Coventry and Warwickshire Joint Health Overview and Scrutiny Committee

Date: Monday, 14 October 2019
Time: 10.00 am
Venue: Committee Room 2, Shire Hall

Membership
Councillor Wallace Redford (Chair)
Councillor Margaret Bell
Councillor Joe Clifford
Councillor Clare Golby
Councillor John Holland
Councillor Jerry Roodhouse
Councillor Rachel Lancaster
Councillor Marcus Lapsa
Councillor Ed Ruane
Councillor Hazel Sweet

Items on the agenda: -

1. General

(1) To note the Appointment of Councillor Redford as Chair for the meeting

(2) Welcome and Introductions

(3) Apologies and Substitutes

(4) Disclosures of Pecuniary and Non-Pecuniary Interests

(5) Chair's Announcements

(6) Minutes of the previous meeting 5 - 8
To confirm the minutes of the meeting held on 20 March 2019.

2. Public Speaking

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

Non-pecuniary interests must still be declared in accordance with the Code of Conduct. These should be declared at the commencement of the meeting
The public reports referred to are available on the Warwickshire Web
www.warwickshire.gov.uk/committee-papers 2

Public Speaking

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

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Agenda Item 1(6)

Minutes subject to confirmation at the next Committee meeting

Coventry City Council
Minutes of the Meeting of Coventry and Warwickshire Joint Health Overview and Scrutiny Committee held at 10.00 am on Wednesday, 20 March 2019

Present:

Members:

Coventry City Council
Councillor J Innes
Councillor D Gannon (Chair)
Councillor D Kershaw

Warwickshire County Council
Councillor W Redford
Councillor J Roodhouse

Other Elected Member: **Coventry City Council**
Councillor F Abbott, Cabinet Member for Adult Services

Employees:

Coventry City Council
Victoria Castree, Place Directorate
Liz Knight, Place Directorate
Gail Quinton, Deputy Chief Executive (People)

Warwickshire County Council
Nigel Minns, Strategic Director, People Group
Paul Spencer, Law and Governance

Other Representative: Andrea Green, Coventry and Rugby Clinical Commissioning Group (CCG)

Apologies: **Coventry City Council**
Councillor M Lapsa

Warwickshire County Council
Councillor M Cargill
Councillor C Golby
Councillor J Holland
Councillor L Caborn, Portfolio Holder for Adult Social Care and Health

Public Business

1. **Appointment of Chair - to confirm the appointment of Councillor Gannon as Chair of the meeting**

RESOLVED that Councillor Gannon be confirmed as the Chair for the meeting in accordance with the terms of reference for the Joint Health Overview and Scrutiny Committee.

2. **Welcome and Introductions**

The Chair, Councillor Gannon, welcomed members to the first formal meeting of the Joint Health and Overview Scrutiny Committee.

3. **Declarations of Interest**

Councillor Roodhouse declared an interest in so far as he was a Director of Healthwatch Warwickshire. He remained in the meeting during the consideration of all business.

4. **Process and Timescales for Completion of the Review of Stroke Services**

The Committee considered a report of Andrea Green, Coventry and Rugby Clinical Commissioning (CCG) which provided an update on the process and timescale to complete the Stroke Improvements pre-consultation business case and the NHS England assurance process. Andrea Green attended the meeting for the consideration of this item.

The report indicated that local commissioners in Coventry and Warwickshire commenced the project to improve services for those who had a stroke or a transient ischemic attack (TIA) in April 2014. The improvements aimed to reduce the number of deaths and the scale disability caused by having a stroke and to improve the equity of stroke care. The improvement began as a review of the hospital stroke and TIA service, however initial feedback from the public and patients led to the expansion of the original scope to include a 'pathway of excellence approach' for stroke care to include action to prevent more strokes, a comprehensive specialist stroke rehabilitation service available across Warwickshire as well as Coventry, and a reconfigured hospital service.

The Committee were informed that the expansion of the scope had added complexity, cost and time in agreeing final proposals and securing assurance on the proposition from NHSE. The complexity arose from a much broader spectrum of professionals and organisations needing to agree the proposals; the requirement for further engagement and completing the option appraisal for bedded rehabilitation; and the additional costs of the proposals.

Reference was made to the additional evidence that had been required prior to completing the pre-consultation business case and next stage assurance with NHSE. This related to workforce planning and further evidence of 'stress testing' the proposals for times of peak demand on hospitals.

Over 40 people comprising the public, patients and professionals attended an event on 5th November, 2018 and participated in a non-fictional option appraisal for the location of stroke rehabilitation beds. On conclusion of the event, the workforce planning was completed. Advice was currently awaited from the expert

stroke clinical network as to the adequacy of the proposed rehabilitation workforce. The Committee noted that once the workforce had been completed, the final costing of the proposals could be concluded and the financial option appraisal completed. The pre-consultation would then be presented for sign off by the health commissioners and the Better Health Better Care Better Value Board, prior to submission to the NHSE for assurance testing.

Further work had also been concluded on ensuring that at times of peak and surge demand, the hospital services could accommodate the additional stroke patients ensuring adequate access to diagnostic and specialist bedded services.

The Integrated Impact Assessment of the proposals had been updated following the non-financial option. The Committee were informed that a detailed report and a summary were shortly to be made available as evidence of the consideration of assessment of the equity, travel and health impacts of the proposals prior to any decision to go out to public consultation. Each NHS provider trust was being asked to sign off the final proposals as deliverable and sustainable prior to the final pre-consultation business case being tested for assurance by NHS England.

Members raised a number of issues in response to the report and responses were provided, matters raised included:

- The role of Scrutiny during the public consultation process
- Further information about the timescales leading up to NHS England assurance
- Further details about the complications that had led to the delays in the finalising of the proposals
- A concern that an individual group of professionals might not be supportive of the proposals
- A request that the Integrated Impact Assessment detailed report and summary be made available to members along with the finalised proposals prior to the submission for NHS England assurance
- Further information about the additional financial implications associated with the proposals
- Whether there were any other areas who had gone down this route where lessons could be learnt from their previous experiences
- Having gone through the current process to date, were there any lessons to be learnt for future projects
- Clarification as to the reasons for the delay in the decision to include prevention
- Further details about the reasons for the additional work and evidence on workforce planning and ‘stress-testing’ the proposals at times on hospitals required by NHS England
- Details about the length of the public consultation, particularly in light of the expansion of the project, with a recommendation for a 12 week consultation
- A request for Board members to be kept updated with progress.

Members were informed that Professor Sir Chris Ham, the recently appointed Independent Chair for Better Health Better Care Better Value, was keen to ensure greater engagement with local Councillors.

RESOLVED that:

(1) The Integrated Impact Assessment detailed report and summary be circulated to Members as soon as possible.

(2) The public consultation to take place over a twelve week period.

(3) Arrangements be put in place in due course for an informal briefing for members on the proposals when appropriate.

(4) The Committee to meet with Professor Sir Chris Ham in the new municipal year.

5. **Any other items of Public Business - Councillor D Gannon**

The Committee were informed that Councillor Gannon's term of office as a City Councillor was expiring in May and he was not seeking re-election in the forthcoming municipal elections. Councillor Redford placed on record his appreciation for the support provided by Councillor Gannon during his time as Chair of the Health and Social Care Scrutiny Board (5) which had allowed for successful supportive partnership working between the two Health Scrutiny Chairs.

(Meeting closed at 10.50 am)

Agenda Item 3

Coventry and Warwickshire
Health and Care Partnership

Item 3

To: Joint Health Overview and Scrutiny Committee **Date: 14 October 2019**

From: Rachael Danter, System Transformation Director, Coventry and Warwickshire Health and Care Partnership

Title: Coventry and Warwickshire Strategic Five Year Health and Care Plan 2019/20 – 2023/24

1 Purpose

This paper shares the draft Coventry and Warwickshire Health and Care Five Year Strategic Plan for consideration and comment.

2 Recommendations

It is recommended that members:

1) Note the process for developing and engaging on the draft Plan; and
2) Consider and comment on the draft Plan ahead of final submission by 15 November 2019

3 Background

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) are required to create five-year strategic plans covering the period 2019/20 – 2023/24, setting out how systems will deliver the commitments in the NHS Long Term Plan.

The NHS Long Term Plan Implementation Framework sets out an expectation that STPs/ICSs bring together member organisations and wider partners as they develop and deliver the plans. A key principle is that the plans should be locally owned.

Local systems were required to share a draft of their plans with NHS England / NHS Improvement regional teams by 27 September 2019. Coventry and Warwickshire's draft is attached at appendix 1 to this report. The regional team will provide feedback on this submission. At the same time, there is an opportunity for local engagement prior to submission of the final plan, by 15 November 2019.

Coventry and Warwickshire
Health and Care Partnership

4 Plan development and engagement

The draft plan is informed by a focused engagement exercise undertaken with staff groups across the system (an on-line staff survey), as well as targeted engagement with patients and carers undertaken by Healthwatch. It also draws on engagement activity with a range of public and community groups conducted by the CCGs and local authorities. The understanding of population needs outlined in the draft plan is drawn directly from the local joint strategic needs assessments. The plan has been developed by the senior responsible officers for each of the workstreams, with involvement from stakeholders across the system. Clinicians have been fully engaged in developing the plan and the supporting clinical planning templates.

There is a period of engagement on the draft Plan from 27 September to 15 November. There is a detailed engagement plan in place, which includes:

- opportunities for the plan to be considered and approved through formal governance arrangements within the NHS (the 7 NHS organisations – the Clinical Commissioning Groups, University Hospitals Coventry and Warwickshire, Coventry and Warwickshire Partnership Trust, South Warwickshire Foundation Trust and George Eliot Hospital – are all required to formally sign off the plan)
- formal and informal engagement with local authorities, including the Health Overview and Scrutiny Committees and Health and Wellbeing Boards
- informal opportunities for awareness-raising and engagement on the content of the plan with key stakeholders, such as Healthwatch Coventry's steering group and Healthwatch Warwickshire's Annual Conference.

5 Draft plan – summary priorities

- Prevention – Through a strategic and targeted approach to earlier intervention, we will make it easier for people to lead healthy lives and stay well for longer.

- Population health – Focus on education, affordable and appropriate housing, stable employment, leisure opportunities and a healthy environment.

- Primary care networks – Building on our 'Out of Hospital' programme by focussing on preventing ill health, supporting people to stay well and providing high quality care and treatment in the home.

- Urgent and emergency care – Simplify our offer and deliver a fully integrated response so that the most appropriate care can be given as quickly as possible.

- Mental health – Deliver a step change by focussing on prevention, early intervention, self-care, wellbeing and recovery. Services for children and young people are a particular priority.

- Cancer – Identify more people at risk of cancer earlier and undertake more community-based screening. Treat patients more quickly.

Coventry and Warwickshire
Health and Care Partnership

- Maternity and Children – Respond to the changing needs of women, babies, children and young people. Consider how to most effectively deliver better health outcomes, quality, and patient experience in the context of existing health inequalities.

- Stroke – Implement a new agreed model of stroke care, ensuring best possible outcomes and patient experience.

- Service improvement – Implement a number of system-wide schemes to remove waste and avoid duplication.

6 Next steps

Coventry Health Overview and Scrutiny Committee (Scrutiny Board 5) will formally consider the draft Plan at their meeting on 30 October 2019. Warwickshire Health Overview and Scrutiny Committee are not scheduled to meet during the engagement period. Members are invited to respond directly to the draft Plan using the contact details below.

Report Author(s):

Name and Job Title:
Rachael Danter, System Transformation Director, Coventry and Warwickshire Health and Care Partnership

Telephone and E-mail Contact:
Tom Phelan, Coventry and Warwickshire Health and Care Partnership
Thomas.Phelan@cwstp.uk

Enquiries should be directed to the above person.

Appendices

Coventry and Warwickshire Health and Care Partnership: Our Strategic Five Year Health and Care Plan 2019/20 – 2023/24 Version 26 September 2019

Annex 1

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OUR PLACE – Coventry

Background of Place

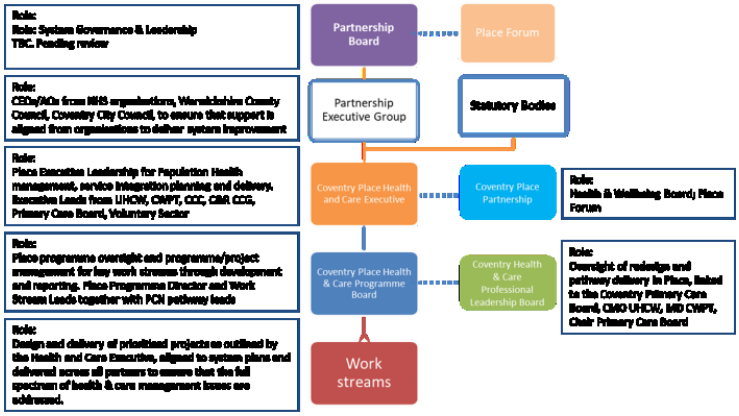
In the past ten years, Coventry's population has grown by a fifth; residents are, on average, eight years younger – with the median age being 32 years in 2017 compared to 40 in England or the region. The number of older people is increasing and this is expected to accelerate and outpace other groups. It is expected that there will be an additional 8,900 people aged over 65 and additional 2,000 people aged over 85 within a decade. This creates an imperative to focus on preventative health amongst the working age population so that people are healthier for longer.

Emergency hospital admissions due to falls in elderly people are higher than average, in addition, the number of older people having vaccinations for flu is also below national average. The under-75 mortality rate from preventable diseases and health related QOL for older people is lower than peer groups. Premature mortality is higher than average, particularly for cardiovascular disease amongst males.

While the amount of money we spend in the NHS is going up each year, the cost of services is going up more quickly, with the points outlined above in mind, we need to identify ways to deliver the same level of services at a lower cost whilst harnessing staff experience, skills and knowledge as an asset to the wider wellbeing economy and delivering on our responsibility as a geographical collaborative to act as a social anchor within society.

Governance Arrangements

The programme governance is aligned to the Coventry and Warwickshire Health and Care Partnership structure, recognising the reporting function into respective statutory boards. The executive group has been established, with representation from Coventry and Rugby CCGs, Coventry City Council, UHCW, CWPT and Primary Care, and is maintaining overarching macro and micromanagement combined as the transformation and delivery process is established.



Clinical Engagement and Transformation

To facilitate the above, a process is being piloted as an approach to deliver more than just assurance, but a standardised approach to all aspects of transformation; through data and

insights, pathway redesign, communication and engagement, through to programme management.

Clinical leadership is key in ensuring the successful delivery of programmes, moreover, it is recognised that this should be transferrable across partner organisations, therefore a professional leadership function is being developed in order to incorporate frontline delivery across all parties.

Primary Care engagement is centred on the NAPC Primary Care Home model. This model focused on building a partnership of like-minded willing practices, coming together with other professionals to create a multi-disciplinary partnership, co-ordinating care around their GP registered. We will now work with our PCN's to support their journey through the NHSE maturity matrix and deliver system impacts.

This Primary Care model is supported by the Out of Hospital contract which requires our community provider to wrap a multi-disciplinary community Place Based Team around our PCN, providing the conditions for integrated care partnership, focused on delivering personalised, risk stratified care. During 2019/20 we will work with PCN's to build the infrastructure they will require to function effectively, embed appropriate governance, deliver their extended access requirements and recruit the workforce they will need to deliver the specifications that come on stream from 2020.

Patient/ Community and Citizen Engagement

Aligned to the joint health and wellbeing strategy, place-based and asset-based JSNAs are in the process of being rolled out across Coventry and Warwickshire. These are based around eight family hub geographies in Coventry and planned along with the health footprint of primary care networks. Engagement for the JSNA development involves local partners and wider stakeholders, to give more in-depth understanding of the assets and needs of geographical areas within Coventry to support programmes and strategies which are founded on community resilience and service delivery at locality level.

Further opportunities for engagement that will be deployed are through the existing Adult Social Care Reference group. This reference group also provides a route to larger stakeholder groups such as Coventry Older Voices (COV). In addition to this CRCCG holds 'patient voice groups' which also provide a route for engagement other than limited attendance at meetings.

Place Priorities/Developments

Coventry Place will deliver a matrix working programme, with vertical and horizontal integration in the form of system pillars from prevention through to urgent/emergency and specialist care, for a range of specialty pathways in the first instance, to deliver the more tactical changes, as the larger scale system transformation programmes continue to develop. This approach provides the opportunity for service user engagement, which will be built upon for the later phases of delivery.

As delivery is achieved and collaboration builds, opportunities will be designed to broaden the model for whole system integration, incorporating the work of wider partners around key cohorts, such as frail elderly and younger persons mental health.

The primary areas of priority for Coventry Place are frailty, mental health, MSK and demand management.

OUR PLACE – Rugby

Background of Place

Rugby is home to 103,443 residents with the 'white British' ethnic group accounting for 84.1% of the population (2011 data) and just over 1 in 10 of the population recorded as being born outside of the UK. The borough has experienced a rate of population growth that is higher than the national average and there is significant local housing development which is anticipated to contribute to an additional 29,760 residents living in Rugby by 20301 over and above demographic growth.

The JSNA provides invaluable data, and the themes are reflected in our Place priorities. General practice, as the first point of contact in local neighbourhoods, is at the forefront of responding to local needs and will increasingly require quality timely data to respond to and plan services to address the needs of their registered populations. We also have individual neighbourhood JSNAs which provide a more focused picture of the health needs in our diverse neighbourhoods and will be used to help PCNs and Out of Hospital Place Based Teams understand and respond to local demand.

Work is currently underway to develop a Vision Statement for our Place which takes into account the information held within the JSNA and reflecting the themes of the Coventry and Warwickshire: Healthy people, stronger communities and effective services, which is imperative for designing our future integrated health and care system.

Governance Arrangements

Rugby has a distinct local identity and a long history of partnership working across health and social care. Rugby has a wide range of community assets and a thriving community and third sector which already work together to address local health and social care priorities. The Rugby Health and wellbeing partnership has been a focal point for Rugby Place partnership working to date, and has brought together a wide range partners. This group is currently reviewing its remit and connectivity to other local forums and the wider Coventry and Warwickshire Health and Care Partnership (ICS) arrangements, however it will take into account the existing infrastructure, which provides a vehicle for collective action to address local health and social care priorities identified through the JSNA, brings together core partners with a commitment to utilising collective available resources to improve health and well-being, to reduce health inequalities, and to deliver high quality, accessible services according to health need.

In addition it is our intention to further strengthen Rugby Place Governance by establishing a Place Executive Group. The initial scoping for the Place Executive Group will involve a range of partners who will come together to create a shared local perspective on :

- How best to build collaboration across statutory partners with accountability and duties to deliver sustainable health and social care provision to meet the needs of Rugby and to appropriately represent Rugby as a place in the context of :
    - development of the local Integrated Care Partnership capable of responding to and addressing the interests and specific place requirements and challenges of Rugby whilst recognising and effectively utilising the assets available within Rugby
    - Understanding and scoping the place priorities for Rugby in context of the Long Term Plan, taking account of existing commissioner and provider obligations and local JSNA and wider determinants of health and social care
    - Identify and address priorities which impact on the sustainability of local health and social care which require an integrated collaborative / local solution and response.
    - Developing population health insights for Rugby Place to establish a clear focus on health outcomes and establish clear base line to assess collective impact
    - Agree how Rugby as a place will interface with Coventry place – in context of patient and financial flows related to UHCW services and patient demand/flow
    - Agree how Rugby place will work with other Warwickshire Place's in context of County wide services/footprint especially services that interface with Social Care Housing Public health etc. LA services in context of integration agenda
    - Connecting a newly established Place Executive to existing Rugby governance / infrastructure such as CCG Rugby delivery Group, Rugby Out Of Hospital working

together board, and Rugby Partnership group to ensure that there is effective joined up governance between Rugby Place and existing groups as well as connectivity to wider ICS

The organisations proposed to be represented within the Rugby Partnership Executive Board include:

- Coventry and Warwickshire Partnership Trust (CWPT).
- Warwickshire County Council (WCC) – adult commissioning and Public Health.
- Coventry and Rugby Clinical Commissioning Group (CRCCG)
- University Hospitals of Coventry and Warwickshire (UHCW)
- PCN representation
- GP One Voice nomination (GP Board – includes links to LMC)
- Rugby Out of Hospital Services (OoH SWIFT)
- South Warwickshire Foundation Trust – Acute

Clinical Engagement and Transformation

Our emerging Rugby Partnership Executive Board includes a strong clinical voice with PCN representation; The CCG has funded GP one voice capacity which is intended to support clinical engagement in place and ICS forums. There is an existing Rugby Delivery Group whichis made up of GP representation from all Rugby practices; and the CCG funds a GP clinical lead representing Rugby who sits on the CCG Governing Body and within this remit will have a lead role to play in supporting clinical representation within Rugby Place.

Patient/ Community and Citizen Engagement

Involving the public and the local voluntary and community sector will be essential to the success of our Place. We will be able to build on the existing engagement channels which have already been established through the work of Coventry and Rugby CCG, the development the local JSNAs, and the work done by the Out Of Hospital working together Board, in addition to creating new channels through the development of the PCNs. We have already connected with the Rugby Health and Wellbeing Partnership Board, and are currently undertaking a reach out exercise to existing patient / citizen forums and service user voice advocacy groups and have made links with Health Watch Warwickshire.

Place Priorities/Developments

The priorities for our Place are subject to agreement however we anticipate there will be a focus on the following themes:

- Designation of urgent care centre provision on St Cross Site in recognition of higher A&E attendances and UCC attendances per 100,000 registered patient populations in Rugby.
- Optimisation of St Cross site for delivery of planed care services which meet the needs of the local population and support equitable access to health provision which is safe and sustainable to be delivered from the St Cross site.
- Integrated working between general practice and the Out of Hospital provider wrapped around PCN’s, to establish multi-disciplinary Place Based Teams capable of delivering the key requirements of the Long Term Plan including 2 hour rapid response and anticipatory care.
- Collaboration and innovation to address the challenge of transferring 30% of out patient’s appointments into Out Of Hospital settings and ensuring equity and access for Rugby residents.
- Designing pathways to respond to local needs and priorities and to address unwarranted variation in GP initiated referrals to effectively respond to high demand specialties e.g. Trauma and orthopaedics, Dermatology and general surgery.
- Prepare and plan collaboratively for the impact of housing growth
- Take account of rurality and pockets of deprivation in developing services.

OUR PLACE – South Warwickshire

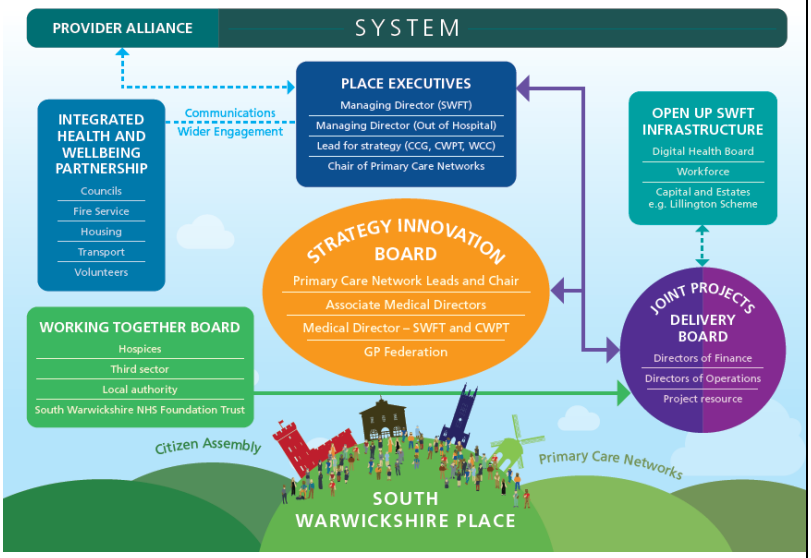
Background of Place

South Warwickshire Place has a population of circa 270,000 and has better overall health outcomes than the national average; women are expected to live to 84.5 years and men to 81 (compared to 82.5 and 78 years nationally). However, there are pockets of high deprivation within the county and groups of people who experience worse health outcomes.

Governance Arrangements

Providers and Commissioners within South Warwickshire have been collaborating at Place for some time and foresaw the benefits of integrated care. This has been strengthened for a number of years through the investment and establishment of the Out of Hospital Care Collaborative (OOHCC). As a result, we have started thinking and planning as a Place before it became part of the NHS plan. We have continued to develop this and worked with all key partners across South Warwickshire to develop an approach that will be our next step on this journey.

The graphic illustrated right, was used to support engagement and describe how we would work together to ensure we achieve the best outcomes for our population. The approach is not a new organisational structure but an illustration of the structures we will adopt to create a collaborative approach to delivering care to our population. The model will facilitate all partners supporting moving resources to where they will have the biggest impact. The proposed approach has been refined and developed with input from all key partners and there has been positive support and ownership.



Place Coordination Group - This group will develop over the next year and membership may change as the scope and remit change. The PCG members will facilitate and ensure delivery of any lead provider contracts and will be responsible for committing their organisation to the delivery of the agreed plans. Primary Care representation on this Group is currently the Chair of the PCNs, however this remains under discussion. The Place Co-ordination group has signed off Estates principles for all organisations, the Communication and Engagement approach, the Place planning process and timetable and the approach to developing Citizens engagement.

Joint Delivery Board has been established between the CCG and SWFT. This Board is currently focussed on delivering the efficiency plans and the development of new forms of contract. The remit of the Board will develop into a wider Programme Delivery Board.

Clinical Engagement and Transformation

The formation of Primary Care Networks (PCNs) has created a structure that will facilitate stronger engagement between the Trust and Primary care. We have created a Strategic Innovation Board that includes the Clinical Directors from each of the seven PCNs and the seven Associate Medical Director from the Trust. Alongside other clinical leaders this group will identify and agree the major transformational changes required to improve the health of patients within South Warwickshire. This group will be supported by a Delivery Board that will mobilise resource to support the delivery of the projects and programmes agreed. This Delivery Board will include analytical skills that will identify and monitor the outcomes and impact of the changes. Clinical leadership of Innovation and transformation has been commenced through the initial meetings of the Strategic Innovation Board.

Patient/ Community and Citizen Engagement

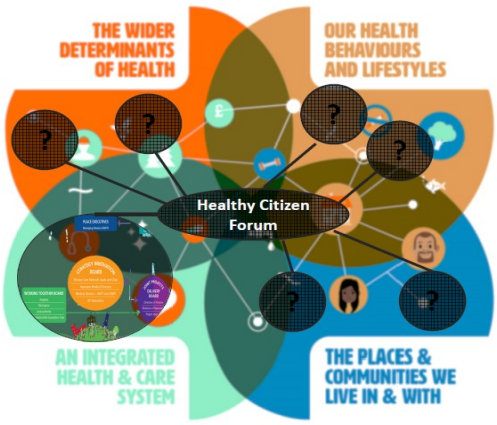
Creating a Citizen's Voice – There is an opportunity as we develop the joint working within Place to review our current approach to engagement. Currently every organisation has their own separate approach to patient engagement. SWFT, the CCG, CWPT, Primary Care and the Local Authority all have their own approach and we have representation from Healthwatch at all levels within the Coventry and Warwickshire System. However, despite all this we often are asking the same people for their views and at times not getting the breadth of representation that provides a balance and considered view. We are proposing to work with partners to create a Citizen's Assembly. This will involve the recruitment of public representation that will inform the development of our plans. It may also include the development of specific Citizen Panels that will work with the Trust to develop options and ideas to create new models of care for specific areas such as Digital.

Place Priorities/Developments

Developing services around PCNs – We are planning our Out of Hospital Services around the new PCN structures. We will use the neighbourhood JSNAs to develop plans that are specific for each PCN. We will identify gaps and plans to address these gaps. The delivery of services and the delivery of the improvement of services will require resources. We plan to work with partners to ensure that we develop joint posts to maximise the resources available and facilitate integrated approach at PCN level. Out of Hospital services and workforce are being developed around each Primary Care Networks.

Changes to contracting - The commissioning landscape over the next few years will change with the roll out of lead provider models at Place and at System. There have been a number of point prevalence audits by SWFT that suggest around 35% of patients are being treated in an incorrect healthcare setting and through the establishment of a new contracting model will facilitate patients being treated in the right place at the right time. This new approach will mean that the CCG and the Trust will share financial risk, manage clinical quality and reduce inefficiencies and waste with the CCG focussing on strategic commissioning with a commitment to improve health outcomes for its population. The Trust will need to develop the team to support the local commissioning role and this may include redeploying the skills in other organisations such as CCGs and Local Authority. An element of this has started with the appointment of a number of joint posts and the establishment of the Joint Delivery Board.

Developing the Health and Wellbeing Partnership – This group is currently led by the Local Authority and is being reviewed to ensure it has a clear role and the right membership. The model illustrated below is based on the Kings Fund approach to developing Population Health Management, is a helpful tool to identify how this wider Partnership will focus on the wider determinants of health, our population's behaviours and lifestyles and the places and communities that we live in. The model shows that Health and Care's engagement in this wider partnership will be essential to improving the wellbeing of our population with overlap between Health and every part of the wider community we serve. It is proposed that we develop the current partnership into a Health Citizens forum that will development the wider partnership working.



Anchor Organisations – SWFT will open up its infrastructure to develop and support all partners to improve the way we provide services. This will include using capital to invest in new digital applications that will improve productivity and patient care. We also plan to create and support the development of an Estates Plan that will be integrated with other providers and create Health hubs in the heart of each PCN that accommodate services from a range of different providers supporting their local communities. The plan currently identifies the opportunities within each network to rationalise the estate and share accommodation and the Trust will lead on these developments working alongside primary care, CWPT and local authority colleagues. Key projects currently identified within the plan include the Lillington Hub and the development of the Ellen Badger site in Shipston.

OUR PLACE –

Background of Place

Warwickshire North is home to 192,278 residents with an extremely diverse locality, with some neighbourhoods experiencing high levels of deprivation, some neighbourhoods with high numbers of BME communities and a number of new housing developments alongside more traditional urban town and rural village communities. Both Bedworth and the North Warwickshire borough have significant numbers of older people as a proportion of their communities.

The JSNA provides invaluable data for Warwickshire North and the themes are reflected in our Place priorities. We also have individual neighbourhood JSNAs which provide a more focused picture of the health needs in our diverse neighbourhoods and will be used to help PCNs and Out of Hospital Place Based Teams understand and respond to local demand. Work is currently underway to develop a Vision Statement for our Place, taking into account the information held within the JSNA and reflecting the themes of the Coventry and Warwickshire: Healthy people, stronger communities and effective services.

