# Preventative & Proactive Care: Primary Care

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Prevention of Type 2 diabetes | • WN GP's have led improvements in diagnosis and management of diabetes patients.<br>• The #onething campaign has been pivotal in raising awareness of the risks and identifying people who are in need of treatment.<br>• The #onething campaign has been run in partnership with Warwickshire County Council. - Hundreds of health checks have been carried out as part of the #onething campaign and during Ramadan at the local mosque. | • A greater proportion of patients will be diagnosed with diabetes meaning they benefit from earlier detection rates and subsequent treatment and control of condition | • Ongoing monitoring of diabetes diagnosis rates<br>• On-going promotion and utilisation of #onething campaign |
| Support better management of diabetes in primary care. | • Proposals are currently being developed to create an 'insulin initiation in primary care service'<br>• The CCG is exploring the potential benefit and appetite to deliver a community diabetes service. | • Increased likelihood that local patients will have their insulin initiation management and general diabetes care in a primary care setting, avoiding the need to be referred into a hospital setting. | • Regular monitoring of numbers of patients having their insulin initiated in a primary care setting rather than local hospital |
| Supporting diabetes patients through provision of high quality education and self care resources and programmes | • Funding has been secured to provide a diabetes education and self care programme for patient<br>• Work is now underway to ensure the delivery and rollout of the education and self care programme | • A greater proportion of patients will benefit from the DESMOND education programme,<br>• This means patients will be provided with necessary skills and education to encourage management of their own condition, avoiding future reliance of GP and hospital services. | • Regular monitoring of access to DESMOND education programme and monitoring of corresponding decrease in GP and hospital attendances. |
| Supporting GP practices to develop a sustainable workforce | • A GP Forward View group has been established with workforce issues identified as a key priority; successfully attracting primary care resilience funds.<br>• The CCG has expressed an interest in developing a GP retention scheme<br>• The CCG is assessing the benefits of creating an international recruitment scheme,<br>• The CCG is actively examining initiatives such as nurse mentorship and nurse prescribing, to achieve a more sustainable workforce. | • Work with Members and key partners to understand the current and forecast workforce capacity to ensure that the CCG works closely with NHS England to attract and retain workforce within the local area. | • The CCG will proceed with a GP International Recruitment application (November 2017),<br>• The CCG will proceed with a GP Resilience Funding application in order to secure central funding to support practices in greatest need and to address and support urgent issues should they arise. |

# Preventative & Proactive Care: Primary Care

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Develop plans for general practice at scale. | • The CCG is working with member practices and the LMC to develop GP clusters and have been successful in joining the Primary Care Home Program which will support work around new models of care for Out of Hospital services and Primary Care Hubs | • Patients will benefit from the sharing of a skilled workforce and exploring possibilities to enhance outreach opportunities. | • Ongoing programme of work for 17/18 |
| Support primary care to improve health in care homes | • The CCG have extended contract period for current Primary Care enhanced support to care homes | • Patients will benefit from the development of an enhanced service to improve the quality of care in nursing homes | • Ongoing programme of work for 17/18 |
| Primary care supports delivery of an End Of Life Improvement Plan. | Our Primary care teams are actively involved in the development of an End of Life improvement plan which includes:<br>• Personalised care planning,<br>• Shared records<br>• Evidence and information<br>• Involving and supporting carers<br>• Education and training<br>• 24/7 access to services | • Patients will benefit from closer partnership working<br>• Advanced care planning and better sharing of data between a range of agencies who together deliver support and care to those who are within the last 12 months of life.<br>• Patients will also benefit from enhanced support in the community to enable them to remain at home where that is their wish. | • Continued monthly meetings of the Palliative Care Network to oversee and deliver the required improvements to the system |
| Improving the quality of GP referrals to reduce inappropriate and unwarranted referrals | • WNCCG are developing a process for GPs across Warwickshire North to peer review GP referrals in order to ensure all referrals are clinically appropriate.<br>• Rugby GPs are using the Referral Support Service to improve quality of referrals. | • A greater proportion of patients will not need to be referred into secondary care and might instead have their condition managed by an alternative community based alternative or through self management | • Peer review process will be adopted by WN GP practices from September '17 with regular review points to assess impact going forward |
| Explore opportunities for practices to work together to increase flexible access to seven day services and same day urgent care through primary care. | • The recently approved out of hospital commissioning model will support integrated working and 7 day week service developments. | • Rugby practices are able to offer their patients access to GP services through the Coventry and Rugby GP Alliance.<br>• The Alliance will deliver GP appointments to patients from all/any practice within the CCG outside of normal working hours with some availability at the weekend to enable patients extended choice of appointment time and location. | • Ongoing programme of work for 17/18 |

