in health and across government,
- through a strong and protected public health system Public Health England, integrate expertise, action, advice and influence, to ensure world-leading health protection, and to set challenging national objectives with clarity over the aims of Public Health,
- work together to tackle public health challenges, using the best new insights of social psychology and behavioural economics to achieve real improvements in public health healthy living,
- effectively bring together all the interests of NHS, social care, education, transport and environment and effect a positive impact on public health,
- adopt a new and collaborative approach to fighting health inequalities**,** rooted in local communities and with the wider determinants of health including economic status, education opportunity, employment, housing and environment – integral to all efforts. A new health premium will reward progress on specific public health outcomes,
- ensure the public health priorities and actions tackle the preventable causes of ill-health,
- work in partnership with all, including businesses and the voluntary sector through the Public Health Responsibility Deal to create an environment that supports informed, balanced, health-improving choices about what people eat and drink and levels of physical activity. Nationally use the five networks focusing on food, alcohol, physical activity, health in the workplace and the role of behaviour change recognising that all of society influences health decisions,
- work with businesses to make them aware of their responsibility for tackling the rising burden of preventable ill-health in order to deliver the improvements all would wish to see and empower local communities to come together to tackle the challenges they face involving more work being done by the voluntary sector, rather than the state,
- work with people wherever possible; and intervene only where necessary, aiming to use the least intrusive approach necessary to achieve the desired effect, seeking to use approaches that focus on enabling and guiding people's choices wherever possible.

7 1.1 Coventry and Warwickshire Public Health Prevention Model

Work is currently underway with partners in the city to design and implement a prevention model that encompasses a number of key strategic developments to improve health and address inequalities. The model aims to reach those individuals in the population who are at risk of developing poor health and who traditionally do not access primary care services or who find it difficult to do so.

The aspirations are that once fully constructed the model will enable individuals to adopt healthier lifestyles and make access to appropriate services easier.

The key components of this Prevention Model are:

- **Making Every Contact Count (MECC)**; training will be available for all key frontline staff in brief advice and brief intervention using the e. Learning tool, but supplemented and reinforced by local training. This is being rolled out to NHS and LA staff in community and hospital settings.
- **NHS Health checks;** a refresh of the current approach is underway, working with CCGs and other partners. Good practice from elsewhere in the region will be built upon.
- **Single Point of Access**; this work is being developing in partnership with the LA, this is building on good practice from other areas that have introduced SPA to good effect in ensuring easier access to Lifestyle Risk Management Services.
- **Lifestyle Risk Management Services;** smoking cessation, alcohol, substance misuse, weight management will benefit from the SPA approach as the pathways into these services will be simplified.
- **Work and Health;** a CHIP funded programme, building on the recommendation from Dame Carol Black's report, is working with small and medium sized enterprises in supporting the health of their workforce via work based health schemes.

7.1.2 Coventry Health Improvement Programme (CHIP)

The Coventry Health Improvement Programme (CHIP) is a 3 year public health partnership programme between NHS Coventry and Coventry City Council. This work commenced in 2008/09 and is due to finish in 2012/13.

The total planned investment is £18m (in addition to mainstream NHS and City Council funding already provided for public health) and it will enable the commissioning of innovative and evidenced based approaches to health improvement. It also provided additional funding to established work programmes as follows:-

- Smoking
- Sexual Health
- Children and Young People's Health and Well Being
- Healthy Weight
- Mental Well Being
- Work and Health
- Alcohol
- Health Checks

External evaluation is being undertaken by Hall Aitken and Warwick University.

Priorities for 2012/13 and beyond.

- To develop the "Every Contact Counts" approach across all NHS and Local Authority Services. This is part of the transformational approach being taken as part of the Public Health Transition to LA.
- To adopt a 'single point of access' approach to all lifestyle risk management services so that as well as signposting patients and the public to service points, these are comprehensive across the full range of Health Improvement issues.
- To use Public Health's new place within the local authority to enhance influence about how local authority services can better deliver a range of health improvement opportunities across the physical environment and to address lifestyle challenges and improve wellbeing – both physical and mental.

High Level Milestones.

By Mar 2012

- All key staff and team leaders will be trained in 'Making Every Contact Count'

By Mar 2013

- Comprehensive simple pathways into lifestyle risk management services will be available through all Local Authority "front door" and points of access. This will also include staff adopting a 'Making Every Contact Count' approach

By Mar 2014

- All new patient and client contacts will have a lifestyle risk management discussion as part of their initial assessment
- A brief intervention and signposting approach will be undertaken for all appropriate patients

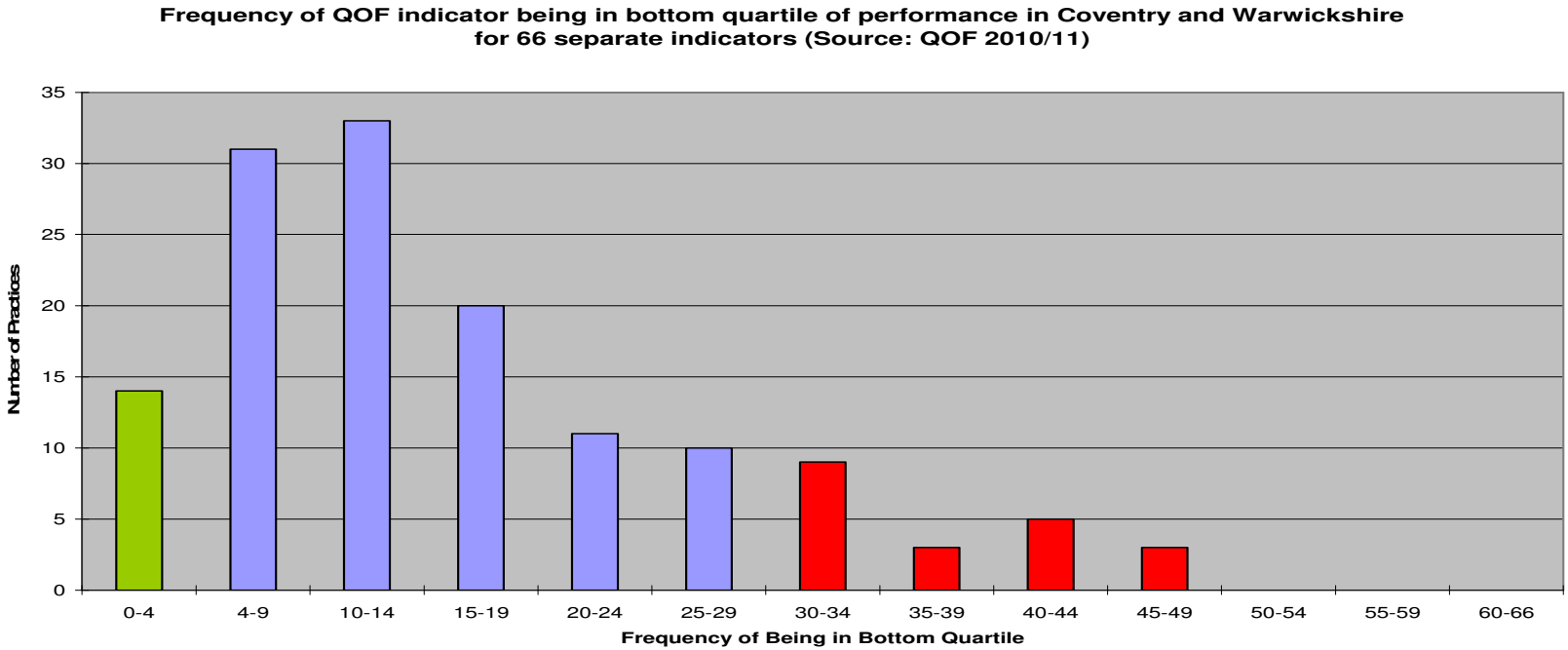
7.2 Primary Care Quality and Safety

There has been a lack of clinical quality markers within general practice with most measures being of activity rather than outcome. The QOF (Quality Outcome Framework) gives a source of measures that are evidenced based but the relatively low target measures and ability to 'exception report' patients means that QOF point scores are a poor indicator of quality within general practice.

The Cluster is developing a suite of measures with the support of CCGs and the LMCs that can be used to improve clinical quality within general practice. These are based on the actual performance within a QOF clinical domain and whether or not a practice is within the bottom quartile for that measure as opposed to points scored.

Practices performance is then assessed by the number of clinical QOF areas in which they are in the bottom quartile.

As can be seen in the following graph, there are a group of practices that are performing significantly differently to their peers.



The impact on patients of this variation can be significant. For example, for patients with Hypertension there are currently 25,374 in the Arden Cluster not adequately controlled. Across practices the performance in this measure varies from 0.5% not controlled to a staggering 41.9%. A similar picture is seen for other Long Term Conditions.

QOF Measure	No of Patients Not Treated to QOF Target	Total Register Size	% Not Treated to QOF Target (range)	Average Patients Per Practice Not Treated to QOF Target	Evidence Base
BP 5 Patients with hypertension >150/90	25374	126998	19.9% (0.5-41.9%)	181	5mmHg reduction in DBP results in 42% reduction in stroke and 14% reduction in CVD over 5 years (NICE)

Priorities for 2012/13 and beyond:

The primary and urgent focus on improving primary care quality will be on removing this variation. GP practices will be encouraged and supported to improve by using this data in the following areas:-

- Primary care performance monitoring and development of action plans for the practices in the bottom quartiles
- As part of a data pack supplied to all GPs for discussion in their annual appraisal
- As part of CCG discussion with practices giving peer pressure
- Education though the protected learning time sessions across the cluster.