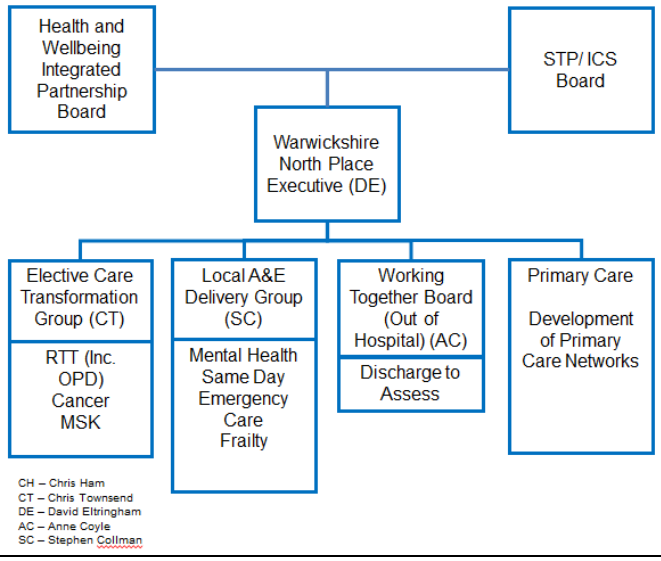
Governance Arrangements

The Warwickshire North Place Executive (WNPE) was established in April 2019. The focus for the group was to provide a forum in which organisations can come together and jointly collaborate to deliver Place level change. The WNPE brings together partners from Health and Care settings within the WN Place to deliver with the following objectives;

- Take on the role of ''Executive'' Body for the Warwickshire North Place Executive and with that in mind make decisions and set priorities for integrated care system delivery and the development of clinically secure and financially sustainable services.
- Identify and set objectives for the delivery of health* care across Warwickshire North (* including some, but not all aspects of social care) and establish a work plan.
- Deliver an Integrated Care System for Warwickshire North so that patients or clients accessing services receive them in a seamless way, regardless of provider. Create an annual operating plan which sets this out.
- Establish appropriate work streams based on priorities and ensure that these work streams are appropriately resourced and deliver the 5 year Place operating plan.
- Hold work streams to account for delivery through appropriate leadership and where difficulties or issues are encountered, work together to resolve issues and unblock problems.
- Clinical and financial sustainability – binding the Place structure within ICS.

The organisations within the WN Place Executive Board include:

- Coventry and Warwickshire Partnership Trust (CWPT).
- Warwickshire County Council (WCC)
- Warwickshire North Clinical Commissioning Group (WNCCG)
- George Eliot Hospital NHS Trust (GEH),
- General Practice (GP)
- WN Out of Hospital Services (OoH)
- Acute Care Clinicians (GEH)



The initial focus of the WNPE has been to improve our collective understanding of each member organisation in terms of operating context and challenges. This approach has supported the WNPE to develop relationships that support the continued establishment of the partnership approach to WN Place. Developing a collective understanding, supported by the JSNA and wider engagement work throughout the development of primary care networks and the George Eliot Hospital Strategy development sessions; identified a number of priorities. The Place Executive is currently developing its place plan within which transformation priorities to deliver place benefits and local system impact are currently being scoped and prioritised.

Clinical Engagement and Transformation

Within the development of our approach to establishing Place and the joint transformation, we have focussed on strengthening our clinical engagement including GP and Acute representation. Our clinical leaders have reviewed how best to support further clinical engagement with an inaugural clinical forum for Warwickshire North taking place on the 18th September. Our initial clinical engagement focus will be building relationships by bringing colleagues together from September 2019 onwards and identifying shared clinical imperatives to address local place challenges. Our intention is that this will lead to clinical leadership and engagement focused on specific pathways with shared ownership across place across clinicians working in acute, community and primary care.

Patient/ Community and Citizen Engagement

Involving the public and the local voluntary and community sector will be essential to the success of our Place. We will be able to build on the current engagement channels which have already been established through the work of Warwickshire North CCG, the development of the local JSNAs, and the work done by the Out Of Hospital Board, in addition to creating new channels through the development of the PCNs. We have already developed an engagement approach which is being discussed with PCN's, have liaised with Health Watch Warwickshire on collaboration to achieve citizen voice representation and influence going forward, and are connecting through the CC engagement team with locality and community workers who have established links within our local neighbourhoods.

Place Priorities/Developments

The initial focus of the WNPE has been to improve our collective understanding of each member organisation in terms of operating context and challenges. This approach has supported the WNPE to develop relationships that support the continued establishment of the partnership approach to WN Place. Developing a collective understanding, supported by the JSNA and wider engagement work throughout the development of primary care networks and the George Eliot Hospital Strategy development sessions; identified a number of priorities.

The Place have focussed on three key priorities for 2019/20 in order to better optimise patient pathways, support Place level resilience in periods of surge pressure, deliver the priorities in the Long Term Plan and the system clinical strategy; Frailty, Mental Health and MSK.

In order to deliver on these priorities, the WNPE have developed a joint transformation programme. Our Year 1 (2019/20) approach to Transformation has centred on the development of the Place Efficiency Plan through the combined efficiency target between George Eliot Hospital and WN CCG. This takes in to consideration the CIP, QiPP and Joint Transformation. The combined efficiency target for 2019/20 is £21.5M. Our connection to the WN health and Wellbeing Partnership Board and Out of Hospital Working Together Boards as part of our governance arrangements will ensure that the joint transformation programme is supported by wider partners where this supports local place impact.

Coventry and Warwickshire
Health and Care Partnership

Item 3 Annexe 2

OUR STRATEGIC FIVE YEAR HEALTH AND CARE PLAN 2019/20 – 2023/24

Coventry and Warwickshire Health and Care Partnership
VERSION – 26TH SEPTEMBER 2019

CONTENTS

EXECUTIVE SUMMARY

Since 2016 when our previous 'Better Health, Better care, Better Value' plan was published, much has happened across Coventry and Warwickshire. We have invested in health and care services, strengthened our partnerships and relationships, and continued to make improvements in care for the one million people we serve.

Our vision is that '***We will do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people at the heart of everything we do.'***

We believe that each of our residents deserves to:

- Lead a **healthy independent and fulfilled life**
- Be part of a **strong community**
- Experience **effective and sustainable health and care services** when they need them.

To achieve this vision and deliver the NHS Long Term Plan (LTP) commitments, additional money will be coming into our system over the next five years. We will use this and our existing resources to respond appropriately to rising demand for health and care services from our growing and ageing population.

Prevention will be at the centre of everything we do. We will invest to promote health and wellbeing. Through a strategic and targeted approach to earlier intervention, we will make it easier for people to lead healthy lives and stay well for longer. The early years are particularly important, and we will work with partners to give every child the best possible start in life.

Our approach to **Population Health** focuses on all of the factors that affect health and their impact on health outcomes. This includes education, affordable and appropriate housing, stable employment, leisure opportunities and a healthy environment. We will build on the work of our Health and Wellbeing Boards and the Year of Wellbeing 2019 to ensure that these determinants are tackled and that associated inequalities are reduced.

The further development of **Primary Care Networks (PCNs) and our Integrated Community/Neighbourhood Teams** are at the heart of our plans. Building on our 'Out of Hospital' programme, these teams will focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment in their own homes when and where they need it. We will also improve the responsiveness of crisis response services and work to achieve closer integration with social care.

Demand for **Urgent and Emergency Care** continues to rise and improving access to appropriate care and early interventions will be critical to meeting and managing demand. Our vision is to simplify our UEC offer and deliver a fully integrated networked response so that the most appropriate care can be given as quickly as possible. We will support patients, their families and carers to do as much as they can for themselves and improve primary care access and pre-hospital urgent care. We will also reduce unnecessary, harmful stays in hospital through increasing same day emergency care and improving timely discharge.

We will deliver a step change in **Mental Health** services by focusing much more on prevention, early intervention and supporting more people to actively participate in their own self-care, wellbeing and recovery. We will ensure timely access to high quality appropriate specialist services when needed, delivered wherever possible in the communities where people live. Improving mental health services for children and young people is a particular priority.

Mental health services will be delivered as locally as possible through our neighbourhood teams, with a commitment to reduce and ultimately remove the need for patients to be treated outside of our area (Out of Area Placements). We will build on our recent improvements to services and support for people with learning disabilities and autism and increase the number of patients cared for locally in their communities.

We will identify more people at risk of **Cancer** earlier and undertake more community-based screening. We will treat cancer patients more quickly in order to improve survival rates and increase the overall experience our patients receive throughout their diagnosis and assessment, their treatment and then living beyond a cancer diagnosis and treatment.

Following extensive engagement with local people, we have commenced a programme to consider how we respond to the changing needs of women, babies, children and young people. Initially, this work will enable staff working in **Maternity and Children's Services** to consider how their services can be most effectively be delivered to improve health outcomes, quality, and patient experience in the context of the existing health inequalities, workforce, estate and financial constraints.

The final phase of our redesign of **Stroke** services will take place over the next 12 months, with implementation of a new agreed model, once public consultation is concluded, evaluated and considered. We are also committed to ensuring other major health conditions such as CVD, diabetes and respiratory disease deliver the LTP commitments.

In order to improve efficiency and value for money, we will implement a number of system-wide **Service Improvement Schemes,** which will look to redesign diagnostic and outpatient services, streamline and modernise radiology and pathology services, improve the productivity of surgical services to reduce waiting times, deliver more care inside the NHS and optimise medicines management. These measures will contribute to us achieving financial sustainability.

We will exploit the opportunities offered by technology (including the introduction of an Integrated Care Record) to support people in managing their own health and care needs in the community. We see our system estate as a key enabler to successful delivery of locally delivered, integrated care and we will work with local authorities to maximise the value of the estate.

To deliver our plan, we have reviewed our system governance arrangements and introduced a new Partnership Board - a mechanism for collaborative action and common decision-making for those issues which are best addressed on a wider scale. The Board is strongly aligned to and heavily influenced by the Health and Wellbeing Boards Concordat and our emerging Strategic Framework. Our Local Authorities are heavily involved in these arrangements.

Within each of our four Places (Coventry, Rugby, Warwickshire North and South Warwickshire), local partnership arrangements are being established that ensure all stakeholders including Local Authorities, voluntary and community groups, NHS commissioners, acute and mental health providers, GPs and other primary care providers and patients and the public have an input into how we progress as a health and care system.

We appreciate the importance of whole system clinical leadership and engagement in delivering our vision. Our Clinical Forum provides clinical advice and expertise to all our workstreams, with clinicians leading our programmes. It ensures the voice and ideas of clinicians, from a range of professions and organisations, lead the development of new clinical models.

Our three CCGs and our Local Authority colleagues are working closely together to consider how they become a leaner and more strategic 'commissioning function'. Our Provider Alliance is working

to share expertise, knowledge and skills and draw on the strength of partners to redesign delivery and develop new models of care.

We recognise the role of Healthwatch, the Voluntary Sector, charities and others in supporting us engage with our communities and citizens to better understand their needs and seek their views. We also acknowledge the critical role of carers and any redesign we consider will be underpinned by a commitment to give people more control over their own health and an ability to co-produce and then fully engage to develop our future plans.

Fundamental to delivering our vision is our workforce. A high priority is to attract, develop and retain a workforce that will be supported and trained to work differently in the future. This requires a profoundly different approach to addressing our challenges and exploiting new ways to utilize the skills staff offer, enabling all to reach their full potential.

This plan outlines our collective ambitions as well as our remaining challenges and how we will overcome them. It also reinforces our commitment and contribution to delivering the NHS Long Term Plan and to ensuring that the additional funding we receive will be invested in the things that matter most, from providing safe and high quality treatment and care to reducing pressure on our staff, investing in new technologies and to adopting a population health approach in order to improve the outcomes for our patients and communities.

1. INTRODUCTION

Since 2016 when our previous 'Better Health, Better care, Better Value' plan was published, much has happened across Coventry and Warwickshire. We have invested in health and care services, strengthened our partnerships and relationships, and begun to make improvements in care for the one million people we serve.

Some of the key achievements that have been delivered since 2016 are:

- We have made a good progress in terms of our **prevention** agenda. The Year of Wellbeing (2019) has proved to be a catalyst for change, galvanizing effort and celebrating and extending existing work on prevention and early intervention, with a specific focus around workplace wellbeing, physical activity and mental wellbeing / social isolation
- With regards our commitment to planning for **population health,** new place-based and asset-based Joint Strategic Needs Assessments (JSNAs) have been rolled out. These underpin emerging work to develop and embed population health management approaches across our system, to enable better understanding of our population and more effectively target interventions to reduce inequalities.
- Good progress has been made with regards **Urgent and Emergency Care** services - on average, there are 6,000 (22.6%) more patients seen across the system within 4 hours each month, compared to 2016; the proportion of patients admitted and discharged on the same day has increased from 29.7% to over 32.4% over the last year; the number of patients in hospital over 21 days has fallen from 7.3% to 5% in the last year; the average length of stay for emergency patients admitted has fallen from 6.1 to 5.1 days; the proportion of patients discharged into nursing homes has fallen from 2.5% of discharges for those over 65 to less than 1%.
- Our **Mental Health** workstream has demonstrated improvement - the Improving Access to Psychological Therapies (IAPT) Service has seen an increase of 996 people between 17/18 and 18/19 and by the end of 19/20 we are forecasting 18,546 people will have accessed this service; our Perinatal Mental Health service saw 4051 women in total since 2018 and by the end of 19/20 it's forecasting it will have seen an additional 1130. Since 2016, the AMHAT services based at University Hospital Coventry and Warwickshire, South Warwickshire Foundation Trust and George Eliot Hospital have supported 13,683 people with acute mental health needs (a 50% increase since service commencement) and the Community Crisis Home Treatment Teams have supported 30,670 people in the community since 2016 an increase by almost 9% over a three-year period.
- With regards to our **Maternity and Paediatric** services there has been a 23% reduction in the number of stillbirths across Coventry and Warwickshire and 17% of women now have access to the same midwife throughout their whole end to end maternity experience.
- A 20% reduction in people with **Learning Disabilities or Autism** in mental health hospitals since March 2016 including a 67% reduction of children in CAMHS Tier 4 beds; 40% fewer adults in secure services due to people being discharged to the community or transitioned to less restrictive hospital environments; and a 16% reduction in people with hospital stays over 5 years; and no admissions to secure services for adults since December 2017

There are also noticeable improvements with regards to the population's health and wellbeing since 2016:

- The smoking prevalence in adults (18+) has reduced from 16.3% to 15.9% across Coventry
- Conceptions to girls aged under 18 has reduced from (rate per 1,000 girls aged 15-17) 26.6 to 22.6 in Coventry and from 18.7 to 17.5 in Warwickshire
- The under 75 mortality rate from cancer considered preventable (age-standardised rate per 1000,000 population) has decreased from 90.1 to 84.9 in Coventry and from 131 to 128 in Warwickshire

- Breastfeeding initiation has increased from 76.4% to 78.3% in Coventry
- A good level of development at age 5 has increased from 65.4% to 67.7% in Coventry and the percentage of pupils achieving a GCSE at grade 9 to 5 in Maths and English has increased from 48.1% to 48.7% in Warwickshire
- The percentage of 16-17 year olds who are not in education, employment or training or whose activity is not known has reduced from 6.8% to 5.4% in Coventry and from 6% to 3.8% in Warwickshire
- Female Healthy Life Expectancy has remained stable at 66.2 years over recent years (compared with a national decline to 63.8 years)
- Those in employment has increased steadily over the last 5 years in Warwickshire which now places it above the national average.

Since 2016, the system has also made significant improvement with regards to ensuring the investment we make in heath and care is more efficient and effective and we can financially sustain the services we provide. Growth in activity and associated costs have been higher than expected. However, between 2016/17 and 2018/19 the system **has reduced our overall system costs by more than £300m** across the NHS organisations. This has been achieved by delivering schemes that focus on removing waste from the system, optimising the use of medicines and reducing the need for high cost, premium rate workforce (agency spend).

We all acknowledge that when we published our previous 'Better Health, Better Care, Better Value' plan, the approach we took wasn't the most beneficial for our system. We have learnt from this experience and this time around have ensured that the plan we have developed is clinically led and locally owned. To achieve this, we have engaged and consulted widely with our patients, our staff, our partners and our communities to ensure that everyone across our system recognises and is bought into what we are trying to achieve.

Working more collaboratively with our partners including NHS organisations, local authorities, primary care, voluntary, community and social enterprise groups, NHSE/I, Healthwatch, the police and the fire services has already unlocked fresh thinking, better integration and more effective service delivery. We will do everything we can to continue this collaborative approach.

2. OUR VISION

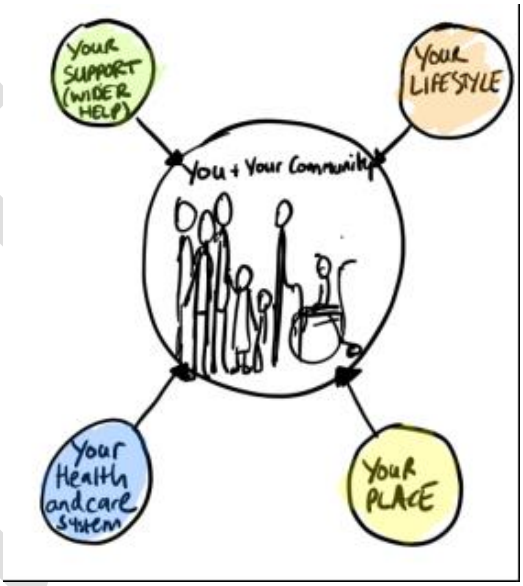
One Health and Care Partnership, Two Health and Wellbeing Boards, Three Outcomes, Four Places

There are a million reasons to be ambitious about living a healthy and fulfilling life in Coventry and Warwickshire. Together, as organisations working to improve health and wellbeing, we share a common vision:

We will *do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people at the heart of everything we do.*

We believe every single one of our one million residents deserves to:

- **Lead a** *healthy, independent and fulfilled life*
- **Be part** *of a strong community*
- **Experience** *effective and sustainable health and care services*



Over the last three years we have been working together on this vision. We now want to use it to change the way we understand population health, prevent illnesses and design services to meet people's often increasingly complex needs over the next 5-10 years.

The NHS Long Term Plan will be a catalyst for change in Coventry and Warwickshire, but we aren't stopping there.
We will look at our health and care services and wider factors that can impact living a heathy, independent and fulfilling life. We will be linking up our Five-Year Plan to both of our refreshed local Health and Wellbeing Strategies.

We have been listening to what local people and our staff have been telling us about what is important to them, and that is now driving a new way of working. Our first important step is the creation of a new Heath and Care Partnership Board, which will meet in public, to oversee the transformation of health and care within Coventry and Warwickshire by building a new relationship between individuals and communities and the services they use.

The Coventry and Warwickshire Health and Care Partnership brings together health and social care services, local authorities, voluntary and community sector organisations and other partners. Our aim is to deliver life-long health and wellbeing benefits for the people of Coventry and Warwickshire. In order to make this happen we are making the following commitments:

- Prevention will be at the centre of everything we do. We are committed to promoting health and wellbeing rather than treating illness. As organisations responsible for public money, we will change where we spend our money to promote health and wellbeing. Through earlier intervention, we're aiming to make it easier for everyone to lead healthy lives and stay well for longer

- Health must not be viewed in isolation. We recognise the importance of education, good work, affordable and appropriate housing, leisure opportunities and a healthy environment to the quality of life of local people. We need to work together to improve the overall health of our population and address inequalities by reducing the health and wellbeing gap that exists between our most deprived and affluent areas

- We all need to do more to look after our own health and wellbeing so that we depend less on our local health and social care services, while knowing they are there when we need

them. Voluntary organisations and community groups play an enormous role in keeping people healthy and independent and we will change how we work with communities to enable community leadership and build capacity. We will do more to support carers too, not only to improve the health of family members they care for, but also their own health and wellbeing

- When people need support from health and social care services, we know that they want accessible, responsive and high-quality services and we will provide them. We will have a focus on making sure that services deliver the right standard of care in a consistent way across Coventry and Warwickshire that builds on best practice and evidence

- We will be honest about the challenges we face. Demands on health care services continue to increase, alongside a shortage of key staff groups and skills to deliver care and financial pressures. While the amount of money we spend in the NHS is going up each year, the cost of services is going up more quickly, so we need to identify ways to deliver the same level of services at a lower cost – for example, through reducing waste and avoiding the duplication of services. We will work together to ensure we are always doing what's right for individuals and make it easier for people to access the right service, the first time

- There will be times when we need to make difficult decisions, but when we do, we will listen to the views of local people and our staff, and we will have transparent processes for making those decisions.

How to get involved

If we are to be successful, we need to put people and communities at the heart of the way we design our new system. We want to start a new conversation that is focused on making sure every individual, every community and every Place is as healthy as they can be.

We will engage with a range of stakeholders to shape the content and direction of our Five-Year Strategic Plan before we publish in mid-November and we will continue to engage on our Health and Wellbeing strategies as we refresh them. Looking ahead we will develop a rolling programme of engagement.

This marks a new way of working – we are at the start of a journey. We want your help to do and shape this.

3. OUR POPULATION NEEDS

3.1 Our approach

New place-based and asset-based Joint Strategic Needs Assessments (JSNAs) are in the process of being rolled out across Coventry and Warwickshire. Both Health and Wellbeing Boards agreed to take a place-based approach to the JSNA, based around 8 family hub geographies in Coventry and 22 geographic areas in Warwickshire. This reflects national policy direction towards population-based health and care systems (based on populations of 30-50k) and has aligned the JSNA approach in our two local authority areas.

Coventry's citywide JSNA profile has recently been updated and in Warwickshire, 8 Place based needs assessments have been completed to date, 6 will be completed by end of September 2019 and a further 6 by end March 2020. The process is being used as a vehicle for engaging and involving local residents, partners and wider stakeholders, to give a more in-depth understanding of the assets and needs of our local communities, and to support programmes and strategies which are founded on building community resilience and shaping service delivery at the locality level.

We are part way through a two-year programme of locality JSNAs, including the development of new data profiling tools in each of the two areas, enabling regular refreshing of data. This place-based approach is providing rich evidence of the needs and assets of local communities to underpin place-based delivery through the Integrated Care System (ICS) and wider population health approaches.

3.2 What do we know about our population needs?

As a system we face a range of challenges, with variation and inequalities evident at Place level:

Overall health: Generally, health in Warwickshire is reported as good compared with the rest of the country. Life expectancy is higher than the national average for both males (79.9 years) and females (83.6 years), compared with 79.6 years for men and 83.1 years for women nationally. By contrast, health in Coventry is below average at 78.3 years for males and 82.4 years for females. People are spending more years in ill-health; in Warwickshire on average 17.5 years for women and 15.8 years for men and is forecast to increase, particularly for males. In Coventry females can expect to live almost a quarter of their lives in poor health (18.9 years) whilst the figure is 15.4 years for males. As people live longer with complex needs, we need to improve how we support people to live independently in their communities for as long as possible, to improve quality of life and ensure services can respond to changing health and care needs.

Population Growth: In the past ten years, Coventry's population has grown by a fifth, making it the second-fastest growing local authority outside of London, with growth particularly high amongst 18-29 year olds. The city's residents are, on average, eight years younger than in England with Coventry's median age being 32 years in 2017 compared to 40 in England. A third of the city's population growth is concentrated in one-tenth of the city, concentrated around the city centre and a few new housing developments elsewhere, which has implications for service planning to ensure fair access. The population is also growing rapidly in some areas of Warwickshire. By 2041 it is projected there will be over 612,000 residents, up 10% more (53,000) from 2016, with the highest increase due in Rugby borough. This population growth is putting pressure on local housing and services. We anticipate that by 2025 in Warwickshire there will be a 4.5% (4,014) **increase in school age children** on 2017, which will increase demand on support services, including school health service, children's social care, and Child and Adolescent Mental Health Service (CAMHS).

Diversity: Coventry and Warwickshire have an increasingly diverse population. In Coventry 33% of the population identified as people from Black and Minority Ethnic (BaME) backgrounds in the 2011 census, with 52% of school children were from BaME backgrounds in the latest school census (up from 38% in 2011). The proportion of BaME groups in Warwickshire in 2011 was 12%, with 20% of school children from BaME backgrounds in the latest school census. In Coventry, Asian Indian forms the biggest BaME group, whilst in Warwickshire the 'White Other' accounts for the largest proportion of BaME groups, largely made up of the European Union accession countries, although Asian Indian accounts for a similar proportion across the county.

Inequalities and deprivation: Whilst Coventry is the 46th most deprived local authority area out of 326 across England (English Indices of Deprivation 2015), Warwickshire is one of the 20% least deprived counties in England. Nevertheless, there are significant variations and inequalities across our area, with deprivation and poor health outcomes experienced in both local authority areas. There are 44 Lower Super Output Areas (LSOAs) in the 10% most deprived nationally in Coventry and Warwickshire; 36 of these are in Coventry, 6 are in Warwickshire North and 2 in Rugby. Preliminary analysis about what drives the life expectancy gap between Coventry and England and within Coventry & Warwickshire suggest the top three conditions are: Circulation, Respiratory and Cancer.

Life expectancy at birth is 7.8 years lower for men and 5.1 years lower for women in the most deprived areas of Warwickshire (Warwickshire North) compared with the least deprived areas. In Coventry, the gap is up to 10 years for males; and 8 years for females. People living in more deprived parts of the city spend a greater proportion of their shorter lives in poor health compared to those living in less deprived parts of the city.

Fuel poverty is an issue across our area, with 15% of all households in Coventry considered to be in fuel poverty (more prevalent than across the West Midlands or England). In Warwickshire there is a higher proportion of people living in fuel poverty compared with other authorities of similar deprivation, with highest levels in Nuneaton, and significant variation across the county.

Employment rates, whilst good or in line with national figures overall are significantly lower in areas of Warwickshire North, and areas of Rugby (Newbold and Brownsover JSNA area), with poorly paid jobs and skills gaps. There are gaps in the employment rate between those with long-term physical health conditions, mental health conditions and learning disabilities compared to the overall employment rate. In Coventry there are inequalities in employment, with residents of White British ethnicity having higher employment rates than amongst residents from BaME backgrounds overall. The city has a notably higher proportion of households in which no working age adult works (17%). There are skills shortages within the local economy, and 10% of the city's working age population have no qualifications at all.

Children and Young People: About 12% of children in Warwickshire (11,400) live in **low- income families** which impacts on their health and wellbeing at an early age, particularly in Warwickshire North (North Warwickshire and Nuneaton and Bedworth). In Coventry one third of households with children are regarded as low-income families. In 2019, 14.9% of Warwickshire pupils and 16.3% of Coventry pupils **have Special Educational Needs support or an Education Health Care Plan (EHCP)**. There are growing concerns regarding **mental health issues and self-harm rates** (10-24 year olds) among young people in Warwickshire. Hospital admissions as a result of self-harm for this age group living in Coventry have declined from a peak in 2013/14 and since 2015/16 have been similar to the national average.

Almost one in three Warwickshire children (31.7%) and 37.8% Coventry children age 10-11 are classified as being either **overweight or very overweight**. The rate of children being admitted to

hospital for **injuries** in Warwickshire is rising and is significantly higher than the national rate. There are also significantly more **hospital admissions for alcohol specific conditions for under 18s** in Warwickshire than the national average (49.6 per 100,000 – the highest in the West Midlands). Coventry is 32.7 (4th highest in West Midlands).

The rate of **under 18 conceptions** has reduced across our area but remains higher than national average in Coventry and higher than other authorities of similar deprivation in Warwickshire. The proportion of **children in care** in Coventry is above the national average. There are also higher levels of children on protection plans or being looked after in care in Warwickshire North and pockets of South Warwickshire.

Older People: We have an **ageing population across** Coventry and Warwickshire. There is a higher proportion of **older people (over 60)** in Warwickshire compared with the rest of the country, particularly in South Warwickshire. By 2041 it is projected that over 85s will increase by 116%, putting increasing pressure on social care, hospital admissions and other services.

Emergency hospital admissions due to **falls** in older people are higher than average across Coventry and Warwickshire, particularly in Coventry, Rugby, Nuneaton, Warwick and pockets of Stratford-on-Avon District. The under 75 **mortality rate from preventable diseases** and measured health related quality of life (QOL) for older people in Warwickshire are not as good as other authorities of a similar deprivation.

Due to an increasing ageing population the demands on adult social care are likely to increase, particularly where people are less wealthy. Estimates suggest that there will be approximately 32% more people aged 74 or over living in a care home in Warwickshire by 2025, compared to 2017. Nearly 60,000 people (11%) in Warwickshire and an estimated 37,000 people (10%) in Coventry are unpaid **carers**, often caring for people with dementia or cognitive impairment.

Chronic diseases: According to 2011 Census date, 17.7% of Coventry residents and 17.1% of Warwickshire residents live with a long-term health condition or disability. Local analysis indicates that in Coventry an estimated 59,800 residents over 16 years old and 27,300 residents over the age of 65 live with a limiting long-term illness or disability. Chronic diseases, including mental health problems, diabetes, and musculoskeletal disorders, are fastest-rising in people aged over 85. By 2025, the burden of disability will grow as a result of the rising number of people living into old age, rather than an increase in ill-health.

Dementia is the biggest growing cause of disability in Warwickshire and is predicted to increase by 17% in people aged 65 or over in Warwickshire between 2019-2025 (from 8,484 to 9,953). The percentage of adults in Coventry aged 65+ with a recorded diagnosis of dementia is 3.9% (2116 diagnoses) and has remained stable over the last two years. However, we know that we are underdiagnosing dementia and we are working to encourage practices to screen for dementia and improve recording of diagnosis and would similarly expect levels to increase as people live longer.

Loneliness and social isolation: Almost 1 in 3 (31%) of the population aged 65 and over are estimated to be lonely 'some of the time' and 7% 'all of the time or often'. In Warwickshire, this equates to over 43,000 people experiencing some degree of loneliness and social isolation in this age group, and around 19,000 in Coventry. With an ageing population, this issue is likely to increase by 2025. Projections suggest that there will be over 21,000 people aged 65+ living alone in the city by 2025. Loneliness and social isolation are not restricted to the older population. Over 32% of people in Warwickshire live in rural areas, often with poor public transport links, which can make it difficult

to access services (particularly in North Warwickshire), and this rural isolation can affect both young and old.
Mental health: One in four adults will experience a mental health problem in any given year. Estimated prevalence of common mental health disorders amongst 16+ is 14.8% in Warwickshire, and 19.1% (c. 55,300 residents) in Coventry. Depression prevalence and incidence rates are increasing across Coventry and Warwickshire.

Suicide rates in Warwickshire have been significantly higher than the rate in England in recent years, with levels over 10 per 100,000 population since 2010-12. With awareness increasing and changes in underlying risk factors, more adults and young people are likely to present to health services with a mental health need by 2025.

Lifestyle-related diseases: Over half of adults across Coventry and Warwickshire are classified as **overweight or obese,** with figures particularly high in Coventry (64.3%), Warwickshire North and pockets of South Warwickshire. Levels of **physical activity** in adults in Coventry are relatively low and declining. In Warwickshire, physical activity is reported to have increased, but rates are still below average in some areas such as Nuneaton and Bedworth, and only 18% of adults walk to work, below the national average. Fewer adults take up the **NHS Health Check** in Warwickshire than in other areas.

Alcohol-related mortality and health problems are relatively high in Coventry, despite alcohol consumption at city level not being especially high overall. Whilst lower than the national average across Warwickshire, there are issues with alcohol-related harm in the county, with hospital stays on average of 590 per 100,000. In Stratford-upon-Avon premature mortality rates (under 75 years) from liver disease have increased over the last two decades and have moved from below to similar national rates; rates in Rugby and Warwickshire North have been similar to national rates over this time.