# Preventative & Proactive Care: Primary Care

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Improve dementia diagnosis. | A range of actions have been identified for 2017/18 with the aim of increasing diagnosis rates, including :<br>• Asking practices to revisit patient lists and check their accuracy and record keeping<br>• Holding an event for practice managers in September<br>• Attending local community events on dementia to raise awareness and provide information and education, and specifically working with nursing homes | • More individuals with dementia will receive a definitive diagnosis of dementia and be able to access a range of appropriate post diagnosis support enabling them to live independently for as long as possible. | • To focus on residents in the care home population with the aim of identifying and diagnosing dementia<br>• To work with primary care on improved identification<br>• To continue to promote the Warwickshire County Council 'Living well with dementia' information portal |
| Consult and work with our member practices on moving to full delegation to commission General Medical Services. | • Member GP practices voted to remain co-commissioned with NHS England.<br>• Warwickshire North CCG intends to consult member GP practices again in December 2017.<br>• For Rugby practices, CRCCG have taken on full commissioning of primary care under a primary care committee. | • Greater opportunity to develop GP Primary Care to reflect the needs of the local population. Reflective of demography and availability of local services | • Ongoing programme of work for 17/18 and beyond. |
| Improvement of primary care estate | • A Local Estates Forum (LEF) has been established covering Warwickshire and Rugby.<br>• Hosted by the CCG and attended by provider trust estates leads, as well as WCC and planning leads from NWBC and NBBC. The LEF provides a forum to explore primary care estate opportunities in the context of the wider health economy. | • The improvement of primary care estate and the greater use of technology will enhance patient care and experience as facilities will be designed with greater flexibility to accommodate multi-disciplinary teams and an increased online access will make it easier for people to be seen quicker. | • Refresh the primary care estates strategy to include new housing and population growth.<br>• Continue to progress the projects which are currently under the Estates and Technology Transformation Fund (ETTF)<br>• Identify, through the Local Estates Forum and wider STP Estates Strategy Group, opportunities for joint working across the estate |

# Preventative & Proactive Care: Out of Hospital

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Develop interdisciplinary teams to work across groups of practices to support case management of frail and vulnerable adults. | As part of the STP workstream for Out of Hospital we have:<br>• Completed engagement with public and stakeholders<br>• Developed new model of care and identified key outcomes for patients<br>• Awarded contracts for the ne model of care | The new model will:<br>• Preventing ill health and improving the quality of life for people with long term conditions;<br>• Effectively manage long term conditions including diabetes, heart disease, stroke<br>• Identify people at risk of ill health or hospital admission who are 'frail'<br>• Avoid hospital admissions for at risk patients for increasing frailty<br>• Better coordinate the care of people with complex problems and support them to live in the community<br>• Better coordinate the care of people with complex problems via joined up hospital and community services | • Agree and sign off new contracts – October 2017<br>• Implement new model of care – October 2017 onwards.<br>• New contract commences – April 2018. |
| Review commissioning arrangements for enhanced service to nursing homes. | • Consulted with providers and customers (nursing homes) to identify what is working well and to explore different models. | • Support to individuals in nursing homes to prevent unnecessary admissions to hospital. | • Agreement of model and approach<br>• Commission and commence new service. |
| Review commissioning model and investments for hospice bedded care for End of Life Patients. | • Discussions with stakeholders commenced to redesign the end of life model of care in Warwickshire North. | • Patients and carers will receive increased level and quality support at end of life.<br>• More patients will be able to end their life in their place of choice<br>• Focus on families and carers, and they support they need if they are caring for an individual who is end of life. | • The CCG will develop community support ('compassionate communities') for end of life patients. |
| Roll out IT systems across all GP practices to support EoL patients across agencies. | • Electronic palliative care system (CASTLE) is in development. | • Patients and carers will receive increased level and quality support at end of life.<br>• More patients will be able to end their life in their place of choice. | • The electronic system will be introduced across all practices. |
| Commission a sustainable social prescribing model which demonstrates invest to save potential. | • Worked with the voluntary sector to work towards an integrated sustainable model<br>• A social prescribing offer is in place in 2 primary Care HUBS. | • Patients will be supported to keep healthy in the community with a range of available local services. | • Continue with the development of a social prescribing pilot and extended coverage. |

