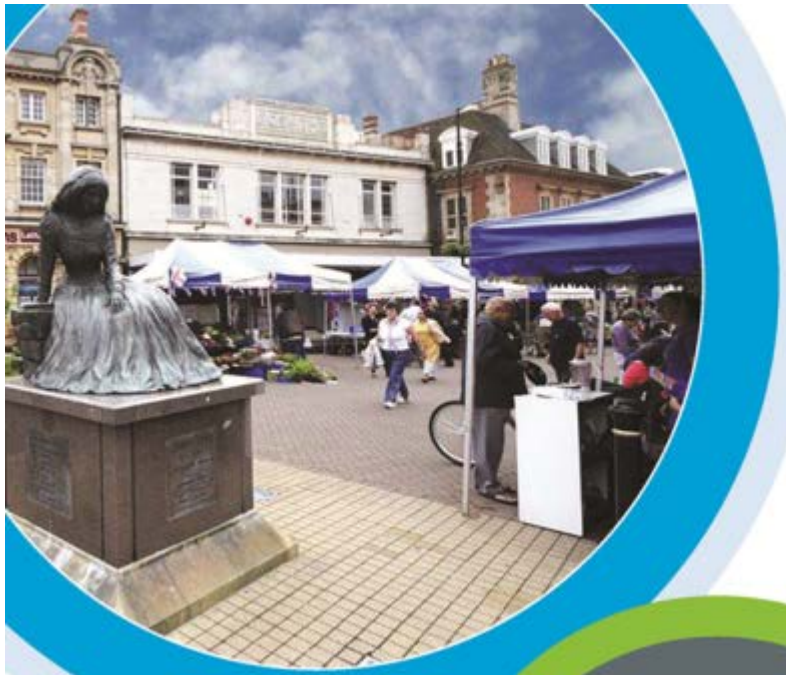
05 – Appendix C



NHS
Warwickshire North
Clinical Commissioning Group

Commissioning Intentions

DETAILED STOCK TAKE AND WORK PLANS 2019/20

Quality & Equality First

Our detailed commissioning stock take and next steps

This document contains a detailed look at our plans, progress to date and next steps for each of the key strategic work programmes. Each section covers the following:

- **Commitment** – what we've said we will do
- **What we've achieved so far** – highlights of work already completed
- **How this will benefit our patients** – to demonstrate the difference you will begin to see
- **The next steps** – the work still to complete

Primary Care

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Prevention of Type 2 diabetes	Commissioned #onething service until June 2019 to include Rugby and HbA1c testing	• A greater proportion of patients will be diagnosed with diabetes meaning they benefit from earlier detection rates and subsequent treatment and control of condition	Ensure that the NHS diabetes prevention programme is rolled out and available to all eligible patients registered with a Warwickshire North GP practice
Support better management of diabetes in primary care	Service went live 01-Oct-17 with 11 practices signed up to provide insulin initiation in a primary care setting.	• Increased likelihood that local patients will have their general diabetes care in a primary care setting, avoiding the need to be referred into a hospital setting	• Map out where local services should sit in relation to diabetes management and determine how primary care is able to support this through local enhanced agreements • Support health care professionals working in primary care with access to appropriate training
Providing high quality education and self-care resources to help support patients with diabetes	• STP wide Diabetes Transformation Group and various Task and Finish Groups have been established to drive the work programme forward. • A local trajectory has been developed to increase the number of places available. • A C&W Diabetes PLT has been agreed and will take place in November • The CCG is aiming to develop a Diabetes Dashboard to monitor the wider impact on a range of system wider and patient health outcomes.	• A greater proportion of patients will have access to and benefit from the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) education programme • Patients will be provided with necessary skills and education to help them manage their own condition,	• Work closely with the new provider (once this is known) and existing providers to ensure capacity is available to eligible patients • Continue to monitor the outcomes associated with this intervention
Supporting GP practices to develop a sustainable workforce and avoid staffing issues	• We have been accepted onto the NHSE International Recruitment scheme • We have submitted a bid for £2m to support GP retention across our STP • We have supported 12 nurses to go through the Nurse Prescribing programme • We have developed an active campaign to support recruitment across our STP - Care for Your Career	• Work with our member practices and key partners to understand the current and forecast workforce capacity and pressures • Ensure that the CCG works closely with NHS England and member practices to attract and retain workforce within the local area	Continue to work with practices and other partners to deliver the STP workforce initiatives including international recruitment, GP retention, staff training and placement of clinical pharmacists within practices.