A similar approach will be developed to ensure that patients with long term conditions are proactively engaged with by ensuring practice disease prevalence is consistent with expected prevalence. Making Every Contact Count will be embedded to ensure that advice is available to drive down determinants of disease, for example, smoking, alcohol and obesity with a suite of quality measures based on the incidence of these.

As stated above, CCG contribution to improving the quality of general practice and reducing unwarranted variation has already produced results and CCGs will continue to focus on further improvements during 2012/13.

Patient safety will be enhanced by this monitoring, support and improvement of quality within general practice. This will be supplemented by:-

- Improved monitoring and reporting of Significant Event Analyses for clinical issues within general Practice
- Join work between secondary and primary care physicians to look at hospital mortality covering
    - Expected death, but occurring in hospital which could/should have been managed in primary care
    - Unexpected death where care in the community may be implicated, eg, Warfarin monitoring
- Learning from these areas being spread through the current educational system

High Level Milestones

By Oct 2012

- Quality review systems will be developed across primary and secondary care to include SHMI data and quality of LTC management within primary Care
- Quality markers for general practice will be agreed as will an implementation of review process involving CCGs

By Mar 2013

- All practices (approx 20) that are outliers in quality markers will be visited, assessed and action plans for improvement agreed and in place
- There will be no practices with greater than 40 QOF clinical markers in the bottom quartile
- Educational programme will be agreed that will address common QOF clinical issues
- Joint primary and secondary care quality review meetings will be established that will include a review of SHMI and poor LTC care management in primary care resulting in hospital admission

By Mar 2014

- There will be no practices with greater than 30 QOF clinical markers in the bottom quartile
- Joint quality review meetings will be established to ensure that community integration is preventing unnecessary hospital admission including ensuring that palliative care patients are supported to die at their place of choice

7.3 Frail Older People

In common with other health economies the Cluster is seeing a year on year rise in emergency medical admissions, with a 10% rise in 2010/11. The extent of the national problem is highlighted in the recent Kings Fund Data Briefing *Emergency bed use: what the numbers tell us* which identifies that:

- More than 70 per cent of hospital bed days are occupied by emergency admissions
- 10 per cent of patients admitted as emergencies stay for more than two weeks, but these patients account for 55 per cent of bed days
- 80 per cent of emergency admissions who stay for more than two weeks are patients aged over 65

This suggests that focusing on reducing length of stay for older people has a significant potential to reduce hospital bed use

In Arden, upwards of 50% of all unplanned admissions are in the over 75 age group (Apr-Sept 2011 projected to full year effect). Early analysis of coding data suggests that circa 74,000 bed days relating to the over 75s with long-term and mental health related conditions ought to be capable of being treated in primary care and community settings (full HRG value circa £15m).

CCGs are working with health and social care partners on the design and implementation of modernized services for frail older people that will relieve pressure on acute hospital emergency services, allowing a significant reduction in acute beds for this client group of between 150 and 200 by the end of the Plan period. New models of care will be established that will enable care to be delivered by primary, community, mental health and social care staff in more collaborative and integrated way out of hospital wherever possible, but with more effective in and outreach services where not. Further details of this model are given in 8.2 below.

(As part of the 2012/13 QIPP delivery plan in Coventry, additional investment to support facilitated discharge has been identified and negotiated into the community services contract.)

Priorities for 2012/13 and beyond:

Very many CCG QIPP schemes focus on achieving improvements in frail older people services.

A mapping exercise is currently underway that will identify the missed potential in schemes to achieve maximum gain across the system for the want of 'scaling up' and seizing innovation potential.

A group of clinician and social care subject matter experts has been drawn together for the purposes of undertaking this mapping and of supporting local work programmes going forward. A baseline report will be produced for consideration by the System Board to inform priority areas for system wide scheme development. An early look at the potential reveals possibilities in the following areas:-

- There are small telehealth pilots underway covering very few patients. The results of the National Demonstrator Pilots s suggest that the gains to be had from scaling up are significant. There is some support across the system to develop a business case that shows how (simple) telehealth (initially) can be

embedded as an integral part of as many pathways as possible for people with long-term conditions. As part of the 2012/13 CQUIN with CWPT, the use of telehealth will be extended to identified LTC patient cohorts across 3 integrated teams, with a total population of circa 150,000.

- Risk stratification is well established in parts of Warwickshire but its use has the potential to be strengthened and spread to other areas. From April 2012, work to pilot risk stratification across 3 integrated teams, with a total population of circa 150,000 will be undertaken, and is linked to a negotiated CQUIN
- The same is true of Virtual Wards and there is some enthusiasm to exploit the potential of Virtual Wards to support more coordinated working in teams comprising people from different organizations. In Coventry, the implementation of integrated teams will ensure more co-ordinated working across general practice, improved communication, improved team working and reduced duplication.
- There is evidence to suggest that providing targeted support to care and nursing homes has a big impact on admissions and delayed transfers of care. There is already a project underway in Coventry in this area and there is some appetite to scale up this work

High Level Milestones

By Mar 2013

- Unplanned admissions for the >75s will have reduced by 10%

By Mar 2014

- Unplanned admissions for the >75s will have reduced by 17%

By Mar 2015

- Unplanned admissions for the >75s will have reduced by 23% (circa 75,000 bed days) (subject to further analysis of the data)

7.4 Well-Being in Mental Health

The numbers of people in out of area placements continues to be high and costly with poor patient outcomes. The reliance on such placements will continue to be reduced both through redesign of local services to meet the needs of patients who challenge services and through a proactive approach to bringing them back. It is also known that people with mental health problems remain under the care of acute psychiatrists when primary care management would be more appropriate for them.

Too many individuals in acute trust hospitals with a mental health problem experience longer lengths of stay as psychiatric liaison services are not consistent or as responsive across the cluster to meet people's needs.

All Trusts and social care colleagues, in the health economy, are working proactively together to develop and implement a new model of mental health liaison across the locality. Using the principles and learning from the Birmingham RAID (Rapid Assessment & Integrated Discharge) the Trusts have committed to introducing a new model of care which recognises the need for a greater level of skills and expertise in mental health from acute staff and a more responsive and flexible dedicated mental health team to support patients. This will cover more proactive front end interventions in A&E to avoid unnecessary admissions and proactive support of inpatients to ensure timely discharge and reducing length of stay and/or ensuring appropriate levels of mental health input are provided to people requiring an acute inpatient stay. Improving the skills and knowledge of the workforce to manage common mental health issues is a fundamental principle for the work. A health economy wide Strategic Steering Group has been established facilitated by the CSS on behalf of the CCGs and all Trusts are represented.

Arden has a broad range of well-being programmes in place in collaboration with local authority partners and third sector organisations. These are designed to support people to manage their own well-being and people can self-refer or be referred by their GP. This includes Books on Prescription available in public libraries across Arden and measured miles to encourage people to take exercise to improve their well-being. Third sector organisations offer well-being drop ins where people can access a range of support on well-being issues and access on-line self help packages. The focus is to reduce the number of people accessing secondary mental health services and offer GPs concrete options which do not involve prescribing. The resources complement the existing IAPT service.

Priorities for 2012/13 and beyond are to:

- commission crisis resolution home treatment teams to deliver a strengthened model of care in the community to support people with dementia, thereby reducing need for inpatient beds and buildings based day hospital care,
- commission acute psychiatric liaison services in acute hospitals and design a single point of contact such that patients can be more effectively signposted to services and pressures on acute services are relieved,
- strengthen support in primary care for people with mental health problems; agreeing thresholds for referring people into secondary care services and for taking people back into primary care from acute services, ie, improving the 'primary care offer' for this client group such that all primary care providers raise the bar to that of the best,
- commission alternative local services to reduce the reliance of out of area placements,
- establish a programme of system and team redesign to bring about greater integration and collaboration in the way community and mental health professionals deliver services to common client groups,
- to seek to develop low secure beds at the Brooklands site and the extension of the locked rehabilitation and rehabilitation pathway to support the treatment and transition of individuals from out of are into local services, and to
- to initiate a review of day services and respite services for people with learning disabilities, with a phased introduction of a new model of care in-year.

High level milestones

By Mar 2013

- Sustainable Retention and Repatriation team will be in place to reduce the need for placements outside of local facilities and to return people in out of area placements back into local services
- Locked rehabilitation facilities will be operational offering enhanced capacity in local services to prevent people leaving local facilities & to speed up people returning to the area
- Phase 1 of the introduction of Crisis Resolution Services for organic patients in Warwickshire will be implemented
- Integrated Acute Liaison services will be operational across the Arden Cluster
- Commissioning Plan for respite and day services for people with learning disabilities will be agreed

By Mar 2014

- Refurbishment of low secure facilities will be operational offering enhanced capacity in local services to prevent people leaving local facilities and to speed up people returning to the area
- Phase 2 of the introduction of Crisis Resolution Services for organic patients in Warwickshire will be implemented
- Recommissioning of day and respite services for people with learning disabilities will be completed.