# Maternity and Paediatrics

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Working collaboratively with local Commissioners and providers to develop a local response to the National Maternity Review – Better Births. | • Undertaken a gap analysis against the Better Births recommendations.<br>• Established a Local Maternity System and workstreams to deliver a new model of Maternity, Neonatal and Paediatric services by 2020. | • Safer, kinder, more family friendly and personalised care.<br>• Access to information to enable decisions about care.<br>• Support centred around individual needs and circumstances. | • Choice of provider for antenatal, intrapartum and postnatal care.<br>• Access to a midwife who is part of a small team of 4-6 midwives.<br>• Plan for Community Hubs.<br>• Establish strategic commissioning approach. |
| Develop and operationalise a Coventry and Warwickshire pre-term delivery pathway and formalise via the contract . | • A pilot pathway is in place to ensure women receive the right care in the right place at the right time.<br>• The mortality rate per 1,000 live births has been reducing in Warwickshire North and Rugby but increasing in Nuneaton and Bedworth:<br>• North Warwickshire 2009/11 – 7.7 20013/15 – 6.3.<br>• Rugby 2009/11 – 5.7 20013/15 – 2.7.<br>• Nuneaton and Bedworth 2009/11 - 4.3 2013/15 - 5.7. | • Reduce the number of babies born out of area.<br>• Infant mortality - reducing the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030. | • Evaluate pilot pathway by during 2018/19. |
| Ensure neonatal intensive care capacity (level 1 to 3 cots) is matched to need. | • Reviewed the recommendations of the West Midlands Neonatal Review. | • Mothers and babies receive care in the right place at the right time. | • Review neonatal cot locations and realign as appropriate.<br>• Consider Alliance commissioning arrangements with NHS England. |
| Improve the wellbeing and development of children aged 0-5 years. | • Delivered the objectives as outlined in the Smart Start Strategy aimed at providing children with the best start in life. | • Early detection and intervention to reduce any long term health and or developmental issues. | • Embed all projects and service developments and monitor impacts. |
| Achieve national requirements related to Special Educational Needs and or Disability (SEND). | • Children that had a Statement of Special Educational Need are in the process of being this transferred to an Education, Health and Care Plan (EHCP). | • All children will have an up to date EHCP that clearly states their needs and outcomes. | • Ensure achievement of all transfer plans in place by March 2018. |

# Maternity and Paediatrics (continued)

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Collaborative commissioning arrangement for children's services with Warwickshire County Council and SWCCG. | • Coventry and Warwickshire CCGs have agreed to work towards collaborative commissioning arrangements.. | • Improved care by reducing duplication through partnership working. | • Agree the plan to implement phase one of the Collaborative Commissioning approach . |
| Review investments on prevention and early intervention services. | • Developed a plan s to review services during 2018/19:<br>• Overnight short breaks,.<br>• community nursing. | • Improving access, earlier identification and intervention, improve patient outcomes. | • Undertake reviews of early intervention and prevention services. |
| Ensure robust arrangements are in place to understand the needs and deliver high quality services to Looked After Children (LAC). | • Reviewed services for looked after children through the joint commissioning arrangements with Warwickshire County Council. | • Reduce health inequalities for looked after children. | • Ensure equality of access to services . |
| Review increasing demand for:<br>• Occupational therapy.<br>• Speech and language therapy.<br>• Physiotherapy. | • Reviewed as part of the joint commissioning arrangements. | • Improve access.<br>• Early identification and intervention.<br>• Improve patient outcomes.<br>• Reduce waiting lists. | • Agree new service model.<br>• Develop new service specification. |
| Working with public health to reduce childhood obesity. | • Worked with Fitter Futures programme to increase referrals into the services. | • Healthier weight and improved outcomes.<br>• Prevention of long term conditions. | • Identify initiatives to increase referral rates. |
| Improving management of long term conditions, for example asthma. | • Worked with School Nursing to identify prevention opportunities to manage long term conditions. | • Improved outcomes and care.<br>• Timely access to services | • Prioritise work programme against the range of long term conditions. |