Smoking: Between one-in-five and one-in-six Coventry adults smoke, and although **smoking** prevalence is decreasing, deaths caused by smoking are relatively high in the city. Although below the national average and declining, 12.6% of adults in Warwickshire **smoke** and this is higher in some areas such as Nuneaton and Bedworth and among particular population groups such as those with serious mental health conditions.

Sexual health: In Coventry the rate of **STI diagnoses** remains consistently higher than the national and regional average. Rates of diagnosis of chlamydia and HIV late diagnosis are also not as good in Warwickshire as other comparable authorities.

Health protection: Across our area, cancer screening rates for at-risk populations are low. Newborn screening rates in Warwickshire are lower than authorities of similar deprivation, while in Coventry, childhood vaccination rates dropped notably in 2017/18 – this is being investigated. Coventry also has high rates for some communicable diseases, with one of the highest rates of TB and a higher prevalence of diagnosed HIV. These diagnoses are particularly prevalent amongst newly arrived communities and vulnerable groups. The number of older people having **vaccinations for flu** is also below national average and **deaths from communicable diseases** are higher than average (all ages).

Housing and Homelessness: Insecure housing and homelessness is a common issue across our area, often linked to poverty, rental rates, house prices and debt. Drug and alcohol addiction, mental health and family relationship problems can also be factors. The rate of statutory homelessness is higher than the national rate, particularly in Coventry, Warwick and Stratford and areas of Rugby. Coventry has a high level of homelessness, particularly amongst young people and families – at any

one night in 2017/18, between 190 to 250 Coventry families with dependent children spent the night in emergency or temporary accommodation.
Air quality and traffic: Certain parts of our area have poorer air quality than EU and international standards. There are problems with air quality (particularly nitrogen dioxide) in parts of Coventry, and in town centres of Warwick, Leamington, Rugby and Nuneaton. Warwickshire has a **higher rate of people killed and seriously injured on roads** nationally, particularly in North Warwickshire.

Crime: Whilst crime rates are generally lower than average in Warwickshire, there are areas of higher crime in Warwickshire North, Rugby and pockets of South Warwickshire (Leamington and Stratford-upon-Avon), including domestic violence and anti-social behaviour. There has been an increase in violent crime in Coventry, although the increase here has been lower than that of England. Nevertheless, people in the city report feeling increasingly unsafe – with nearly a third of young people saying they feel unsafe in the city.

Our communities: Across Coventry and Warwickshire, local engagement through our place-based JSNAs has highlighted a wealth of voluntary and community activity. There is a growing recognition that health and wellbeing is determined and shaped by the places and communities people live in, and that solutions to addressing and improving health outcomes must also be rooted in local people and communities.

3.3 Our approach to engagement for our Five Year Strategic Plan

Our approach to engagement has been to build on the wide-ranging engagement already undertaken across our system including:

- The development of the Health and Wellbeing Strategies for Coventry and Warwickshire
- The work done to develop local, Place based Joint Strategic Needs assessments (JSNAs)
- CCG engagement relating to key services such as maternity, children centres and planned care
- Engagement on the future of health commissioning and CCG Commissioning Intentions

In addition, Healthwatch Coventry and Healthwatch Warwickshire undertook specific engagement on the priorities in the NHS Long Term Plan, making contact with over 800 people. The insights from which will be used to help inform and shape the future health and care system.

As this approach continues to develop, we will ensure we keep the dialogue open with all stakeholders, staff, Elected Members, patients and the public, voluntary and community sector and partner organisations. This Five Year Strategic Plan is the start of the journey and there will be many more opportunities to influence the delivery of the priorities in the plan moving forward.

We have also engaged with our staff to understand and hear their views about the NHS Long Term Plan and the changes they believe we need to make over the next few years if we are to deliver all the requirements, targets and standards set.

What we have been told so far

Engagement activities undertaken by Healthwatch as well as public/community engagement undertaken by the CCGs and Local Authorities highlights the following six themes as important to our communities:

- You want better access to services
- You want services centered around you

- You want a focus on self-care and prevention
- You want the best quality service
- You want a joined-up service
- You want better communication, advice and guidance

We have considered all of these themes in developing our Five Year Strategic Plan and we will continue to consider them when planning or commissioning new services and/or making changes to existing ones.

During August and September, we conducted a survey with staff working in both the NHS and local authorities. Staff representation across all the organisations was good and most respondents both live and work in the Coventry and Warwickshire area, with a good split of representation from each of our four Places (Coventry, Rugby, South Warwickshire and North Warwickshire). The following was identified:

- Quality of services and joined up care were all highlighted as positives, although often with the caveat of mounting pressures to the system
- Improve access, better IT, funding, communication, collaboration and integration were highlighted as needing to improve, and a greater focus on prevention was also raised
- Most people felt spending the extra investment wisely was the most important factor, closely followed by joined up working and better support for the workforce
- Preventing people from becoming ill, keeping them fit and healthy was more important for the NHS and social care to address than treating people when they become ill
- Choice and control and letting people manage their own health and wellbeing was more important for the NHS and social care to deal with than giving the best possible care and treatment without choice

4. OUR SYSTEM PRIORITIES AND WORKSTREAMS

As a system we are required to deliver the commitments made in the Long Term Plan (LTP) and the detail underpinning each of these commitments can be found in the individual service planning templates. However, there are some unique challenges in Coventry and Warwickshire, and we will therefore prioritise to respond to local need.

We will ensure that **Prevention** is a key priority. The NHS spends around £20bn each year on conditions associated with lifestyle choices such as smoking, alcohol misuse and obesity. If we could reduce our local share of this by 25%, we would **save £6.3m over five years** – we aim to do this by radically changing our approach to prevention by empowering patients and giving them better access to support and advice and investing in early years prevention.

We have struggled to consistently deliver our NHS Constitutional Standards in several areas such as Urgent and Emergency Care, Mental Health (including Out of Area placements) and Cancer. Consequently, these will remain key local priorities until we are able to demonstrate the required improvements.

Urgent and Emergency Care (UEC) - demand for urgent care continues to rise and improving the performance of our urgent care system is one of our key priorities. We have already made progress in reducing hospital urgent admissions, but this is still a challenge. Our vision is to simplify the UEC offer across Coventry and Warwickshire and to fully integrate the response so that the most appropriate care can be given as quickly as possible, as close as is necessary for the immediate need of the patient, whilst supporting patients and their families to do as much as they can for themselves.

The detail of our commitment to deliver the requirements associated with pre-hospital urgent care, same day emergency care and improved, timely discharge can be found in the UEC planning template. This commits to

- providing an acute frailty service for 70hours a week with assessment being within 30 minutes of arrival
- introducing Urgent Treatment Centres (UTCs) by autumn 2020
- increasing the number of people discharged on the same day, through a comprehensive model of Same Day Emergency Care (SDEC)
- aiming to record 100% of patients' activity in A&Es, UTCs and SDEC units via the Emergency Care Data Set (ECDS) by Mar 2020
- operating a Clinical Assessment Service (CAS) as a single point of access for patients, carers and health professionals to support integrated care and improved hospital discharge to reduce the number of people delayed in hospital, particularly over 21 days

As a result of this activity we are looking to reduce pressure on emergency hospital services, to maintain the level of demand for true acute services within the current footprint. That is to use the efficiencies gained, to offset expected unmitigated growth if nothing else was done, and demographic growth pressures continued unchecked.

In 2017/18 we spent nearly £13million more that the lowest 5 of 10 similar CCGs on non-elective activity in the top 10 spend programme areas. Nearly £9million of this is related to 3 programme areas (neurology, trauma & injury and genitourinary) and the majority of this is related to frailty. If we can halve the current trend of growth in A&E attendances and hospital admissions, we could **save £12.65m over five years** – we aim to do this by investing in primary care, self-help and same day emergency care.

Linked to this we will also prioritise how we improve the way we manage our frail patients. Many frail older people remain in hospital longer than they need to due to a lack of step down support which often leads to a further deterioration in their mobility and independence. If we reduce our 'stranded' patient numbers by 40% we will **save £14m over five years** and we will achieve this by implementing a system-wide best practice frailty model.

Mental Health has also been chosen as a key priority in order to continue our work on the MH5YFV and take forward the LTP ambitions.

For children and young people, we are focusing on our tier 3.5 service development and working with partner Mental Health Trusts across the west midlands to develop a New Care Model for delivery of tier 4 services. This work is particularly focused on the needs of children with mental health problems and autism. For other specialist CAMHS services we continue to embed our pathways approach and strengthen the earliest parts of the pathway within primary care. We are a trailblazer site for working with schools and are committed to driving this initiative at pace.

For adults, between now and 2023/24 we will continue the work to deliver the MH5YFV targets with emphasis on out of area placements, including the strengthening of CRHTT and MH Liaison to Acute hospitals, expanding services for those requiring early intervention in psychosis and access to psychological therapies through IAPT and improving the uptake of alcohol care services. Reducing the need for patients to be managed outside of our area offers a potential **saving of £2m over five years** and we will work hard to realise as much of this saving as possible. We will scope the mental health community pathways and strengthen primary care mental health through collaborative work with emerging PCNs, including improving the rate of annual health checks undertaken across the system.

Our local challenge, evidenced through a review of mental health services, is that people are too often accessing specialist care when a more local community approach would deliver better outcomes and experiences. We will seek to do this by focusing on a step change in prevention, early intervention and supporting more people to actively participate in their own self-care, wellbeing and recovery; whilst ensuring timely access to high quality appropriate specialist services when needed, delivered wherever possible, in the communities where people live. Aligned to this principle, services will be delivered as locally and in as integrated a way as possible through our Places.

In responding to a more strategic approach and greater provider collaboration, opportunities will be explored with the national new care models programme (including adult eating disorders and CAMHS Tier 4), with the devolvement of mental health specialised commissioning to providers and CWPT will continue to work actively as a member of the mental health alliance for excellence, resilience, innovation and training (MERIT) programme.

Cancer remains a system priority both in terms of delivery of the existing constitutional standards but also in terms of the new requirements in the LTP. We are fully committed to ensuring faster/earlier diagnosis through enhanced screening programmes and increased/improved diagnostic capacity as well as embracing and implementing innovation, ensuring we offer the most safe and precise treatment available. After treatment patients are offered a follow-up pathway that suits their needs and enables them to get rapid access to the clinical support they need, if they feel their cancer has recurred.

Primary Care and Integrated Community Care - building on our Out of Hospital model along with the exciting introduction of Primary Care Networks (PCNs), the system has made a commitment to ensure that the ongoing development of PCNs remains a system priority for the foreseeable future. We will look to develop fourteen Place Based Team ('PBTs') aligned to the PCNs within each Place

and bring together health and social care professionals to co-ordinate, lead and align services to meet the needs of their patient population.

The PCNs will allow us to accelerate the partnerships that have formed between general practice, hospital teams, social care, hospices and the Out of Hospital Collaborative to develop person centred integrated services for our most vulnerable patients. Focusing on Frailty, end of life and other long term conditions the PCNs and PBTs will take a proactive, multidisciplinary approach to supporting people remain independent in their usual place of residence for as long as is possible. This new way of working will be facilitated through significant investment in workforce, IT and estate.

There are also several key service transformation programmes that have been identified as priorities for the next 18 months.

Population Health - building on the Kings Fund model of Population Health and our pilot relating to Children and Young People (CYP) in crisis as 'proof of concept' for future PHM model/approach, we are committed to developing this approach at pace in order to change the way we prioritise investment, commission services and deliver treatment and care to our population. As part of our approach to population health we want to hold ourselves to account for the impact of our plans and strategies and demonstrate progress and are developing a strategic outcomes framework to achieve this.

Stroke services - having been through a significant planning phase to develop a proposal to redesign Stroke service across Coventry and Warwickshire, we will now move into the implementation phase and deliver the improvements we have planned for, once public consultation is concluded, evaluated and considered. The proposed model would see the expansion of rehabilitation services across the STP and the centralisation of all stroke admissions, to ensure that all of our population has access to inpatient care in a hyper-acute stroke unit and community-based specialist rehabilitation services when they need them. We are making a significant investment to improve access to address the current gaps and remove the inequities in current local services.

Maternity and Paediatric services– a key work stream within the Local Maternity Services (LMS) Plan 'Choice and Personalisation' has a longer term, more strategic, objective to define the future clinical model for maternity and neonatal services across Coventry and Warwickshire to ensure an integrated care pathway. This programme, following completed extensive engagement, will enable front line staff working in maternity and paediatrics to consider how services can be most effectively be delivered to improve the health outcomes, quality, and experience of services in the context of the existing health inequalities, workforce, estate and financial constraints.

Our Service Improvement Schemes – in order to improve efficiency and value for money, we have agreed several system-wide programme of work that will reduce overall cost across the system:

- **Musculo-skeletal (MSK)services-** identified as a system priority in the Clinical Strategy in 2018, this transformation offers the opportunity to reduce/remove unwarranted variation across the system, ensure evidence-based intervention rates are in line with the national average, ensure that the capacity to treat MSK services across the system is the most efficient it can be and deliver significant cost savings.

  In 2017/18, we spent nearly **£7.75illion** more that the lowest 5 of 10 similar CCGs on MSK elective activity. This higher spend is in Coventry & Rugby and South Warwickshire. We have developed plans to improve our pathways and realise as much of these cost savings as possible.

- **Diagnostics –** the system acknowledges that there is huge opportunity to redesign the way diagnostic services are delivered across the system. Addressing workforce challenges as well as reducing duplication and variation and cost reduction are three of the key outputs from this workstream.

  The 2017 2nd Atlas of Variation in NHS Diagnostic Services demonstrated large variation in diagnostic tests across the country with opportunities that need exploring around MRI activity, non-obstetric ultrasound activity, DEXA scanning, gastroscopy procedures, endoscopic ultrasound procedures, audiology assessments, diagnostic sleep studies and urodynamic (pressures and flows) tests – where one or more Place had significantly higher rates than England.

- **Medicines Optimisation and Pharmacy Integration -** The Medicines Optimisation and Pharmacy Integration workstream has been identified as a key system priority due to its interaction across other workstreams and the potential for significant savings across the System (see more detail under enabling workstreams below).

  In 2017/18, we spend over £7million more than the lowest 5 of 10 similar CCGs on prescribing in the top 10 spend programme areas. We have explored this variation and we believe some of this spend is warranted i.e. higher spend is leading to better outcomes. However, we still believe up to **£3m could be released.**

- **Premium workforce costs –** we appreciate that any money spent on premium cost workforce, (agency and locum staff) brings not only a potential impact to the quality of care offered to patients but also increased cost to the system. As such, we will introduce a phased programme to reduce this spend over the next five years, resulting in a potential cost saving to the system of **£11.5m over five years** with a further undefined savings expected at Phase 2 (reducing the overall substantive system workforce costs)

Schemes that deliver short term savings have already been implemented. Therefore, the schemes above will reduce costs over a longer time period.

5. RESPONDING TO THE NHS LONG TERM PLAN

In addition to our local priorities, we are also fully committed to delivering the other requirements highlighted in the Long Term Plan (LTP). Our clinicians have been critical to planning and agreeing our delivery models that achieve success. Clinical work-streams or Expert Advisory Groups (EAGs) have developed both the approach and a more detailed plan for each of the relevant clinical chapters with formal sign off being undertaken by the Clinical Forum. Clinical engagement will continue to be undertaken across the system to ensure that all delivery co-dependencies and enablers are understood and highlighted, ready for development of operational plans in the new year.

We recognise that we need significant transformation at every level to become an Integrated Care System (ICS). To achieve this, Clinical Leadership is critical and needs to be central to all we do. Shifting to a population health model rather than a reactive and transactional care model is essential and clinicians will drive this shift. Our new system governance arrangements ensure that Clinical Leadership and engagement is well embedded at both System and Place.

Our Clinical Forum provides clinical leadership, advice and challenge for the work of the Partnership in meeting our ambitions. It provides clinical advice and expertise to all our workstreams, with clinicians leading programmes of work. It ensures that the voice and ideas of clinicians, from across the range of clinical professions and organisations, are the number one driving influence in the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

At Place, Transformation Boards are established with clinicians from local health and care sectors, working together to redesign care pathways in line with the Partnership Board strategy and agreed Place priorities. Representatives from the Place arrangements link in to the Clinical Forum to ensure that there is continuous alignment with what is delivered at Place and what is delivered at System and that learning is shared.

5.1 Out of hospital care

Out of hospital care has been a key priority across Coventry and Warwickshire for some time with the successful introduction of the Out of Hospital (OoH) service in late 2017. The clinical model for this service aligns closely with the model described in the NHS Long Term Plan and builds on the following principles and focused particularly on supporting the top 15% of the population identified as having complex needs:

- Proactive and preventative care tailored around the needs of the individual
- Empowering patients/local people to support each other and themselves in their health and care,
- Multi-disciplinary health care professionals working together and taking accountability for improving the health and care outcomes of populations.

As our model evolves, the OoH community teams will expand their role to include things such as increasing the diagnosis and improving the care we provide to people with dementia, both at home, in hospital or in care homes. They will also develop their role in relation to population health management, using a Frailty Index to identify patients and patient groups for targeted care, prevention and gaps in service to improve patient outcomes. A key enabler will be digital technology, and the teams will look to utilise home-based monitoring equipment to predict and prevent potential hospital admissions.

As the building blocks of the emerging new model of OoH care, eighteen Primary Care Networks (PCNs) (127 GP practices) have formed in Coventry and Warwickshire. Supporting the development of the PCNs has and will remain a key priority and we are fully committed to meeting the new funding guarantees for primary and community care. Our focus will, in part, be on ensuring that they are positioned to successfully deliver the nationally mandated requirements, including the seven new Network services. Recognising the key role that the PCN Clinical Directors will play not only in the success of the networks themselves but also as the voices of general practice at Place level, we will offer them support to develop in their new roles.

As PCNs mature, Practice Based Teams will evolve within each Place and bring together health and social care professionals to co-ordinate, lead and align services to meet the needs of their patient population. These Multi-Disciplinary Teams will be supported by a risk stratification tool which will identify patients most at risk, allowing services to put in place preventative interventions. The MDTs also work closely with patients, relatives and carers, to give them more control over the co-ordination of their own care.

Enhancing support to people living in care homes is an improvement priority for the Coventry and Warwickshire Frailty Improving Value Group. We will roll out the Enhance Health in Care Homes model across all care homes as staffing and funding grows and ensure stronger links between PCNs and their local care homes, with all care homes supported by a consistent team of healthcare professionals, including named general practice support. As part of this, we will ensure that individuals are supported to have good oral health, stay well hydrated and well-nourished and that they are supported by therapists and other professionals in rehabilitating when they have been unwell.

5.2 Personalised care

Across the system there is recognition of the opportunities that increased personalisation brings, particularly as an enabler to delivering better health outcomes across our local population. In order to achieve these benefits, we will continue to work in collaboration with partners to transform the nature of our commissioning and service delivery arrangements.

We will develop and train our local workforce to support this shift towards an increasingly partnership-based approach, planning with people rather than for them and by 2023/24 we plan to deliver the six standards of the Universal Comprehensive Model of Personalised. Our current position reflects some positive work in relation to Personal Health Budgets and Social Prescribing with the wider adoption of the Comprehensive Model in preparation and planning stage. Our intentions are:

- **Social prescribing and community-based support -** social prescribing link workers (SPLW) will support people to receive more personalised care that address their holistic needs, recognising the interface between health-related clinical issues and wider determinants of health. Primary Care Networks will be fully funded to cover the cost of Social Prescribing Link Workers (SPLWs) from 1st July 2019. Based in GP practices, SPLWs will facilitate the navigation through the wider community to support people to identify and access wider societal support to help address their individual needs and tackle cause rather than effect.
- **Shared decision making -** We will use the national Shared Decision Making, Self-Assessment Checklist, once published to assess our starting point for Shared Decision Making and as a basis for an action plan which will focus on: supportive systems and processes, trained teams, commissioned services and prepared public. Over the next 5 years we will use the self-assessment checklist, develop and implement action plans across our key pathways. We will

start this work in MSK as we are aware there are a lot of national resources and support available to enable improvements.

- **Enabling choice -** CCGs are required to self-assess their position against the minimum standards of the Choice Planning and Improvement Guide 2016 by NHS England and NHS Improvement. Choice is offered through eRS, which is used by all our GPs and is promoted through the local Public and Patient Participation Group (PPPG) which includes a member of each existing practice-level Patient Reference Group. Group members feed back to their own practice groups to promote choice, and patients can also access the choice page on CCG websites. GPs are also robustly engaged with eRS through CCG/GP meetings, Protected Learning Time and the GP Newsletter. Managing choice with providers is undertaken through regular contract management meetings, and there are processes in place to support patients requesting alternative provider as required. We will also work to optimize our pathways in our NHS providers to encourage our providers to be patient's preferred choice and to repatriate activity back to our Health and Care Partnership.
- **Personalised care and support planning -** People with long term physical and mental health conditions have person centred support plans in place. All existing assessment, planning, decision-making and review pathways and processes have been mapped and a person-centred approach rolled out. Workforce training requirements will be reviewed to ensure that a skilled workforce can deliver person centred support plans.
- **Supported self-management -** People will be supported to identify community-based support options and to identify individual assets that enable them to self-manage their health care. This may include the development of education/health coaching and peer support options
- **Personal health budgets (PHB) and integrated personal budgets -** PHBs are routinely available for CHC eligible patients across the system; implementation of Personal Wheelchair Budgets is also underway. We will continue to review, develop and expand the local PHB offer to maximise opportunities for patients to meet their outcomes through PHBs.

5.3 Digitally-enabled primary and outpatient care

We will continue to develop digital-first primary care with some of our GPs already offering digitally enabled consultations. We will support primary care to develop this further so that every one of our patients has the right to choose this and other digital options. This will be supported by national developments e.g. framework for digital suppliers, adjustments to GP payment formulae and review of GP regulations and terms and conditions.

We will reduce face to face outpatients by 30% by 2023. We are implementing 4 key projects to support delivery of this requirement to address these redesign opportunities:

- Demand Management Schemes: GP Referral Support and Management Schemes, Referral avoidance services (E-Referral Advice and Guidance; Consultant Connect; Capacity Alerts) Triage and Treatment services (MSK, Ophthalmology, Dermatology)
- Primary and Community based Treatment Services: First Contact Practitioners, MDTs working in PCNs
- Follow-Up Transformation: No requirement for follow up (No FU) for minor conditions; Patient initiated follow up (PIFU), Virtual follow up (VFU), Telehealth by phone or Skype, Nurse led follow up (NL) where a consultant is not warrantedDigital Solutions (Remote monitoring; Telehealth; Video consultations).

5.4 Increasing Focus on Population Health

Building on our systems model, we have now committed to use the King's Fund model of population health (taken from their Vision for Population Health, November 2018) as our approach to improving the health and wellbeing of people in Coventry and Warwickshire. We are using the model to develop our understanding of how all parts of the system contribute to health and wellbeing, and the roles that each organisation play and how they relate to each other.

As part of this approach, we want to hold ourselves to account for the impact of our collective plans and strategies and demonstrate progress against our priorities. We are developing a strategic outcomes framework in consultation with stakeholders and local communities. Our starting point is the high-level ambitions and outcomes outlined in our Place Forum/Health and Wellbeing Boards Concordat (our shared agreement that outlines what we will achieve together and how we will work collectively to achieve it), which we are building into our population health model.

We recognise that shifting to more preventative care requires more intelligent predictive modelling of population characteristics and risk, so actions can be better targeted to improve outcomes. Information and intelligence systems need to become smarter at identifying patients who are amenable to prevention and treatment actions and using wider determinants to understand health and wellness.

Our strategic outcomes framework will complement the core narrative and articulate in measurable terms what success will look like in implementing this new approach to deliver our three strategic outcomes:

- Our population will lead healthy, independent and fulfilled lives
- Our population will be part of a strong community
- Our population will experience effective and sustainable health and care service

5.5 Prevention and Health Inequalities

Prevention is becoming embedded across the Partnership, with primary, secondary and tertiary prevention approaches already being taken forward in many of our system workstreams, e.g. the Out of Hospital (OOH) and Mental Health workstreams have a clear prevention focus at all levels. Our prevention approach comprises action on the wider determinants of health - the social, economic or environmental factors affecting health, such as housing, employment, education, or parks and green spaces – particularly championed in Coventry, which is a Marmot City. As part of our upscaling prevention activity, we have piloted new approaches to building community capacity and resilience, through funded projects with voluntary and community sector partners. Evaluation has been shared with system leaders to inform future activity.

A key aspect of our approach to prevention has been a commitment by our two Health and Wellbeing Boards (working jointly) to deliver a Year of Wellbeing in 2019 across Coventry and Warwickshire, to promote population and community health and wellbeing. This initiative is being used as a catalyst for change at both an organisational and community level, to galvanise effort and celebrate and extend existing work on prevention and early intervention. At an organisational level, it is being used to prompt culture change by encouraging partners from across the health and care system to champion and take ownership of the prevention agenda. At a community level, existing preventative activity is being promoted to increase its reach and impact, with a general campaign using positive language to encourage our communities to make one positive change.

For reasons both of fairness and of overall outcomes improvement, we plan to take a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care. We have identified Circulation, Respiratory and Cancer as the top three conditions driving our health inequalities. Our Population Health and Preventative Care working group will support our CVD, Respiratory and Cancer groups to: understand these health inequalities, engage with the relevant communities, implement interventions to address inequalities and monitor and evaluate the impact. This will be supported by the RightCare PCN Focus Packs and nationally developing dashboards.

In contributing to the ambition of an extra five years life expectancy by 2035, our staff are committed to utilising every contact they make with patients, carers and the public, to promote prevention activities and opportunities to improve health. Details of the activities we intend to undertake with regards to smoking, obesity, alcohol, air pollution and antimicrobial resistance are highlighted in our Prevention and Inequalities planning template.

5.6 Further progress on care quality and outcomes

A strong start in life for children and young people

Our activities to achieve a strong start in life for children and young people currently sit in several disparate work programmes and are overseen by various working groups/ programme boards across our system. Each of these workstreams are aware of the requirements and are developing plans and agreeing new service models to ensure delivery of the targets set out in the Long Term Plan. Detail of how each group will deliver the LTP targets is found in the following separate planning templates:

- Maternity and Neonatal Services
- Children and young people's mental health services
- Learning Disability and autism
- Children and young people with cancer
- Redesigning other health services for children and young people

In the short term, ambitions will be reviewed by these working groups/ programme boards and where needed new actions added to their work plans. In the longer term, we will develop Children and Young People's Transformation Programme and Programme Board – the timing of this will depend on the development of the national transformation programme. Together with the Maternity Transformation Programme and the Local Maternity System Board - this will work in a matrix way with the other working groups/ programme boards to enable achievement of the long-term plan ambitions.

Better care for major health conditions

Over the last 2 years, we have been developing working groups and work programmes for the major health conditions (Diabetes, Cancer, Mental Health, Stroke, CVD, Respiratory, Frailty).
More recently we have reviewed our clinical leadership and relaunched our Clinical Forum with a new system clinical lead (chair of clinical forum) and further emphasised clinical leadership in our governance structure. Our existing groups are being formalised as sub-groups of our Clinical Forum with a clinical lead and SRO leading each workstream.

The Long Term Plan ambitions have been reviewed by these working groups/ programme boards and where necessary new actions have been added to their work plans as highlighted in the relevant planning templates. These show how they will achieve the following key targets:

Cancer	• Roll out of Rapid Diagnostic Centres from 2019 • Introduce faster diagnosis standard so patients receive diagnosis within 28 days by 2020 • HPV primary screening for cervical cancer by 2020 • Offer personalised care to all appropriate cancer patients by 2021 • Extend lung health checks model by 2022 • Deliver stratified follow-up for people worried about recurrent cancer by 2023 • Diagnose 75% of cancers at stage 1 or 2 by 2028
Cardiovascular disease	• We will improve community first response and defibrillator networks • Deliver cardiac rehabilitation to at least 85% of those eligible by 2028
Stroke Care	• Introduce improved post-hospital rehabilitation model by 2020 • Deliver ten-fold increase in the number of our patients who receive a thrombectomy after a stroke by 2022 • Deliver thrombolysis to all appropriate patients by 2025
Diabetes	• Introduce more preventative activity • Expand provision of structured education to newly diagnosed patients • Introduce self-management support tools • Ensure all pregnant women are offered continuous glucose monitoring by 2021 • Ensure more people achieve the recommended diabetes treatment targets in primary care • Provide access to MDT footcare teams and inpatient diabetes inpatient specialist nursing teams
Respiratory disease	• Reduce the variation in quality of spirometry testing to increase diagnosis • More primary care staff trained to provide specialist input • Expand pulmonary rehabilitation, including use of digital technology and self-management tools • Optimise medication through medication reviews and patient education • Introduce risk scoring for deteriorating/vulnerable patients
Adult Mental Health services	• Integrated primary and community mental health care in place by 2023/24 • Increase in access to NICE-approved IAPT services by 2023/24 • Increased alternatives for people in crisis in place including NHS 111 by 2023/24 • Improved ambulance service response (vehicles and staff) to people experiencing mental health crisis by 2023/24 • Liaison services in place in all acute hospital A&E departments, with 70% delivered 24 hours a day by 2023/24
Short waits for planned care	• Roll out the use of Musculosketal (MSK) First Contact Practioners by 2023/24 • Extend access to online support for MSK patients • Reduce Face to face outpatient attendances by 30% by 2023/24

We are taking a pathway approach to better care for major health conditions. There are common components to these pathways which are independent priorities in the NHS Long Term Plan and there are sections addressing these as part of the individual service planning templates. This approach to planning along with our developing approach to matrix working ensures that actions that contribute to more than one workstream are jointly owned and supported.

5.7 NHS staff will get the backing they need

Workforce is seen as a key enabler to providing the stepped change required in delivering the Long Term Plan (LTP) and is therefore a critical priority for the system. The leadership for this resides with the Local Workforce Action Board (LWAB) with a clear line of sight to the Programme Delivery Group and on to the Partnership Executive Group (PEG). Membership includes NHS providers, education and local authority representation along with primary care. The work of the LWAB, underpinned by the 2017-2021 Workforce Strategy, set out a vision to support the system's ambition to transition to an Integrated Care System.

Where we are:

A governance review has been undertaken with all stakeholders and although there is a degree of development and maturity to be reached, the core principles for delivery are agreed:

- Respond to system wide workforce priorities
- Optimise use of funding from the C&W pound
- Respond and deliver themes of the NHS People Plan
- Collate, analyse and utilise workforce data from across the system
- Support the development of workforce planning expertise across the sytem

To support delivery of these principles, the LWAB has now formed four constituent sub groups focussed on key areas of delivery - recruitment and retention; leadership and organisational development; workforce planning and education and development.

We continue to develop connectivity, building on local relationships, to deliver against key workforce challenges, and opportunities. We also recognise that some workforce action needs to happen at national/regional level, alongside local action at organisational, PCN and place levels.