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Develop plans for general practices to work at scale	• Out of Hospital has now been mobilised and the first Place Based Team (PBT) has been established in Warwickshire North. • 8 Clusters have been established in Coventry, and Warwickshire North are in development	• Patients will benefit from the sharing of a skilled workforce and exploring possibilities to enhance outreach opportunities	Support the development of primary care at scale, both through work with the Warwickshire North GP Federation and with practices directly as part of locally developed GP clusters.
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Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Support primary care to improve health in care homes	The CCG has maintained enhanced primary care support to care homes for 2018/19 and is in discussion with a group of practices and care homes to expand the scheme in Nuneaton	• Patients will see improvements to the quality of care in care homes	A plan is in place to develop a care home enhanced services in Nuneaton initially. This involves a single GP practice to cover a care home to provide medical cover for a care home.
Primary care supports delivery of an End Of Life Improvement Plan	End of life (EoL) beds commenced in April 2018, in the north of the CCG area. Discussions continue in the south of the CCG area to commence beds in another home. Workforce development continues to be rolled out, with a comprehensive training programme implemented at GEH. An EoL enhanced service, which includes using an Electronic Palliative Care Register, was promoted to primary care in April 2018 and as of June, 10 practices have signed up.	• Patients will benefit from closer partnership working • Advanced care planning and better sharing of data between a range of agencies who together deliver support and care to those who are within the last 12 months of life • Patients will also benefit from enhanced support in the community to enable them to remain at home where that is their wish	Warwickshire North Palliative Care Network to continue to meet on a monthly basis to oversee development of end of life work Review of the Electronic Palliative Care Register across STP footprint and commissioning decision on its future Continued workforce development, with particular focus on communication skills Further investigation into end of life care for individuals with dementia
Improving the quality of GP referrals to reduce inappropriate and unwarranted referrals	Peer review process was launched in April 2018. 90% of practices have signed up. Several new pathways or interventions have been developed as an outcome of the audits and reviews.	• 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	• Support practices to continue the peer review process as part of the Making Quality Referrals initiative. • Further develop practice suggestions for initiatives that have been generated
Consult and work with our member practices on moving to full delegation to commission General Medical Services, giving the CCG the opportunity to take on more responsibility for general practice commissioning	• A further vote was carried out with practices, resulting in the CCG applying successfully for co-commissioning • Warwickshire North CCG became fully delegated by NHS England for primary care commissioning on 01 April 2018	• Greater opportunity to develop GP Primary Care to reflect the needs of the local population • Improved access to primary care • Improved quality of care being delivered to patients • Greater local ownership and relationships between CCG and member practices • Greater patient involvement in shaping services • Ensures primary care remains strong for the future	Continue to support services being resourced and delivered within primary care. Work with practices to understand and implement any opportunities for reducing practice admin requirements.

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Improve dementia diagnosis and post diagnostic support	The CCG continues to focus on improving dementia diagnosis rates, working closely with Warwickshire County Council, care homes and primary care. A mapping exercise is underway to map older populations, care homes and GP practices so that targeted assessments and support can be rolled out in areas where dementia prevalence is likely to be higher. The CCG is also investigating what benefit and advantages Admiral Nurses would bring to the area.	• 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 •This work will ensure that flexible and timely access to post diagnostic support is available to support carers who provide essential care for a person with dementia	• Targeting care home provision for people living at home with no diagnosis • Targeting GPs where there are higher numbers of estimated people living with dementia • Proposals being taken through governance board around utilising nurses to undertake cognition assessments on behalf of GPs • Continue to work with partners across Coventry & Warwickshire to carry out a system wide review into the offer to carers • Engaging with GPs to continue the Dementia Pop-up Clinics within surgeries – space for Alzheimer's Societies Dementia Navigators to offer information / Advice
Improvement of primary care estate – buildings, number of practices, technology available etc	• We commissioned the Design Buro to refresh our primary care estates utilisation exercise. • Projects in cohort 1 and 2 of the Estates Technology and Transformation Fund (ETTF) are either in train or completed. • We secured funding from NHS England to undertake options appraisals on those projects within cohort 3 of the ETTF. These are due to be completed at the end of June 2018. • We continue to hold the monthly Local Estates Forum (LEF), and attend the STP Estates Strategy Group (ESG) to ensure that we are working with partners to look at potential opportunities for collaborative working across public estate.	• 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 multidisciplinary teams and an increased online access will make it easier for people to be seen quicker	We continue to hold the monthly Local Estates Forum (LEF), and attend the STP Estates Strategy Group (ESG) to drive this intention and to ensure that we are working with partners to look at potential opportunities for delivering out of hospital and Multi-disciplinary Teams (MDTs) across the primary care estate