# Urgent and Emergency Care

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Develop integrated urgent care services with simple access for patients. | • Reviewed current services against national standards.<br>• Commenced work with providers to realign Urgent Care Services in Coventry to more closely link to A&E to aid overall capacity and demand management. | • A more responsive, joined up service which will be easier to navigate for patients<br>• Patients will receive the optimum level of services in the appropriate setting regardless of how they access the service. | • Work will continue in 2017/18 to develop an integrated model of care<br>• Completed integrated service by December 2019 |
| Reduced reliance on urgent and emergency care over time, with integrated teams/communities proactively managing people at higher risk. | • CRCCG is supporting the Sustainability and Transformation Plan Out of Hospital work stream with a focus on supporting patients (and carers) more proactively in the community.<br>• Established 4 multidisciplinary hubs that aim to identify the most complex needs patients, and integrates with the voluntary care sector, Primary Care and Local Acute Trusts as required.<br>• Further development of the Rugby Social Prescribing offer | • Greater proportion of patients will receive treatment and care in a place that suits them.<br>• Greater emphasis on provision of support to help patients to manage conditions themselves | • Continue to develop this model of care in line with the development of the a new model of Community services across Coventry and Warwickshire |
| Integrated rapid response and support once people are in the urgent / emergency care system, with urgent social care response incorporated. | • Commenced discussions with providers and stakeholders around potential development of new pathways to support frequent flyers in A and E.<br>• Exploration of a social prescribing model<br>• Enhanced ambulatory care model at George Eliot Hospital<br>• Completed the development of the Urgent Primary Care Assessment Service in Rugby which is preventing unnecessary admissions to hospital for frail elderly patients. | • A greater proportion of patients will receive treatment and care in a place that suits them with a greater emphasis on provision of support to help patients to manage conditions themselves.<br>• Patients avoid unnecessary admissions to hospital. | • Work with providers to increase the number of conditions delivered through a community ambulatory emergency care model.<br>• Investigate the development of new pathways<br>• Development of social prescribing model |
| Appraisal of a new stroke pathway which will deliver the NHS Midlands and East Stroke Service Specifications and associated step change benefits. | • Undertaken pre-consultation engagement with public, patient groups, local authorities and other key stakeholders<br>• From engagement feedback, have assessed and defined a clinically viable option | • Improved access to specialist services in a Hyper Acute Stroke Unit<br>• Localised rehabilitation services<br>• Improved anticoagulation for AF patients<br>• Reduction in mortality<br>• Reduction in the levels of dependency of people after suffering a stroke | • NHS England Assurance<br>• Develop an implementation plan<br>• Consult on agreed plan |

# Planned Care

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Provision of care in convenient community locations. | • The CCG has well developed plans in place to create a Community Dermatology , Atrial Fibrillation Service and community Audiology service.<br>• An integrated MSK service has been introduced to prevent patients from unnecessary hospital visits. | • A greater range of services delivered closer to patients homes. Reduced travel times, no parking costs , increased convenience for the local population. | • Ensure delivery of these new services within 17/18 financial year |
| Reducing unnecessary hospital outpatient attendances | In order to reduce unnecessary follow up hospital outpatient attendances:<br>• A programme of redesign work and targeted workshops has been planned with UHCW & GEH with an aim of reducing outpatient follow up attendances .<br>• Workshops undertaken in ENT and T&O<br>• Future workshops arranged re: Ophthalmology, General Surgery, and Dermatology | • Reduction in unnecessary patient visits to hospital<br>• Reduced travel and car parking charges for patients<br>• Improved patient satisfaction | • Action plans being created at specialty level with provider to ensure reductions in follow up care are delivered during 17/18 financial year |
| Ensure commissioning policies are reviewed and aligned across both CCG's | Through active commissioning involvement in the Arden wide policy development group:<br>• A number of policies have been developed , revised and implemented via the Arden policy group to promote a consistent commissioning approach across C&W | • Ensures equity of access for patients and a consistent approach to policy development across the Coventry & Warwickshire footprint | • A planned programme of review during 17/18 financial year and beyond is in place |
| Explore advice first opportunities for GPs | Warwickshire North CCG has commissioned a telephone advice and guidance system called Consultant Connect. This will enable:<br>• local GPs to call a team of local specialty consultants to seek appropriate advice.<br>• This service will launch in Warwickshire North in the middle of September in 4 specialties initially - Urology, Cardiology, Gynaecology and Diabetes. | • Potential for significant reduction in unnecessary hospital visits.<br>• Consultant Connect system encourages GPs and Consultants to have conversation re: management plans with patient present and at the centre of the decision making process | • 4 specialties to be live on the system by end September 2017<br>• Additional 4 specialties to be added to the system by 31st March 2018. |