Dementia – what the service change programme will achieve for 'James'

James – March 2012
James went to his GP because everyone was telling him he kept forgetting things, the GP did a few tests and referred him on to the Memory Assessment Clinic (MAC). After a few tests they said he had early signs of dementia but it wasn't conclusive, they told him to go back to his GP in a few months or come back to the clinic. Eight months later things had got worse so he went back to the MAC and they started him on medication and sent him back to his GP to monitor him. His wife had heard there were some support groups but no one had said anything, the GP wasn't sure so she asked at the MAC, they gave her some details of services but none of them were local so it was difficult to reach them of get some help. As James' condition got worse he started going to see the consultant and attending outpatients, these were difficult and fraught events, getting him there and back, but there was not a lot of help in the home managing his behaviour. Eventually James was admitted as an in-patient in the local mental health hospital, he was there for such a long time that he had forgotten about home and was eventually moved into a nursing home, the only one available was some distance from his home making it hard for his wife to visit.
James – March 2014
After seeing his GP with memory loss issues James was referred into a local Memory Assessment Service. They gave him a diagnosis of early signs of dementia and linked him and his family to a post diagnosis support service. The service was run by a voluntary organisation and provided him and his wife with support in coming to terms with the diagnosis and outlined what the future might look like and enabled them to prepare for it. James and his wife used this support to make adaptations to the home and prepare them to enable them to cope when James' condition deteriorated. In the meantime the MAC had initiated prescribing and, via his GP, linked James into the local Dementia Crisis Resolution Home Treatment team. When James became more difficult the local Crisis Resolution Home Treatment team was able to intervene to support and stabilise James in his own home making links to ensure he had the correct package of support to ensure his needs were met at home. James became very poorly but the ongoing support of the CRHT ensured he was supported at home until the family felt that nursing home care was the right place. However, as he was not admitted to hospital, the family were able to review the most appropriate home for him and did not feel hurried into taking the first available place.

7.5 Best Practice in Acute Hospital Care

The Clinical Senate and System Board has over the past two months considered issues around the sustainability of acute services. In summary:-

1. Coventry and Warwickshire has 3 acute hospitals within a relatively small geographical area serving a population of just less than one million
2. There has been a transformation in acute healthcare over the past two decades, with increasing complexity in investigation and treatment and a need for greater specialisation to improve outcomes
3. It is no longer possible to provide all that is required within the Arden health economy at every acute hospital site
4. In line with national directives some reorganisation has already taken place and benefits realised from centralising some aspects of care formerly provided from multiple sites, eg, in complex cancer surgery, interventional cardiology, hyper-acute stroke management, specialist care in renal medicine and transplantation, neurosurgery and neurology, specialist paediatrics and high risk maternity, major vascular surgery, and major trauma
5. However there remain significant variations in treatment and outcomes for a number of conditions, and hospital mortality rates are higher than is desirable
6. Further to this, numerous recent reports[1] have identified the need to address the fact that the UK is not providing uniformly high quality emergency and elective care for severely ill medical and surgical patients.

[1] Acute medical care: The right person, in the right setting – first time. Report of the Acute Medicine Task Force October 2007, RCP
Emergency General Surgery: The Future - A Consensus statement ASGBI 2007
Emergency Surgery Guidance for providers, commissioners and service planners 2011 RCS
The Higher Risk General Surgical Patient Towards Improved Care for a Forgotten Group 2011 RCS
An Age Old Problem; A review of the care received by elderly patients undergoing surgery NCEPOD 2010
Knowing the Risk: A review of the peri-operative care of surgical patients NCEPOD 2011

The Cluster's Medical Director is working with Provider Medical Directors and other senior clinicians to agree a programme of work to achieve the following:-

1 Optimised 24/7 acute care for the most severely ill and injured and those requiring complex tertiary specialist care
2 Provision of a full range of specialist clinical networks across all sites ensuring local access for investigation, diagnosis, the majority of urgent and elective procedures, and longer term care
3 Retention of acute medical and surgical assessment facilities and ambulatory care on the current acute sites
4 Safe and appropriate levels of inpatient care and elective surgery on each site
5 A focused role for each acute site in the wider system, supported and reinforced by clinical networks
6 Local integration between acute care and community services (primary and social care)

The sustainability of acute services will be reliant on a collaborative clinical network approach between Providers developed in close liaison with commissioners. There is not a single model, and this work is being carried out against a background of significant and successful reorganizations of services that have already taken place over the past decade. For example, there is already in place mature networks for major trauma, cancer, vascular surgery, neurology and neurosurgery, cardiovascular and stroke services, renal medicine & transplantation, as well as a countywide pathology service.

The current focus is on areas where there are either: i) impending medical workforce issues such as in paediatrics and general surgery (eg, emergency cover); or ii) suboptimal outcomes evidenced by variation in practice and data. Having assessed the current state of clinical outcomes and impact of existing networks across Arden a process of defining the clinical and financial profile of those specialties with outcomes and/or workforce issues is being embarked upon. This will involve Provider and CCG stakeholders over the next 3 months (March – May 2012) identifying options and establishing consensual clinical support for solutions. This process will be clinically led and managerially supported, from CCGs and Providers, which is essential in developing solutions that have broad, strong clinical backing and an evidence base that will generate public support.

All acute Providers will be closely involved in this work, which will drive the changes that are needed across a range of medical and surgical specialties to improve outcomes for patients, make best use of resources across the whole system, and will aim to ensure collaboration through clinical networking to minimise organisational and structural change, and, wherever possible, to maintain access to services locally. Where optimal care is reliant on relocation of services on fewer hospital sites (eg from 3 sites to 1 or 2 sites), the decision will be made, using appropriate clinical criteria, regarding which hospital site(s) should be chosen,

The Clinical Senate in January 2012 agreed that more detailed work be undertaken to explore the need for centralisation of emergency care for severe acute illness and high risk elective procedures and considered that the first priority was to bring to resolution ongoing work on Paediatric and Obstetric services at the George Eliot Hospital. The next priority was considered to be General Surgery emergency care, on the basis that Coventry and Warwickshire currently has 9 consultant breast or vascular surgeons who may withdraw from the General Surgery emergency rota over the next few years, leaving all 3 existing sites stretched.

The Senate supported further evaluation of the role of Collaborative Clinical Networks in delivering a high standard of care across providers, making best use of existing facilities and staff, dealing appropriately with issues of complexity and risk, and counterbalancing any necessary centralisation by improving local access to prevention, diagnosis, and long term care.

Immediate Priorities (for completion by 11 May)

- Establish clinical specialty profiles containing baseline information and benchmarking on activity and outcomes for each site
- Meet with stakeholders, i.e. clinicians and managers from Acute Trusts, CCGs and PCT, to:
  - Review and confirm the clinical specialty profiles
  - Achieve consensus on the evidence base for any change
  - Identify priorities and potential solutions
- Produce of options for testing and assessment prior to consultation.

A key priority for the acute work programme will also be to streamline pathways of care. A visual representation of how things may be different in 5 years' time is given in Figure 2 below: (→ 2012 → 2015)

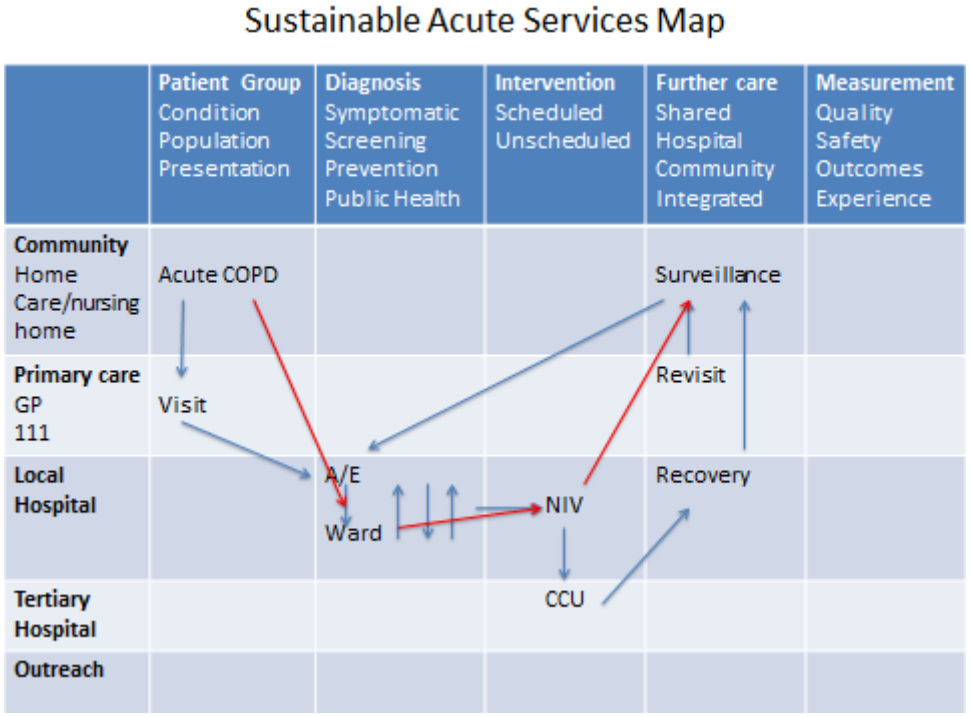


Figure 2 – Arden Sustainable Acute Services Map

High Level Milestones

By Mar 2012

- Paediatric and maternity service configuration will be resolved

By Mar 2013

- All Acute Trust SHMIs will be within the expected range
- Secure sustainable services for paediatric and maternity services will be in place
- New model for future provision of emergency general surgery care will be defined and agreed by clinicians and organisations, along with the plan for implementation
- Integrated model for improved provision of adult respiratory care will be implemented across Acute Trust localities
- Further specialties for collaborative improvement will be identified
- Collaborative hospital improvement programme will be in place, with agreed specialty and general improvement themes supported by shared commissioners incentives

By Mar 2014

- Model for emergency general surgery care will be in place
- Outcomes for respiratory care will be improved with demonstrated reductions of inpatient COPD mortality
- Excellent general and specialty outcomes will be achieved across general and specialty areas as evidenced by local and national specialty audits and performance data
- Effective collaborative programme involving wider range of medical and surgical specialties will be in place and demonstrating improved outcomes and cost reductions as a result of lower morbidity and reduce need for inpatient care

7.6 Innovation

Innovation as defined in "Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS"; Department of Health, 5th December 2011: "An idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied".