Out of hospital

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Develop multidisciplinary teams working across groups of practices to support the care delivered to frail and vulnerable adults	• A contract was awarded for the new Out of Hospital model which commenced on 1 April 2018. The contract is outcomes based and there will be a two year transition programme for the new care model to be developed and implemented. • An Integrated Single Point of Access (iSPA) has been implemented. • The Place Based Teams (PBTs) have started to be rolled out across both CCGs. • A single point of access has been established in both Coventry and Rugby and Warwickshire North • The contract has placed great emphasis and responsibility on the Provider for co-production of the new care model, to include engagement with patients, carer, staff and system partners.	The new model will help to: • Prevent ill health and improve the quality of life for people with long term conditions • Effectively manage long term conditions such as diabetes, heart disease, stroke • Identify people at risk of ill health or hospital admission who are 'frail' • Avoid hospital admissions for at risk patients with increasing frailty • Better coordinate the care of people with complex problems and support them to live independently for longer • Better coordinate the care of people with complex problems via joined up hospital and community services	Fully develop Locality Hubs for specialist service teams. Fully implement Placed Based Teams aligned to the newly emerging GP Clusters to manage the health and wellbeing of patients at population levels of 30-50,000.
Review commissioning arrangements for enhanced service to nursing homes	The CCG reviewed the performance of the existing enhanced service to nursing homes and decided to continue with the scheme where it was working well, and look to expand the scheme to include some residential homes as well as nursing homes	• Help ensure people in nursing homes only go to hospital when necessary by providing more care at the home	The CCG will continue to meet with a cluster of GP practices with a view to rolling out the enhanced service.
Review commissioning model and investments for hospice bedded care for end of life patients	Following discussions with colleagues in South Warwickshire CCG, the CCG agreed a model of investment for 2018/19. Two community-based end-of-life beds were commissioned in the north of the CCG area and started in April 2018	• Patients and carers will receive increased level and quality support at end of life • More patients will be able to end their life in their place of choice • Focus on families and carers, and the support they need if they are caring for an individual who is at the end of their life	The CCG continues to work to try and develop two community-based end-of-life beds in the Nuneaton area of the CCG. Dialogue with the local hospice, Mary Ann Evans, and the local acute, George Eliot Hospital, continues, to explore what options the GEH site could offer in terms of additional end-of-life bedded care

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Roll out IT systems across all GP practices to support end of life patients across agencies	Ten GP practices have signed up to use an end-of-life IT system (CASTLE Register) to support end-of-life patients to facilitate multidisciplinary working through access to a shared record containing key clinical information	• Patients and carers will receive increased level and quality support at end of life • Patients will only have to tell their story once as their data will follow them	The CCG will meet with colleagues in South Warwickshire CCG and clinical leads to discuss the future of the CASTLE Register across Arden. Following discussions and recommendations, the CCG will make a commissioning decision on the future of the CASTLE Register
Commission a sustainable social prescribing model, which enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services	The social prescribing service continues to operate successfully in the local area, helping patients by linking them in with resources and support in the community	• Patients will be supported to keep healthy and remain independent for longer by accessing an appropriate range community services and support	Social prescribing will be reviewed in due course to establish the impact it has had and the value that it offers. Other CCG schemes, such as working with high intensity users of A&E, suggest there is still scope to develop social prescribing in the area

Maternity, child and young people

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Working together with local commissioners and providers to implement the recommendations of the National Maternity Review 'Better Births'.	• The Local Maternity System has been established and the Transformation Plan signed off via the STP Board and assured via NHS England • Three work streams are in place to deliver the Transformation Plan, and key trajectories and milestones have been agreed	• Safer, kinder, more family friendly and personalised care. • Ensure patients feel more involved in the decisions about their care • Ensure support is centred around a patient's individual needs and circumstances • 20% of women will receive continuity of carer.	Implement the recommendations from Better Births, the West Midlands Neonatal Review and the LMS Transformation Plan.
Ensure women at risk of premature delivery receive the right care in the right place at the right time leading up to the birth of their child.	A pilot between UHCW, GEH and SWFT has demonstrated that working collaboratively as a system ensured that Coventry and Warwickshire women and babies are not transferred out of area.	• Where safe to do so babies delivered as close to home as possible • Improve infant mortality by reducing the number of stillbirths and neonatal deaths by 20% by 2020 and 50% by 2025 from the 2015 baseline	Implement the recommendations from Better Births, the West Midlands Neonatal Review and the LMS Transformation Plan.
Ensure we have the right amount of neonatal cots (level 1 to 3 cots), based on patient need	• The Choice and Personalisation work stream of the LMS has established a Clinical Steering Group that is developing a range of potential scenarios for the future clinical model for maternity and neonatal services • NHSE Specialised Commissioning and the Operational Delivery Network are members of the LMS	Women and babies receive care in the right place at the right time.	Implement the recommendations from Better Births and the West Midlands Neonatal review.
Achieve national requirements related to Special Educational Needs and or Disability (SEND).	• All Statements of Educational Need have been transferred to Education Health and Care Plans (EHCP) • Plans in place for imminent CQC/Ofsted inspection	All children will have an up to date EHCP that clearly states their needs and outcomes to ensure they receive the best care to meet their needs.	Through the SEND partnership and the Designated Clinical and Medical Officers review processes to improve timeliness and quality of EHCPs.
Improve services for Looked After Children (LAC) by ensuring we understand their particular needs.	Ensure Initial and Review Health Assessments are completed, are of high quality and accurately reflect the health needs of the child or young person	Ensure looked after children receive the targeted support they require.	LAC CYP receive initial and review health assessments.