# Planned Care (continued)

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| To ensure social prescribing model is meeting the needs of our communities | • The CCG has invested financial resource in a social prescribing model during 2017/18 and | • The social prescribing model will support people with a wide range of social, emotional or practical needs, and many schemes are focussed on improving mental health and physical well-being | • We will be evaluating the model to ensure that impact is maximised and workload burden is reduced on primary care. |
| Work with our Local Authority partners to progress the implementation of the Carers Strategies which were refreshed during 2016/17 | • New Carer's strategy launched for patients in Warwickshire, including Rugby.<br>• New county-wide carers service commissioned by WCC commenced 1st June 2017<br>• CCG is represented on the Warwickshire Carer's Strategy Board and - working to support partner organisations. | • More people will be supported to care for patients who may be their family members or friends.<br>• Carers will benefit from receiving their own support with a new well-being check being delivered by the new Warwickshire wide Carer Well-being Service. | • The CCG will continue to promote the new service as far and wide as possible for e.g through GP practices, pharmacists, hospices and a range of voluntary sector organisations. |
| Continue to support Public Health in their efforts to achieve healthier lifestyles | • We have commissioned with Warwickshire County Council a physical activity and weight management services for children and adults. | • A greater proportion of patients will be supported to achieve a healthier lifestyle | • CCG will continue to promote weight management service<br>• Programme will be evaluated at the end of 17/18 financial year |
| Engage with our local communities to explore how to improve screening uptake | Screening programmes are:<br>• Focusing on bowel, breast and cervical screening uptake.<br>• Training sessions have been scheduled and undertaken in Coventry in July with support from Cancer Research UK | • A greater proportion of patients will receive screening opportunities resulting in earlier detection of cancer and increasing survival rates. | • Targeted health promotion activities covering bowel, breast and cervical cancers will continue. |
| Commission services that secure prompt access to diagnostics and specialist care and that are compliant with national quality standards | • A demand and capacity assessment in relation to diagnostics has been undertaken by the Coventry & Warwickshire Cancer Board. | • A greater proportion of patients will now benefit from speedy access to a range of diagnostic investigations | • Waiting times and access to diagnostic services will be monitored by the CCG on a routine monthly basis |

# Planned Care (continued)

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Continue to support Public Health in their efforts to achieve healthier lifestyles | • For Rugby Patients, we have commissioned with Warwickshire County Council a physical activity and weight management services for children and adults. | • A greater proportion of patients will be supported to achieve a healthier lifestyle | • CRCCG will continue to promote weight management service<br>• Programme will be evaluated at the end of 17/18 financial year |
| Deliver a year on year improvement in the one year survival rate; maximise involvement in Survivorship Programmes | The primary care cancer network is actively :<br>• Working with primary care to support them to improve consistency and quality of GP referral<br>• Actively working with a range of providers to ensure that screening uptake for bowel related conditions improves. | • A greater proportion of patients will survive and learn to manage bowel related conditions | • On-going monitoring and review of programme and on-going monitoring of survivor rates |
| Ensure all elements of the Recovery Package are commissioned (holistic needs assessment, care plan, pain management, review by GP) | • The CCG has implemented the Living With and Beyond Cancer (LWBC) Programme I<br>• The LWBC will incorporate delivery of Stratified Follow Up (SFU) pathways in breast, bowel and prostate cancer and delivery of the Recovery Package to all cancer patients. | • A greater proportion of patients will receive treatment and care in a place that suits them with a greater emphasis on provision of support to help patients and carers to manage conditions themselves. | • We will focus attention on agreeing an approach for collecting data on long-term quality of life for cancer patients. |
| Electronic GP referrals | • The CCG is responding to the national target - 100% of all GP referrals by October 2018 to be made electronically. | • Patients empowered to make appointments themselves with a provider of their choice at a time and date convenient to themselves.<br>• Greater utilisation will also result in reduced waiting times for local patients | • Working group created involving reps from primary, secondary care and Local Medical Committee (LMC) to drive forward greater utilisation rates in advance of national milestone in October 2018. |