Existing structures for implementing innovation in Coventry and Warwickshire are:

- HIEC (West Midlands South) where the Cluster is an active partner
  (*NHS Partners:* Birmingham and Solihull Mental Health NHS Foundation Trust; Coventry and Warwickshire Partnership NHS Trust; George Eliot Hospital NHS Trust; NHS Coventry; NHS Warwickshire; South Warwickshire NHS Foundation Trust; University Hospitals Coventry and Warwickshire NHS Trust. *University Partners:* Coventry University; University of Warwick. *Private Sector Partners:* GE Healthcare*;* Novo Nordisk LTD. *Charitable Partner:* Myton Hospices)
    - Since March 2010 £900k has been invested in 15 local projects, selected as priority areas for the local area and to fit with HIEC goals of expanding the use of e-health technology and changing behaviours

- Additional £200k has been invested to support roll out of ambulatory care project across system in 2012
- The HIEC is well positioned to become a in partner an Academic Health Science Network

- Warwickshire Partnership: tripartite agreement between University of Warwick, UHCW NHS Trust, and GE Healthcare
  - In early 2011 the University of Warwick, University Hospitals Coventry and Warwickshire and GE Healthcare signed an agreement to work together, sharing knowledge and expertise for mutual benefit.
  - One strand of work has demonstrated improvement in the hospital stroke pathway in conjunction with the Digital Lifecycle Management Group

- WISDEM (Collaborative Approach Towards Tackling Diabetes and Associated Conditions in Coventry and Warwickshire); has infrastructure funding provided by Novo Nordisk and is leading clinical research and education for staff and patients across the whole spectrum of care in the community
- CLRN (West Midlands South), now chaired by the Arden Cluster Medical Director, has a good research recruitment record across primary and secondary care and plans to increase the volume of commercially supported studies

Further actions:

- Clinical Commissioning Groups will be supported by the CSS in attaining their duty to seek out and adopt best practice, and promote innovation
- High Impact Innovations identified in "Innovation Health and Wealth" will be incorporated in commissioning

7.7 QIPP Schemes

The process of developing QIPP schemes partially mirrors the wider contract negotiation process that has been agreed within the Cluster. Specific CCGs lead the process on behalf of all Cluster CCGs and are paired with Cluster contract leads. Responsibility for scheme delivery for the vast majority of schemes has been delegated to CCGs and they discharge this responsibility as lead commissioners for particular Providers with the support of colleagues in the CSS. For example, responsibility for delivering mental health QIPPS on behalf of all CCGs rests with Rugby CCG as the lead 'coordinating' commissioner for mental health.

A summary of QIPP schemes showing schemes by Provider is attached at Appendix 12. Within the Milestone Tracker schemes are grouped in accordance with the required format.

Here, in order to demonstrate how schemes link to delivery of the service change strategies outlined in this Plan, schemes are shown mapped to the 5 transformational work programmes described in Box 1 Page 4. Some schemes, in the main those seeking to improve productivity by reducing elective activity, are shown separately, as are 'enablers':

Work Programme	QIPP Scheme	Scheme Value by Work Programme PYE 12/13
Healthy Living and Lifestyle Choices	Tobacco Control: Social Marketing Campaigns (C & W) Alcohol: LES/DES in Primary Care (C & W) Sexual Health: re-commission to improve quality (C) Obesity: Plans for weight management; childhood measurement; exercise referral; maternity (W)	Nil

	Health Checks: LES in Primary Care (W)	
Primary Care Quality and Safety	In addition to the quality improvement work programme identified by the Milestones in Section Page the following schemes will also enhance primary care quality and safety:- Direct Access Diagnostics Primary Care Prescribing	£6,999k
Frail Older People	Pathway improvement schemes: • ambulatory care • stroke • end of life Broaden reach of Community Emergency Response Teams Improve support to nursing homes Strengthen early supported discharge Introduce Trusted Assessment Improve community based support for long-term conditions: admissions avoidance and short stay (incl telehealth) ***all of these schemes will contribute to a reduction in unplanned care (A&E and inpatients) thereby contributing to plans to deliver A&E targets*** ***upwards of 50% of all unplanned admissions are in the >75 age group and so all schemes contribute to the frail older people service change programme. Many will, of course, also impact on services provided to other sections of the population***	£8,734k
Well-Being in Mental Health and Achieving Service Excellence	Reduce out of area placements Establish local locked rehabilitation Reduce excess bed days (RAID) Reduce inpatient stays (RAID) ***Acute psychiatric liaison is being significantly strengthened to deliver these schemes thereby relieving pressure in acute services and contributing to achievement of acute trust access and waiting time targets***	£5,325k
Best Practice in Acute Care	Optimised 24/7 acute care for the most severely ill and injured and those requiring complex tertiary specialist care Provision of a full range of specialist clinical networks across all sites ensuring local access for	£1,507K

	investigation, diagnosis, the majority of urgent and elective procedures, and longer term care Retention of acute medical and surgical assessment facilities and ambulatory care on the current acute sites Safe and appropriate levels of inpatient care and elective surgery on each site A focused role for each acute site in the wider system, supported and reinforced by clinical networks Local integration between acute care and community services (primary and social care)	
Productivity/Efficiency Improvements	Reductions in 1st Outpatients: (Pulmonary Rehabilitation; community gynecology; community dermatology; orthotics; GP referral management* Reduction in follow-ups: through protocol and threshold agreement* Reduction in inpatient spells: referral screening service; physiotherapy; GP referral management* High cost secondary care drugs and devices: establish protocols and thresholds Long-term oxygen therapy; establish protocols and thresholds Continuing Healthcare Reviews and Assessments: improve practice to reduce packages and costs ***these schemes are designed to reduce pressure on acute trusts thereby contributing to plans to deliver RTT targets***	£15,634k
Enablers	PCT Running Costs Estates Rationalisation	£1,200k
Savings		£39,388k

As identified in Section 6 above, contract negotiations are on-going and final QIPP values have yet to be signed-off. The savings identified above are, therefore, subject to change at the end of March.

The Cluster recognizes the crucial importance of starting the planning process for 2013/14 almost immediately upon submission of this Plan. Work to identify further QIPP schemes for in-year implementation is already underway. This will build in resilience for 2013/14 as well as present opportunities to increase the level of QIPP savings achieved in 2012/13.

- Every GP practice is being benchmarked against upper quartile performance in its utilization of secondary care services to ensure that the potential in primary care to manage down secondary care activity is exploited. Minimum performance standards will be set for all practices.
- Every QIPP scheme is being assessed for the potential to scale up
- The system-wide potential for telehealth is being explored, as is the potential to extend use of risk stratification and the virtual ward model of care
- The Cluster, in partnership with Providers, is working with the SHA's analyst team to model future demand and capacity based on delivering targeted commissioning strategies designed to reduce acute care activity

8 Capacity Implications including Workforce

The essential characteristics of Arden's future care delivery system will be based on the following principles:

- The right capacity in the right place (including the right balance between hospital and community based care)
- The right care delivered by the right individual at the right time
- The right sized healthcare delivery system, reflecting the funding available and QIPP scheme impacts on acute, community and primary care capacity requirements
- Clinically driven patient-centred pathways, ensuring the best care is provided in line with evidence of effectiveness

Shifts in activity from tertiary services to secondary services are expected (ie, reduced lengths of stay in forensic secure units); as are shifts between primary and community care as the impacts of the service change programmes outlined in this Plan are achieved. A new model of care for primary and community services will change the way health and social care clinicians collaborate in the delivery of services that 'wrap around the patient'. The need for long-term residential placements will be reduced as a result of providing enhanced reablement services and more care for people in their own homes or in supported housing.

8.1 Key implications of proposed changes

The Cluster is working with CCGs, Acute Trusts and Local Authority Adult Social Care services to maximise the gains to be had from scaling up service change opportunities and from introducing new ways of delivering care to achieve system wide impact. At the current time the same number of healthcare providers is envisaged in Arden (given that they are all moving towards FT status).

High level transformational change programme milestones are summarised in Section 7; quantification of the detailed impacts of these programmes on activity, capacity and workforce will be better understood over the coming months.

- The Frail Older People programmes will lead to a significant reduction of unplanned care activity in hospitals (and an anticipated reduction in the number of acute beds of between 150 and 200 by the end of the Plan period).
- Given the impact of this shift on acute trusts and the aims of the Acute Services Sustainability programme, portfolios of individual hospitals in the future will almost certainly look different from how they look today.

Paragraphs 8.3, 8.4 and 8.5 summarise the known impacts in 2012/13 at the time of writing this Plan. Contract negotiations are still underway, however, and some QIPP schemes remain to be agreed.

8.2 Shape and Structure of the System – Arden's Future Service Delivery Model

What will also be different in 5 years' time is the way in which care is delivered by health and social care colleagues in primary and community care settings.