Urgent and emergency care

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Make it easier for patients to understand and access the right type of urgent care service in an emergency	• Initial development work in progress with NHS England, NHS Digital and UHCW to assess the potential for developing Urgent Treatment Centre/s locally • "Ask NHS" app symptom sorter and service signposting available and promoted to Coventry and Rugby residents calling 111 - part of regional 111 developments	• A more responsive, joined up service which will be easier to navigate for patients • Patients will receive the optimum level of services in the appropriate setting regardless of how they access the service	• Supporting national and regional 'Choose Well' and 111 marketing campaigns inc during the winter season • Continued promotion of Ask NHS app to patients and carers calling the 111 service
Reduced reliance on urgent and emergency care over time, with integrated teams/communities proactively managing people at higher risk	• The Place Based Teams (PBTs) have started to be rolled out across both CCGs. An Atherstone PBT went live in May 2018, and a Bedworth one is due to follow in September 2018 • A single point of access has been established in both Coventry and Rugby and Warwickshire North which will give access to all rapid response community services via a single contact point	• Greater proportion of patients will receive treatment and care in a place that is more convenient for them • There is more support available to help patients to manage conditions themselves	• CWPT will be introducing PBTs across Coventry, aligned with Clusters, from September 2018 • An enhanced service proposal is being rolled out to all Practices in Coventry and Rugby and Warwickshire North to support them with the identification and case management of patients to direct to this service
Integrated rapid response and support once people are in the urgent / emergency care system, with better links to urgent social care services	• The UPCA service for Warwickshire north was established in January 2018 • Agreement to continue the service has been made, and funding will continue • The service will be fully staffed by October 2018, and additional services may be added, e.g. Community IV	• More patients will receive treatment and care in a place other than A&E and which is more convenient • There is more support available to help patients to manage conditions themselves • Patients avoid unnecessary admissions to hospital because more suitable care is available and more easily accessible • Services can help prevent hospital admissions and facilitate early discharge, improve patient safety and improve choice by enabling patients to stay in their homes	Community IV is still in discussion as part of an extension to the UPCA service which was launched in WN in January 2018. The UPCA currently covers 5 conditions, but there is potential to expand this once the service is fully staffed, which is expected to be in October 2018.

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Provide better, clearer and easier-to-access alternatives to A&E to help patients receive the best care for their need when it isn't a life threatening emergency	• Design stage for new holistic case management service to support patients frequently attending A&E for avoidable reasons • Exploring options to enable direct booking from NHS 111 into GP Extended Hours • Ongoing development of regional NHS 111 Clinical Assessment Service to increase the numbers of calls safely signposted to alternative services other than 999 and A&E	• A greater proportion of patients will receive treatment and care in a place that suits them with a greater emphasis on provision of support to help patients to manage conditions themselves • Providing Nursing Home staff access to clinical support via NHS 111	• Implement new holistic case management service to support patients frequently attending A&E for avoidable reasons • Implement solution to enable direct booking from NHS 111 into GP Extended Hours • Ongoing development of regional NHS 111 Clinical Assessment Service to increase the numbers of calls safely signposted to alternative services other than 999 and A&E
Improve stroke services across the area to reduce the number of strokes suffered, improve immediate care for those that do have a stroke and provide better support and rehabilitation after a stroke	• Undertaken pre-consultation engagement with public, patient groups, local authorities and other key stakeholders • Used engagement feedback to develop a clinically viable proposal that provides the services people need	• Improved access to specialist services in a "hyper acute" stroke unit • Localised rehabilitation services • Improved anticoagulation for AF patients • Reduction in mortality rates as a result of strokes • Help people continue to live independently, where it is safe to do so, following a stroke	Work with NHS England to assure the new proposals •Develop an implementation plan •Consult with patients, the public and other stakeholders on an agreed plan