What we are currently doing aligned to the themes of The Interim People Plan

The LWAB and representative organisations are fully committed to the NHS People Plan and both collaboratively and as individual organisations are aligning activity to those themes. Some of these activities are identified in the table below:

Making the NHS the best place to work	**Improving NHS leadership culture**
• Scope/develop a system wide recruitment campaign, to live, learn and work within Coventry & Warwickshire. • Develop and extend health and wellbeing initiatives to support our staff • Facilitate system rotational posts, particularly in supporting the growth and retention of mental health nursing roles and of AHP's • Support greater integration and awareness of primary, community and inpatient services amongst the workforce	• Deliver local programmes enabling GPs/Practice Managers to learn alongside senior clinicians/non-clinical staff • Deliver a BAME Leadership programme with a further cohort in 2019 • System-wide reverse mentoring programme for our diverse workforce • Scope system leadership skills/behaviours • Leadership programmes in place in all NHS providers • Develop a leadership offer to support staff who work in integrated teams • Produce system-wide induction video
Addressing urgent workforce shortages	**Delivering 21st century care**
• Develop nursing associate role • Staff retention rate/Sickness absence discussed and aligned to local metrics for realistic achievement, with consideration of staff retention	• Develop Assistant Practitioner roles in inpatient and community teams and integration of care navigator roles and social prescribing • Operate a local apprenticeship hub, maximizing efficiency relating to

• Utilise best practice across the system to release greater time to care • Promote flexible working options to assist recruitment and retention • Develop and pilot new roles across disciplines, including medical, therapies e.g. physician assistants	procurement of apprenticeships • Deliver a range of activities to promote health careers in disadvantaged communities • Review organisational sign up to initiatives such as 'Stepping into Health' a Local University project aimed at 'Male Career Changers into Healthcare.'
Developing a new operating model for workforce	
• Work collaboratively within the Integrated Care System (ICS) • Align occupational coding across organisations to ensure consistency in data reporting • Establish a more robust/holistic approach to workforce planning so that we have a system wide understanding of workforce demand and supply trajectories, making best use of data • Ensure workforce information in digital platforms is used to maximise workforce productivity.	

What we still need to do:
We still need to undertake work to ensure our workforce is fit for the future and that we maximise their potential to deliver the LTP. With regards to **partnerships** we will work collaboratively to ensure our workforce plans are reflective and consistent with the system clinical strategies that deliver LTP commitments. We will develop greater connectivity to our partner voluntary and charitable organisations including the further development of volunteering and we will develop a support offer for our newly emerging PCN's and Place-based teams. Where there are specific workforce shortages, we will establish system shared development programmes for all organisations , e.g. Sonography. We are also committed to stabilising the current general practice workforce, putting in place the a more robust approach to GP workforce planning, developing Primary Care networks and investing in the development of the wider primary care workforce

With regards to **valuing and supporting our people**, we will agree system staff well-being and workforce metric measures and interventions and monitor/utilise them as a 'temperature check' of how staff are feeling. We will develop strong system leaders, ready to take ownership, do things differently and take individual and collective responsibility. We plan to agree workforce diversity measures for our leadership team and wider workforce and ensure system compliance with the new Workforce Disability Equality Standard. We are keen to increase alignment with the digital and estates enabling workstreams and upskill our workforce to maximise the effective use of technology.

We acknowledge that, as a system, we need to **streamline our processes,** join up how we operate consistently and drive 'value for money.' We will develop a system-wide response to international recruitment, particularly for the nursing workforce. We will establish one collaborative bank across the system, we will develop a route for Nursing Associates to become registered nurses, maximising the use of the apprenticeship levy and we will lead the work to eliminate premium rate staff costs, wherever possible.

System wide workforce metrics are being developed to support us focus our action and measure outcomes. Current NHS data is shown below for ease of reference:

	UHCW	GEH	SWFT	CWPT
Total Headcount - as at 31st August 2019)	9013	2446	4856	3625
Total WTE - as at 31st August 2019)	7900.25	2079.94	4032.65	3142.88
Sickness Absence % - as at end of July 2019	4.69%	4.32%	4.79%	5.76%
Vacancy % - as at end of July	13.02%	9.7	5.8%	13.40%

6.0 BUILDING A SUSTAINABLE PARTNERSHIP

6.1 Our Partnership Governance arrangements

Our approach to collaboration begins in each of the 18 neighbourhoods/PCNs which make up Coventry and Warwickshire, with our 127 GP practices working together, with community, mental health, social care service and voluntary sector teams, to offer integrated health and care services for populations of 30-50,000 people. These integrated services are focused on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it. We see these as critical building blocks within a mature ICS and PCNs will be key partners in identifying possible Place- based opportunities for increased out-of-hospital models of care well as horizontal efficiencies (shared clinical workforce, collective back-office functions).

Neighbourhood teams sit within each of our four local Places (Coventry, Rugby, South Warwickshire and Warwickshire North). These places are the primary units for partnerships between NHS services, local authorities, the voluntary sector, charities and community groups, which work together to agree how to improve people's health and improve the quality of their health and care services. The focus for these partnerships is increasingly to move away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment.

These place-based partnerships, overseen by the Coventry and Warwickshire Health and Care Partnership Board, are key to achieving the ambitious improvements we want to make. However, we recognise that there are also clear benefits in working together across a wider footprint and that local plans need to be complemented with a common vision and shared plan for Coventry and Warwickshire as a whole. We apply three tests to determine when to work at this level:

1. to achieve a critical mass beyond local population level to achieve the best outcomes;
2. to share best practice and reduce variation; and
3. to achieve better outcomes for people overall by tackling 'difficult issues' (i.e. complex, intractable problems).

6.2 Our Health and Care Partnership Board

Building on the Coventry and Warwickshire Place Forum, a system-wide Partnership Board has been established to provide us with a mechanism for collaborative action and common decision-making for those issues which are best tackled on a wider scale. This is strongly aligned to and heavily influenced by the Health and Wellbeing Boards Concordat and our emerging Strategic Framework. It meets four times a year in public and is chaired on a rotational basis by either Health and Well Being Board Chairs or by the NHS Independent Chair.

6.3 The Partnership Executive Group (PEG)

The Partnership Executive Group (PEG) is one of the delivery committees of the Partnership Board and includes each statutory organisation. It is responsible for overseeing delivery of the Five Year Plan and building leadership and collective responsibility for our shared system objectives. The PEG also includes attendance from the System Clinical Lead, the System Finance Lead and the System Transformation Director and NHSE/I representation.

The Programme Delivery Group (PDG) reports to the PEG on a monthly basis. This will be the vehicle by which the PEG and ultimately the Partnership Board oversee and monitor the deliverables identified in this Five Year Strategic Plan.

6.4 Our Journey to becoming and ICS

Consistent with the NHS Long Term Plan, we are working toward being a mature ICS by 2021. A full self-assessment against the recently updated NHS ICS Maturity Matrix was undertaken in July 2019. This allowed us to identify key areas of strength as well as areas requiring further focus going forward.

As a system we are performing well regards System Leadership, Partnerships and Change Capability, and Coherent and Defined Populations with work already undertaken on leadership, developing the system architecture and governance, and ensuring there are coherent and defined populations at System, Place and Neighbourhood.

Whilst some progress has been made against elements of System Architecture and Strong Financial Management and Planning, Integrated Care Models and Track record of Delivery, further work is required and challenges remain, particularly with regards to financial management, delivery of some of the constitutional standards and demonstrating transformational delivery.

Following our self-assessment, we updated our ICS Roadmap with the key milestones required to achieve mature ICS status including a single 'Strategic Commissioning' function and a commitment to move to four Integrated Care Partnerships (ICPs). Our ICS roadmap is overseen by the Partnership Executive Group and reported against to the Partnership Board.

6.5 Our System Enabling workstreams

Estates

The estates workstream has been a key enabler in driving the development of Place Based estates strategies linked to clinical priorities. Key personnel from each organisation at Place have been brought together to develop a programme that will ensure the infrastructure is able to respond to the unique and changing demands of each Place whilst making best use of existing and fixed assets. This has driven the prioritisation of schemes that offer system benefits to several partners at once, rather than individual organisations. A clear governance structure is in place to link the enabling workstreams (estates, medicines optimisation and digital) with clinical, workforce workstreams and Place.

The approach we have taken is underpinned by the following:

- Development of plans underpinned by clinical assumptions/priorities linked to the NHS Long Term Plan (LTP)
- Bottom up plans at 4 Places – Coventry, Rugby, South Warwickshire and Warwickshire North
- Include all key partners – primary care, secondary care, community care, mental health, Local Authorities
- Deliver as much care as possible closest to patients/communities – a 4-tiered facilities approach at neighbourhood, community hub, DGH and Tertiary/Specialist centre level
- Ensure sustainability for all service redesign/reconfiguration - workforce, facilities, financial
- Consolidate and centralise complex services to improve quality and safety, maximise workforce efficiency and make services sustainable
- Enhance the use of mobile/agile working and system consolidation of non-clinical services

All partners have existing estates strategies (including a single Primary Care Strategy) and continue to update and refresh these in line with the system clinical priorities and the development of local priorities at Place. Significant progress has been made with partners coming together to support

delivery of system priorities and overcome organisational constraints. The approach to developing the required estates infrastructure at Place has fostered system level thinking which has then changed and shaped individual organisational estates strategies. These plans not only respond to system clinical priorities but unlock several benefits for several organizations at any one time.

The Estates Strategy Group has increased its membership, to ensure all organisations are represented at the monthly meetings. An implementation plan/workplan is utilised to monitor and manage progress of actions/schemes with a risk register in place to identify/mitigate and manage risk across the system. Key estates workstreams are in place to support the implementation and delivery of the strategy around Capital Developments, Efficiencies, Primary Care and Disposals.

Work has now commenced to consider the entire estates workforce with a view to sharing resource and working more flexibly with all the workforce, particularly where specialist, technical knowledge/expertise is required, or workforce is scarce.

The System Estates Strategy has been refreshed with future schemes identified ready for prioritisation in the late Autumn.

Medicines Optimisation and Pharmacy Integration

Medicines Optimisation has a major influence on delivering better health outcomes for individual patients and improving the health at a population level particularly with regards to reducing inappropriate prescribing and ensuring patient safety across care pathways. For this reason, Medicines Optimisation is part of the LTP, NHS 10 Point Efficiency Plan in the NHS Next Steps on the Five Year Forward View and Lord Carter's review on productivity in NHS Acute Hospitals.

The Medicines Optimisation and Pharmacy Integration workstream has been identified as a key system priority due to its interaction across other workstreams and the potential for significant savings across the System. Our approach:

- Plan underpinned by clinical assumptions/priorities linked to the NHS LTP
- Bottom up plans at 4 Places – Coventry, Rugby, South Warwickshire and Warwickshire North
- Establish bottom up shared learning – individual focus for each Place which can then be shared up at System and cascaded down to all other Place groups
- Include all key stakeholders – primary care, secondary care, community care, LPC, APC, GP Alliance, CSU, PHE, Healthwatch etc
- Ensure sustainability for all service redesign/reconfiguration

The Medicines Optimisation and Pharmacy Integration Steering Group (MOPISG) has increased its membership, to ensure all aspects of the system are represented at monthly meetings. This group will become Medicines Optimisation and Pharmacy Integration Programme Board with representation from each Place. Utilising RightCare data, financial and statistical analysis, the workstream will focus on areas whereby the most system efficiencies can be made. An implementation plan/workplan is utilised to monitor and manage progress of actions/schemes with a risk register in place to identify/mitigate and manage risk across the system.

A System Lead for Medicines Optimisation and Pharmacy Integration post has been approved by the PEG and will be implemented to provide dedicated capacity. This role will be pivotal for the system-wide oversight and driving the programme across multiple organisations.

At Place, activity is driven and monitored through the Medicines Optimisation and Pharmacy Integration Place Groups. These report up into the Place Executive Committees as well as the

Medicines Optimisation and Pharmacy Integration Board. Each Place currently has three identified in-year priorities to focus on with sub-categories forming part of the workstreams.

Digital

The Digital workstream is a critical enabler in supporting our system deliver the NHS Long Term Plan (LTP). Key personnel from every organisation across the system have been brought together to develop a programme that will ensure the infrastructure is able to respond to the unique and changing demands of Place and System whilst also making best use of existing systems. The sharing of knowledge and where possible standardisation of IT systems will achieve a more efficient way of working, reduce duplication and provide the potential for any future system wide integration requirements. This has driven the prioritisation of schemes that offer system benefits to several partners at once, rather than individual organisations.

The approach we have taken is underpinned by the following:

- Development of a Digital Strategy underpinned by clinical assumptions/priorities linked to the NHS Long Term Plan
- Planning undertaken at Place and System and then aligned to maximise opportunities
- Include all key partners – primary care, secondary care, community care, mental health, Local Authorities
- Deliver as much care as possible closest to patients/communities utilising digital technology such as video consultations etc. This will support Place based working and allow other enabling workstreams, such as the estates workstream to deliver their requirements
- Using technology and digital system integration, support organisations to consolidate and centralise complex services to improve quality and safety, maximise workforce efficiency and make services sustainable
- Enhance the use of mobile/agile working and system consolidation of non-clinical services.

The Digital Transformation Board (DTB) has a wide representation with input from all organisations across the System as well as Place and external groups such as the LMC, Ambulance Service, NHSE/D, Information Governance (IG) and Chief Clinical Information Officer (CCIO) etc. A workplan is utilised to monitor and manage progress of actions/schemes with a risk register in place to identify/mitigate and manage risk across the system. The Digital Strategy is currently being refreshed with future activities identified ready for prioritisation by late November.

At Place, activity is driven and monitored by the individual Place Digital Leads who report up into the Place Executives, and the DTB.

Empowering people - this plan acknowledges the transformation in relationships between the population and the clinical and care communities. Records will no longer be fixed to organisations or clinicians but in the future there will be a joint collection and curation approach across all stakeholders using new tools such as apps and wearables.

As part of the Integrated Care Record (ICR) programme a Patient Portal will allow patients access to a summary of their care record including appointment. This will become a Personal Health Record (PHR) which will hold care plans and allow patients to contribute to their health record through the integration with health apps and wearable devices. By 2023 the Summary Care Record (SCR) functionality will be moved to the local shared health and care record systems and be able to send reminders and alerts directly to the patient.

Supporting health and care professionals- all staff need to be equipped with the skills to work in a digital environment and the interim NHS People Plan addresses the need for an increase in the technical skills of the NHS workforce for both specialist and non-specialist staff. The DTB will work with the Local Workforce Action Board (LWAB) to ensure that an integrated approach to staff digital skill development is taken.

Supporting Clinical Care - the ICR will make a significant impact on the delivery of clinical care by allowing clinicians to access a single source of data from across care providers, be that acute, community, mental health, social or primary care. Other partners may be added in the future.

Subject to local prioritisation, other specific areas where digital approaches will improve clinical care are a single Cancer IT system, an integrated Digital pathology network and a single pharmacy solution for all Providers.

Improving population health - as part of the ICR programme a Population Health Management (PHM) tool for data analytics will be procured and implemented. Through risk stratification and predictive modelling it will support System level strategic planning and proactive healthcare management at the Locality / Primary Care Network (PCN) level.

Improving clinical efficiency and safety - provider Digital Maturity will take the greatest step forward in the next 2-3 years as all three acute providers either will or might replace their EPRs. This will deliver ePrescribing to all areas which will improve safety and a more modern EPR solution that will improve general efficiency. Demand and capacity modelling tools will be developed to assist System flow for patients.

Research

Coventry and Warwickshire Health and Care Partnership is committed to a focus on innovation to drive outcomes across health and social care. There is currently variance across the system in terms of innovation maturity, but we are seeking to build a culture of innovation across all partner organisations and embed innovation into all workstreams, so it's 'everyone's business.'

All NHS Coventry and Warwickshire hospitals are research active, partaking in clinical trials with dedicated research departments. Providers work together as a West Midlands South region, potentially exploring a shared clinical trial matching platform. There are good working relationships and partnerships with both Coventry University, and Warwick University and Medical School.

The AHSN network provides an interface between industry, academia and the NHS and the AHSN Implementation Lead provides 'on the ground' capacity to continue developing links with industry and academia. The role is also involved in the NHSE Test Beds, proactively identify potential opportunities for pace of test beds adoption and implementation. Utilising the Innovation Technology Tariff, Innovation Technology Payment and Accelerated Access Collaborative, the AHSN Implementation lead supports system implementation.

Each Provider has a dedicated research department working on health research recruitment. This will ultimately be supported with the development of the integrated health record, and associated population health management work. As a genomics ambassador, UHCW is a leading centre for genomics, one of 18 regional Trusts who come together to form the West Midlands *Genomic* Medicine Centre.

The West Midlands south region operates a Membership Innovation Council which continues to foster a culture of partnership and collaboration with members from across Coventry and Warwickshire and Hereford and Worcester systems coming together to share best practice. All providers in the region also have access to the services of MidTech who provide commercialisation and intellectual property advice and the AHSN Implementation Lead ensures system awareness.

Coventry and Warwickshire host a clinical Entrepreneur, a research midwife based at UHCW. We are also proposing an Innovation, Quality Improvement and Research workstream to increase the sharing of learning across all providers.

6.6 Place

Within each of our four Places (Coventry, Rugby, Warwickshire North and South Warwickshire), local partnership arrangements are being established that bring together our Councils, voluntary and community groups, NHS commissioners, acute and mental health providers, GPs and other primary care providers. Although early days, it is intended that these Place partnerships begin to take responsibility for the cost and quality of health and social care for their populations as well as their well-being through increased prevention. Each of the four Places are developing their own arrangements to deliver the ambitions set out in the NHS Long Term Plan.

These new ways of working reflect local priorities and relationships, but all provide a greater focus on population health management, integration between providers of services around the individual's needs, and a emphasis on care provided much closer to where people live; in primary and community settings. The model also builds on existing partnership working by bringing those commissioning and providing services into an even stronger alignment.

The extent and scope of these arrangements is a matter for local determination, but they typically include elements of shared commissioning, integrated service redesign and delivery, aligned or pooled investment and joint decision making. Other key members of these partnerships include:

- voluntary and community sector organisations and groups
- housing associations
- other primary care providers such as community pharmacy, dentists, optometrists
- independent health and care providers including care homes and hospices.

A more detailed overview of each of the Place arrangements is shown in Annex 1.

6.7 The role of the Strategic Commissioner

During 2019/20 the CCGs have begun to consider how they work together differently in the context of the NHS Long Term Plan's conclusion that CCGs will, in the future, become '*leaner, more strategic organisations'*. In May 2019, the Governing Body of each CCG considered a report which set out different options to create a 'single commissioner' for Coventry and Warwickshire. Engagement with and decisions of the three CCGs' GP memberships will conclude in November 2019. Following on from this, transitioning to more joint working will likely be an area of focus for the CCGs in 2020/21.

Whatever organisational form the CCGs ultimately take, the approach to commissioning must change. Going forward, we have agreed that we will use the same methodology and approach as the Out of Hospital (OoH) outcome-based contract for the following areas; maternity and paediatrics, mental health and potentially planned care. In the longer term, it is intended that Integrated Provider

Contracts will provide the mechanism for these functions ('delivery/place commissioning' functions) transferring this from the strategic commissioner.

As commissioners acting within the same system, CCGs and Local Authorities will maintain close engagement throughout this plan period to ensure a 'true' Strategic Commissioning function is created. The Coventry and Warwickshire Collaborative Commissioning Board ('the CCB'), which draws representation from three CCGs, Coventry City Council and Warwickshire County Council, will continue to have a critical role in ensuring continued alignment in commissioning arrangements between health and social care, as well as in developing the conditions for commissioning integrated and preventative services.

The CCGs' commissioning intentions for 2020/21 were published at the end of September 2019 and identify several priorities that the CCGs will focus on during the year to develop both strategic and delivery/Place commissioning.

6.8 Our Provider Alliance

The Provider Alliance was formed in September 2018 with health and care providers from across Coventry & Warwickshire committing to work together to share expertise, knowledge and skills and draw on the strength of the collective to work in partnership to redesign delivery and develop new models of care.

The alliance comprises NHS providers and the two local authorities plus Primary Care. Their main objectives are:

- Respond to the system need to redesign end to end pathways and determine the most appropriate partnerships to undertake this (System, Pan-System or Place)
- Influence and shape the strategic commissioning development pipeline
- Oversee the assessment of risks and opportunities associated with each pathway redesign
- Determine the most effective form for the management of the end-to-end pathways e.g. prime contractor, prime provider or alliance and influence the commissioning of these forms
- Develop the governance principles and structures that will enable and drive the collaborative efforts between providers and commissioners and identification of the resources to do it
- Develop a delivery roadmap for each opportunity, identifying the required capability and capacity to deliver
- To provide a forum to share best practice.

As the strategic commissioning function develops, the provider alliance will need to build capacity to respond to the pipeline of outcome-based contracts as well as work with partners in place. Initial meetings focused on the establishment of the alliance, agreed ways of working and the scope of the work programme.

It is recognised that there are clinical relationships and co-dependencies for which it is anticipated the Clinical Forum or Clinical Groups at Place will be the most appropriate groups to critically appraise the proposals for new models of care through a clinical lens.

In July 2019 the MCYP Programme started Phase 2 of the Maternity and Paediatrics workstream that will be undertaken during 19/20 into 20/21. Phase two will enable front line staff working in maternity and paediatrics to consider how services can be most effectively be delivered to improve the health outcomes, quality, and experience of services in the context of the existing health inequalities, workforce, estate and financial constraints. The Provider Alliance is a key vehicle for the provider collaboration throughout the process.

6.9 Partnership working

Many of the key partnership arrangements have already been mentioned and detailed in this document such as PCNs, our four Places, Commissioners and the Provider Alliance. However, our relationship with our Local Authority (LA) colleague goes from strength to strength and is one of the most important relationships in delivering our approach to Population Health.

We recognise that the Voluntary Sector organisations are also important partners in our system and have the potential to support us deliver the requirements of the LTP, if we enable them. Alignment with the voluntary and community sector ('VCS') is delivered through multiple channels including the Place based partnerships, the local Working Together Boards (as part of the OoH Transformation Programme) and the Practice Based Teams. We will build on these existing relationships to ensure that the VCS is enabled to contribute to the overarching outcomes that our Partnership is seeking to achieve for the benefit of all communities in Coventry and Warwickshire.

6.10 Our future approach to Engagement

As identified in the New Local Government Network (NLGN)report 'Community Commissioning – Shaping Public Services through People Power,' a radically different relationship between citizen and the state is required for the public service to deliver its preventative agenda. The report argues, community commissioning results in numerous benefits for both people and Places with evidence available that individual wellbeing, community cohesion as well as policy effectiveness all improve based on greater participation among citizens. This ultimately means handing power and resource, that is currently held by public sector institutions, over to communities.

The commissioning of public services is one of the most important functions of the public sector but also one that is deeply embedded within institutions. Community Commissioning makes a convincing case for why the process needs to be led by citizens and service users not public sector professionals. Importantly, it also explains in detail how this shift is happening in practice.

Although at the very start of this journey, our future model of engagement will be rooted in true integration and meaningful collaboration within every neighbourhood and we are committed to make the changes required to transfer this powerbase. Our approach will be underpinned by the following principles:

- Change is done with and not too people. Building on the work already undertaken by our Local Authorities, we want to continue to develop a relationship between public services, people, communities and businesses that enable shared decision making, democratic accountability and voice, genuine co-production and the joint delivery of services
- We will adopt an asset-based approach that recognises and builds on what individuals, families and our communities can achieve rather than focus on what they lack
- We will encourage behavior change in communities that build independence and support people to be in control
- Wellbeing, prevention and early assessment and intervention will become bigger priorities
- A Place-based approach will redefine services and put people, families and the communities at the centre
- We will continue to develop an approach that supports the development of new investments and resourcing models, enabling more collaboration with a wide range of organisations and communities of all sizes, e.g. the voluntary sector and charities
- We will be honest and transparent with our public about what can and can't be achieved, and why, even if this sometimes means having difficult conversations. This will help manage the expectations of our population.

We also acknowledge that the community and voluntary sector do fantastic work to support our population, especially those who might struggle to access services and feel their voice is lost or seldom heard. We will work with and support these organisations to make sure as many people as possible have a say in the future to ensure that our services are fit for purpose and reflect the needs of our entire population.

6.11 Our approach to Quality

In line with our Partnership's system-wide vision, we are committed to improve the quality and outcomes for users of health and care services across Coventry and Warwickshire. We will seek to achieve this through a standardised approach to quality assurance at both System and Place levels. Partnership working, reducing unwarranted variation, reducing avoidable harm and improving the personalised patient experience will all contribute to achieving this approach.

As commissioning and provider organisations, we aim to address the 'quality gap' by transitioning from our established approach to quality to one where commissioners and providers across the system work better together to maximise the impact that can be achieved through quality assurance and quality improvement activities.

Our approach to quality, forms one aspect of the broader system strategy to improve health outcomes. Historically there have been three areas that NHS Commissioner's monitor - patient safety, patient experience and clinical outcomes. The Strategic Commissioner will move away from this approach to one which establishes and monitors outcomes-based contracts. Quality monitoring becomes critical as the delivery of clinical outcomes drives payment rather than activity. Each lead provider will take responsibility/accountability for contractual quality monitoring of sub-contractors.

Our future clinical outcomes approach will form the basis of a new system wide quality dashboard which will operate at both System and Place level. System level will focus on the monitoring of outcomes and Place level will focus on the delivery of specific KPIs that underpin delivery of these outcomes. Monitoring at Place level will need to be statistically sophisticated and robust enough to account for normal statistical variation and statistical special cause variation, which requires further work. This approach recognises that getting collective, accurate and detailed reporting is fundamental to achieving these aims.

There will be clear system governance processes in place with the strategic commissioner having oversight of the clinical outcomes dashboard. The lead providers in the Integrated Care Partnerships (ICPs) will develop their own Clinical Governance Committees and will monitor the KPI dashboards of their own contract and their sub-contractors. The governance will include the process of escalation and de-escalation of concerns at a system level, strategic level and place-based level, based on a risk-rated approach. A new Integrated Care System Quality Surveillance Group will have oversight of those red-rated risks, ensuring effective management of these, but also ensuring the dissemination of best practice between lead providers across the ICS.

7. Finance, Activity and Workforce Assumptions

7.1 Finance Assumptions

In 2018/19 the system out-turned at an aggregated position of £14.7m deficit from our control total; this contained £36.7m of sustainability and recovery funds. The reported efficiency within this position amounted to nearly £100m representing a reported year on year aggregate efficiency of circa. £300m since 2016; however, we acknowledge that this has been underpinned by a significant volume of non-recurrent and provider productivity.

The system workstreams have largely allowed cost containment against rising demand rather than remove costs. The system has committed to a financial plan that shows year on year improvement in the underlying financial position, with year four and five starting to show a reversal of the trend.

In 2019/20 two significant contracts changed to reflect the commitment to improve the "system £". This has refocused the discussions from that of transactional contracting to wider conversation of pathway improvement. The programmes for Place underpin the delivery, with future operating models for MSK, frailty and mental health.

Alongside this, is the workforce plan. Organisationally, a significant impact has been made on the agency spend reducing by over £14m from 2016/17; however, there are still areas of shortage and the ability to provide the workforce to support transformational change is still a challenge. This provides a focus on the innovative use of workforce in the system work programme.

Moving forward the system is committed to the implementation of Aligned Incentive Contracts (AICs) and is currently working through both the financial strategy and associated risk share that will help to manage risk across the system.

During 2019/20 a system capital allocation was issued against which providers were asked to manage their programmes. This presented the system with a number of challenges due to its mixture of foundation and NHS trusts; however, providers came together to agree a common methodology and an agreed spend within the envelope allocated.

The STP had total allocations of £1.356bn for 2018/19 and had an adverse variance to planned control totals of £26.18m at the year end. George Eliot and UHCW posted deficits for 2018/19 as they have over recent years. SWFT has consistently delivered surpluses over the past decade and CWPT have delivered another small surplus in line with the planned control total.

Combined NHS underlying system financial position at the beginning of 2019/20 is a deficit £101m.

	Coventry & Rugby £000's	Warwickshire North £000's	South Warwickshire £000's
Underlying Position - Surplus/(Deficit)	(54,246)	(29,384)	(18,018)

Finance Principles

In order confirm our desire to work together to deliver an improved financial picture, several principals have been agreed. The 8 agreed principals are listed below:

1.	We all agree to collaborate under the principle of "one system, one budget" and to make decisions based on the best use of NHS resources. We will work towards wider public sector resource utilisation.
2.	We all agree to promote an unrelenting focus on eliminating waste whilst maintaining, if not improving, quality.
3.	We all accept the need for expenditure within a given ICS footprint to be contained within the available resources (within our control) to commissioners in the ICS.
4.	We all agree to deliver an improved year on year collective financial position.
5.	We all agree to share information openly in order to inform collective decision making.
6.	We all agree to actively support demand management initiatives (as modelled in the system-wide demand and capacity plan) intended to keep actual aggregate year on year growth as close to zero as possible.
7.	We all agree to facilitate the sharing of patient information between organisations (within IG rules) to support the delivery of proactive and preventative care, including demand management.
8.	We will collaborate and facilitate the redistribution of resources to ensure that patient needs can be addressed in the most cost-effective care setting.

One of the agreed financial principals aims to contain expenditure within the available resources allocated to commissioners in the system. Dealing with demand in a different way will be key in reducing and containing the cost of delivering clinical services, another agreed financial principal.

Productivity and Efficiency

The total efficiency required by the system is £119.4m for 2019/20; £51.7m for commissioners and £67.7m for providers. The system recognises that attempting to deliver savings in a traditional manner will not deliver the scale of savings required and therefore a different approach is needed.

Focus on Cost

With the commissioner letting contracts for each of the 4 places for a (largely) fixed sum, the focus will need to move away from income to the cost base of delivering services. Multi-year contracts provide certainty of income to providers while incentivising innovation. Integrated Care providers will need to work differently to respond to the demands with modest year on year growth in contract values.

The cost base for NHS providers is generally in two parts; workforce and estate. Provider workforce costs tend to increase in response to demand from patients for services whether planned care or urgent care.
Managing demand for services give the opportunity to;

- add costs - where providers must engage additional clinical workforce over establishment and therefore incurs premium costs, and;
- reduce costs – where demand can recurrently be dealt with in a different way;

Capital

Given the ongoing constricted position on capital nationally it is essential that the system makes the most efficient use of estates. The estates strategy focuses on both utilisation and the potential for capital receipts. Future planning intends to draw on the experience used in the 19/20 response to

the system capital allocation to ensure an equitable approach to future development and back log maintenance.

PFI

Increasing costs of some PFI buildings have not covered by inflationary tariff uplifts in recent times. Overall estates usage could have an impact on making sure the right blend of services are delivered on the right sites to give the best operational fit for each site. Going forward we need to maximise the amount of specialised services delivered on the UHCW site, and currently the provision of specialised services is being reviewed across the system.

7.2 Activity Assumptions

Activity plans have been based on the application of demographic, non-demographic growth, based on current activity rates, and planned service changes. The activity plans are responsive to both System and Place based needs, and support the delivery of the Long Term Plan requirements including reducing face to face outpatient attendances, increasing same day emergency care and increasing planned care to ensure that patients receive timely and effective care.