A new service delivery model will be established to better care for people who do not need the care of specialist secondary care clinicians in a hospital setting. Staff will be developed to work in new ways to deliver services that horizontally and vertically integrate as follows:

Horizontal Integration

More care will be made available out of hospital and care delivery will be better co-ordinated between primary, community, secondary, social, and voluntary sector providers. This 'horizontally integrated' model will support, in particular, frail older people and all people with long-term conditions and it will help to prevent unnecessary unplanned admission to hospital. Benefits of Horizontal Integration:-

- Proactive care that seeks to predict issues and manage them before crises occur. This will involve using risk stratification tools and managing patients on Virtual Wards. It will allow more rapid discharge of frail patients into a safe environment within the community.
- Reactive Care that seeks to provide a timely response to patients in crisis that enables them to be maintained at home if clinically appropriate. This will be delivered by Community Emergency Response teams, maximising gains from the new "111" service, introducing "Assess to Admit" protocols, and scaling up intermediate care services.

Within Coventry Community Services, for example, implementing an integrated teams approach to primary and community services during the early part of 2012-13 will provide an opportunity to improve patient outcomes and prevent unnecessary admissions, as well as contributing to a facilitated discharge.

Vertical Integration

CCGs have been leading on areas of work to improve working relationships between primary, community and secondary care. They will ensure that referrals into secondary care are clinically appropriate and timely. Benefits of Vertical Integration:-

- Better management of patients with long-term conditions, ensuring that secondary care can provide the clinical support and expertise to enable the overall clinical quality delivered in primary care to be driven upwards.
- Routine access into secondary care being managed to ensure that patients are being seen at an appropriate stage in their illness and after appropriate care and investigation in primary care. This is already being achieved in some areas by the development of care pathways for common conditions such as referral for hip and knee replacement. A Referral Support Service is also in place to provide advice and feedback on the quality of the referral.
- Stronger collaboration in the way hospital mortality is very closely monitored within the Cluster. Although the focus of hospital mortality audits is on hospital actions, some deaths may be attributable to care in the community, eg, warfarin monitoring. A project is being developed with CCGs to ensure that primary care is involved in audits and that actions and learning are fed back into primary care. It is expected that this will be expanded to include patients admitted to hospital with sub-optimal management of long term conditions within primary care.

A visual representation of this service delivery model is shown in Figure 3 below:-

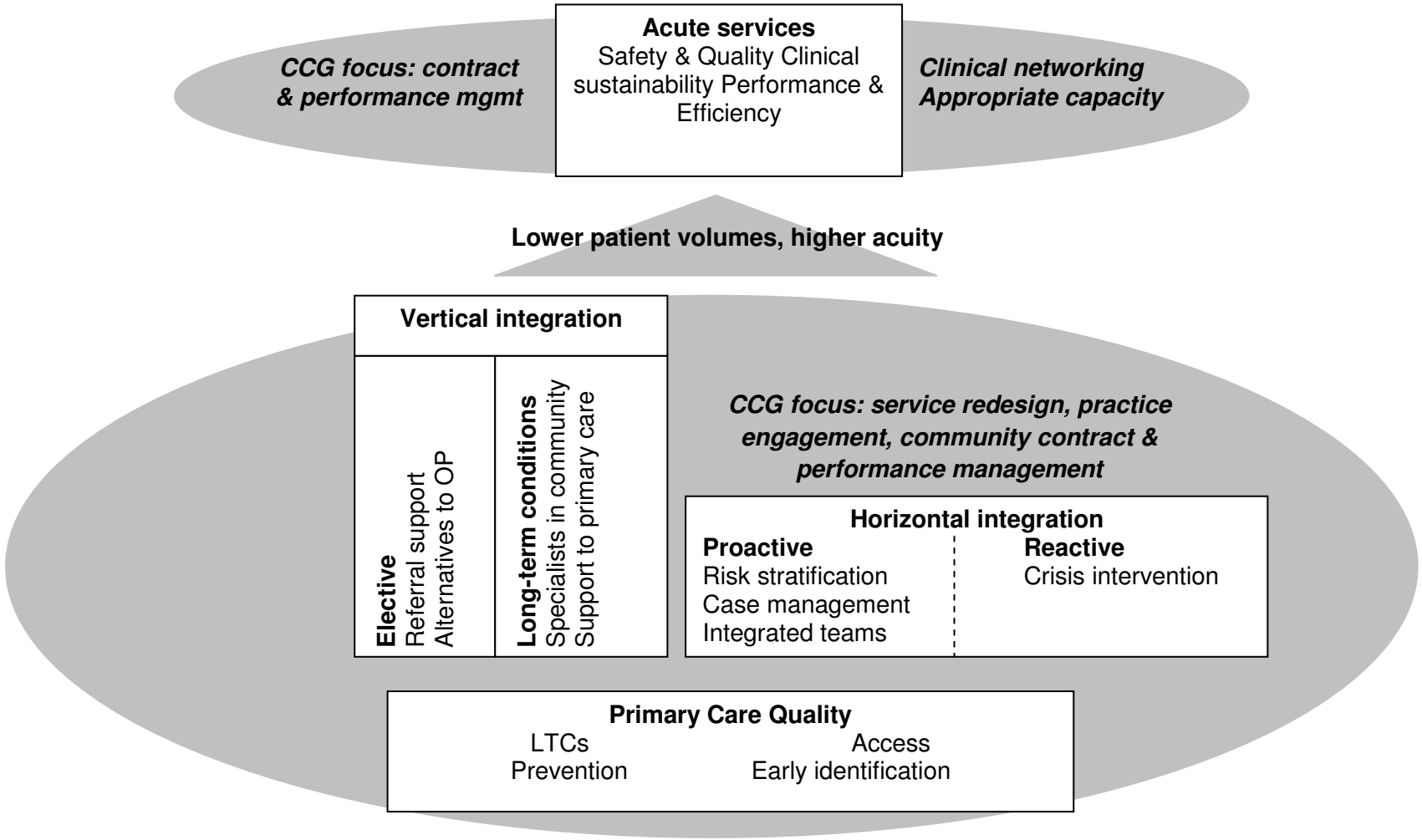


Figure 3 – Arden Service Delivery Model

8.3 Activity Impact of 2012/13 QIPP schemes

Scheme description	Scheme Ref.	Activity Type	GEH	SWFT	UHCW	GrandTotal
Cancer	61	Outpatients			2,381	2,381
GP Referral Management - Managing Expected Activity/Referral Support Service	14. tbcW 110C	Outpatients	1,742	2,466	4,149	8,357
Maternity	59	Outpatients			10,500	10,500
Cardiology churn - follow up rate reduction	39. tbcW 109C	Outpatients		300		300
Community Dermatology Development	39. tbcW 109C	Outpatients	986			986
Other OP specialties	39. tbcW 109C	Outpatients	7,630	10,345	27,846	45,821
Total reduction in Outpatients			**10,358**	**13,111**	**44,876**	**68,345**
Community (Admiss. Avoid + Short Stay) - CERT acute outreach	1. 130W 113bC	Emergency Medical	821	1,095	615	2,531
Community (Early Supp. Discharge)	58	Emergency Medical			3,935	3,935
Mental Health (RAID) - Acute Psychiatric Liaison	6. 117W 117C	Emergency Medical	2,111	2,315	5,441	9,867
Total reduction in Non-elective admissions			**2,932**	**3,410**	**9,991**	**16,333**
GP Referral Management - Low Priority Procedures	16	Elective	0	0	900	900
Total reduction in Elective admissions			**0**	**0**	**900**	**900**

8.4 Changes to % distribution of expenditure

	2011-12 FOT	2012-13 Plan	% Change
Income	**£000s**	**£000s**	**%**
Resource Limit	1,451,800	1,465,865	1%
Other	14,984	14,984	0%
Surplus b/f	5,976	6,000	0%
Total	**1,472,760**	**1,486,849**	**1%**
Expenditure			
Primary Care	199,982	203,771	2%
MH & LD	150,736	148,411	-2%
Cont Care	69,143	66,612	-4%
Acute	575,715	550,909	-4%
Spec Services	104,533	111,637	7%
Ambulance	26,046	26,093	0%
Community	133,432	135,465	2%
Prescribing	135,489	132,814	-2%
Other	34,156	31,593	-8%
Commissioner running costs	31,828	31,180	-2%
2% SHA Transformational Fund	-	27,915	0%
Contingency	5,700	14,450	154%
Total	**1,466,760**	**1,480,849**	**1%**
NET SURPLUS	**6,000**	**6,000**	**0%**

8.5 Provider Declared Bed Reductions in 2012/13

	March 2012	2012-13 Plan	% change
CWPT	412	412	0
GEORGE ELIOT	338	316	-7
SOUTH WARWICKSHIRE	642	635	-1
UHCW	1,281	1,281	0
ARDEN TOTAL	**2,673**	**2,644**	**-1**

8.6 Workforce Implications

There is clarity about the high level workforce impacts associated with Arden's service change programmes. QIPP and service leads are currently working with Provider partners and social care colleagues to refine the detail of QIPP programmes including service and specialty level workforce impacts. High level impacts are summarised below:-

Continuing Healthcare
There will be some re-design of this service as teams begin to work jointly with partner organisations across health and social care. As referrals for assessment are rising it is likely that more staff will be required and a calculated figure of 3 wtes in Warwickshire and 4 wtes in Coventry has been planned for. In order to maximise efficiency of this service consideration may be given to centralising services and standardising processes. Working with social care colleagues a Trusted Assessment initiative has been implemented.

Frail Older People
The Frail Older People programme will drive a reduction in acute activity and an increase in community and primary care. The impacts of individual projects are currently being planned. Currently, many schemes are planned to be delivered within existing capacity but assumptions are being tested.