Planned care

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Provision of care in convenient community locations	• Community Dermatology Service launched in May 2018 offering clinics from Nuneaton, Coleshill and Atherstone • New ambulatory ECG service delivered in local GP practices • Atrial Fibrillation Pathway Redesign launched to provide better diagnosis, initiation and management in primary care	• A greater range of services delivered closer to patients homes. Reduced travel times, no parking costs , increased convenience for the local population	Review impact and expand scope where appropriate
Reducing unnecessary hospital outpatient attendances	A number of workshops have taken place with a view to ensuring patients are seen in the most appropriate location, reducing the complexity in accessing the right service in the right place and reduce unnecessary hospital attendances. Workshops have taken place in MSK, Ophthalmology, Dermatology, (Inc. Plastics)	• Reduction in unnecessary patient visits to hospital • Reduced travel and car parking charges for patients • Improved patient satisfaction	Further workshops arranged to take place before and during Autumn 2018 relating to, General Surgery, ENT (Ear, Nose and Throat) and Gastroenterology.
Ensure commissioning policies are reviewed and aligned across both CCGs	• Work continues through the 2018/19 financial year to review existing commissioning policies on a Coventry & Warwickshire footprint level • A programme of horizon scanning continues throughout the year to identify new guidance being introduced by other commissioners that may benefit Coventry and Warwickshire patients	• Ensures equity of access for patients and a consistent approach to policy development across the Coventry & Warwickshire footprint	Revise commissioning policies where they differ from those identified in the national consultation. Ensure policies are policed and managed more effectively with range of partner organisations.
Explore “advice first” opportunities for GPs	Established Consultant Connect (Telephone Advice & Guidance) system in Warwickshire North. Operates in 7 clinical specialties. Where calls connect to a Consultant, positive outcomes are reported. 62% of calls result in referrals to hospital being avoided and in 10% of calls admissions to hospital being avoided.	• Potential for significant reduction in unnecessary hospital visits • Consultant Connect system encourages GPs and Consultants to have conversation re: management plans with patient present and at the centre of the decision making process	Increase range of specialties available on the system and encourage greater level of usage by Warwickshire North GP practices.
To ensure social prescribing model is meeting the needs of our communities	In 2018/19, the CCG is expanding the current care navigation / social prescribing service to include a new cohort of residents - those who are high intensity users of A&E. It is anticipated that providers will work more intensively with this cohort, signposting and linking them in to a range of services and groups so that individuals feel less isolated and better supported.	• 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	In 2018/19, the CCG is expanding the current care navigation / social prescribing service to a new cohort of residents - those who are high intensity users of A&E. It is anticipated that providers will work more intensively with this cohort, linking them in to a range of services and groups so that individuals feel less isolated and better supported.

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Work with our Local Authority partners to progress the implementation of the Carers Strategies which were refreshed during 2016/17	• The CCG continues to be part of the Warwickshire Carers Strategy Delivery Board, which oversees and leads on the development of strategies to deliver improved support carers. • Partners continue to work with the new Carer Wellbeing Service to ensure that they are reaching carers across the county.	• Ensure those acting as carers for family members or friends are given the right support • Provide wellbeing checks to carers	CCG will be increasing engagement with carers who look after somebody with dementia by holding regular meetings with a carer and patient reference panel 2019-20. This will allow local carers to feed into the dementia strategy and future commissioning intentions of the CCG.
Continue to support Public Health in their efforts to achieve healthier lifestyles	Fitter Futures Warwickshire (FFW) has been commissioned to reduce obesity, improve healthy eating, improve mental well-being, increase physical activity levels	• A greater proportion of patients will be supported to achieve a healthier lifestyle	• support stronger integration and signposting between CCG commissioned services and WCC/CCC Public Health services through our commissioning and contracting approaches • ensure a strong focus on reducing inequalities and evidencing our impact across our commissioning activity by promoting workplace wellbeing for our staff and those of our provider organisations • celebrating good practice around prevention and wellbeing • strengthening our approach to Making Every Contact Count across our commissioned activity • championing system-wide initiatives including #onething and The Daily Mile
Provide quicker access to cancer diagnostics and specialist care and that are compliant with national quality standards	Cancer Waiting times will continue to be monitored through the commissioner/provider contractual arrangements. It has been recognised that a wider system wide diagnostic review will be required however this will require additional resource.	• A greater proportion of patients will now benefit from speedy access to a range of diagnostic investigations, reducing waiting times and improving patient outcomes	• In line with national Cancer planning guidance, work closely with South Warwickshire CCG (as lead) to ensure a local diagnostic demand and capacity review is undertaken • Continue to with in collaboration with West Midlands Cancer Alliance ensuring future demand on services is made available as part of a wider work stream