7.3 Workforce Assumptions

Assumptions across the Coventry and Warwickshire system are based on the following core principles:

- the overall workforce numbers and cost will not increase however there will be a continued focus on the redesign of job roles ensuring generic skills are recognised and optimised
- Spend on agency staffing will continue to reduce and a truly flexible workforce established with the ability to flex supply and demand in a more efficient and effective way
- System wide working will improve with rotational posts and services ensuring previous organisational boundaries are removed allowing staff and services to be directed to areas of most need.

7.4 Key risks to delivery and mitigating actions

As a system, we have identified five key areas of risk associated with our ability to deliver this plan over the next five years. These are:

- Financial sustainability in the short to medium term
- Building a workforce that is fit for the future
- Having the right information/evidence to inform effective decision making for our population
- Capacity of clinicians within the system to engage in the programme of activities required
- Maintaining positive system relationships through times of change and challenge

Having identified these risks, we intend to work up a detailed system risk register, describing each risk in more detail and aligning mitigating actions for each risk by the mid-November submission. We will then manage risk through the Programme Delivery Board and the Finance Advisory Board, reporting on a monthly basis to the Partnership Executive Group.

8 Conclusion

Or Five Year Strategic Plan reaffirms our commitments to realising our ambitions and delivering both local priorities and those set out in the Long Term Plan. It provides a reflection on what we have achieved, but also an honest view of the challenges that lay ahead of us and our responsibility to address them.

Our collaboration is underpinned by a governance structure that continues to evolve and there is a commitment from all partners to work together to implement solutions that will improve the health outcomes and well-being of our population.

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Item 4

Coventry and Warwickshire Joint Health Overview and Scrutiny Committee

14 October 2019

Developing Stroke Services in Coventry and Warwickshire - Public Consultation

Recommendation(s)

1. For the Joint Health Overview and Scrutiny Committee to review the attached Pre Consultation Business Case and Consultation Documentation

2. For the Joint Health Overview and Scrutiny Committee to provide their formal response to the Consultation

1.0 Key Issues

1.1 The aim of our proposals are to improve stroke services, which are part of both CCG plans and the health and care system improvements identified by the Coventry and Warwickshire Health and Care partnership.

1.2 Comparisons of the performance and outcomes of current local stroke services against best practice standards and the achievements of other health systems in England, show we could achieve better health outcomes for patients and more effective and efficient services. It is clear from the analysis of current service provision that there is also considerable unwarranted variation and inequity in the range of services available for patients across the system.

2.0 Options and Proposal

2.1 Options for the future delivery of stroke care have been co-produced and appraised through a process involving extensive professional, patient and public engagement.

2.2 The resultant Pre-Consultation Business Case (PCBC) describes the process and outputs in detail, proposing the implementation of a new service configuration that would see:

- Removal of the current inequities in service provision across Coventry and Warwickshire
- Prevention of c.230 strokes in 3 years by bringing anticoagulation prescribing to best practice levels
- Centralisation of hyper-acute and acute care at University Hospitals Coventry and Warwickshire (UHCW)

- The provision of 2 sites for bedded rehabilitation at George Eliot Hospital and Leamington Rehabilitation Hospital for the 30% of the population experiencing a stroke who cannot go home with Early Supported Discharge or Community Stroke Rehabilitation
- The provision of new community services to deliver consistent Early Supported Discharge and Community Stroke Rehabilitation services at home for 70% of stroke patients, enabling them to return directly home after hyper acute and/or acute care.

2.3 The preferred future stroke pathway and delivery model will create services that meet the NHS Midlands and East Stroke Service Specification and will enable providers to deliver an “A” rating on The Sentinel Stroke National Audit Programme (SSNAP) performance targets for stroke care.

2.4 Extensive public and patient engagement and co-production to help inform and shape the proposed pathway has taken place over the last 4 years (details included within the PCBC). Further public engagement is being gathered via a public consultation process on the proposed future stroke pathway.

2.5 Clinical engagement with acute and community stroke clinicians has taken place in developing the pathway options to ensure that any proposals are deliverable and achieve the best practice clinical outcomes

2.6 The preferred future stroke pathway considerably improves the quality of outcomes and clinical care and removes the current significant unwarranted variation in access to care provision across Coventry and Warwickshire.

2.7 It is unusual for us to develop a PCBC that only proposes one option to achieve the improvements, however this is a proposal for a whole stroke pathway improvement and not just a business case for as single service improvement. The complexity and interdependencies of handover of care, and need for an integrated workforce approach across the pathway, has led to the proposed option and pathway.

2.8 The PCBC was submitted to NHS England for a Strategic Service Change Regional Panel review and assessment of the readiness to proceed to public consultation. The NHS England Panel review meeting took place on 15 August 2019. The Panel granted provisional assurance against the five assurance tests in the NHS England Planning, Assuring and Delivering Service Change for Patients, subject to minor amendments.

2.9 These amendments have been completed, and the resulting consultation document has been signed off by NHS Coventry and Rugby Clinical Commissioning Group, NHS South Warwickshire Clinical Commissioning Group Governing Body and NHS Warwickshire North Governing Body in preparation for consultation.

2.10 The full Consultation Document is attached to this paper for your formal response. Please note that this document is still undergoing final minor

amendments, prior to the consultation launch. Any further changes will be highlighted verbally at the meeting.

3.0 Financial Implications

3.1 Detailed modelling and remodelling has been undertaken throughout the development of the PCBC to quantify the projected demand for stroke services; this has taken full account of forecast population and housing growth.

3.2 The activity projects have then been used to derive costs of the proposed new model. The table below summarises the current and future additional cost of the proposed stroke pathway/service. It must be noted that the increase in acute/bedded costs to CCGs identified is due to national tariff changes that are already within contractual baselines.

3.3 All commissioner and provider organisations have signed up to delivering the proposed model within the financial envelope identified and have included this within their financial plans, with this forming a part of the developing five year plan. Whilst financial risks have been identified, all commissioning and provider organisations involved have signed up to jointly mitigating these risks.

3.4 This proposal represents an investment of nearly £3.1 million into the Coventry and Warwickshire Health System.

	Current Investment by CCG	**Cost of Proposed Model**
	£000s	**£000s**
Community Early Supported Discharge and Rehabilitation	1,663	4,775
Ambulance additional journeys		171
Atrial Fibrillation Community Investment		128
Community elements	**1,663**	**5,074**

Additional cost of community model	3,411
Additional cost of Acute model	374
Less savings on Continuing HealthCare packages	-700
Net additional CCG investment	**3,085**

4.0 Environmental Implications

4.1 An Integrated Impact Assessment has been produced for the proposals, which can be found at

https://www.strokecovwarks.nhs.uk/mf.ashx?ID=41245f6d-f5c1-4025-97d7-b90a4e8637d2

5.0 Timescales associated with the decision and next steps

5.1 Proposed timescale for public consultation: Wednesday 9 October 2019 to Tuesday 21 January 2020, with a formal pause from Monday 23 December 2019 to Sunday 5 January 2020 (to recognise the Christmas holiday period and potential for members of the public to be unable to contribute).

5.2 This results in a consultation period of 14 weeks.

Background Papers

1. Developing stroke services in Coventry and Warwickshire Public Consultation - Full Document.
2. Improving Stroke Outcomes for Coventry and Warwickshire Pre-Consultation Business Case
3. The appendices to the Pre-Consultation Business Case - https://www.coventryrugbyccg.nhs.uk/mf.ashx?ID=fe0bcbe5-5231-4999-a51b-40c08b72991d

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Coventry and Rugby CCG
South Warwickshire CCG
Warwickshire North CCG

Improving Stroke Outcomes for Coventry and Warwickshire

Pre-Consultation Business Case

Contents

APPENDICES

1.0 EXECUTIVE SUMMARY

1.1 Purpose of this Document

This document aims to describe the process through which we have worked with all key stakeholders since the outset of the programme in 2014, to develop a proposed new clinically and operationally sustainable model for stroke services across Coventry and Warwickshire that:

- meets nationally and locally defined requirements and guidance for the provision of stroke services
- has considered the growing bank of evidence for the most effective treatment and care services/pathways and lessons from other systems developing best practice care models
- has been shaped by substantial stakeholder engagement throughout the journey
- has had clear and consistent multi-agency governance and assurance
- has undergone open and transparent appraisal both financially and non-financially to ensure the long-term viability of the model
- is aligned with local and national strategy

This document also describes how stroke services are currently provided across Coventry and Warwickshire, sets out the issues and inadequacies with the current services and our proposal for change.

We recognise that stroke services across Coventry and Warwickshire can achieve better health outcomes for patients by being set up in line with established best practice guidance. In so doing, they can also be more effective and efficient.

As system leaders it is our role to present the community with a clear service pathway and proposal for change. This will require us to make changes to the structure of the existing services, including enhancing some services and reducing or stopping others when they are no longer appropriate. We believe that through delivery of this business case we will create services that contribute to a more effective health and social care system.

1.2 Stroke and TIA Definition

Stroke is the leading cause of disability and fourth largest cause of death in the UK. Just over 1,200 people a year in Coventry and Warwickshire have a stroke and are taken to one of our three local hospitals. In 2016/17 there were over 15,000 stroke survivors on local GPs stroke registers and over 320 people were diagnosed with a Transient Ischaemic Attack (TIA).

A stroke occurs when the blood supply to part of the brain is cut off and is therefore unable to carry essential nutrients and oxygen to the brain, causing brain cells to become damaged or to die. The damage caused can have different effects on the body and how people think, feel and communicate, depending on where the damage occurs.

There are two types of stroke:

- Ischaemic stroke – most strokes are an ischaemic stroke, caused by a blockage that cuts off the blood supply to the brain; and
- Haemorrhagic stroke – these are caused by bleeding in or around the brain.

A Transient Ischaemic Attack (TIA) is also known as a mini-stroke; whilst the same as a stroke, the symptoms last for a short amount of time and no longer than 24 hours, as the blockage that stops the blood getting to the brain is temporary.

As people age their arteries become harder and narrower and are at more risk of becoming blocked, causing ischaemic strokes. Certain medical conditions and lifestyle factors however – including high blood pressure and obesity - are known to speed up this process and increase the risk of a stroke.

1.3 Governance Arrangements

The development of the Pre-Consultation Business Case has been a Commissioner-led process overseen initially by the Warwickshire and Coventry CCG Federation and now by the Strategic Commissioning Joint Committee (comprising CCG Clinical Chairs, Accountable Officers, Chief Financial Officers and other key members of all three local CCGs). However, it has extensively involved key stakeholders through a multi-agency project governance structure. This structure was established at the beginning of the programme in 2014 and has been in place throughout.

Local acute and community service providers, as well as ambulance, Local Authority and patient representatives, have been represented at various levels, including via:

- Stakeholder Board – comprising provider strategy and medical leads;
- Clinical Review Group – comprising Medical Leads to support the development of the clinical model; and
- Activity and Finance Workstream.
- Clinical and Operations Group – comprised of Clinical and Operational Leaders

A full description of the governance and assurance structure and arrangements can be found in section 5.1.

1.4 The Case for Change

There is a strong and growing evidence base, that the organisation and timeliness of stroke specialist assessment and treatment significantly affects outcomes. The following key issues have been identified with the current service organisation and provision which results in locally increased mortality and morbidity following a stroke:

- The current service provision across Coventry and Warwickshire does not meet the requirements of the NHS Midlands and East regional Stroke Services Specification, particularly in ensuring that all patients suffering a stroke receive appropriate hyper acute care within the first 72 hours. Currently, on average 4 patients per day do not receive hyper acute assessment;

- The HASU/ASU beds and rehabilitation services for Coventry and Warwickshire patients do not universally meet all of the national performance standards for best practice care. Indeed, the latest published data in the NHS Atlas of Variation (2015) showed that the number of patients in Coventry and Warwickshire directly admitted to an Acute Stroke Unit within 4 hours of onset of a stroke was amongst the lowest in the country;
- There is variable service provision and inequality of access to key services for Coventry and Warwickshire patients which must be corrected; particularly to HASU beds, inpatient rehabilitation, specialist community rehabilitation and Early Supported Discharge (ESD). Cohorts of patients in Warwickshire North and South Warwickshire currently have no access to some of these services;
- Inadequate provision exists in primary prevention, in the form of gaps in anticoagulation therapy for those with atrial fibrillation to reduce the risk of stroke, with evidence that we could avoid c230 strokes over 3 years by bridging this gap;
- The Sentinel Stroke National Audit Programme (SSNAP) results between Dec 2017-Mar 2018 show that Coventry and Warwickshire services are poor when compared to national average performance in delivering rapid access to appropriate services. The most significant issues arising from the SSNAP audits in support of the case for improvement are:
    - The proportion of patients scanned within 1 hour – in one of the local units 13% of patients are scanned within an hour, in comparison to a national average of 52.4%;
    - The median time taken for patients to be scanned – most recent results show it takes just over 2 hours and 43 minutes at one of our hospitals for patients to be scanned, against a national average of just under an hour;
    - The time taken for patients to be admitted to a Stroke Unit – whilst the national average time for patients to be admitted to a Stroke Unit is 3 hours and 52 minutes, it takes between 6 and 11 hours for patients in Coventry and Warwickshire; and
    - The proportion of patients assessed by a Stroke Specialist Consultant Physician within 24 hours is below the national average for two of the three acute providers in Coventry and Warwickshire.
- There is considerable variation in the acute care provided across the three sites, particularly in relation to lengths of stay. It is clear from review work undertaken that, due to a lack of specialist stroke ESD and community stroke rehabilitation services, patients are currently staying longer in the available acute stroke beds than is in their best interest;
- Critically, there are insufficient Stroke Specialist Consultants to operate an improved and effective service within the current configuration of services, given the requirement to staff services on each of the three acute sites. At the outset of this work, there were only four permanent Stroke Specialist Consultants working across the three acute providers. Five years later this is still the case. There are known

national shortages of these specialists and recruitment to vacant posts has been challenging for all providers.

Given these issues, work is clearly required to improve local stroke care across Coventry and Warwickshire so that more patients can survive their stroke and achieve their optimum level of recovery and independence.

1.4.1 Clinical Best Practice

The assessment of current services and design of the future clinical model and pathway has taken into consideration published evidence, guidance and observations of best clinical practice at other organisations in England.

The NHS Midlands and East Stroke Specification sets out the criteria, as recommended by the External Expert Advisory Group, that different parts of the stroke pathway need to meet to deliver high quality care to patients. These are the expected standards that commissioners should adopt when commissioning stroke care services. The proposed clinical model has been developed with the NHS Midlands and East Regional Stroke Services Specification at the forefront of thinking.

Learning from other stroke service models in England

Members of the Coventry and Warwickshire Stroke Clinical Review Group have learned from a number of other stroke units in the country which had been identified as demonstrating clinical best practice and from published evaluation findings. These included the London Stroke Model, Nottingham stroke service, Stoke on Trent stroke service and North Essex ESD service. The evidence is clear that centralising stroke treatment at a much smaller number of hospitals with specialist stroke care has considerable benefits.

The Coventry and Warwickshire model proposed has been designed taking into account learning from the operation of each of these sites as well as wider documented evidence. This has included testing the capacity planning for the proposed new service provision; the capacity we have planned is broadly in line with the findings from research into stroke services at other best practice regions with similar demographics.

Early Supported Discharge (ESD) and Community Stroke Rehabilitation

There is strong evidence nationally that a new and comprehensive ESD service will be able to reduce patient's length of stay in hospital. Within Coventry, ESD services were piloted from December 2014 to May 2015 and following the success of the pilot, standard ESD has been substantively commissioned in Coventry only since September 2015.

Data from the pilot and the current service provide strong evidence of the success and reach of the proposed model. Full details of this evidence can be found in section 4.3.

The success of an ESD service rests on the provision of high quality, sustainable community stroke rehabilitation services. The community stroke rehabilitation element of the proposed model provides flow through the system that enables ESD to sustain high quality, high

intensity, and timely discharges for those most likely to gain full or near to full recovery post stroke. It also provides interdisciplinary rehabilitation to support flow from bedded rehabilitation for those who have had a moderate to severe stroke, to enable appropriately supported discharge from hospital.

Atrial Fibrillation (AF)

There is evidence that optimally treating high risk AF patients has the potential to avert 230 strokes over three years in Coventry and Warwickshire ('The Size of the Prize on CVD prevention', Public Health England and NHS England).

This evidence indicates that there is significant clinical and financial benefit potentially from this intervention and it has been factored into the activity and financial modelling for the proposed new service.

1.4.2 Local and National Strategy

The proposed new service model is in line with the following local and national strategy documents:

- The National Stroke Strategy (2007), which advocated provision of specialist stroke units, rapid access for TIA patients, immediate access to diagnostic scans and thrombolysis (for those who need it) and Early Supported Discharge.
- The NHS England Five Year Forward View (2014), which cited the centralisation of 32 stroke units in London to 8 units and the reduction in mortality rates and lengths of stay in hospital that resulted from this service change.
- The NHS Long Term Plan (2019) which includes commitment to improved post-hospital stroke rehabilitation models by 2020
- Coventry and Rugby CCG's Commissioning Intentions (2017 – 2019)
- South Warwickshire CCG's Strategic Plan (2016 – 2020)
- Warwickshire North CCG's Vision for Quality Clinical Vision
- The Coventry and Warwickshire Sustainability and Transformation Plan

1.5 Summary of Current Stroke Service Provision

The current services in Coventry and Warwickshire for patients who suffer a stroke or have a Transient Ischemic Attack (TIA) are provided locally by three acute hospital trusts and a local provider of community physical and mental health services, as listed below:

- University Hospitals Coventry & Warwickshire NHS Trust (UHCW)
- South Warwickshire NHS Foundation Trust (SWFT),
- George Eliot Hospital NHS Trust (GEH)
- Coventry and Warwickshire Partnership NHS Trust (CWPT).

The services currently provided are described in the table below.

Services	UHCW	SWFT	GEH	CWPT
HASU beds	6	0	0	Not Available
ASU beds	30	12	18 (+1 assessment bed)	Not Available
Inpatient stroke Rehabilitation beds	6	20	Not Available	Not Available
Total beds	42	32	19	Not Available
TIA service	7-day consultant-led	5-day service	7-day nurse-led	Not Available
Thrombolysis	Yes	Treated at UHCW	Treated at UHCW	Not Available
Carotid imaging	Yes	Yes	2 sessions	Not Available
Carotid endarterectomies	Yes	Treated at UHCW	Treated at UHCW	Not Available
Stroke outreach team	Not Available	Yes	Yes	Not Available
Early Supported Discharge (ESD) service	Not Available	Rugby residents only	Not Available	Coventry residents only
Community Stroke Rehabilitation	Not Available	Not Available	Not Available	Yes

A more detailed description of the key services in the current system is provided below.

1.5.1 Hyper Acute Stroke Units

There is a Hyper Acute Stroke unit (HASU) at University Hospitals Coventry & Warwickshire NHS Trust (UHCW). This offers 24-hour, 7-day cover with rapid assessment for patients on arrival to the Emergency Department. It includes rapid access to imaging and thrombolysis as appropriate and wider access to other specialist skills and diagnostics.

The HASU sees all Coventry and Rugby patients who are suspected of having a stroke, and also patients from north and south Warwickshire who are assessed by a paramedic to be FAST-positive within 4 hours of onset of symptoms.

As soon as patients are assessed as having a stroke (this can sometimes be in the ambulance or in the Emergency Department in UHCW), all patients are seen by the Stroke Consultant-led Team for a multi-disciplinary assessment. This assessment determines likely diagnosis and if confirmed as a stroke, they are admitted to the HASU.

However, not all Coventry and Warwickshire patients suspected of having had a stroke are immediately taken or directed to the HASU. Therefore, not all patients have an immediate specialist assessment, where they will also have access to the full range of specialist skills and diagnostics. This is a significant gap in the current service provision when it is compared to the NHS Midlands and East regional Stroke Services Specification, which identifies that any patient within 72 hours of onset of stroke symptoms can benefit from assessment and treatment in a hyper-acute centre.

There is a cohort of patients from north and south Warwickshire who are either:

- Taken to, directed to or who self-present at their local general hospital; or
- Assessed by a paramedic to be FAST-positive after 5 hours of onset of symptoms and are then taken to their local general hospital Emergency Department i.e. George Eliot Hospital NHS Trust (GEH), or South Warwickshire NHS Foundation Trust (SWFT).

After the hyper acute element of care at UHCW:

- Patients are discharged home if medically appropriate;
- Where further acute care is needed, Coventry and Rugby patients are transferred to the Acute Stroke Unit (ASU) at UHCW;
- Patients from south and north Warwickshire needing further acute care are repatriated to the local ASUs at SWFT or GEH respectively, within 72 hours if possible, subject to bed availability. If there is no ASU bed available in their local hospital, they are admitted to UHCW ASU until a local bed becomes available.

1.5.2 Acute Stroke Units

All three local acute providers deliver Consultant-led Acute Stroke Care on a 24 hour, 7 day basis and have brain imaging available on all sites.

1.5.3 Rehabilitation, Outreach and Early Support Discharge

There is considerable variation in the stroke specialist rehabilitation services available across the area, as described in the table below.

Rehabilitation service	Coventry & Rugby CCG	South Warwickshire CCG	Warwickshire North CCG
Inpatient rehabilitation	6 beds at the Hospital of St Cross for patients from Rugby aged 65 years and over	20 beds in Leamington Spa	No specifically designated beds
ESD	Available to all patients	Not available	Not available
Community rehabilitation	Community Stroke rehabilitation services for Coventry residents provided by CWPT. Community general rehabilitation services for Rugby residents provided by SWFT	Stroke Outreach therapy service provided by SWFT	Stroke Outreach therapy service provided by GEH. Community general rehabilitation services provided by SWFT

The lack of comprehensive access to specialist stroke rehabilitation services is a gap when comparing the current services to the requirements of the NHS Midlands and East regional Stroke Services Specification.

1.5.4 TIA

For those patients experiencing a TIA, carotid imaging is available on site at both UHCW and SWFT; it is available for two sessions each week at GEH. Patients presenting at GEH who require carotid imaging when carotid imaging is not available are transferred to UHCW. All patients from across Coventry and Warwickshire requiring a carotid endarterectomy undergo surgery at UHCW.

Both UHCW and GEH provide onsite TIA clinics on a daily basis, 365 days a year. UHCW's clinics are Consultant-led, whilst GEH clinics are nurse-delivered with Consultant leadership.

Since January 2016, all high-risk TIA patients in the south Warwickshire region, who previously would have been seen at SWFT, are now seen at UHCW.

1.6 Proposed Future Clinical Model

A significant amount of work has been undertaken by clinicians from across the health economy to design a new model for stroke services that meets the clinical best practice outlined in the NHS Midlands and East Stroke Services Specification.

1.6.1 Stakeholder engagement.

Over the last five years, the model of care has been co-designed through public and patient representative engagement. The rationale behind the proposed model has been shared extensively, including with:

- Local commissioners;
- Health, social care and other key partners including the Stroke Association;
- The Warwickshire and Coventry Adult Social Care and Health Overview and Scrutiny Committees and District and Borough Council Scrutiny Committees
- The Public and Patient Advisory Group specifically established to advise on the development of proposals since the project started in 2014;
- Stroke survivors in stroke clubs and
- Health professionals and other key stakeholder groups (i.e. Local Authorities, Councillors).

All of these parties have helped to shape and inform the development of the proposed stroke service model. During the engagement in 2017 they have been supportive of this proposed model assuming that a number of key access factors, particularly for carers and relatives, can be mitigated. We have taken this feedback on board and reshaped the proposals during 2018 to reach this final case. Further, engagement in 2018 helped to shape the process for appraising the options for bedded rehabilitation; coproducing the desirable criteria to be used for the non-financial appraisal and culminating in stakeholder participation in the non-financial option appraisal.

1.6.2 Options development and analysis

Development of the Options

To develop the proposed model a range of options have been considered; initial development work focused on the acute stroke pathway only. A long list of scenarios was developed and explored for the provision of an acute pathway. The long list is as follows:

- Scenario 1 - Do Nothing
- Scenario 2 - HASU at UHCW / 1 ASU at UHCW
- Scenario 3- HASU and ASU for Coventry and Rugby patients up to discharge at UHCW, and for North and South Warwickshire patients up to day 7, with repatriation to ASU and SWFT or GEH at day 8 as required. (discounted as clinically not viable)
- Scenario 4 - HASU at UHCW / 3 ASUs at UHCW, SWFT & GEH
- Scenario 5A - HASU at UHCW / 2 ASUs at UHCW & SWFT
- Scenario 5B - HASU at UHCW / 2 ASUs at UHCW & GEH

An assessment based on clinical viability using the following criteria was undertaken:

1. Be capable of meeting the Midlands and East Stroke Service Specification;
2. Be clinically viable in terms of both activity and workforce. Local clinicians agreed that to be clinically sustainable, a Stroke Unit would require a minimum of 10 stroke beds being operational.

Assessment of each of the long list options found that option 2 is the only option that would be capable of sustaining the expert workforce required to drive improvements to outcomes. As such all other options were clinically unsustainable. The details of the assessment are described in sections 5.3 and 5.4.

A single preferred acute pathway clinical option was at this stage selected. This was discussed with local Councillors who are the Health portfolio holders and members of the Public and Patient Advisory Group during 14th to 17th September 2015. It was also considered at the Health Overview and Scrutiny Committees in Warwickshire and Coventry in September 2015. All groups were generally supportive of the model but asked that it be expanded to include comprehensive stroke rehabilitation services and interventions to prevent strokes. The model of care was therefore extended to include these.

During June and July 2017, a further comprehensive public engagement process was undertaken on a proposal for a centralised hyper acute and acute service, bedded rehabilitation on two sites, ESD, community stroke rehabilitation at home and improvements in AF anticoagulation therapy. This resulted in some specific concerns being raised regarding access and travel, most of which are addressed through an action plan working with Council colleagues. Alongside this the stroke expert Clinical and Operations Group leading the clinical design of the future stroke service model was asked to revisit the work completed to date and to consider if there was another method of delivering bedded rehabilitation for the Coventry and Rugby population, to address the travel for carers concerns raised.

This further work identified that there were a number of potential scenarios for providing the bedded rehabilitation aspect of the pathway. A long list of potential scenarios was developed by the Clinical and Operations Group. These scenarios were assessed against their ability to:

- meet national guidance and the requirements of the NHS Midlands and East Regional Stroke Service Specification
- demonstrate at least the minimum levels of delivery of: quality; being safe; being sustainable and better outcomes for patients

Following these clinical assessments two viable stroke rehabilitation options remained:

Rehab Option 1: Early Supported Discharge Service (ESD) and community rehabilitation in all areas. Bedded rehabilitation at South Warwickshire Foundation Trust (SWFT) in Leamington and George Eliot Hospital (GEH) in Nuneaton

Rehab Option 2: ESD and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry with specialist therapy in-reach. Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton

These options were then taken forward for full non-financial appraisal by all key stakeholder groups. Details of the options appraisal are provided within section 5.7

On the basis of this work, an options appraisal of the two viable options for providing bedded rehabilitation was carried out. The appraisal involved representatives from all key stakeholder groups, examples include; patients and carers, local councillors, voluntary sector and community support NHS clinicians, social care commissioner and managers.

The outcome of the options appraisal identified Rehab Option 1 as the preferred option:

Early Supported Discharge Service (ESD) and community rehabilitation in all areas. Bedded rehabilitation at South Warwickshire Foundation Trust (SWFT) in Leamington and George Eliot Hospital (GEH) in Nuneaton.

Integrated Impact Assessment (IIA)

Two Integrated Impact Assessments have been undertaken in 2015 and 2017/18 as proposals have developed. They were completed to estimate the possible implications of re-designing stroke services on patients and their carers and how these effects may be distributed amongst different groups and geographies. The impact assessment focused on three main areas; travel and access; health and determinants of health and equality. The IIA made recommendations to enhance potential positive outcomes and minimise negative impacts of the proposals.

The assessment and scoring from the IIA suggest that proposals for the centralisation of all acute care and proposed models for rehabilitation would have an overall positive impact on patients and carers compared to the do-nothing scenario. Whilst the centralisation and community bedded rehabilitation options will invariably negatively impact on travel and access for some patients and carers, particularly from the North and South of Warwickshire, the expected health benefits, greater proportion of time recovering at home and a greater

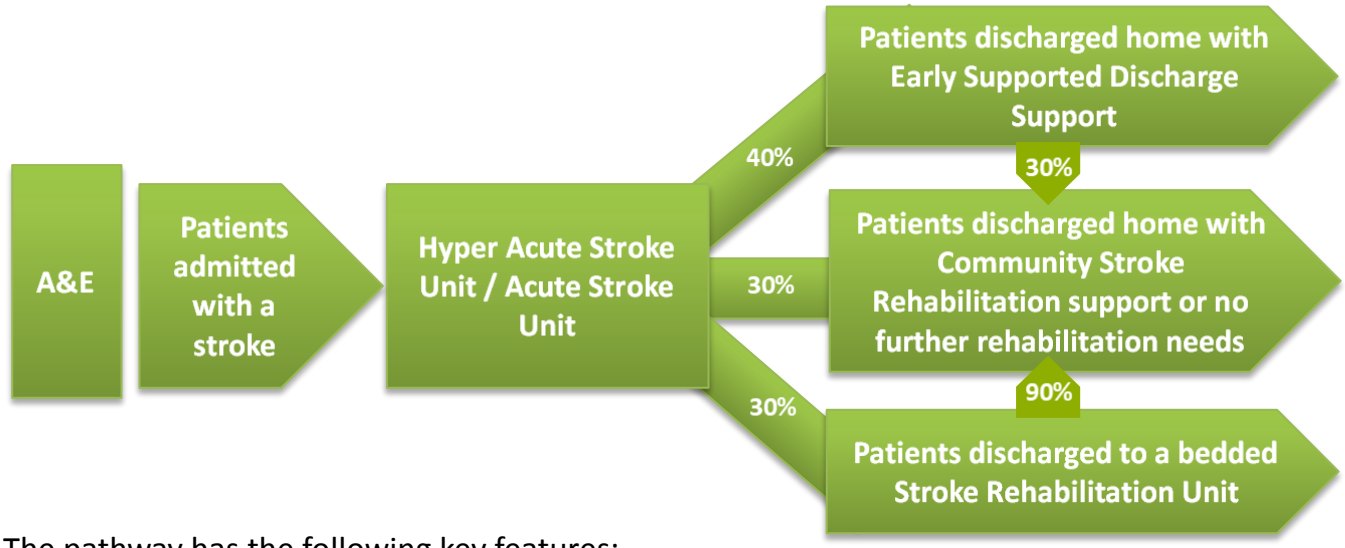
equity of exemplar service provision across the area, in the proposals would more than offset any negative impacts.

1.6.3 The proposed future model for stroke services

We believe that the resulting proposed new pathway of excellence will be the best possible clinical model for stroke services in Coventry and Warwickshire for the following reasons:

- It has been designed taking into account the requirements of the NHS Midlands and East Stroke Services Specification and the latest clinical best practice evidence;
- It improves equity of access to stroke services across Coventry and Warwickshire;
- It fits with local and national strategy;
- It will create workforce development opportunities and improve recruitment and retention of stroke specialist staff;
- It has been tested through a range of clinical quality assurance processes, including the West Midlands Clinical Senate and West Midlands Cardiovascular Network;
- Significant stakeholder engagement and co-production of the proposals through the engagement activities undertaken has provided support to proceed with this option.