Care and residential home work streams are being supported by enhanced GP initiatives, outreach nurses from secondary care, community nurses and matrons. The Coventry and Rugby Clinical Commissioning Groups are investing in community nurses to support this work stream. Community nursing teams will work more closely with GPs to be led by a Matron coordinator. The expansion of telehealth has the potential to create productivity efficiencies next year.

The Cluster has engaged the support of the third sector in home support and Age UK works in secondary care to support discharge and patients attending A&E to prevent admission. Volunteers support patients in hospitals with feeding and ward activities. They also sit with patients and support visitors.

A transformation in the way community teams work (improved integration) will build upon the opportunities afforded by 'transferring' community services last year. This will be supported by Section 256 agreements, reablement plans and the carers' strategy.

Paediatrics
A paediatric review is considering the right configuration of services for the future and there is almost certainly going to be a transfer of some staff from GEH to UHCW. Options are being finalised and public consultation is due to be launched in May. Currently, trainee doctors have been withdrawn from GEH, but depending on the outcome of the review, there is the possibility that trainees could be re-introduced. An increase in Consultant Paediatricians will be needed to

support new models of care in the future. Paediatric nurses are being supported to gain advanced assessment and triage skills at Coventry University. Midwives are participating in Normality training to ensure they have the skills to promote normal birthing. Advance neonatal nurses will be recruited to support the neonatal middle grade rotas.

Maternity
Planned reductions in outpatients and improvements in the maternity pathway may in the future lead to a redistribution of community midwives around the Cluster. UHCW and GEH have midwife to birth numbers above national ratios. The Cluster has asked for investment and recruitment plans to ensure both units meet national workforce norms. GEH will deliver by September 2012 and UHCW by June 2012.

Midwifery Led Units are being established. SWFT plans to introduce an MLU in 2013/14 or 2014/15 depending on the progress of other Trust developments. SWFT is recruiting midwives and has been doing so for the last two years.

Children's Complex Continuing Care
Staff increases are anticipated in Children's Complex/Continuing care to reflect an increase in the number of case reviews at 3, 6, 9, or 12 months although this has yet to be quantified. A project manager is being recruited for a fixed term maximum of 2 years to lead the redesign of emergency and urgent care pathways to reduce the number of emergency admissions. Health visitor numbers are being increased in line with national requirements. A detailed skill mix and workload review will happen in parallel and the potential to support other children's services ie school nursing will be explored.

Diagnostics
A project manager will be recruited to lead the implementation of a decision support tool to reduce diagnostic test requests by primary care. Depending on the level of reduction achieved, there may or may not be an impact on staffing.

Physiotherapy/iMSK/Back Pain
Skill mix, capacity and productivity linked to these areas is being reviewed. There is the potential for future disinvestment or realignment of resources across providers. This could potentially impact on the workforce but this cannot be quantified at this stage.

Mental Health
The service redesign programme will result in the configuration of new inpatient services in addition to the shift towards community based services and will require a rebalancing of the workforce between acute and community services. Carer support, acute in-reach, and assertive outreach services are all being enhanced. The drive to repatriate out of area placements will increase the workload of local teams and require a review of local skill mix and availability of enhanced skills. Personal Health Budgets will be available over the next two years to those clients that are eligible for continuing health care and we will seek to offer them for other patients in response to individual needs, staff training will need to be updated to reflect this.

Reduction in Elective Activity (outpatients and inpatients)
The Cluster has a number of elective care QIPPs that will reduce activity and improve productivity in hospitals. This ought to present opportunities to reduce staff. Further work is being done to identify the potential for further reductions (with the SHA's analyst team using their acute demand and capacity planning tool) and workforce impacts will be considered further when this modelling work is complete.

Emergency Activity
General surgery consultant emergency rotas are being reviewed to ensure patients receive care from the right consultant with the right skills 24/7. The expectation is that there will be separate rotas for general surgery, breast surgery, colorectal surgery and urology.

To support this expected service shift a skills review and assessment of nurses has been commissioned by the workforce boar d. Training needs identified will be delivered through on line learning.

Transforming Community Services
To fulfil the ambition of Making Every Contact Count the workforce board has commissioned a piece of work to roll out training to every practitioner in the cluster through supported on line teaching. This approach, begun in 2011, evaluated well and proved to be effective, value for money and to have delivered tangible benefits to patients.

Assistive Technology
In April 2011 GEH introduced VitalPAC into its Emergency Medical Unit (EMU). VitalPAC is an innovative electronic software system which helps monitor the condition of hospital patients. It will enable nurses to electronically record and analyse vital signs and other clinical data such as pulse, blood pressure and temperature. The system helps ensure that patients who are getting sicker are quickly identified and treated. It also makes it easier to identify patients who are well enough to be discharged. It comes complete with VITAL e-learning support.

This project is still in the early stages and workforce implications will be known following future evaluation.

Workforce Management
During 2012/13 the cluster will create a strategic workforce management group, to meet quarterly, comprising human resources, medical and nursing colleagues to support activities of the Clinical Quality Review group that oversees the performance management of Contract Schedule 5.

8.7 Arden Collaborative Information Management and Technology (IM&T) Programme

The Arden system operates a Collaborative IM&T Programme. The programme aim is to encourage the organizations in the Arden system to use IM&T collaboratively to support the delivery of QIPP and service transformation. The programme is co-ordinated by the Cluster Chief Information Officer, and managed through a Programme Board, chaired by the Cluster Chief Executive, which is a sub-group of the Arden System Board. The Programme Board comprises both IT and non-IT Directors from all organizations in the health economy, and currently includes two CCG representatives.

The agreed Arden Collaborative IMT plan sets out principles and process for collaboration, overall vision, current collaborative IM&T plan, and specific areas for future development.

Current developments include:-

- Telehealth pilots and planning for rollout
- Electronic transmission of all correspondence including letters, discharge summaries from Arden providers to GPs
- Information sharing pilots, particularly focusing on making primary care records accessible in secondary settings as appropriate
- Development of e-tools to support the Common Assessment Framework for adults as part of a national demonstrator project led by Warwickshire County Council.

Agreed priority areas for future development include:-

- Wider information sharing at the point of care, with effective operation of alarms and alerts across care pathways
- Digital tools for citizens and patients, including access to own records and correspondence, self care tools, extended use of telehealth and assistive technologies
- Shared information for analysis and performance management including risk stratification, pathway analysis
- Collaboration on operational systems (eg PACS and laboratory systems re-procurement) and transactional systems (eg GP electronic requesting, referral management systems)
- Collaboration on underpinning infrastructure (eg networks, end user devices) and IT service provision (eg service desk co-ordination).

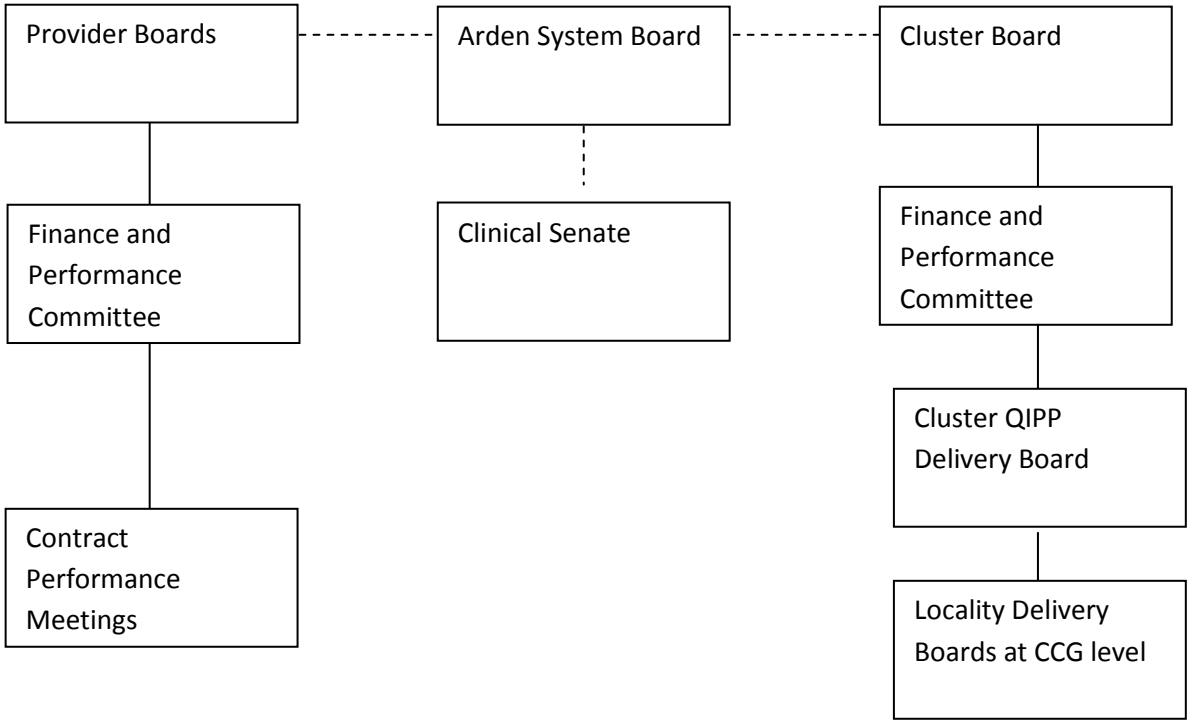
Appendix 13 details how the Arden Collaborative Plan meets the Key Lines of Enquiry

9 Implementation and Delivery

9.1 Governance and Business Processes

The Cluster Board will continue to exercise its duty to oversee delivery of this Plan and will support CCGs to assume greater levels of responsibility through schemes of delegation. The Board will continue to assure itself that services delivered in Arden are safe and are of the highest quality. The Chair and non-executive directors will continue to work alongside Directors and CCG Chairs as members of the Cluster's Finance and Performance Committee (chaired by the Cluster Chair). The Cluster has well established business processes in place and CCG Chairs and Chief Operating Officers are assuming greater levels of responsibility for leading those processes, particularly in relation to QIPP and CQINN negotiations within contracts.