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Engage with our local communities to explore how to improve cancer screening uptake	There is a local push to improve uptake across the national screening programmes. In 2016 owing to poor local uptake CCGs identified Bowel Screening as its priority area. There are a number of related initiatives that are being taken forward: Promoting Bowel, Breast and Cervical Screening In total 160 potential 'non-clinical champions' have been trained (including non-clinical GP practice cancer champions). This training has focussed on reaching "Seldom Heard" groups, within the communities and population groups with the poorest uptake. The Primary Care Cancer Education Network Group is currently reviewing options working closely with WMCA to determine how it Promoting bowel screening through GP Endorsement; Promoting Bowel Screening among those who initially 'DNA' (do not return FOB specimen) Resource has been secured from PHE/NHSE for a two-year programme working through the C&RGP Alliance to support practices across C&W in offering evidence based interventions. Based on local statistics (late diagnosis, poor survival rates) Lung Cancer has been identified as a priority for 2018/19.	• A greater proportion of patients will receive screening opportunities, resulting in earlier detection of cancer and increasing survival rates	In line with locally developed plans, continue to work towards improved screening rates across the 3 main screening programmes
Deliver a year on year improvement in the one year survival rate, maximise involvement in survivorship programmes	•Delivered a successful Coventry & Warwickshire Lung cancer education event in March 2018, attended by over 300 GPs •Cancer information packs have been distributed to practices across Coventry and Warwickshire •Established a Coventry & Warwickshire wide lung cancer pathway group •Established a Coventry & Warwickshire cervical screening group	• Improved cancer outcomes for the local population in the long term •Raised awareness of the importance of all cancer screening •Increased the uptake of cancer screening •Reduced inequalities in cancer screening, promoting early diagnosis	•Planning underway of next Coventry and Warwickshire cancer education event •Continue to promote bowel, breast and cervical screening •Promote bowel screening through a range of primary care initiatives •Development of a Primary Care cancer strategy Develop a training programme for non-clinical cancer champions

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Ensure all elements of the recovery package are commissioned (holistic needs assessment, care plan, pain management, review by GP)	• Funding secured via Macmillan for a Coventry and Warwickshire Senior Manager to lead Living with and Beyond Cancer (LWBC) programme and a Practice Nurse facilitator to support PC cancer care reviews • Develop baseline for LWBC provision across Coventry and Warwickshire providers • Developed task and finish group to monitor progress and provide programme direction • Breast cancer pathway workshop June 18 • Continued work with West Midlands Cancer Alliance (WMCA) and local providers to implement the breast stratified pathway • Further work with WMCA and trust organisations to plan implementation of colorectal and prostate cancer stratified pathways	•People living with and beyond cancer have improved quality of life, and improved health and wellbeing • People are more confident in their ability to self-manage their health, and make appropriate use of health care resources, leading to a reduction in GP and A&E attendances • People live longer due to healthier lifestyle and better management of the consequences of treatment, e.g. CVD • Implementing the Recovery Package supports the wider implementation of stratified pathways of care, leading to fewer patients in face to face follow up, allowing reallocation of resources to focus on patients with complex needs	• Production of a Coventry and Warwickshire Living Well Beyond Cancer implementation plan • Use the baseline information to support prioritisation of work plans • Continue the rollout of practice nurse training for Cancer Care Reviews • Continue to support Trusts to deliver the Recovery Package
Improve ability for GPs to refer electronically	The CCG has supported local GP practices and local Trusts to meet the requirement for all GP referrals to be made electronically by 1st October 2018.	• Patients empowered to make appointments themselves with a provider of their choice at a time and date convenient to themselves • Greater utilisation will also result in reduced waiting times for local patients	• Ongoing monitoring of utilisation of the system will continue. • Support, training and engagement with Practices and Providers will continue to ensure benefits are realised. • Appointment Slot Issues (ASI's) will be monitored to ensure our local Trusts are working too the National target of no more than 4% ASI's. • Continue to encourage the use of Advice and Guidance (A&G) within eRS (or alternative systems) to prevent unnecessary referrals. • Continue to encourage our local Providers to publish all appropriate services to eRS with the overall aim of achieving one referral method/ route.
Deliver a year on year improvement in the one year survival rate, maximise involvement in survivorship programmes	•Delivered a successful Coventry & Warwickshire Lung cancer education event in March 2018, attended by over 300 GPs •Cancer information packs have been distributed to practices across Coventry and Warwickshire •Established a Coventry & Warwickshire wide lung cancer pathway group •Established a Coventry & Warwickshire cervical screening group	• Improved cancer outcomes for the local population in the long term •Raised awareness of the importance of all cancer screening •Increased the uptake of cancer screening •Reduced inequalities in cancer screening, promoting early diagnosis	•Planning underway of next Coventry and Warwickshire cancer education event •Continue to promote bowel, breast and cervical screening •Promote bowel screening through a range of primary care initiatives •Development of a Primary Care cancer strategy Develop a training programme for non-clinical cancer champions