At a high level, the proposed future pathway is as follows:



The pathway has the following key features:

- Provision of a single centralised Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at UHCW, with the necessary infrastructure, support and workforce to assess and diagnose all patients suspected of having had a stroke from across Coventry and Warwickshire, within 72 hours of onset;
- Home-based stroke specialist ESD service across all of Coventry and Warwickshire;
- Home-based community stroke rehabilitation across all of Coventry and Warwickshire;
- Bedded stroke rehabilitation services for those patients that require more intensive support after discharge from the ASU and
- A systematic focus on preventing stroke in the form of an integrated anticoagulation pathway that acts to reduce the risk of stroke.

The CCGs are clear on the improved outcomes they wish to see delivered through this change. By ensuring a consistent, high quality service offer, improvement will be made against the following three key clinical outcomes:

1. Reduced levels of mortality for people who have suffered a stroke: case adjusted mortality rates for Coventry and Warwickshire will meet those of comparable population areas;
2. Reduced levels of dependency for those who have suffered a stroke: outcomes will be at least comparable with similar populations by improving and increasing access to the specialist stroke ESD and community rehabilitation services at home, and specialist bedded stroke rehabilitation, and
3. An improvement in cognitive function for people after suffering a stroke: outcomes will be at least comparable with similar population areas.

1.6.4 Equity of access to services

Put simply, under the new model, all patients across Coventry and Warwickshire will be seen more promptly and in the right place by specialist skilled professionals, where they will receive the highest quality care.

There will be no inequality of access to the appropriate specialist care. A consistent stroke service will be in place across all of Coventry and Warwickshire, removing the current inequity of access to services. This applies to all elements of the pathway, including HASU and ASU beds and stroke specialist rehabilitation services.

Centralisation of acute care and standardised bedded rehabilitation will ensure a body of suitably qualified and experienced staff is available to see and treat all patients. The home-based rehabilitation will provide an extra 620 packages of care and the anticoagulation therapy will prevent 230 strokes over three years.

1.6.5 Quality assurance

In order to ensure that the new model is appropriate clinically, the following quality assurance reviews and processes have been undertaken:

Health Gateway Review 0;

National Clinical Advisory Team Review;

West Midlands Strategic Clinical Network Assurance;

West Midlands Clinical Senate Review;

Assessment of the fit against the “Five Tests” for Reconfiguration;

Two Integrated Impact Assessments (IIA); and

A Privacy Impact Assessment (PIA).

The outcome from all of these tests has been supportive of the new model. In particular, external clinical advice has agreed that our preferred model is appropriate and based on best practice.

1.7 Financial and Activity Impact

The preferred option for the proposed future clinical model for Coventry and Warwickshire has been agreed by all stakeholders to provide the best possible quality of care for stroke patients. However, given the finite resources within the health economy, it is also important to demonstrate that the proposed new model is affordable. Finance and activity modelling work has therefore been undertaken to estimate the likely impact on patient flows, costs and potential savings from the potential new models and is described in section 7.

1.7.1 Bed capacity modelling

Modelling has been undertaken to establish the number of beds required to manage demand through the current service model (do nothing state) and to manage the flow of patients through each of the options under consideration for the proposed future state.

Activity for 2017/18 was used to form the baseline for modelling, with growth of 1.07% assumed annually. In establishing the future bed base, the following assumptions were made:

- HASU length of stay would continue to be up to 3 days;
- ASU length of stay is expected to reduce from the current 18 days (spell average) to 11 days at day 1 of introduction of the full pathway;
- the HASU will operate at 85% bed occupancy, the ASU and bedded rehabilitation will operate at 90% bed occupancy, to allow the future service to manage peaks in activity to deliver the necessary patient flow through the system;
- 40% of patients on the Acute Stroke Unit will require a standard ESD package, with a further 30% of patients suitable for bedded rehabilitation provision and 30% discharged with community rehabilitation;
- 30% of the patients discharged with ESD will go on to receive community stroke rehabilitation support.
- 90% of the patients discharged from bedded rehabilitation will go on to receive community stroke rehabilitation support.
- There will be no bed base reduction at any of the acute providers. Beds that are identified as not required for stroke care will be used to support the delivery of other acute hospital activity.

The results of this work on bed modelling are shown in the table that follows:

Bed/Service provision	Current	Future	Difference (Beds)
Hyper Acute Stroke beds	6 beds at UHCW	12 beds at UHCW	+ 6 beds
Acute Stroke beds	30 ASU beds at UHCW 12 ASU beds at SWFT 18 ASU beds plus 1 assessment bed at GEH (Total 61 beds)	31 ASU beds at UHCW	- 30 beds
Community Stroke Rehabilitation beds	6 inpatient rehabilitation beds at Rugby site, UHCW for Rugby patients aged 65+ 20 inpatient rehabilitation beds at Leamington site, SWFT for SW patients only (Total 26 beds)	17 for C&R CCG (preferred option 9 in SWFT/8 in GEH) 12 beds in SW (SWFT) 10 beds in NW (GEH) (Total 39 beds)	+ 13 beds (N.B. different specification of beds)
Total bed numbers	**93 beds**	**82 beds**	**- 11 beds**

1.7.2 Financial modelling

The financial implications of the proposed model have been assessed. This assessment has been discussed at STP level and the following principles agreed by both Commissioners and Providers:

- The bedded part of the stroke pathway will continue to be covered by tariff under the current tariff cost envelope.
- The three CCGs will invest the required amounts in the additional ambulance transfers, elements of prevention and the community stroke rehabilitation pathway

In line with these assumptions, estimates have been produced by Commissioners and Providers of income, activity and costs under the current model and the future model options. These estimates have been based on 2017/18 planned activity and prices to enable a consistent approach to be taken.

Assumptions have been made for future demand driven by changes in population demographics and expected growth rates for Coventry and Warwickshire. It is important to note that there will be no savings to Commissioners from the planned bed base realignment outlined in the previous section.

The table that follows provides the results of the financial analysis of the investment required by CCGs in the community elements of the pathway.

Community pathway elements	£000s
Historic Investment by CCGs	1,663
Revised Investment by CCGs	5,074
Additional Investment by CCGs	**3,411**

Additional cost of Acute model	374
Less savings on CHC packages	-700
Net additional CCG investment required	**3,085**

This analysis indicates that the CCGs will be required to invest a further £3.1m in the community pathway. It has been agreed how this investment will be split between the CCGs:

- Proposed investment levels are within CCG financial plans for 2019/20 (on a part year basis) and will be in 2020/21 (on a full year basis). The five-year financial plan being developed will include the impact of this service provision.
- The source of funding for stroke prevention (Atrial Fibrillation anticoagulation therapy) is savings delivered from elsewhere within CCG budgets.

Section 7.3 provides full details of the financial modelling that has been undertaken.

1.7.3 Financial risks

A number of financial risks have been identified whilst undertaking the modelling and are described in full in section 7.4.4. Of those risks identified, all have in place mitigation plans and only two of the risks are identified as high.

The first, is the risk of failing to achieve an acute length of stay of 11 days. It is expected, based on clinical evidence nationally and locally, that the introduction of bedded rehabilitation, ESD and Community Stroke Rehabilitation across all geographical areas will achieve this reduction in the acute length of stay.

The second, is the risk that the realignment of use of the beds no longer required for stroke as part of the proposed model, will result in a reduction in provider income for those beds. A period of transitional activity and associated cost has been agreed to mitigate the potential impact should this risk materialise.

1.7.4 Conclusions

The financial analysis indicates that the CCGs would be required to invest £3.1m in the proposed model of care, to fund the delivery of the community elements of the pathway.

Some modest financial savings will accrue to the CCGs as a result of the new model: £0.7m from a combination of the impact of improved anticoagulation therapy for AF and reduction in long term NHS funded packages of care through the improved rehabilitation offer.

This is considered an appropriate investment to make to remove the current system inequality, increase the quality of services, improve outcomes and access, addressing the key issues outlined above.

After the consultation process, and as part of mobilisation, further work will be undertaken on the timing of the required investments.

1.8 Implementation

Implementation will be overseen by the formation of an Implementation Board, chaired by a Chief Executive of one of the provider organisations (to be nominated), with membership comprising at least one Executive from each of the provider and commissioner organisations. The Implementation Board will have responsibility and accountability for signing off progression through the implementation gateways defined.

It is proposed that the already established Stroke Clinical and Operations Group will reconfigure to become the Implementation Team, with day to day responsibility and accountability for managing the delivery of the new networked clinical model.

1.8.1 Timescales

Implementing the proposed new clinical model represents a significant change to current services and as such will be a complex process.

We are currently in the early stages of implementation planning as the focus to date has been on comprehensively engaging with all key stakeholders to design the most appropriate service delivery model.

Acknowledging that greater detail will be provided during and following consultation, the present outline implementation timeline is provided overleaf. A high-level project plan Gantt chart illustrating the key tasks and project gateway decision points that will be used by the Implementation Board to determine whether implementation can progress has been developed.

Business Case	
Business case complete	June 2019
NHS England Assurance process commences	June 2019
Consultation period	October 2019 –January 2020
Governing Bodies consider consultation results and decision made (BC updated with consultation outcomes)	January 2020 - February 2020
Contract signed	March 2020
Proposed Mobilisation and Implementation should pathway be agreed	
Community pathway mobilisation/ implementation	
Recruitment commences to ESD and CSR posts	March 2020
Mobilisation of ESD and CSR	May 2020
ESD and CSR fully implemented	Jan 2021
Acute pathway mobilisation/ implementation	
Recruitment commences to acute posts	March 2020
Adequate acute staffing in post. Go/No Go gateway decision	Jan 2021
UHCW: additional HASU/ASU beds implemented	April 2021
SWFT: ASU beds closed / SWFT CSRB implemented	
GEH: ASU beds closed / GEH CSRB implemented	
Complete pathway implemented	**April 2021**

A significant amount of work has been undertaken with regard to the future workforce requirements, identifying a proposed future workforce model and the potential actions required to implement such a model. This work is described in sections 6.2 and 8.1.4.

1.8.2 Risks

This is a complex service reconfiguration and as such work has already taken place to identify the potential risks to delivery of the proposed new clinical model and to develop appropriate mitigation plans. The key risks include, workforce planning, capacity planning and maintaining affordability given these two risks. Full details of the risk analysis and mitigation plans are described in detail in section 8.1.5

2.0 BACKGROUND AND CONTEXT

This document describes how stroke services are currently provided across Coventry and Warwickshire, sets out the issues with the current services and our proposal for change.

Just over 1,200 people a year in Coventry and Warwickshire have a stroke and are taken to one of our three local hospitals. In 2016/17 there were over 15,000 stroke survivors on local GPs stroke registers and over 320 people were diagnosed with a Transient Ischaemic Attack (TIA). Current stroke services in Coventry and Warwickshire have improved over time and are providing a good standard of care but, they are not meeting the latest national and regional guidance and evidence.

Comparisons of the performance and outcomes of current stroke services across Coventry and Warwickshire with best practice standards and the achievements of other health systems in England, show we can achieve better health outcomes for patients, more effective and efficient services. The range of services currently available to our patients also varies considerably based on where people live.

The Coventry and Warwickshire Sustainability & Transformation Plan (STP) defines the re-configuration of stroke services as outlined in this Business Case as a key priority as part of its Emergency and Urgent Care Workstream. It is important to note that each of the leaders within the STP has agreed that the model outlined in this business case is the right one and should be implemented.

As system leaders it is our role to present the community with a clear service pathway that is easy to navigate. This will require us to make changes to the structure of existing services; enhancing some and reducing or stopping others when they are no longer appropriate. We believe that through delivery of this business case we will create services that contribute to a more effective health and social care system.

We begin by outlining the current way in which stroke services are delivered.

2.1 Current services

The current services in Coventry and Warwickshire for patients who suffer a stroke or have a Transient Ischemic Attack (TIA) are described in the table below. These services are provided locally by three acute hospital trusts: University Hospitals Coventry & Warwickshire NHS Trust (UHCW), South Warwickshire NHS Foundation Trust (SWFT), George Eliot Hospital NHS Trust (GEH) and a local provider of community physical and mental health services, Coventry and Warwickshire Partnership NHS Trust (CWPT).

Providers of Stroke, TIA & Related Services

Provider	Stroke / TIA Services
University Hospitals Coventry & Warwickshire NHS Trust (UHCW) – covering Coventry, Rugby and parts of Warwickshire	• Hyper Acute Stroke Unit (6 beds); • Acute Stroke Unit (30 beds); • Only site that undertakes thrombolysis; • Inpatient Stroke Rehabilitation Beds (6 beds in Rugby); • TIA Service (7-day Consultant-led service); • Carotid imaging available; • Only site to undertake carotid endarterectomies.

Provider	Stroke / TIA Services
South Warwickshire NHS Foundation Trust (SWFT) – covering south Warwickshire population for acute care and Warwickshire population for general community services	• Acute Stroke Unit (12 beds); • TIA (5-day service); • Carotid imaging available; • Stroke patients requiring thrombolysis treated at UHCW; temporary transfer of high risk TIA patients (in place from January 2016); • Inpatient Stroke Rehabilitation Beds (20 beds in Leamington Spa); • Stroke Outreach team; • ESD service for Rugby residents.
George Eliot Hospital NHS Trust (GEH) – covering north Warwickshire, south west Leicestershire and parts of north Coventry	• Acute Stroke Unit (18 + 1 assessment bed); • TIA (7-day nurse-led service); • Patients requiring thrombolysis, or carotid endarterectomies transferred to UHCW; • carotid imaging, 2 sessions a week at GEH otherwise UHCW; • Stroke Outreach team.
Coventry and Warwickshire Partnership NHS Trust (CWPT) – covering Coventry for Community and Mental Health services (and Warwickshire for Mental Health)	• Community Stroke Rehabilitation and ESD service for Coventry residents.

2.2 Hyper Acute Stroke Unit

A hyper acute stroke unit (HASU) offers 24-hour, 7 day cover with rapid assessment for patients on arrival to an Emergency Department. This includes rapid access to imaging and thrombolysis as appropriate and wider access to other specialist skills and diagnostics.

At UHCW, a single 6-bedded HASU has been in operation since 2008 providing a Consultant-led service, with immediate on-site access to vascular and cardiac imaging, radiology and neuro-interventional and neuro-radiology imaging.

The HASU sees all Coventry and Rugby patients who are suspected of having a stroke and all patients from north and south Warwickshire for whom an ambulance has been called and they are assessed by a paramedic to be FAST-positive, within approximately 4 hours of the onset of symptoms.

However, not all Coventry and Warwickshire patients suspected of having had a stroke are immediately taken or directed to the HASU. Therefore, not all patients have an immediate specialist assessment, where they will also have access to the full range of specialist skills and diagnostics.

There is a cohort of patients from north and south Warwickshire who are either:

- Taken to, directed to or self-present at their local general hospital; or
- Assessed by a paramedic to be FAST-positive after 4-6 hours of onset of symptoms and then taken to their local general hospital Emergency Department i.e. GEH or SWFT.

Patients who are taken to UHCW are seen by the Stroke Consultant-led Team for a multi-disciplinary assessment to determine likely diagnosis. If a stroke is confirmed, the patient is admitted to the HASU, as well as being assessed for their suitability for thrombolysis and their ongoing care needs.

After the hyper acute element of care at UHCW:

- Patients are discharged home if medically appropriate;
- Where further acute care is needed, Coventry and Rugby patients are transferred to the Acute Stroke Unit (ASU) at UHCW;
- Patients from south and north Warwickshire needing further acute care are repatriated to the local ASUs at SWFT or GEH respectively, within 72 hours if possible and subject to bed availability. If there is no ASU bed available, they are admitted to the UHCW ASU until a local bed becomes available.

2.3 Local Acute Stroke Units

All three local acute providers deliver Consultant-led Acute Stroke Care on a 24 hour, 7 day basis and have brain imaging available on all sites. Their bed allocation is as follows:

Number of Acute Stroke & Related Beds

Provider	ASU	Assessment	Total Beds
UHCW	30	0	30
GEH	18	1	19
SWFT	12	0	12
Total			61

2.4 Rehabilitation, Outreach and Early Supported Discharge

There is considerable variation in the range of stroke specialist rehabilitation services that are available across Coventry and Warwickshire.

The table below details the current service availability for CCG resident populations:

Rehabilitation service	Coventry & Rugby CCG	South Warwickshire CCG	Warwickshire North CCG
Inpatient rehabilitation	6 beds at the Hospital of St Cross for patients from Rugby aged 65 years and over	20 beds in Leamington Spa	No specifically designated beds
ESD	Available to all patients	Not available	Not available
Community rehabilitation	Community Stroke rehabilitation services for Coventry residents provided by CWPT. Community general rehabilitation services for Rugby residents provided by SWFT	Stroke Outreach therapy service provided by SWFT	Stroke Outreach therapy service provided by GEH. Community general rehabilitation services provided by SWFT

2.5 TIAs

For patients experiencing a TIA, carotid imaging is available on site at UHCW and SWFT and for two sessions each week at GEH. Patients presenting at GEH who require carotid imaging when carotid imaging is not available, are transferred to UHCW. All patients from across Coventry and Warwickshire requiring a carotid endarterectomy undergo their surgery at UHCW.

Both UHCW and GEH provide onsite TIA clinics on a daily basis, 365 days a year. UHCW's clinics are Consultant-led, whilst GEH clinics are nurse-delivered with Consultant leadership.

Since January 2016, all high-risk patients in the south Warwickshire region, who previously would have been treated at SWFT, are now treated at UHCW.

2.6 Conclusion

Stroke is the fourth commonest cause of death in the UK each year. In Coventry and Warwickshire just over 1,200 people each year experience a stroke.

Current stroke services in Coventry and Warwickshire have improved over time and are providing a good standard of care but, they are not meeting the latest national and regional guidance and evidence.

It is clear from the analysis of current service provision that there is considerable unwarranted variation and inequity in the range of service provision for patients across each CCG footprint in Coventry and Warwickshire. For example, access differs to inpatient rehabilitation beds, specialist community rehabilitation and ESD.

3.0 THE CASE FOR CHANGE

There is strong and growing evidence, that prompt specialist assessment and treatment significantly improve a person's chance of surviving with the least complications and disabilities following a stroke. The evidence shows that patients are 25% more likely to survive or recover from a stroke if treated in a specialist centre. Patients need fast access to high quality scanning facilities and some need fast thrombolytic treatment. Being within 30 minutes (by ambulance) from a hyper-acute unit will permit a more expert assessment, quicker treatment and far higher chances of a full rehabilitation. The most recent clinical guidelines from the RCP Stroke Working Party in 2016, state that 'patients with acute stroke should be admitted directly to a hyper-acute unit….'.

There are several issues with the current service provision in Coventry and Warwickshire. To investigate the current state of Stroke and TIA services we have undertaken reviews of our service provision, performance and outcomes. We have also reviewed and identified best practice to understand how local services compare and can be improved. This work has been undertaken by a Clinical Review Group comprising of local medical leads and a Clinical and Operations Group comprising of local clinical and operational leaders, supported by external clinical review and challenge from the National Clinical Director for Stroke and the West Midlands Cardiovascular Network. Their work is summarised through this section, the outputs of which have told us that a number of key improvements are needed. We have used these insights to develop our proposed future clinical model and priorities for action.

3.1 NHS Midlands and East Stroke Services Specification

The Midlands and East Stroke Services Specification (Appendix 1) was developed by NHS Midlands and East in October 2012 and updated in 2015. The specification was developed by an External Expert Advisory Group in consultation with stakeholders, including Stroke Networks, clinical staff working in the field, commissioners, patients and carers who have experienced NHS services. It built on clinical best practice to describe the standards commissioners should adopt, setting out the criteria that pathways need to meet to deliver high quality care and outcomes.

The specification states that a "whole pathway approach" to the provision of stroke services is crucial to maximising clinical outcomes for patients, to achieve the resultant quality of life and improve their experience of stroke services. In particular, the first 72 hours of care is vital. The specification defines components of the pathway with recommended timescales for each phase.

The three CCGs that cover Coventry and Warwickshire need to commission stroke services in line with the Midlands and East Stroke Services Specification. However, the current Stroke and TIA service provision across Coventry and Warwickshire does not meet the requirements of this specification. In particular, not all patients suffering a stroke receive appropriate hyper acute care within the first 72 hours and there is a lack of comprehensive access to ESD services and specialist community stroke rehabilitation.

3.2 Primary Prevention

There is inadequate provision in primary prevention of stroke in Coventry and Warwickshire. Local data suggests patients with atrial fibrillation are going unidentified and improvements can be made to better manage atrial fibrillation, hypertension and diabetes locally.

The clinical evidence shows that:

- Reducing blood pressure in all adults with diagnosed and undiagnosed hypertension by 5 mmHg reduces risk of cardiovascular disease (CVD) events by 10%
- Statin therapy to reduce cholesterol by 1 mmol in people with a 10 year risk of CVD risk greater than 10% reduces the risk of CVD events by 20-24%
- Anti-coagulation of high risk AF patients averts one stroke in every 25 treated

NHS Commissioning for Value and Public Health England analysis identified that there are significant opportunities in Coventry and Warwickshire to prevent the occurrence of strokes through ensuring that Atrial Fibrillation is identified (to the right prevalence rate), anticoagulation treatment is optimised and patients at high risk of having a stroke are managed appropriately (see data below).

The Size of the Prize in Cardiovascular Disease Prevention – Coventry and Warwickshire

1. The diagnosis and treatment gap, 2015/16

Hypertension	Estimated adult population with hypertension	230,500
	Estimated adult population with undiagnosed hypertension	92,800
	GP registered hypertensives not treated to 150/90 mmHg target	25,700
Atrial Fibrillation (AF)	GP registered population with Atrial Fibrillation (AF)	15,900
	Estimated GP registered population with undiagnosed AF	8,000
	GP registered high risk AF patients (CHA2DS2VASc >=2) not anticoagulated	3,200
CVD risk	Estimated adult population 30 to 85 years with 10 year CVD risk >20%	63,500
	Estimated percentage of people with CVD risk ≥20% treated with statins	49%

2. The burden: first ever CVD events, 2015/16

Coronary Heart Disease	1,650
Stroke	1,000
Heart Failure	900

3. The opportunity: potential events averted and savings over 3 years by optimising treatment in AF and hypertension, 2015/16

Optimal anti-hypertensive treatment of diagnosed hypertensives averts within 3 years:	150 heart attacks	Up to £1.10 million saved[2]
	230 strokes	Up to £3.40 million saved[1]
Optimally treating high risk AF patients averts within 3 years:	260 strokes	Up to £4.60 million saved[1]

3.3 Access

There is significant inequality of access to HASU/ASU beds and rehabilitation services for Coventry and Warwickshire patients.

3.3.1 HASU / ASU beds

Not all patients suspected of having had a stroke from across Coventry and Warwickshire are immediately taken or directed to the HASU for an immediate specialist assessment, where they will have access to the full range of specialist skills and diagnostics. All Coventry and

Rugby patients suspected of having had a stroke are treated in the HASU, whilst patients from the rest of Warwickshire will only be taken to the HASU if they are assessed by a paramedic to be FAST-positive within 4 hours of the onset of symptoms.

There remains a cohort of patients from north and south Warwickshire who are either:

- Taken to, directed to or self-present at their local general hospital; or
- Assessed by a paramedic to be FAST-positive after 5 hours of onset of symptoms and are then taken to their local general hospital Emergency Department i.e. GEH or SWFT. Once at their local general hospital, if they are assessed to be in the hyper acute phase of a stroke and will benefit from thrombolysis, they will be transferred to UHCW as an emergency patient. Otherwise, once confirmed as a stroke patient, their care will remain at their ASU.

Thrombolysis is only delivered from one site as Coventry and Warwickshire only has sufficient numbers of patients having a stroke for one unit to operate safely. UHCW has the required staff and infrastructure to deliver this.

3.3.2 Rehabilitation

Access to rehabilitation services is inequitable.

- Stroke inpatient rehabilitation beds are currently only available to south Warwickshire patients and a small cohort of patients from Coventry and Rugby.
- ESD services are only available to Coventry patients.
- Community stroke rehabilitative services are available to residents of Coventry and Rugby, with Outreach teams providing more limited post-hospital support to patients in north and south Warwickshire.

3.4 Performance and Outcomes

The Sentinel Stroke National Audit Programme (SSNAP) measures stroke service performance against a range of key areas critical to delivering optimal outcomes for patients. The results for the period October 2018 to December 2018 (Appendix 2) show that Coventry and Warwickshire services need to improve. The most significant issues arising from the SSNAP audits in support of a case for improvement are the:

- proportion of patients scanned within 1 hour – two of the local units are more than 20% below the national average of 52.4%;
- median time taken for patients to be scanned – across the system it varies from 26 minutes to just over 1 hour and 52 minutes for patients to be scanned, against a national average of just under an hour;
- time taken for patients to be admitted to a Stroke Unit – whilst the national average time for patients to be admitted to a Stroke Unit is just over 3.5 hours, it takes between 3 hours 20 mins and over 11 hours for patients in Coventry and Warwickshire; and
- proportion of patients assessed by a Stroke Specialist Consultant Physician within 24 hours - two of the three acute providers are significantly below the national average.

The most recent results against these four metrics can be found in the table below:

Key SNNAP Metrics - October 2018 to December 2018

Domain Metric	Time Period	England Average	GEH	SWFT	UHCW
Proportion of patients scanned within 1 hour of clock start[1]	Oct 2018 – Dec 2018	54.5%	31.9%	34.1%	67.4%
Median time between clock start and scan	Oct 2018 – Dec 2018	0h 52m	1h 40m	1h 52m	0h 26m
Median time between clock start and arrival on Stroke Unit	Oct 2018 – Dec 2018	3h 37m	11h 34m	3h 58m	3h 20m
Proportion of patients assessed by a Stroke Specialist Consultant Physician within 24hours	Oct 2018 – Dec 2018	84.4%	88.4%	63.6%	75.2%

3.5 Length of Stay

The Clinical Review Group completed two separate point prevalence audits in October and December 2014, to ascertain the appropriateness of patients in acute hospital beds at the time of the audits. These audits found that of the 93 beds available across Coventry and Warwickshire, all were occupied in the first audit, with 77% (72 beds) occupied in the second audit.

The audit was repeated by the clinicians in 2017, to test whether these findings were still relevant, the results confirmed the findings remain relevant.

The audits identified a number of patients who were in acute stroke inpatient beds that could have been benefitting from rehabilitation support outside hospital, had those services been available. These included patients that could have been:

- discharged with support from either a standard or enhanced ESD service
- discharged to a residential or nursing care home
- discharged with a package of care including further community stroke rehabilitative care, or
- receiving onward support in a specialist stroke rehabilitation unit, this latter being the largest cohort of the patients.

Analysis of current activity data still supports these conclusions. Average lengths of hospital stay for patients that have experienced a stroke vary between 17 and 25 days (average length of stay for the system is 18 days). This is significantly longer than the length of stay in areas where they have optimised the configuration of services such as London, who achieve an average length of stay of 11 days.

[1] The term 'Clock Start' is used throughout SSNAP reporting to refer to the date and time of arrival at first hospital for newly arrived patients, or to the date and time of symptom onset if patient already in hospital at the time of their stroke. https://www.strokeaudit.org/results/Clinical-audit/Regional-Results.aspx

3.6 Best Practice Standards of Care

3.6.1 HASU / ASU beds

Whilst there have been improvements made in stroke care locally, there remains inequity of access to services for patients suspected of having had a stroke. In particular there is inequity of access to both hyper acute stroke care (for those outside of the 4 hour window) and adequate rehabilitation services, to meet the national best practice care standards.

The latest published NHS Atlas of Variation data (published in September 2015 using 2013/14 data) showed the number of patients in Coventry and Warwickshire directly admitted to an acute stroke unit within 4 hours of onset of a stroke was amongst the lowest in the country.

Extract from Map 40, NHS Atlas of Variation

Percentage of people with acute stroke who were directly admitted to a stroke unit within four hours of arrival at hospital by CCG, 2013/14			
CCG Name	**Rate**	**95% Lower Limit**	**95% Upper Limit**
NHS Coventry and Rugby	43.00	38.20	47.94
NHS Warwickshire North	38.10	32.32	44.23
NHS South Warwickshire	34.20	29.64	39.06

This data highlights local variance from best practice standards and national performance in accessing the right care at the right time to help improve patients' chances of survival, optimising their independence and in minimising the level of disability resulting from a stroke.

3.6.2 Rehabilitation

As has been highlighted above, there is considerable unwarranted variation in the range of stroke rehabilitation services provided across Coventry and Warwickshire. In the north of Warwickshire and in Rugby, there is limited or no access to local stroke specialist rehabilitative care and there are varying levels of rehabilitative care in hospitals. This results in significant inequity in service provision for our population.

3.7 Findings from Local Stroke Review

A significant work programme was undertaken by the Clinical Review Group (CRG), which was led by the nominated lead clinical representative for all three CCGs, with the clinical leads of stroke and rehabilitative care for all local providers involved.

This work included a review of local stroke services, which concluded that:

- **HASU:** Not all patients with a suspected stroke are being seen in a specialist hyper acute stroke unit and therefore some may be missing the opportunity provided by a hyper acute assessment and/or unit;
- **Service configuration:** Local services are not configured in the best way to achieve the improved standards that other best practice areas have achieved, as demonstrated in the NHS Atlas of Variation;

- **Workforce:** There are insufficient Stroke Specialist Consultants to operate an improved stroke service as currently configured and a national shortage of Stroke Specialist Consultants;
- **Equity of service provision:** There is a need to address the inequity of access to services, particularly stroke specialist rehabilitation;
- **Length of Stay:** Due to a lack of specialist stroke ESD and community stroke rehabilitation services, patients are currently staying longer in the available acute hospital stroke beds than is ideal; and
- **Community services:** Many patients are currently in stroke acute hospital beds whilst they are waiting for other community-based services, such as care packages.

Appendix 3 contains the complete review document.

3.8 Workforce Challenges

A workforce review undertaken by the Clinical and Operational Group has identified existing gaps and a high probability of long-term workforce challenges and constraints, which make continuing with the current configuration of services a risk. There is a particular issue with respect to the Stroke Specialist Consultant workforce where there is an acknowledged national shortage of Stroke Consultants. The BASP 2011 report Meeting the Future Challenge of Stroke indicated a deficit of circa 163 posts.

At the outset of this work, there were only four permanent Stroke Specialist Consultants working across the three acute providers and recruitment to vacant posts has been challenging for all providers. Five years later this remains the case. To respond to this challenge, the Clinical Review Group signed up to developing a new, networked clinical workforce model as part of the future service model to ensure sufficient medical cover across all three acute sites.

There is also a potential challenge relating to stroke nurse staffing as there may be a change in nursing skills mix required, with an increase in the ratio of qualified nursing staff needed and a decrease in the numbers of unqualified nursing staff.

Optimising the limited specialist workforce across the area will improve recruitment, retention, education and training and help to mitigate the workforce sustainability risk.