The Cluster also has an established Programme Management Structure:-



The System Board will maintain an overview of system-wide planning and delivery, with the support of the Clinical Senate which will provide advice and leadership in respect of clinical strategic direction. The Clinical Senate will play a key role in promoting new areas for QIPP development. It formally signs off proposed QIPP plans and informally monitors any specific unintended consequences of service change programmes. Where problems are identified, CCG chairs will pursue resolutions in formal discussions at contract performance and clinical quality review meetings.

A bi-weekly meeting of CCG COOs and contracts leads has been responsible for harmonising the approach to specific QIPPs and the wider plan across all CCGs, maintaining ownership across the Cluster. Each CCG feeds these developments into its emerging governance processes for sign of by its Board.

This current matrix approach is underpinned by formal agreements that are fit for purpose whilst CCGs are not established or authorised organisations. The arrangements for Bi-lateral and more collective approaches to collaborative commissioning between CCGs will be reviewed and developed to ensure they are fit for purpose within the new commissioning architecture. CCGs have contributed to all iterations of the System Plan and will review and sign of the final document.

In addition CCGs have agreed to produce their own Cluster specific delivery plans, which contextualise and localise the cluster plans. This additional iteration of the planning process will offer a further opportunity to evolve CCG specific plans. Each CCG's specific delivery plan will also be used to underpin the 'Do, Share, Buy' analysis that has already taken place. This process will contribute to the summary Business Cases that will be submitted to the Cluster to create the initial configuration of staffing and support required by CCGs to deliver their plan and to evolve their governance infrastructures on the way to establishment and authorisation.

Much good work on delivery is already underway within CCGs:

Within Coventry, Godiva CCG has led the contract negotiations with CWPT regarding community services and has developed a strong working relationship with the Trust based on clinical leadership and direction. There is a clear focus on developing integrated teams across general practice and community teams (initially for community nursing services, but to be extended) based on populations of circa 50,000, as a means to reducing emergency admissions into hospital, and facilitating discharge from hospital. There is an alignment between the QIPP targets for reducing emergency admissions, the commissioning intentions, and the CQUINs which have been signed off, with exciting developments around integrated team innovative working and the implementation of new initiatives around risk stratification and telehealth. There is a clear understanding around the invaluable contribution that community services can make to achieving some of the challenges relating to the acute contract, particularly in reducing emergency admissions and length of stay. Additional investment in in-reach discharge facilitator's posts has been identified, and service redesign in community services has been completed to complement acute provider contracts. CCGs are working closely with CWPT to strengthen clinical input into pathway review, quality improvement and service specification review through its clinical reference groups. As well as holding the Provider to account through routine contract monitoring and the CQR process, CCGs will also be holding its constituent members to account regarding the general practice contribution to integrated team working. An integrated teams project board has been established to oversee the various inter-linked workstreams.

CCGs recognise their role in improving the quality of general practice. During 2011/12, significant progress has been made through CCG clinical leadership to improve referral patterns, long-term condition care and outcomes and prescribing. Plans are already well advanced for strengthening this further during 2012/13, through the alignment of education and training, as well as incentives in the system such as the QOF Quality and Productivity Indicators.

North Warwickshire CCG is working in partnership with Providers to improve quality and outcomes. A quality forum has recently been established involving clinicians at GEH and the CCG meeting together on a monthly basis to review identified opportunities for improvement. The aim is to establish a culture of continuous improvement. The forum provides an opportunity to discuss cases in an open, non-blame environment with the clinicians working together to identify changes to improve patient experience and outcomes. Changes to referral forms have been agreed that allow GPs to indicate the level of concern they have about particular patients. The aim is to help consultants prioritise the most serious cases and to ensure that consultants differentiate between referrals where the

GP strongly suspects a likely diagnosis of cancer from those where the GP is simply seeking reassurance, perhaps on behalf of the patient, or simply needs to rule out the possibility.

In support of the drive to improve quality and to ensure that every part of the system is outcomes focussed, South Warwickshire CCG is creating a Quality and Integration post with the sole focus of working with SWFT and Warwickshire County Council to drive quality improvement through integration.

9.2 Programme Management Approach

The Programme Management Office (PMO) was set up in 2011/12 and has the following responsibilities:

- To screen all programmes and projects for delivery against criteria in line with SHA and DH requirements for reporting
- To confirm and challenge project managers and executive sponsors on delivery of projects
- To provide regular reports to the programme board
- To service the programme board
- To report to the SHA and DH on delivery
- To escalate and flag areas that are not delivering to the programme board, ie, to identify and mitigate risk

The Cluster Programme Delivery Board meets monthly to scrutinise QIPP scheme performance and, where performance is behind schedule, to support project managers to develop robust remedial action plans.

9.3 Leadership Capacity

Executive Director support to CCGs for QIPP planning and delivery is shared between the Cluster's Transformation Programme Director and the Director of Performance with other Directors and the CCG Chief Operating Officers having Executive Sponsor responsibility for QIPP plans. The Cluster's two Medical Directors for Primary and Secondary Care have specific roles in leading the Primary Care Quality and Sustainable Acute Specialties components of QIPP transformation respectively, working closely with the Transformation Programme Director in doing this.

The Cluster's Transformation Programme Director will be responsible for assuring the Cluster Board that the aspirations and objectives outlined in this Plan are being delivered. The System Board will sign-off the programmatic approach to System Plan delivery and the Transformation Programme Director will monitor delivery against key milestones. Formal reports on delivery will be considered by both the System Board and the Cluster Board, as well as by individual CCG Boards for local aspects of this Plan.

The Cluster's Nurse Director (supported by the Medical Directors) has a specific responsibility for ensuring QIPP schemes address fully any quality and safety issues and for ensuring that there are no unintended consequences for quality and safety inherent in any service change programmes.

Clinical leadership for QIPP is shared between CCG Chairs and the Cluster's Nurse and Medical Directors who come together at monthly Clinical Senate meetings where QIPP transformation is a core agenda item.

9.4 Programme Funding

Details of how the 2% strategic change reserve funds (£28m) are to be utilised non-recurrently are included in Arden finance plans for 2012/13. There are a variety of purposes described in support of the transitional changes associated with QIPP schemes, as detailed in the recent submission to the SHA. These plans include pump priming pilot schemes, funding double running costs and termination costs and support of QIPP delivery where this straddles two financial years.

10 System Engagement

10.1 Plan Development

This Plan reflects priorities identified through dialogue and engagement with all local stakeholders in various fora, both in respect of recent service change proposals or in respect of the earlier, separate, Coventry and Warwickshire PCT plans.

Provider and local authority system planning leads have been engaged in the writing of this Plan from the very beginning and have commented on all versions of the Plan produced. The content of this Plan has been subject to significant scrutiny by Providers not least because all parties are committed to ensuring that this Plan really does drive a system-wide transformational programme of service change and the foundations for the system's collaborative effort going forward.

From a commissioning perspective, CCG Chairs and Chief Operating Officers have influenced very much of the content of this Plan and they have been eager to demonstrate within the Plan the significant progress they are making as the take on more and more of the commissioning agenda. CCGs are proud of the achievements they have already been able to demonstrate as commissioners and, again, have been eager to demonstrate this within the Plan.

CCG Chairs and Medical and Nursing Directors are members of the Clinical Senate which is the senior clinician reference Group in Arden. The Clinical Senate has debated very many of the strategies outlined in this System Plan and all members have been invited to comment on Plan content. The final version of this Plan has been shared with Senate members for sign-off. Further, the Clinical Senate will be instrumental in agreeing the clinical engagement strategies to be deployed that will secure successful delivery of System Plan objectives.

Stakeholders listed below will be fully engaged in taking this Plan forward. The Cluster acknowledges that it needs to engage more effectively with the 3rd sector and it will do this.

- All NHS Providers
- Clinical Commissioning Groups
- Coventry Health Overview and Scrutiny Committee
- Warwickshire Health Overview and Scrutiny Committee
- Coventry Health & Wellbeing Board
- Warwickshire Health & Wellbeing Board
- Coventry City Council
- Warwickshire County Council
- Coventry Local Involvement Network
- Warwickshire Local Involvement Network
- 3rd Sector partners

QIPP scheme design and delivery has been delegated to CCGs and Chief Operating Officers are personally overseeing negotiation of QIPP schemes in contracts and their subsequent achievement. GPs have worked with local secondary care clinicians in clinical reference groups and small task and finish groups to agree new QIPP schemes and to re-model services to ensure increased quality and better productivity/cost efficiency. CCG leaders, board members and other clinical leads have worked hard alongside practices to engage them in the commissioning agenda and to embed QIPP initiatives. CCG Chairs are members of both the Clinical Senate and of the System Board and, as such, take an active role in debating whole system issues and problem solving. CCGs meet as a Federation, although it is not as yet clear that the Federation will agree a role beyond authorisation in April 2013. CCGs meet regularly with the Executive Management Team

as members of a Joint Collaborative Commissioning Board and play an integral part in decisions about how the system reform agenda is delivered. The views of CCGs as potential customers of the CSS mean that they are having a real influence in the way in which the CSS is being developed.