Mental health and learning disabilities

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Improving access to Child and Adolescent Mental Health Service (CAMHS)	• Follow up waiting times reducing throughout 2018 • Community Hub offering drop-ins and group work to open in Rugby in the Autumn 2018	• Earlier access and interventions • Reduced unnecessary demand for specialist care by ensuring more appropriate care is available and easy to access	• Further integrate pathways with family/ community hubs • Monitor and evaluate impact of transformation schemes on outcomes for young people • Review referral to treatment pathway to ensure reduced waits are sustained • Promoting the Dimensions Tool as a means of parents and families describing need to referrers and the Rise service directly, as well as identifying means of self-directed help and support • Applying to NHSE for Green paper funding to develop school based mental health teams if and when the local LTP area is invited to apply
Development of an enhanced service to improve the response for children in crisis.	• Camhs Tier 3.5 Business Case developed for sign off • Business case developed for Expansion of the Acute Liaison Team AT UHCW to improve access and assessment from five days to seven days	• Access to the service seven days a week • Improved crisis aversion • Reduced length of stay in a hospital bed	• Monitor impact of seven day service • Approve and implement enhanced crisis service
Pilot additional support for CAMHS/LD and ADS children and young people in crisis -	Business case developed and Accelerator Bid to NHSE for additional investment	Community support preventing hospital admissions	Monitor impact of service
Pilot outreach support for children, young people and families waiting for an ASD diagnosis and those who have recently been diagnose with ASD.	Business case developed and Accelerator Bid to NHSE for additional investment	Community support and early intervention and prevention	Monitor impact of service

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Embed the Suicide Prevention Strategy and reduce suicide rates by 10% against the 2016/17 levels	£251k has been secured for STP to test safe havens for suicide prevention, with base in Warwickshire to reflect high prevalence areas	• Raise awareness of support available to those contemplating suicide • Reduce levels of suicide	• Ongoing monitoring of the service (following commencement of the Safe Haven pilot in February 2019) to understand the effect on suicide prevention. • Ensuring there are safe drop in places available for men in their community • Expanding the existing suicide prevention campaign 'It Takes Balls to Talk', to reach additional community assets such as barbers and workplaces • Develop a social prescribing offer for men who are socially isolated or experiencing difficult life events • Deliver evidence based mental health awareness and suicide prevention training to non-mental health professionals including social care, primary care, A&E, Job Centre and Citizens Advice Bureau staff • Develop a network of champions and train the trainers within healthcare settings to drive an ambition towards zero suicide
Increase access to specialist perinatal mental health services	A successful bid to enhance and build capacity within this service	It is anticipated the expansion across all 3 CCGs will support an additional 222 women per year (an increase of 30% on current numbers).	To expand the capacity and capability of the Perinatal Mental Health Team to provide an evidence-based multidisciplinary service for women with moderate–severe/complex perinatal mental ill health.
All Out of Area Placements to be eliminated by 2021	• CQUIN development – Out of Area Placement Co-ordinator to be recruited by July 2018 • Analysis in progress: benchmarking and assessing current position in OAPs and LoS • *The CCG and CWPT are actively aiming to meet the aspiration that by 2021, no patients are placed 'Out of Area'; ensuring care is coordinated as close to a patients home as possible*	Ensure that treatment and care coordination is delivered to patients locally, increasing clinical outcomes and recovery.	• Undertake detailed analysis of the acute activity, identifying where patient flow issues, in relation to threshold for admission and executing efficient discharge processes • Work with provider to ensure there is clarity regarding expectation in relation to Out of Area Placements • Revising the approvals pathway for acute Out of Area Placements • Undertaking parallel work to support repatriation

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Review mental health crisis response and self-harm (i.e. provision of services that support crisis care as per the Mental Health Crisis Concordat)	• Exploring self-harm pathway	• Improved and increased access to a more responsive crisis service	Proposals include: a) Developing a self-harm register to improve the mechanisms of support for young people b) Ensuring the JSNA place based process focusses on areas of high self-harm referrals c) Ensure all proposals compliment and align with TCP work to support young people with ASD d) Review impact of Self-harm training delivered by Primary Mental Health Workers e) Link with the emerging Public Health led self-harm strategy f) Exploring Bristol's SHOP (Self Harm OutPatient) clinic and distrACT app and whether these would be suitable
Improved referral and access criteria for services – focusing on respite, rehabilitation and specialisations	Scoping QIPP (Quality, Innovation, Productivity and Prevention) opportunities to improve quality of care for patients and patient experience	• Improved patient experience, clinical outcomes and access to services	• Continue to assess clinical outcomes across trusts and how the 'gold standard' for Rehab and Recovery can be replicated • Ensure understanding amongst employers and supporting people back into employment/voluntary roles • Review what creative therapy/physical activities are available and effective • Review what access is available for ongoing support • Look at possibility of pooling budgets/ideas to create a more effective, whole system approach