3.9 Benefits

The key benefits being sought from these proposals mostly relate to access to services and clinical outcomes. A Benefits Realisation Plan has been developed (Appendix 4) identifying the key indicators that will be measured to monitor the improvements resulting from the new pathway.

At a summary level, these are:

- More timely access to stroke-related services, including a specialist assessment at the outset of a stroke;

- Improved mortality rates overall;
- Reduced level of long-term disability;
- Increased number of patients admitted to a centralised Stroke Unit within 4 hours;
- Increased number of patients given a brain scan in a timely manner;
- The financial cost of the new proposals assumes financial savings resulting from reducing the incidence of strokes as a result of better prevention (i.e. improved diagnosis and treatment of AF) and from reductions in long term care costs as a result of the increased access to better rehabilitation services and access to the HASU for all. Whilst it can be assumed that there is likely to be financial savings resulting from reduced social care requirements (as a result of improved health outcomes/reduced disability following the onset of stroke) these benefits have not been included or quantified within either the benefits or financial analysis.

3.10 Conclusion

The comprehensive review of local services has identified a range of significant issues with current service performance, access and outcomes against expected best practice and published guidance. Significant scope for improving the quality of services and delivering consequent benefits in patient outcomes and experience has been identified across the stroke pathway, from prevention to acute care.

Given this range of access, quality and significant workforce issues, work is clearly required to improve local stroke care across Coventry and Warwickshire so that more patients can survive their stroke and achieve their optimum level of recovery.

4.0 SUPPORTING EVIDENCE AND BEST PRACTICE

This section further explains the work that has been done to ensure that we are proposing the best possible clinical model for Coventry and Warwickshire.

We believe that the new service model proposed in this Business Case is the best possible clinical model for stroke services in Coventry and Warwickshire for the following reasons:

- It has been designed taking into account the NHS Midlands and East Stroke Services Specification and the latest available clinical best practice evidence;
- It ensures equity of access to services across Coventry and Warwickshire;
- It fits with local and national strategy;
- It has been tested through a range of quality assurance processes that have been undertaken and
- The range of engagement activities that have been undertaken have in general agreed that it is the best option, with some concerns from the public about travel for carers and relatives.

4.1 The Midlands and East Stroke Services Specification

In 2011, following the benefits realised by the London Stroke Model, the then NHS Midlands and East Strategic Health Authority (SHA) set out its ambitions for regional improvements in Stroke and TIA healthcare, underpinned by a vision to provide fast access to the best standards of service possible.

This resulted in the Midlands and East SHA commencing a review of stroke services in 2012, to help drive an improvement in the way that patients have access to high quality stroke, TIA and rehabilitation services. The underpinning aim of this was to deliver:

- Centralisation of Stroke Units;
- Reduced unwarranted variations in clinical outcomes and services and
- Services based on evidence and best practice.

In response to the latter, the NHS Midlands and East developed the Stroke Services Specification, which used a comprehensive and current evidence base to agree best practice. The NHS Midlands and East Stroke Services Specification evidence base includes:

- National Stroke Strategy (2007) Department of Health;
- National Clinical Guidelines for Stroke (2016) Royal College of Physicians;
- Quality Standards Programme: Stroke (2010) National Institute for Clinical Excellence;
- Stroke Service Standards (2010) British Association of Stroke Physicians Quality and Outcomes Framework for 2012/13 (2011) NHS Employers;
- The NHS Outcomes Framework 2012/13 (2011) Department of Health;
- A Public Health Outcomes Framework for England 2013-2016 (2012) Department of Health;

- The 2012/13 Adult Social Care Outcomes Framework (2012) Department of Health and
- Supporting Life after stroke (2011) Care Quality Commission.

The specification identified 7 phases of the stroke care pathway, as follows:

The specification defines components of the pathway with recommended timescales for each phase, as follows:

Regional Specification Pathway and Lengths of Stay

The proposed future clinical model for Coventry and Warwickshire has been developed with the Midlands and East Stroke Services Specification at the forefront of thinking. In particular:

- All patients suffering from a stroke will receive appropriate hyper acute care within the first 72 hours,
- There will be comprehensive access to ESD services and specialist community stroke rehab, and
- There will be greater focus on primary prevention in the form of improvements in identifying atrial fibrillation and using anticoagulation to reduce the risk of stroke.

4.2 Equity of access

Achieving the best outcomes for patients experiencing a stroke requires access to the full range of specialist stroke rehabilitation services for the whole population. Equity of access is therefore a core requirement for high quality stroke services, with access to services being based on patients' needs and not their home address.

Under the new model, all patients across Coventry and Warwickshire will be seen more promptly and in the right place by specialist skilled professionals, where they will receive the highest quality care.

There will be no inequality of access to the appropriate specialist care. Centralisation of acute care and standardised bedded rehabilitation will ensure a body of suitably qualified and experienced staff is available to see and treat all patients. The home-based rehabilitation with provide an extra 620 packages of care and the anticoagulation therapy will prevent 230 strokes over three years.

A consistent stroke service will be in place across all of Coventry and Warwickshire, removing the current inequity of access to services. This applies to all elements of the pathway, including HASU and ASU beds and stroke specialist rehabilitation services.

4.3 Clinical best practice evidence

The Midlands and East Stroke Service Specification is based on a comprehensive evidence base and agreed best practice. However, given the time that has elapsed since its publication, in developing the future clinical model and pathway for Coventry and Warwickshire, we have also observed best practice in other organisations/health systems.

London Stroke Model

Evidence is clear that centralising acute stroke treatment at a much smaller number of hospitals has considerable benefits. The London Stroke Model was implemented in July 2010 and in their November 2010 stroke newsletter from the stroke clinical director Dr Tony Rudd, the London Cardiac and Stroke Networks reported that:

- The average length of stay for Stroke patients decreased from 15 days in 2009/10 to 11.5 days year-to-date at August 2010;
- The 2010 National Sentinel Stroke Audit evidenced that 84% of London patients were spending 90% of their time on a dedicated stroke unit against a national average of 68% for periods Q1 2009/10 – Q1 2010/11; and
- The 2010 National Sentinel Stroke Audit evidenced that 85% of high-risk TIA patients were being treated within 24 hours, against a national average of 56% for periods Q1 2009/10 – Q1 2010/11.

The reconfiguration has been shown to have delivered an absolute reduction in mortality of 3% and enabled an additional 6% of people to achieve independent life at home after a stroke. More than 95 extra lives are saved every year in London alone as a result of concentrating specialist stroke care in eight HASUs.

The London HASU model, which operates 24 hours a day, seven days a week, avoids £5.2 million each year.

National Institute for Health Research Published Evaluation Findings

On 28 May 2019, the National Institute for Health Research published "Evaluation of reconfigurations of acute stroke services in different regions of England and lessons for implementation: a mixed-methods study" . Earlier NIHR evidence published in 2014 showed that the London model appears to perform better on key indicators such as mortality. This study adds to the earlier published evaluations by evaluating the longer-term results of the London model as well as the subsequent reconfiguration of Manchester services.

The 2019 evaluation was a mixed-methods study comparing the effectiveness of the different models of stroke service centralisation implemented in London, Manchester and the Midlands and East region with the rest of England. The paper concludes that:

- Centralised service models where all stroke patients are eligible for treatment in a hyperacute stroke unit seem to perform better than those with more selective admission criteria. If all patients went to a specialist unit for stroke, there were fewer deaths than if some patients went to units that were not specialist.
- Centralising stroke services led to fewer patient deaths, less time spent in hospital, provision of better care and overall good patient experiences and value for money.
- This should guide other urban regions looking to reconfigure their stroke care so that the changes can be made as effectively as possible.

Other models

Members of the Clinical Review Group made contact with and/or visited a number of other stroke units in the country, which had been identified as demonstrating clinical best practice, or were in areas of similar demographics to Coventry and Warwickshire. These included the following services and key findings:

Nottingham stroke service

- There are two general hospitals, Nottingham City Hospital (NCH) and Kings Mills Hospital (KMH), which treat 2500 strokes per year, including 600 mimics;
- There are 16 HASU beds at NCH and four at KMH with an average length of stay of 2 days;
- There are 20 ASU beds at NCH and 16 at KMH with an average length of stay of 7 days;
- There is standard ESD capacity for c.30 patients in the south (NCH area) and a community Stroke team. ESD for the KMH team is unknown; and
- There are 40 rehab ward beds at NCH, of which 21 are for standard rehab and for which there is daily consultant input. The other 19 beds are for complex slower rehab with twice a week input from consultants, due to aiming for more therapist led care. There are 20 rehab beds at KMH.

Stoke stroke service

- There is a Hub and Spoke model for the city and county. There is 1 HASU and 1 ASU at University Hospitals of North Midlands (UHNM), 1 ASU at Stafford Hospital, 1 ASU at Macclesfield Hospital and 1 ASU at Leighton/Crewe. 1,200 patients are treated per year;
- There are six HASU beds at UHNM;
- There are 26 ASU beds at UHNM, 10 at Stafford Hospital, 12 at Macclesfield Hospital and 10 beds at Leyton/Crewe. This is a total of 58 ASU beds and the average length of stay across HASU and ASU is 5-7 days.

North Essex ESD service

- The service is spread over four sites and is led by a stroke service lead that actively in-reaches every morning to the stroke ward to identify ESD candidates. The stroke co-ordinator then meets with the patient on the ward, introduces the service and arranges an initial visit for within 24 hours of discharge;
- On average 75% of acute strokes are discharged through the ESD service (349 patients in 2013-14);
- Approximately 50% of patients are referred for further rehabilitation with the community stroke team; and
- The ESD team has access to a community stroke team for longer-term rehabilitation and refers 50% of patients.

The capacity proposed for Coventry and Warwickshire, for each aspect of Stroke and TIA service provision is broadly in line with that expected from the results of the primary research into stroke services at other best practice regions with similar demographics. These included the Nottingham, Stoke and North Essex services outlined above.

Coventry ESD and Community Stroke Rehabilitation Pilot

There is clear evidence nationally that an ESD service can reduce length of stay in hospital. The experience in Coventry from the development of an ESD service has supported this.

In Coventry in December 2014 a pilot ESD service was established to support the discharge of appropriate patients over the winter period. Analysis of the impact of the service was undertaken, including consideration of the numbers of individuals who were supported to leave the Stroke Unit; the level of ESD support offered and what impact this had on the length of stay on the Stroke Unit.

In the first 3 months of the ESD provision, the provider was able to evidence a reduction in the average length of stay by 9 days compared to the same time period in the previous year. However, this also included facilitating an earlier discharge of 12 patients from the Stroke Unit who were suffering from other neurological conditions or having had a recent TIA, as part of the team's approach to free up capacity on the Stroke Unit.

As a result of the positive outcomes of the pilot, the service was substantively commissioned for Coventry in September 2015. The service model in place in Coventry is a standard ESD service, matching the model proposed for the whole of Coventry and Warwickshire in this Business Case. The clinical performance and results of this service therefore offer strong evidence supporting the success of the proposed model.

The length of stay for Coventry patients has reduced overall on average by 11 days. Analysis of the percentage of patients suitable for ESD from SSNAP has shown that on average 53% of patients were found to be suitable over the last year. The results are shown below:

- Dec – Mar 2017 = 62.8%
- Apr – Jul 2017 = 61.9%
- Aug – Nov 2017 = 47.5%
- Dec – March 2018 = 42%

The numbers of patients during the last two financial years who have been discharged out of hospital supported by the Coventry ESD service are as follows:

- Apr 2016 - Mar 2017 = 281
- Apr 2017 – Mar 2018 = 274
- Apr 2018 – Mar 2019 = 267

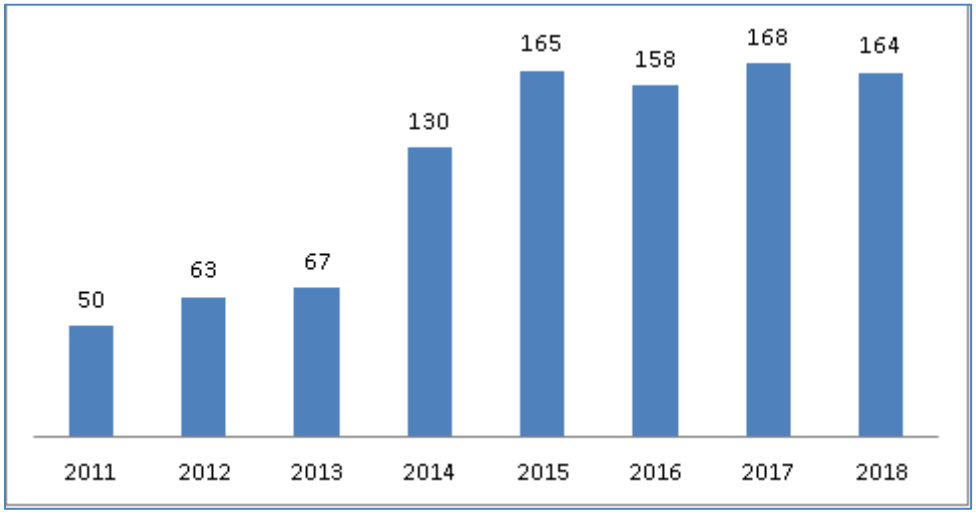
The existing Coventry Community Stroke Therapy Team (CST) provides community stroke rehabilitation support to ESD patients needing ongoing therapy beyond the 6 weeks of ESD support (approximately 30% of all ESD patients) to enable them to achieve their potential and maximise gains and independence post stroke. The team also supports the 30% of stroke patients with moderate to severe stroke who are discharged from the HASU/ASU directly home. This team supports those with the highest levels of impairment and complexity; the majority of the patients will require 2 therapists for each and every therapy session.

The success of the ESD service is dependent on the existence of sustainable, high quality community stroke rehabilitation. Community stroke rehabilitation supports:

- Patient flow from ESD to enable response times within 24-48 hours and intensity of treatment for this cohort with the most potential for change to remove long term disability. The flow to community stroke rehabilitation enables ESD to sustain high quality, high intensity, timely discharges for those most likely to gain full, or near to full, recovery post stroke;
- Patient flow from bedded rehabilitation for those who have had a moderate to severe stroke and who are now medically stable and able to return to the community. Community stroke rehabilitation provides: interdisciplinary rehabilitation to support discharge from hospital and meet a person's maximal level of independence; carer and social care support for long term decisions regarding care and environment needs; goal setting based on participation in the community despite levels of disability, including consideration of return to work and meaningful roles for those affected by stroke.
- Access to and availability of beds in the HASU/ASU by maintaining the flow of patients through the system

The Coventry community stroke rehabilitation team sits alongside the ESD team as a sister service, facilitating timely handover from the ESD team to maintain patient flow into this early intervention team. The proposed model therefore includes plans to ensure equivalent provision across Coventry and Warwickshire. Existing service activity and outcomes have been used as the evidence base for our modelling.

The chart below shows the annual volumes of patients supported to leave hospital by the existing Coventry CST team. A significant step change in activity can be noted from the point at which in-reaching to hospital and the ESD service began in 2014.



The figures below show the CST service reported outcomes, taken from their latest Key Performance Indicator report (October to Dec 2018), which demonstrate on average:

- 8% reduction in disability (using the Modified Rankin Score[2]);
- Of the patients suitable for scoring there was on average a 25-point improvement per patient in increased functional independence on discharge from the service using FIM/FAM[3] (Functional Independence Measure and Functional Assessment Measure).
- 10% improvement in independence in Activities of Daily Living (using the Modified Barthel Score[4]) and;
- 88% of patients achieved all of the agreed rehabilitation goals; a further 8% of patients partially achieved the agreed goals.

Atrial Fibrillation (AF)

There is evidence that optimally treating high risk AF patients has the potential to avert 230 strokes over three years in Coventry and Warwickshire ('The Size of the Prize on Cardiovascular Disease prevention', Public Health England and NHS England referenced in Section 3.2 above). This evidence indicates that there is significant clinical and financial benefit potentially from this kind of intervention.

[2] The Modified Rankin Score (mRS) is a **6 point** disability scale with possible scores ranging from **0 to 5**. A separate category of 6 is usually added for patients who expire. The Modified Rankin Score (mRS) is the most widely used outcome measure in stroke clinical trials

[3] **FIM+FAM** is designed for measuring disability in the brain-injured population. FIM is an 18 item global measure of disability, FAM specifically addresses cognitive and psychosocial function, which are often the major limiting factors for outcome in brain injury.

[4] The **Barthel scale** or **Barthel** ADL **index** is an ordinal **scale** used to **measure** performance in activities of daily living (ADL). Each performance item is rated on this **scale** with a given number of points assigned to each level or ranking

4.4 Local strategy

4.4.1 CCG Commissioning intentions and work priorities

Improving stroke care in the way proposed in this Business Case fits with the strategies of each of the CCGs in Coventry and Warwickshire as follows:

Coventry and Rugby CCG's Commissioning Intentions (2017 – 2019)

Coventry and Rugby CCG's Commissioning Intentions document for 2017/18 – 2018/19 sets out its seven key priorities. Stroke forms part of its Urgent & Emergency Care priority, with the CCG setting out its plan to work with partners to commission a single integrated stroke pathway that secures consistent specialist care, including rehabilitation.

South Warwickshire CCG's Strategic Plan (2016 – 2020)

South Warwickshire CCG's 2016 – 2020 Strategic Plan, translating our 2020 Vision into Reality, acknowledges that for some services where there is a strong relationship between the numbers of patients and the quality of care – including stroke – there is evidence to suggest improvements in outcomes and patient experience that are derived from having expertise, facilities and equipment in one place. As such, it sets out the vision to centralise stroke services to work towards the delivery of the NHS Midlands and East stroke pathway, given the evidence this will deliver better clinical outcomes.

Warwickshire North CCG's Vision for Quality Clinical Vision

One of the four clinical priority areas for the CCG comprises urgent and emergency care, including emergency general surgery, stroke services and cardiovascular disease. The CCG's plan for improved stroke care centres on:

- Improving identification of patients at risk of cardiovascular disease through primary and secondary care prevention and developing a pathway for heart failure, including cardiac rehabilitation services;
- Commissioning TIA services from a provider of specialist stroke care; and
- Commissioning additional stroke rehabilitation services in the local area.

4.4.2 Coventry & Warwickshire Sustainability & Transformation Plan

The Coventry and Warwickshire Sustainability & Transformation Plan (STP) defines the re-configuration of stroke services as outlined in this Business Case as a key priority as part of its Emergency and Urgent Care Workstream.

It is important to note that each of the leaders within the STP has agreed that the model outlined in this business case is the right one and should be implemented. The STP Board discussed and approved this Business Case at its meeting on 20 May 2019.

4.5 National strategy

Every year over 100,000 people in the UK have a stroke. Stroke is the leading cause of disability and fourth largest cause of death in the UK, with costs to the NHS and economy of circa £7 billion a year. Whilst there has been a gradual decline in mortality rates, due to public campaigns such as FAST, stroke remains the single largest cause of severe acquired disability,

driving the need for continued investment in delivering appropriate quality and timely services.

The National Stroke Strategy (2007) previously set out a clear direction for the development of stroke services in England over a 10-year period, with recommendations for the entirety of the patient pathway from prevention to end of life. The evidence-based strategy advocated provision of specialist stroke units, rapid access for TIA patients, immediate access to diagnostic scans and thrombolysis and early supported discharge.

The NHS England Five Year Forward View (2014) also advocated new models of care, including specialist care, citing examples of the centralisation of 32 stroke units in London to 8 units and the resulting reduction in mortality rates and lengths of stay in hospital.

The NHS Long Term Plan set out a series of ambitions for improving stroke care, with key milestones for improved post-hospital stroke rehabilitation models.

The National Stroke Programme, developed jointly by NHS England and the Stroke Association, seeks to support local organisations to deliver better prevention, treatment and care and meet the ambitions for stroke set out in the Long-Term Plan. The national programme aims to:

- Improve post-hospital stroke rehabilitation models for stroke survivors
- Deliver a ten-fold increase in the proportion of patients who receive a thrombectomy after stroke so that each year 1,600 more people will be independent after their stroke
- Train more hospital consultants to offer mechanical thrombectomy
- Deliver clot-busting thrombolysis to twice as many patients, ensuring 20% of stroke patients receive it by 2025 – the best performance in Europe
- Enhance the Sentinel Stroke National Audit Programme (SSNAP) to identify further need and drive improvements
- Ensure three times as many patients are receiving 6 month reviews of their recovery and needs – from 29% today to 90%

The Sentinel Stroke National Audit Programme (SSNAP) June 2017 recognised overall continued improvement in the management of strokes within acute stroke units and discharge, but there are still notable variances across the country:

- Some organisations are still not providing 24 hour hyper-acute stroke care;
- Nearly 10% of applicable patients do not receive swallow assessments within 72 hours of admission;
- In-hospital stroke patients tend to be identified and managed slowly
- Approximately one 5th of stroke admissions are not seen by a specialist stroke physician within 24 hours of admission;
- At least 50% of stroke patients will suffer from depression or cognitive impairments in the weeks following their stroke and will require psychological support.

The proposed new model set out in this Business Case aligns to the ambitions and commitments set out in the Long Term Plan and National Stroke Programme. It has been developed recognising the local variations from accepted clinical best practice set out within SSNAP and the national direction of travel. This includes the centralisation of HASU services.

The model also has the values, principles and pledges within the NHS Constitution at its core, ensuring that the population of Coventry and Warwickshire receive improved access, equity and quality of care to further improve the quality of their lives.

4.6 Conclusion

There is an established and increasing evidence base establishing best practice in stroke care. NHS England has set out key ambitions and commitments for the improvement of stroke services nationally, which are reflected in local commissioning strategies and priorities.

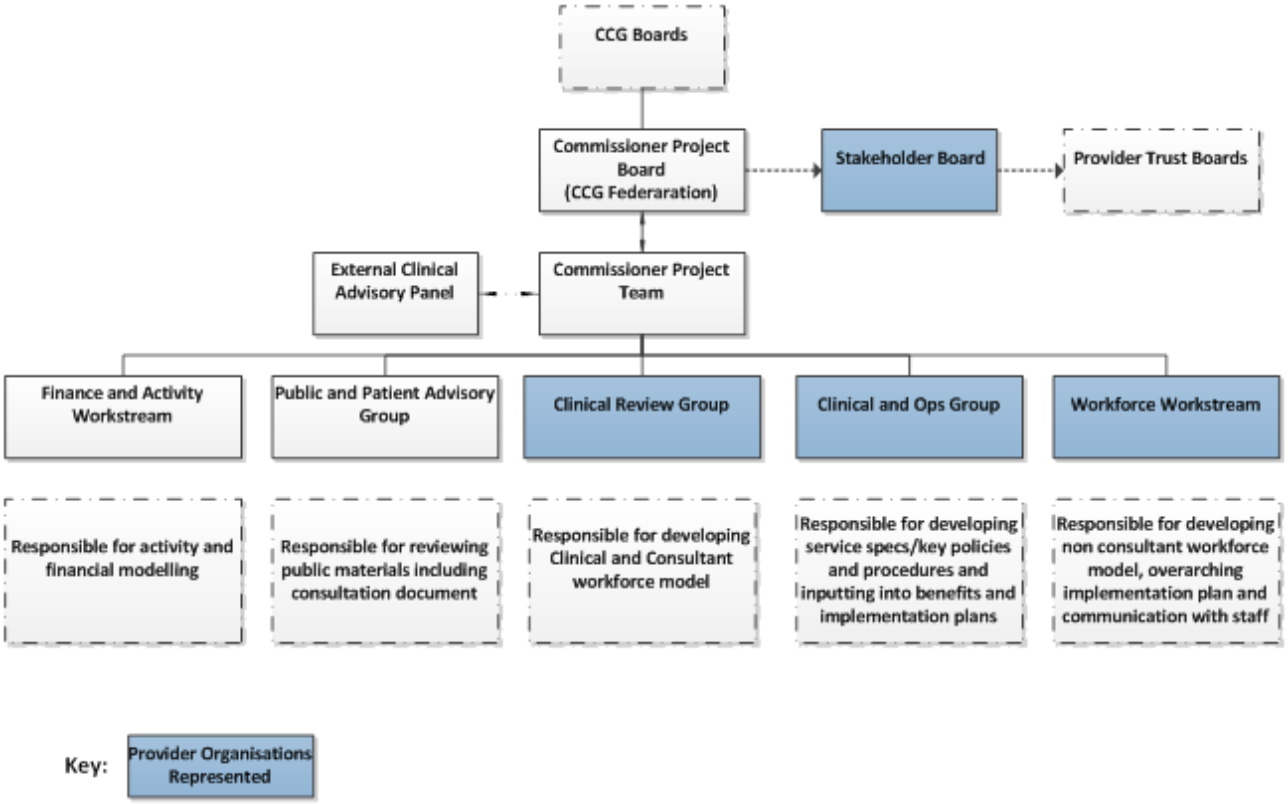
Evaluations of centralised HASU/ASU service models have been completed, demonstrating that centralised stroke services have led to fewer patient deaths, less time spent in hospital, the provision of better care and overall good patient experiences and value for money.

This section has summarised the strong evidence base and the national policy direction and priorities that support the proposed new clinical model set out in this Business Case.

5.0 OPTIONS DEVELOPMENT AND APPRAISAL

5.1 Assurance & Governance Arrangements

Whilst the development of the Pre-Consultation Business Case has been a Commissioner-led process overseen initially by the local Warwickshire and Coventry CCG Federation and now by the Strategic Commissioning Joint Committee (comprising CCG Clinical Chairs, Accountable Officers, Chief Financial Officers and other key members of all three local CCGs), it has extensively involved key stakeholders through a multi-agency project governance structure as shown below:



The Senior Responsible Officer for the project is Andrea Green, Chief Officer for Warwickshire North CCG, who is responsible to the Warwickshire & Coventry CCG Federation and now to the Strategic Commissioning Joint Committee, which acts as the Project Board.

Local acute and community service providers, as well as ambulance, Local Authority and patient representatives, have been represented at various levels, including via:

- Stakeholder Board – comprising provider strategy and medical leads;
- Clinical Review Group – comprising Medical Leads to support the development of the clinical model;
- Activity and Finance Workstream.
- Clinical and Operations Group – comprised of Clinical and Operational Leaders

The Clinical Review Group has been a primary group in expanding the clinical model beyond the hyper-acute and acute stroke phases to include the community and rehabilitative phases of care; helping to build the evidence and model for this.

The Clinical and Operations Group has provided clinical and operational management expertise, oversight and challenge into the development and evaluation of;

- potential scenarios for service delivery
- staffing models of each aspect of the proposed service options
- implementation plans

There has been an extensive programme of pre-consultation engagement with the public including, stroke survivors and carers. The project also established a Public & Patient Advisory Group which is chaired by a Stroke Association representative. A member of this group attends the Stroke Stakeholder Project Board. This group has overseen the pre-consultation engagement to date and has helped to broaden the voice of the patient/public, feeding into the Chair who sits on the Stakeholder Board. The pre–consultation engagement is further described in section 5.2 and in detail in appendices 5-7.

5.2 Stakeholder Engagement

The CCGs have undertaken an array of stakeholder engagement activities and co-production with regards to improving the Stroke and TIA service provision across Coventry and Warwickshire. Throughout the engagement programme, the focus has been on ensuring that there is good visibility, clarity and understanding of the services currently being delivered and the evidence base for the proposed changes in the stroke pathway and services. The engagement process provides the platform through which patients, carers, the public, health professionals and other key stakeholder groups (i.e. Local Authorities, Councillors etc.) are able to voice their thoughts, observations and concerns.

The feedback from the pre-consultation activities has resulted in two phases of development of potential scenarios, the first to identify and build the scenarios for the provision of Hyper Acute and Acute services (sections 5.3 and 5.4) and the second phase to facilitate the inclusion of rehabilitation services and primary prevention of stroke (sections 5.5 and 5.6). Crucially the pre-consultation engagement has supported the co-production of the options under consideration and the non-financial appraisal of those options.

The summarised findings from the engagement processes are noted in section 5.2.2. Appendices 5 and 6 contain full details of the engagement processes.

5.2.1 Pre-consultation engagement approach and objectives

A programme of pre-consultation engagement has been undertaken in two phases:

- **Phase 1** was undertaken in 2014/15 to build up the possible scenarios for the Hyper Acute and Acute pathway; and
- **Phase 2** followed on from the outcome of Phase 1, in which it was identified there was the need for the inclusion of rehabilitation and prevention of stroke in patients with Atrial Fibrillation. Phase 2 focused on the option of UHCW providing the centralised specialist HASU/ASU units with localised rehabilitation at home via ESD, bedded and community rehabilitation.

The engagement builds on significant work that has been undertaken in recent years to help improve stroke and stroke-related services across the local health economy.

5.2.2 Summary of Engagement, Themes and Responses

The responses from stakeholders throughout the engagement process were varied, mainly depending on the location of those being engaged, with issues and queries being raised in relation to each scenario. It is important to note that most respondents acknowledged that 'something' needed to change. Depending on their personal circumstances, how that change would affect them varied across the county.

The overriding theme however, appears to be an acknowledgement of the need for intensive hyper acute care at the onset of a crisis. This is offset by concerns around the longer and costlier travel journeys some patients and families will experience during the acute phase of care.

The consultation material will address the key concerns and queries raised through the pre-engagement process. It is acknowledged that the issue of travel, transport and parking is the predominant theme and this has not only been included in an extended Integrated Impact Assessment in 2017/18, but the Coventry and Warwickshire CCGs are already engaged with the West Midlands Combined Authority to establish a long-term transport plan for vulnerable people which includes patients and carers. Work is in train with local Councils to see if local policies might better support transport for carers and relatives not just for those who have a stroke, but others who are deemed vulnerable.

Other areas of concern raised that the consultation document has addressed include:

- Travel, transport and parking: including costs of travel and difficulty in parking at UHCW, the impact on both patients and family/carers/visitors and ambulance travel times;
- The loss of rehabilitation beds in Rugby;
- Concerns about capacity in UHCW;
- Concerns about recruitment to serve the new model;
- Whether the longer distance to UHCW for those patients who live further afield, negates the benefit of being taken to the HASU for assessment;
- Whether the closure of acute stroke services at GEH and SWFT will result in the closure of other services;
- Risk of over-crowding on the UHCW site, and potential negative impact on beds for those that most need them; and
- The need for good communication between the hospital units and Consultants and other staff. There is a perception that teams across sites do not currently communicate when patients are being transferred.

5.2.3 Health Overview and Scrutiny Committees

The programme has undertaken extensive stakeholder engagement and co-production with regards to developing and appraising the options for improving stroke service provision across Coventry and Warwickshire. A key aspect of this process has been regular engagement with Council Overview and Scrutiny Committees. Senior members of the programme have attended committee meetings to provide updates on progress and receive feedback and comments.