# Mental Health

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Implementing a new Child and Adolescent Mental Health Service (CAMHS) and deliver transformation priorities- reduced waiting times, early interventions in schools, community eating disorder service. | • Commissioned the Provision of a specialist eating disorder service.<br>• Procurement of newly redesigned service which includes early intervention support.<br>• Referral to treatment for emergency, urgent and routine appointments in 16/17 between 98-100%. | • Earlier access and interventions .<br>• Crisis aversion .<br>• Reduced demand for specialist care. | • Reduce avoidable placements to in-patient beds.<br>• Ensure a highly-skilled workforce can meet demand.<br>• Local Transformation Plans to be annually refreshed.<br>• Ongoing monitoring of transformation priorities . |
| Review Mental Health Crisis response and self-harm (i.e. provision of services that support crisis care as per the Mental Health Crisis Concordat). | • Reviewed the Crisis Concordat to ensure that our services are up to date and fit for purpose. | • Improved access to a more responsive crisis service. | • Update the crisis concordat plan with an identified CCG lead. |
| Implement an all age Neurology developmental pathway for adults with suspected ASD and/or ADHD. | • Adult diagnostic pathway and support launched in February 2017. | • Autistic Spectrum Disorder diagnosed locally . | • Create all age ASD pathway . |
| Continue transforming care for people with learning disabilities – phase 2 (repatriation of patients out of area and/or in NHSE commissioned beds. | • Established a Transforming Care Board<br>• Created a register of those patients in a hospital bed or a risk of admission. | • Delivery of patient centred care closer to home .<br>• Reduction of avoidable admissions. | • A reduction across TCP footprint of 24 beds from 61 to 37 by March 2018 across CCG and NHSE .<br>• Working closely with our provider to redesign services. |
| Agreed specifications for services commissioned with clear referral and accessibility criteria – focusing on respite, rehabilitation, specialling. | • A review of all the mental health service specifications commenced. | • Improved patient experience, clinical outcomes and access. | • Review current specifications and reflect transformation changes via the contracting process. |

# Mental Health (continued)

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Embed our local mental health CQUINS for active case management and acute mental health admission avoidance. | • Local CQUINs have demonstrated a reduction in readmissions. | • Improved access to care coordinators.<br>• improved discharge planning for patients . | • Continue previous CQUIN initiative .<br>• Focus on a cohort of frequent attenders. |
| Review the options for a joint commissioning approach to learning disability with Warwickshire County Council as the lead partner. | • Collaborative commissioning arrangements agreed. | • Individualised care for patients with learning disability. | • Work collaboratively with our local provider to understand activity and allocation of resources. |
| Commission services to deliver national Early Intervention in Psychosis standards and increase access to individual placement support. | • Progress being made towards NICE compliance standards. | • 53% of people with first episode of psychosis starting treatment with a NICE-recommended package of care within two weeks of referral. | • Working with the service to review and benchmark staffing capacity and capability.<br>• Review service specification.<br>• Embedding specialist employment support . |
| Commission additional psychological therapies, integrated with physical health. | • Ensure a highly-skilled workforce with the right capacity and skill mix.<br>• Increased and expanded access to psychological therapies (i.e. reaching new patient cohorts (BAME). | • Increase access for those presenting with depression and or anxiety from 16.8% to 19%<br>• 50% of people who access treatments achieve recovery. | • Provision of Employment Advisors .<br>• Explore adoption of access to new digital therapies.<br>• Test, design and implement integrate pathways for IAPT and LTCs focusing on Diabetes, Asthma and COPD. |
| Increase access to annual health checks, progressing towards 75% uptake by 2020. | • Standard monitored as part of the Service Development Improvement Plan with CWPT. | • Patients to have regular access to annual reviews. | • Promote annual health checks as part of the 5 year plan. |

# Mental Health (continued)

| Commitment | What we have done | Patient Impact | Next Steps |
|---|---|---|---|
| Improving access to CAMHS services | • Awarded a new contract to deliver a new model for emotional wellbeing service<br>• Improved access through earlier identification of need and closer working with Schools | • Earlier access to intervention from a range of MDT settings promoting resilience (Rugby) | • Contractual and governance arrangements to be agreed<br>• A two year implementation phase<br>• Outcome based commissioning model |
| Continue to develop the community-based Assessment & Treatment service that is providing an alternative to in-patient admission for people with Learning Difficulties in crisis. | • Community Intensive Support team developed and currently being reviewed to evaluate outcomes. | • Ensure patients with behaviours that challenges are supported to remain in the community. | • Continue as part of a 5 year plan.<br>• Undertake service redesign prevent avoidable admissions. |
| Providers to improve transparency on service costs, performance, and activity. | • New performance Indicators have been developed for inclusion in the Mental Health contract. | • Better understanding of the numbers of patients seen, timescales and areas for improvement. | • Monthly monitoring of indicators to identify areas requiring support, investigation or investment. |
| Embed effective and timely primary care mental health support across our HUBs. | • Active Case managements is focusing on input to the four GP hubs. | • Timely access to first line intervention services promoting emotional resilience. | • Mental health worker attendance at multidisciplinary hub meetings. |