The Clinical Senate is providing senior clinician and social care oversight of the way in which service change strategies are being developed. The Senate supports the activities of the System Board by being the senior clinical reference group to which it refers and from which it receives its advice. The Senate recognises the crucial importance of its role in promoting clinician engagement both within and between organisations and members are actively engaged in promoting the joint work necessary to deliver sustainable acute services for the future and the underpinning service models to support this.

Local Authority Chief Executives and Directors are members of the System Board and Senate and, as such, are fully engaged in system senior leadership and planning. Cluster Directors in their various roles meet regularly with counterparts in social care services to promote social care engagement in the health agenda and vice versa. Both parties work particularly closely to support delivery of reablement services, ie, in drawing up agreements about the use of S256 monies and to agree winter plans.

Both PCTs have developed 'Concordats' with their respective Local Authorities that describe the way the partnership will work to promote better collaboration in service planning and commissioning. For example, successful work has been implemented with social care in 2011/12 in respect of out of area mental health placements. Supported by CQUIN funding, CWPT has supported the repatriation of clients and this has reduced placement costs for the year by circa £1.8m.

Joint work has also been undertaken on the establishment of 'Health Watch', Patient Advice and Liaison Services and Deprivation of Liberty Safeguards.

All staff are well educated about the importance of the QIPP agenda in achieving long term clinical and financial sustainability of services. Regular communication about QIPP is cascaded throughout the Cluster through Coffee with Directors meetings, Team Brief and team meetings. A Staff Engagement Group meets monthly to consider issues affecting staff over the transition period to the new commissioning architecture.

Formal negotiations with staff side happen through the Joint Negotiating and Consultation Committee.

The Arden Cluster Equality and Human Rights Group meets quarterly with representatives from all Directorates and a Chief Operating Officer representing CCGs. The purpose of the Group is to ensure that all Cluster activities take account of the equality and human rights agenda. The Cluster has a policy in place covering the way it Equality Impact Assesses all change programmes and this will be applied to all programmes arising out of this Plan

A two year strategy was approved by the Board in January and is available to view on line at:
http://www.coventrypct.nhs.uk/OurWork/EqualityandDiversity/SingleEqualityScheme

The Cluster's Equality Delivery System Action Plan is attached at Appendix 14 and is available on line at:
http://www.coventrypct.nhs.uk/OurWork/EqualityandDiversity/EqualityDeliverySystem . This includes targets for the Cluster, the Commissioning Support Service and CCGs.

10.2 Embedding engagement to transform healthcare

The Cluster will develop with CCGs a programme of comprehensive communication, engagement and consultation with the public about Coventry and Warwickshire's vision for transformation of local health services.

This will involve:-

- Communicating with stakeholders and the public on why transformation in Coventry and Warwickshire healthcare is needed and the benefits it will bring
- Comprehensive stakeholder analysis for each workstream of change
- Agreeing a mutual understanding with partners about what 'success' will look like for each element of service change
- In-depth engagement with identified stakeholders on each element of service redesign required
- Public consultation where necessary on service change proposals

A communications and engagement strategy has already begun in the following areas:-

- Comprehensive pre-consultation engagement with the public and partners ahead of the launch of consultation on paediatric and maternity services and on dementia services.
- Engagement with stakeholders, service users and carers around the frail older people programme.
- Early high level clinical discussions around the acute sustainability agenda and the need for clinical networks.
- Stakeholder and public involvement in developing the Joint Strategic Needs assessments in Coventry and Warwickshire

10.3 Involving patients in clinical commissioning

CCGs are already ensuring that engagement with patients and the public is meaningful throughout the commissioning process. With support from the public and patient involvement team in the Commissioning Support Service, CCGs are ensuring strong patient and public engagement in the re-modelling of clinical services. The input spans the totality of the commissioning cycle, from feedback on those services that might warrant redesign (because of poor patient experience) to monitoring of recently redesigned services to ensure changes generate the anticipated benefits from a user perspective.

The PPI team has also been working with individual GP practices and the primary care team to increase participation in the Patient Participation Direct Enhanced Services, leading to a 100% take up in some CCGs. The relationship between LINks and CCGs has been developed ahead of the LINks in Coventry and Warwickshire taking on the greater role of Healthwatch.

11 Risks

Nature of Risk	Likelihood	Consequence	Risk score	Mitigating Action	Residual Risk Likelihood	Residual risk consequence	Residual risk score	Risk Owner
Overarching Strategy								
System Board partners fail to agree best way of designing and delivering the high level strategic objectives identified in this Plan leading to loss of opportunity to maximise gains from change programmes and to a failure to achieve required system-wide impact where it would be right to aim for this	4	4		Arden Cluster CEO and CCG Chairs to work with System Board partners to shape the future culture of the System Board and to agree the values and beliefs under-pinning its work with the aim of securing agreement to a Compact that sets out the commitment of the System Board to deliver the agenda outlined in the System Plan	2	4		Cluster CEO
QIPP								
Difficulties in changing clinical behaviour	4	4	16	Clinical engagement and ownership of new models across commissioners and providers, supported by the Clinical Senate	2	4	8	CCG Chairs
Planning assumptions about activity impacts of schemes prove wrong leading to failure to effect activity shifts out of secondary care	3	4	12	Thorough review of business cases and planning assumptions and robust approach to scheme implementation and continuous review and rectifications. Plus identification of new schemes and scaling up opportunities. Agree risk sharing across organisations	2	3	6	CCG Chairs and QIPP Leads
Insufficient capacity to support robust QIPP programme manage	4	4	16	Ensure QIPP programme management is prioritised and maintains a high profile with the Board. Establish really sound 'right first time' approaches to all that is done. Reduce duplication in monitoring and reporting and accountabilities	1	4	4	DCD

Commissioning Development								
Some CCGs do not re-constitute in authorisable form in a timely manner causing conflict between CCGs	4	4	16	Active facilitation with SHA support to achieve timely, authorisable CCGs. Resolve through Collaborative Commissioning Board if issues emerge.	3	4	12	DCD
CCG configuration is unsustainable because some CCGs pull staffing out of CSS	4	4	16	Early and on-going conversations on Do/Share/Buy to ensure all CCGs understand the impact of their actions on others	2	4	8	DCD
Inability of CSS to meet expectations ie because conflicting priorities of CCGs impacting on CSS's reputation	3	4	12	Utilise CSS Management Board to resolve any emerging issues at an early stage.	2	3	6	DDS
Provider Development								
Failure for one or more of the three non-FTs to reach FT status	3	4	12	Proactive support by Cluster and CCGs to support FT application (e.g. Cluster membership of GEH project team) Systematic tracking of adherence to TFA timelines.	1	5	5	CEO
Workforce								
Difficulties in re-configuring workforce to support new models of care, particularly in the community	3	4	12	Engagement of Coventry and Warwickshire Workforce Board in workforce planning, supporting new training programmes and mentorship arrangements. Ownership of Plans on part of providers to give confidence that proposals are sound and have high likelihood of success	2	3	6	DNQS
Impact of on-going changes in commissioning structure on retention of skilled commissioning staff to drive QIPP programmes	3	4	12	Develop OD plan for CSS with staff involvement. Resolve Do/Share/Buy discussions as quickly as possible.	3	3	9	DDS
Finance and Performance								

Failure to achieve financial balance as a result of not identifying sufficient QIPP schemes	4	5	20	Continue to work with providers through contract negotiations to identify additional QIPPs and review potential to scale up current QIPPs.	2	5	10	DT CCG Chairs
Failure to achieve financial balance through poor delivery of QIPP/transformation	4	5	20	Robust programme management arrangements, including project plans with clear KPIs and milestones Ensure incorporation of QIPP schemes into contracts with providers, including risk-sharing, as appropriate	3	4	12	DCD CCG Chairs
Failure to deliver national performance targets	3	5	15	Incorporate all national targets into contractual frameworks with providers and ensure robust performance management through contract performance meetings. Robust and timely monitoring through finance and performance committees.	2	5	10	CCG Chairs
Hospitals fail to reduce capacity in line with proposed plans, compromising QIPP delivery and financial balance	4	5	20	Collaborative capacity planning and appropriate risk-sharing between commissioners and providers. Provider engagement in plans from 1st principles	2	4	8	Contract leads

Signatories to the Arden Cluster System Plan

Provider CEOs

Name/Designation	Signature	Date
Stephen Jones NHS Coventry and NHS Warwickshire – Arden Cluster		
Rachel Newson Coventry & Warwickshire Partnership Trust		
Kevin McGee George Eliot Hospital		
Andrew Hardy University Hospitals Coventry & Warwickshire		
Glen Burley South Warwickshire Foundation NHS Trust		

Clinical Commissioning Groups

Tony Feltbower Godiva and InSpires CCGs		
Adrian Canale-Parola Rugby CCG		
Heather Gorringe North Warwickshire CCG		
Inayat Ullah Nuneaton and Bedworth CCG		
David Spraggett South Warwickshire CCG		

Cluster Nursing Director

Fay Ballie Director of Nursing		

Cluster Medical Directors

Name/Designation	Signature	Date
Francis Campbell Medical Director Primary Care		
Martin Lee Medical Director Acute Care		

Local Authority CEOs

Jim Graham Warwickshire County Council		
Martin Reeves Coventry City Council		