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Continue to implement our local mental health Commissioning for Quality and Innovation (CQUINs) to improve case management and acute mental health admission avoidance	Success with year 1 Mental Health in A&E CQUIN (Commissioning for Quality and Innovation) and looking to expand provision in year 2	• Reduction in avoidable mental health admissions • Improvement in the use of care coordinators • Improved discharge planning for patients	• Maintain the reduction of A&E attendances of 20% for the Y1 cohort of patients • Identify a new cohort for Y2 (at least 25-30 people), who could benefit from psychosocial interventions and reduce attendances to A&E of this cohort by 20% - • Continue on the work to provide better, targeted, more appropriate support to frequent attendees at A&E • By Q4 the Trust to have a plan in place to mainstream this work
Implement an all age neurology developmental pathway for adults with suspected Autistic Spectrum Disorder (ASD) and/or Attention Deficit Hyperactivity Disorder (ADHD)	• Service has been implemented - which covers assessment, diagnosis and post-diagnostic support, in line with NICE guidance for Coventry and Warwickshire residents. • Q award nomination for the service	• Patients with suspected Autistic Spectrum Disorder (ASD) and/or Attention Deficit Hyperactivity Disorder (ADHD) are diagnosed locally and given the right support for their individual needs	The service will continue to provide a therapy led multi-disciplinary diagnostic assessment (including Developmental Dyspraxia screening), focused post-diagnostic support and signposting beyond the service.
Providers to improve transparency on service costs, performance, and activity	• Across the STP we have commissioned Mental Health Strategies to deliver mental health simulation modelling to provide rich data to inform commissioning decisions	• Better understanding of the numbers of patients seen, timescales and areas for improvement, as well as how money is being spent to improve services	Maintain and develop high quality services • Ensure a highly-skilled, confident workforce with the right capacity and skill mix accessing top-up training in new competencies for long-term conditions
Continue transforming care for people with learning disabilities and/or autism	Created the infrastructure to effectively deliver Care, Education and Treatment Reviews locally. Commissioned new community services for people at risk of admission including a pilot intensive support service for children and young people with learning disabilities and/or autism; intensive support for adults with autism and forensic community support for adults. Developed a system-wide recovery plan for the Transforming Care Partnership with a focus on admission avoidance and discharge.	Delivery of person centred care in the community to reduce avoidable admissions. Increased discharges of people with a learning disability and/or autism from mental health hospitals.	Continue to deliver the Arden Transforming Care programme with a focus on admission avoidance, accelerating discharge, ensuring commissioned services are meeting need and embedding the programme post April 2019. Work with regional commissioners to jointly commission services and redesign care pathways, including complex care and forensic rehabilitation services and services for people with autism.

Commitment	What we have achieved so far	How this benefits our patients	Next steps (19/20)
Further development of joint commissioning arrangements for people with disabilities across the STP.	Created an integrated commissioning function for people with learning disabilities and autism across health and social care for Coventry and Warwickshire (hosted by Warwickshire County Council). Initial priority areas have been agreed. Coventry and Warwickshire are leading the new West Midlands commissioning collaborative for people with disabilities. Jointly reviewed the CWPT block contract for people with learning disabilities and agreed recommendations, including the development of 6 outcome based service specifications aligned to a revised pricing and activity matrix .	Improve the integrated commissioning pathway; including for young people in transition. Improve the quality of provision for our disabled population by integrating health and social care support around individuals.	To further develop integrated commissioning intentions across the STP footprint and West Midlands as appropriate; coordinated through the integrated commissioning function. To implement the recommendations of the collaborative review of Coventry and Warwickshire Partnership Trust (CWPT) learning disability services. To develop an integrated plan for the re-commissioning of short break services and day services.
Continue to focus on improving health outcomes for people with Learning Disabilities, including increasing the uptake of annual health checks and the implementation of the STOMP (Stop over medication of people with a learning disability, autism or both with psychotropic medicines) agenda and LeDeR.	Agreed a sub-regional health improvement action plan. Commissioning resource has been identified to drive delivery In partnership with CWPT and HEE jointly funded a GP fellow specialising in learning disabilities to support and promote LD strategic programmes in primary care, The CCG is working collaboratively across Coventry and Warwickshire CCGs and social care partners to support the review of deaths of patients with learning disabilities	Improved health outcomes for disabled people. Reduced premature mortality of people with learning disabilities and/or autism.	Continue to focus on improving health outcomes for people with Learning Disabilities, including the implementation of the STOMP (Stop over medication of people with a learning disability, autism or both with psychotropic medicines) agenda
Improve the support offer for people with autism	Engaged with people with autism to support the development of a bid for funds to NHSE to pilot a community support service for children and young people with autism	Improved support offer for people with ASD	Work with commissioning partners across Coventry and Warwickshire to revise a commissioning statement of intent for people with autism.