Below is a summary of meetings attended:

September 2015 Health Overview and Scrutiny Committees in Warwickshire and Coventry

2nd June 2016 Nuneaton and Bedworth Health Overview and Scrutiny Panel

13th October 2016 Brooke Overview and Scrutiny Committee (Rugby Borough Council)

6th July 2017 Nuneaton and Bedworth Health Overview and Scrutiny Panel

10th July 2017 Coventry Health and Wellbeing Board

13th July 2017 Brooke Overview and Scrutiny Committee meeting

22nd February 2018 Nuneaton and Bedworth Health Overview and Scrutiny Panel

27th February 2018 Warwickshire and Coventry Council Joint HOSC Members briefing session

8th October 2018 Coventry Health and Wellbeing Board

20th March 2019 Coventry and Warwickshire Joint Health Overview and Scrutiny Committee

18th April 2019 Nuneaton and Bedworth Health Overview and Scrutiny Panel

The feedback from each meeting attended has been considered and any requirements for further engagement/consultation that came out of those meetings have been detailed below with reference to the specific meeting the request came from.

Rugby Borough Council's Brooke Overview and Scrutiny Committee

Andrea Green, Senior Responsible Officer for the project on behalf of the Coventry and Warwickshire CCGs and Chief Officer NHS Warwickshire North and NHS Coventry and Rugby CCGs and Dr Adrian Canale-Parola, Chairman of Coventry and Rugby CCG attended Rugby Borough Council's Brooke Overview and Scrutiny Committee meeting on 13 July 2017 to present the Improving Stroke Services In Coventry and Warwickshire engagement document and respond to questions. Key points discussed included:

- the methods by which consultation materials would be publicised and stakeholder groups would be engaged
- the expected impact of ESD and community stroke rehabilitation on outcomes and the number of Social Care packages required following implementation and
- the rationale for the 6 beds at St Cross Hospital not being included.

It was agreed that a full list of consultees would be shared with the Scrutiny Committee and explained that minimum clinical standards based on bed numbers needed to be considered in assessing the viability of units. 6 beds had been identified as too small a number to sustain a viable unit.

Members were informed that outcomes of the engagement period will be considered in August/September 2017.

Further bed modelling has been considered since the engagement report and more information will be available during the consultation period.

Summary of Nuneaton and Bedworth Health Overview and Scrutiny Committee

Members considered the stroke engagement document at their meeting on 6 July 2017, below is a summary of the key points raised and responses to those points:

- Transport: councillors were clear that this was a very real issue for local residents both in terms of getting to UHCW and parking capacity and costs whilst there. The recent Integrated Impact Assessment completed since the engagement phase will be available to provide information at the consultation stage.
- Rehabilitation: the importance of getting this right and ensuring patients are cared for close to home. Further bed modelling has taken place since the engagement phase and more information will be available at the consultation stage.
- Workforce: a need to understand concerns about workforce capacity and skills. Further workforce assessment has taken place and more information will be available at the consultation stage.
- Carers: the importance of supporting and listening to carers during the process and ensuring there is a sufficient community service offering to support them. Carers have been listened to during the engagement phase they will continue to be engaged during and after the consultation phase.
- Nuneaton: ensure more engagement in Nuneaton during the consultation phase. Every effort will be made to engage widely and comprehensively with the people of Nuneaton.

Warwickshire and Coventry Council Joint HOSC Members briefing session

Warwickshire and Coventry Council worked together to form a joint HOSC Members briefing session on 27 February 2018, to hear about the proposals after taking account of the public engagement during June and July 2017.

The final proposals and actions to address the outcomes of the engagement in June and July 2017 and the latest Integrated Impact Assessment were presented.

Coventry and Warwickshire Joint Health Overview and Scrutiny Committee

At its meeting on 20 March 2019, the Committee considered a report presented by Andrea Green, Senior Responsible Officer, which provided an update on the process and timescale to complete the Pre-Consultation Business Case and the NHS England assurance process. Members raised a number of issues in response to the report and responses were provided. Particular areas of questioning included the reason for the delays in the project progress and additional work that had been required.

The Committee resolved that the public consultation should take place over a twelve week period and requested that arrangements be put in place for an informal briefing for members on the proposals when appropriate.

5.3 Long-List of Scenarios - Hyper Acute and Acute Services

At the onset of the project a set of underpinning principles were agreed by Commissioners for the potential scenarios for the delivery of stroke services. These were:

- All scenarios must meet the requirements of the NHS Midlands and East regional Stroke Service Specification and therefore provide for:
    - A Hyper-Acute Stroke Unit – to remain at UHCW;
    - Acute Stroke Unit(s) with one aligned to the HASU at UHCW at a minimum;
    - A standard Early Supported Discharge service;
- Stroke rehabilitation beds will be provided locally for the post-acute phase of care: for those patients who no longer require acute stroke care, but have ongoing care and rehabilitation needs that prevent them from returning home;
- All high risk TIAs would be seen at UHCW.

Based on the above principles, a longlist of scenarios for the provision of Hyper Acute/Acute services was developed by the Clinical and Operations Group as follows:

Scenario 1 - Do Nothing

Scenario 2 - HASU at UHCW / 1 ASU at UHCW Centralisation

Scenario 4 - HASU at UHCW / 3 ASUs at UHCW, SWFT & GEH

Scenario 5A - HASU at UHCW / 2 ASUs at UHCW & SWFT

Scenario 5B - HASU at UHCW / 2 ASUs at UHCW & GEH

During the work to develop the above scenarios, two additional scenarios were considered:

- Scenario 3 - a scenario was introduced which sought to have a HASU and an ASU for Coventry and Rugby patients up to the point of discharge, and north and south Warwickshire patients at UHCW up to day 7. The latter cohort of patients would be repatriated to a local ASU at SWFT or GEH as appropriate, if a longer acute hospital stay was needed. This scenario was later discounted following external advice sought from a senior External Clinical Advisory Panel member who cautioned against splitting a patient's acute length of stay in an ASU;
- Scenario 5 – a 2-ASU scenario was considered, with one ASU being specified at UHCW and the other at either SWFT or GEH. It was later agreed that this scenario would be sub-divided into Scenarios 5A –and Scenario 5B, with specific locations at SWFT and GEH identified for each.

5.4 Short-List of Scenarios - Hyper Acute and Acute Services

5.4.1 Clinical and Operational Viability Assessment of Scenarios

Having developed the long-list of scenarios, an initial assessment based on clinical viability was undertaken. The criteria against which the scenarios were assessed were developed by the Clinical Review Group. These were that each scenario must:

1. Be capable of meeting the NHS Midlands and East Stroke Service Specification;
2. Be clinically viable in terms of both activity and workforce. Using the findings of the visits to Stroke services that were demonstrating best practice, members of the Group agreed that to be clinically sustainable, a Stroke Unit would require a minimum of 10 stroke beds being operational.

To support the assessment of the scenarios against criteria 2 above, capacity modelling was completed, the results of which are shown in the table overleaf.

Shortlisting Exercise Based on Clinical Viability – Modelling Results for Total No of Beds

	Scenario 1	Scenario 2	Scenario 4	Scenario 5A	Scenario 5B
UHCW	**42 beds** (6 HASU / 30 ASU / 6 Stroke Rehab)	**43 beds** (12 HASU / 31 ASU)	**40 beds** (10 HASU / 30 ASU)	**40 beds** (12 HASU / 28 ASU)	**39 beds** (13 HASU / 26 ASU)
SWFT	**32 beds** (12 ASU / 20 Stroke Rehab)	**0 beds** (All ASU)	**3 beds** (All ASU)	**2 beds** (All ASU)	**0 beds** (All ASU)
GEH	**19 beds** (All ASU)	**0 beds** (All ASU)	**2 beds** (All ASU)	**0 beds** (All ASU)	**3 beds** (All ASU)

It can be seen that in Scenarios 4, 5A and 5B, the Acute Stroke Units at both SWFT and GEH are projected to require considerably fewer than 10 beds, which was determined as the minimum threshold for sustaining an acute stroke service. This is predominantly due to:

- A shift of suspected stroke activity from SWFT and GEH to UHCW;
- Reduction in overall lengths of acute hospital stay by the introduction of an ESD service and additional support in the community.

On the basis that Scenarios 4, 5A and 5B result in the Acute Stroke Units at SWFT and GEH being clinically unsustainable, these scenarios were discounted. This left two scenarios under consideration i.e. **Scenario 1** – Do Nothing; and **Scenario 2** – Centralisation.

Given that Scenario 1 – Do Nothing does not meet the Midlands and East Stroke Service Specification requirements and was included for comparative purposes only, the Coventry & Warwickshire Stroke project identified only one clinically viable scenario for the acute phase of the pathway: Scenario 2 - Centralisation. As only one clinical viable scenario remained for the provision of hyper acute and acute services, financial modelling was not undertaken on the non-viable options.

5.4.2 Patient and Public Engagement and Feedback

In parallel, in 2014/15 the pre-engagement phase of the project with the public was handled informally through meetings with stroke groups and groups representing the 'nine protected characteristics' equality strands and identified in the initial Integrated Impact Assessment. The purpose was to ascertain their thoughts and wishes for an acute stroke service.

The 2015 engagement exercise then engaged on the following 4 scenarios:

1. Do nothing;
2. Maximise centralisation at UHCW (hyper acute and acute unit for ALL patients);
3. All patients go to UHCW Hyper-Acute unit for 2 – 3 days then patients who are from the Warwickshire North area transfer to GEH and patients from South Warwickshire transfer to Warwickshire Hospital; and
4. All patients go to UHCW Hyper-Acute unit for 2 – 3 days then North and South Warwickshire patients transfer to one other hospital, either the George Eliot Hospital or Warwick Hospital with closure of stroke facilities at the other unit.

The feedback captured in the Engagement Report was considered by the Project Board who, in response to the feedback, decided to expand the scope of the project to include specialist stroke community rehabilitation services and action to prevent more strokes for patients with Atrial Fibrillation.

5.5 Long list of Scenarios – Rehabilitation Services

The original principles for the stroke service improvements described in section 5.3 had only included the ESD aspects of out of hospital care. Following the feedback received in 2015 from the first engagement phase, a decision was made by Commissioners to expand the scope of the business case to include specialist stroke community rehabilitation and action to prevent more strokes; namely increased anticoagulation rates for those with Atrial Fibrillation.

There is clear clinical best practice evidence in the Midlands and East Specification and also described from other health systems and the Coventry pilot, that improved outcomes and shorter lengths of stay are achieved by services that enable those patients suitable for ESD to receive ESD and community rehabilitation. This evidence is detailed in section 4.3.

This evidence strongly suggests that ESD and an expansion of community rehabilitation in patients own homes are a prerequisite in whichever new pathway is introduced for Coventry and Warwickshire.

A proposed model of care that included the expanded scope above was developed. At this stage there appeared to be only one way to secure a clinically viable, future end to end pathway. So, from 15th June to 28th July 2017 a further, comprehensive, 6 week public engagement process was undertaken on a proposal for a centralised hyper acute and acute service, bedded rehabilitation on 2 sites, ESD, community stroke rehabilitation at home and improvements in AF anticoagulation therapy.

This engagement included the following activities:

- More than 500 stakeholders received electronic engagement and a questionnaire via NHS and Local authority partners, Healthwatch and the voluntary sector;
- Five public meetings were held;
- There were nine community engagement events and meetings;
- Local media advertisements, including two items on local radio throughout July 2017 and 27 articles in local newspapers.

The key concerns identified by the public from this engagement related to concern for carers of those living in Coventry and Rugby, who would need to travel to access the bedded stroke rehabilitation proposed for them at George Eliot Hospital and Leamington Rehabilitation Hospital i.e. not a local provision for this cohort of individuals. This feedback was considered in the updated Integrated Impact Assessment and most of these addressed through an action plan working with Council colleagues. Alongside this, the stroke expert Clinical and Operations Group leading the clinical design of the future stroke service model, was asked to revisit the work completed to date and consider if there was another method of delivering bedded rehabilitation for the Coventry and Rugby population, that might mitigate this.

The following longlist of scenarios was identified by the Clinical and Operations Group for the provision of rehabilitation services:

Scenario 1 ESD and community rehabilitation in all areas. Bedded rehabilitation at South Warwickshire Foundation Trust (SWFT) in Leamington and George Eliot Hospital (GEH) in Nuneaton

Scenario 2a ESD and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry with specialist therapy in-reach and bedded rehabilitation at SWFT in Leamington only.

Scenario 2b ESD and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry with specialist therapy in-reach. Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton

Scenario 3a ESD in all areas (no community rehabilitation). Discharge to Assess in Coventry with in-reach. Bedded rehabilitation at SWFT in Leamington only

Scenario 3b ESD in all areas (no community rehabilitation). Community bedded rehabilitation provided in Coventry with specialist in-reach. Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton

Use of rehabilitation beds at the Hospital of St Cross, Rugby was not considered clinically feasible for inclusion in the long list. Splitting the specialist rehabilitation model over three hospital bedded units would demand a workforce model that clinicians agreed could not be recruited to and sustained. The key drivers for this were:

- the reduced size and patient volumes that each rehabilitation unit would be managing would present viability challenges for the size of clinical teams and retention of clinical skills in each of the units;

- operating over three units would increase the additional workforce needed and the national workforce shortage in specific skill sets led to concerns regarding the ability to recruit sufficient staff to operate the services.

5.6 Short list of Scenarios – Rehabilitation Services

5.6.1 Clinical and Operational Viability Assessment of Scenarios

Having developed the long-list of scenarios, the Clinical and Operations Group reviewed each option to assess their ability to meet the following minimum essential criteria:

- meet national guidance and the NHS Midlands and East Regional Stroke Service Specification
- must demonstrate at least the minimum standards of quality; be safe; be sustainable and deliver better outcomes for patients

In addition, the Clinical and Operations Group assessed the long-list options against nine standard, health service best practice criteria:

1. *Better access to services – equality; travel; car parking*
2. *Improved clinical quality – better health outcomes; better configuration; enabling new methods of delivering care*
3. *Improved environmental quality – conditions conducive to effective care; meeting patient and staff expectations; functional suitability*
4. *Development of services – increasing quantity*
5. *Improved strategic fit – meeting strategic needs of the locality or region*
6. *Meeting training, teaching, research needs – easier to recruit, train, retain staff; protecting accreditation standards; improve productivity*
7. *More effective use of resources – human; service; facilities; better value for money*
8. *Ease of delivery – practical delivery and implementation*
9. *Meeting national, regional policy initiatives*

Against these nine criteria each option was scored by the Clinical and Operations Group, to facilitate a robust discussion about the relative risks, benefits and issues with each. The agreed scoring criteria used a scale of 0 to 4, with the following descriptors:

Score	Description
4	Excellent degree of confidence in delivery model. High certainty of delivery of model and associated outcomes
3	Comprehensive and able to fully meet requirements. High level of confidence in delivery model and associated outcomes
2	Acceptable level of confidence in delivery model. Reasonable level of confidence in delivery model and associated outcomes
1	Limited degree of confidence in delivery model. Fails to meet requirements of delivery model and associated outcomes
0	Deficient model that offers no confidence in ability to deliver the model and associated outcomes

As a result of this assessment process, 3 scenarios were rejected due to not meeting the essential criteria. Two viable options remained:

Option 1 Early Supported Discharge Service (ESD) and community rehabilitation in all areas. Bedded rehabilitation at South Warwickshire Foundation Trust (SWFT) in Leamington and George Eliot Hospital (GEH) in Nuneaton

Option 2b Early Supported Discharge Service (ESD) and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry with specialist therapy in-reach. Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton.

These options were to be taken forward (as Option 1 and Option 2) for full non-financial appraisal by all key stakeholder groups. Details of the non-financial appraisal process are provided in section 5.7.

5.6.2 Patient and Public Engagement and Feedback

The Clinical and Operations Group shortlisting process had identified two viable options for the provision of bedded rehabilitation; both assume that ESD and community stroke rehabilitation at home will be delivered in all areas.

Further engagement sessions were carried out with the Patient and Public Advisory Group and wider stakeholder groups to recap on the journey so far, gather feedback and agree the process for appraising the viable options.

One of the key activities undertaken was the co-production of the list of desirable non-financial criteria against which the options would be appraised. An initial meeting with the Patient and Public Advisory Group in August 2018 resulted in the development of a set of patient and public focussed criteria with which to assess the options for future stroke bedded rehabilitation services. These were shared with wider members of the public via 4 public engagement sessions in September 2018. These sessions tested and further developed the detail of the desirable criteria.

Key themes already captured from previous engagement in 2017 and the Integrated Impact Assessment were also incorporated into the desirable criteria.

5.7 Options Appraisal

The results of the option development work had found that there was only one option for the provision of HASU/ASU services and the establishment of ESD and community rehabilitation across Coventry and Warwickshire. The only aspect of the stroke pathway with options for consideration was therefore the bedded rehabilitation provision.

A wide and representative group of stakeholders were invited to a non-financial options appraisal event, to appraise the two viable options for the provision of bedded stroke rehabilitation. The stakeholder group included patients and carers, local councillors, voluntary sector and community support groups, community pharmacists, NHS clinical staff, NHS commissioners, social care commissioner and managers. The process of inviting stakeholders to this event involved mapping our comprehensive stakeholder lists against the nine protected characteristics within equality law and cross-referencing these to the 2017/18 Integrated Impact Assessment to ensure appropriate representation was achieved.

The options appraised were:

1. One bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa and one bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton.
2. One bedded rehabilitation unit in the Coventry area, not on an NHS hospital site, with specialist therapists coming into the site to provide rehabilitation into the unit; one bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa and one bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton.

Both options assumed that HASU/ASU care would be provided at UHCW and ESD and Community rehabilitation at home would be delivered in all areas.

As described in section 5.6.2 above, through extensive patient and public engagement a list of non-financial desirable criteria was co-produced and used to appraise each of the clinically viable service delivery options. These criteria are shown in the table below.

Stakeholder coproduced desirable criteria for the non-financial options appraisal

Equality, accessibility and consistency of services	Services should be equitable, consistent and always available Availability of car parking / accessibility of public transport Equality of access no matter where you live, who you are and what your personal circumstances are Staff development, training, skills and information should be consistent – from ambulance teams to rehab therapists No patient or carer should feel disadvantaged by the new service
Improved clinical quality of services	Service should focus on the best quality and the best possible outcomes and recovery Providing better long term health outcomes for patients Addressing existing clinical problems that not all clinical services are available on all sites There needs to be the right balance of staff, in the right places with the right skills and knowledge Providing the opportunity to ensure that we have the best clinical outcomes for every stroke patient
Improved delivery of services	Professionals who are delivering the services should understand the stroke patients' feelings and the consequences of having a stroke We should create an environment where experiences, knowledge and information can be shared to benefit stroke survivors and their carers All stroke services should work together with a smooth transition at all points in the stroke patients care Patients should feel that staff are working in one team for their patient, even if they work for different organisations. Holistic services need to be considered as they help people to not fall through the cracks Services should integrate and include community and voluntary

Development of personalised services	Services should be personalised with care that is right for each individual patient Loved ones and carers need to be supported, informed and consulted at all stages Services should be modelled on the best outcome and care for patients not what can be done with the current staff or finances Patients and loved ones should receive timely, awareness raising communications and signposting All or other health considerations should be taken into consideration when planning the patients care

The options appraisal event used the following process:

- The co-produced desirable criteria were reviewed as a group and weightings agreed for their relative importance
- Smaller table top groups were then asked to consider each of the two viable options against the desirable criteria to enable each individual present to score these
- Each table then fed back their scores which were entered into a single spreadsheet.
- The result was a consensus view from those attending the options appraisal event on the options for bedded rehabilitation.

The agreed weightings and resulting scores for each option are shown below:

The non-financial options appraisal desirable criteria	Weight (decimal)	Option 1 Table Score (from 0 to 10) as decimal	Option 2 Table Score (from 0 to 10) as decimal	Score for Option 1	Score for Option 2
Equality, accessibility and consistency of services	0.27	0.70	0.51	18.78	13.76
Improved clinical quality of services	0.32	0.86	0.39	27.03	12.30
Improved delivery of services	0.24	0.85	0.45	20.09	10.69
Development of personalised services	0.18	0.77	0.57	14.06	10.37
			TOTAL	**79.97**	**47.12**

Options were scored on a scale of 0 to 10, where 0 indicated an option completely failed to meet the criteria and 10 indicated that an option completely met the criteria. As the results above show, the **preferred option from the non-financial options appraisal was option 1**.

> *One bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa and one bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton.*

Full details of the options appraisal can be seen in Appendix 8.

5.8 Risk Assessment of Options

To support Commissioners in assessing the clinical and operational delivery feasibility of each of the bedded rehabilitation options and further support the decision-making as to the preferred option, a risk assessment was undertaken by the Clinical and Operations Group.

At the non-financial options appraisal event stakeholders had challenged the Clinical and Operations Group assessment that it would not be possible to sustainably staff 3 hospital sites for rehabilitation. The option of providing bedded rehabilitation at the Hospital of St Cross, Rugby was therefore included in the risk assessment to enable a robust re-assessment of this position.

The options risk assessed were:

Option 1	*ESD and community rehabilitation in all areas. Bedded rehabilitation at SWFT in Leamington Spa and GEH in Nuneaton*
Option 2	*ESD and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry, not on an NHS hospital site, with specialist therapy in-reach. Bedded rehabilitation at SWFT in Leamington Spa and GEH in Nuneaton*
Option 2 using Rugby	*ESD and community rehabilitation at home available in all areas. One bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa, one bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton and one bedded rehabilitation unit at the Hospital of St Cross, Rugby.*

The Clinical and Operations Group agreed a set of criteria to reflect the range of clinical, operational delivery and healthcare system risks that any model could present. The agreed risk assessment criteria are shown in the table that follows.

	Risk Assessment Criteria
1	Patients are transferred to the bedded rehabilitation provider that are ready for rehabilitation but have medical needs outside the capability of the rehabilitation provider
2	Patients developing complications and/or deteriorating cannot be appropriately supported in the bedded rehabilitation provider, leading to transfers to A&E
3a	Difficulty in recruiting and retaining sufficiently skilled clinical staff to cover the rotas – Consultants
3b	Difficulty in recruiting and retaining sufficiently skilled clinical staff to cover the rotas – Nurses
3c	Difficulty in recruiting and retaining sufficiently skilled clinical staff to cover the rotas - other clinical staff
4	Difficulty in securing a high quality, sustainable provider with on-site facilities conducive to rehabilitation
5	Limitations on the capabilities of the bedded rehabilitation reduce capacity, impacting on patient flow out of UHCW
6	Lack of consistent clinical governance arrangements across the providers reduces the system ability to manage the quality of care
7	Adverse impact on wider NHS provider sustainability in the health system, that could impact on the need for changes in other local services
8	Fragmented care and unnecessary delays in the management of patients journeys due to lack of access to social workers and/or other community-based infrastructure to support patient needs assessment
9	An inability to sustain staff skill levels and competence in stroke rehabilitation

Each of the options was assessed against the risk criteria, using a NHS standard likelihood and consequence assessment matrix.

Consequences	Likelihood				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Negligible (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

To ensure consistency in the scoring of each option the following assumptions were agreed and applied when considering each option against the risks.

1. Beds provided at the Hospital of St Cross in Rugby would be providing the same level of service as those provided by SWFT and GEH
2. The number of beds provided at the Hospital of St Cross in Rugby would be based upon the geographically identified number of patients closest to the location
3. For all options risk assessed ESD and community stroke rehabilitation would be provided as per the Business Case
4. For all options, clear service specifications would be in place for the services commissioned
5. The beds provided for community bedded rehabilitation with in-reach (Option 2) would all be provided from one location

The results of the risk assessment are shown below.

	Option 1		Risk
	L	C	Score
1	3	2	6
2	1	1	1
3a	3	2	6
3b	3	4	12
3c	3	4	12
4	1	5	5
5	2	4	8
6	1	2	2
7	2	2	4
8	2	2	4
9	2	3	6
			66

	Option 2		Risk
	L	C	Score
1	4	3	12
2	4	3	12
3a	3	2	6
3b	4	4	16
3c	4	4	16
4	4	5	20
5	3	4	12
6	2	2	4
7	3	3	9
8	3	2	6
9	4	3	12
			125

	Option 2 using Rugby		Risk
	L	C	Score
1	3	2	6
2	1	1	1
3a	3	2	6
3b	4	4	16
3c	4	4	16
4	1	5	5
5	2	4	8
6	1	2	2
7	4	4	16
8	3	2	6
9	4	3	12
			94

As is shown in the results above, Option 1 has a lower level of risk than Option 2, having a total risk score of 66 compared to 125. The risk assessment also supported the original assessment that developing a third rehabilitation unit in Rugby poses higher risks of an inability to recruit the required nursing and therapy staff and critically, presents a significant, red risk of having an adverse impact on wider NHS provider sustainability in the health system, that could impact on the need for changes in other local services.

The risk assessment therefore supports the results of the non-financial options appraisal in determining that **the option with the least clinical and operational service delivery risks is Option 1**.

One bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa and one bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton.

The full risk assessment document can be found in appendix 9.

5.9 Integrated Impact Assessment and Equalities

Integrated Impact Assessments have been carried out in 2015 and 2017/18 as proposals have developed, the purpose of these was to identify the groups most likely to be affected by stroke and provide a full analysis of the impacts of the potential scenarios on travel and access, determinants of health and equality.

The scenarios considered within the 2017/18 assessment reflect the short-list of options identified through the process described in sections 5.3, 5.4, 5.5 and 5.6:

Scenario 1: Do nothing

Scenario 2a: all stroke patients in Warwickshire will be treated at UHCW throughout both the hyper-acute and acute phases. When appropriate for discharge, patients will be sent home for supported rehabilitation or, in the case of bedded rehabilitation requirements (around 30% of patients), will have the choice of either GEH or Leamington Spa Hospital (LSH) dependent on proximity to usual residence and/or bed availability.

Scenario 2b: all stroke patients in Warwickshire will be treated at UHCW throughout both the hyper-acute and acute phases. When appropriate for discharge, patients will be sent home for supported rehabilitation or, in the case of inpatient bedded rehabilitation requirements (around 30% of patients), will be transferred to either GEH or Leamington Spa Hospital (20%) with the remainder of patients in Coventry and Rugby (10%) being commissioned a suitable care home bed in Coventry, with access to a specialist in-reach stroke rehabilitation team.

The Integrated Impact Assessment (IIA) documents are appended (appendices 10 and 11).

The following table summarises the potential scale of the impact for each of the elements of service changes on patient numbers and estimated numbers of those by district and in the quantifiable equality population groups. These are considered a broad estimate of the scale of impacts for consideration alongside the following impact assessments. The impact on carers and visitors can be assumed to follow a similar distribution in the absence of additional information to the contrary.

IIA estimates of impacts for the proposed changes by district and assorted equality groups, based on 2015/16 data.

Element of the Service Change	Description	Estimated numbers impacted	By Area	By Equality group
Centralisation Stroke	All Stroke patients **not currently** treated at UHCW for hyperacute and acute stage	726	Coventry – 19	Age (over 65s) - 582
			North Warwickshire – 84	BAME - 89
			Nuneaton & Bedworth – 86	Males - 346
			Rugby – 32	Female - 380
			Stratford – 133	Deprived areas - 58
			Warwick – 191	Pregnant/maternity - 13
			Out-of-Area – 81	
Centralisation (TIA)	All TIA patients not currently treated at UHCW.	165	Coventry – 1	Age (over 65s) - 135
			North Warwickshire – 23	BAME - 24
			Nuneaton & Bedworth – 44	Males - 79
			Rugby – 3	Female - 86
			Stratford – 25	Deprived areas - 9
			Warwick – 41	Pregnant/maternity - 3
			Out-of-Area – 28	
ESD and community rehabilitation	All stroke patients **suitable for ESD and community recovery and rehabilitation** post-acute stage (70%) including those currently receiving ESD and community rehab	952	Coventry – 245	Age (over 65s) – 683
			North Warwickshire – 76	BAME - 137
			Nuneaton & Bedworth – 199	Males - 510
			Rugby – 86	Female - 442
			Stratford – 99	Deprived areas - 131
			Warwick – 123	Pregnant/maternity – 21
			Out-of-Area – 123	
Complex and bedded rehabilitation	All stroke patients requiring inpatient rehabilitation post-acute stage (30%) including those currently receiving inpatient rehab	408	Coventry – 105	Age (over 65s) - 323
			North Warwickshire - 33	BAME - 65
			Nuneaton & Bedworth - 85	Males - 190
			Rugby - 37	Female - 218
			Stratford - 42	Deprived areas - 45
			Warwick – 53	Pregnant/maternity - 5
			Out-of-Area – 53	

Source: The Strategy Unit.

Summary of the impacts and potential mitigations identified in the IIA

The proposed changes are designed to improve outcomes for all stroke patients regardless of their area of residence: thereby increasing the likelihood of survival, decreasing recovery time with lower risk of complications and permanent disability, enabling shorter lengths of stay in hospital with more time at home, receiving appropriate support and rehabilitation.

The total number of stroke patients likely to be affected by the changes is estimated, using 2017/18 activity data, to be an additional 699 patients in the hyper and acute phase, an estimated total of 1,268 patients for the ESD and community rehabilitation and 349 patients for bedded rehabilitation. It is important to note that because many patients will receive input and care from a combination of all of these stroke services, individual patients will appear multiple times in these numbers.

Three principle areas of impact were identified in the IIA:

- Travel and access
- Health
- Equality

It is recognised that there will be negative short-term impacts felt by some of the carers of, and regular visitors to stroke patients during the inpatient stays in both the hyper/acute and rehabilitation phases, particularly those reliant on public transport.

Carers and visitors in North Warwickshire, Warwick and Stratford-upon- Avon district will be disadvantaged most in terms of longer and further journeys in relation to acute care in Coventry. Carers and visitors from Coventry and Rugby will be impacted most during the rehabilitation phase, should their relatives need rehabilitation in a bedded setting prior to discharge home, as the rehabilitation beds will located in Nuneaton and Leamington only.

On balance the negative impacts of increased travel time and distance for some visitors and carers is offset by improved availability of specialist stroke treatment throughout the pathway, reduced lengths of stay (during both the acute and rehabilitation phases) and the potential improvement in health outcomes and reduction in disability for all stroke survivors.

Nevertheless, the CCGs have established a Health and Transport planning group with the Local Authorities to develop plans to address the transport and travel challenges faced. Membership includes voluntary and community providers, Public Health and Local Council representation. Responsibilities of the group include:

- developing a fuller understanding of the criteria/eligibility arrangements around current access to various transport schemes
- developing a consistent message around health services in Warwickshire and Coventry regarding parking costs and information provided by healthcare providers about travel costs and who is entitled to concessionary parking schemes.
- supporting the development of cross border acceptance of public transport travel passes between different bus providers in Warwickshire and Coventry.

To support those visitors and carers who will be using public transport, information regarding existing direct and non-direct public transport services will be made available, as will information about voluntary and subsidised transport schemes. Consideration will also be

given to inpatient visiting hours, especially during winter, to reduce the amount of time visitors and carers spend traveling in the dark.

UHCW is currently working with partners to creating additional car parking on site of circa 1600 spaces, which are anticipated to be in place by March 2021.

Summary of overall impacts and conclusions

The technical documents included at appendix 11 of this business case provide a full account of the scores for each element of the IIA. For example, the EIA scores can be found in section 5.3 and appendix 7.10 of the technical documents and the health scores are in section 5.2 and appendix 7.9 of the technical documents. The summary scores are shown below:

Scenario	Travel & Access	Health			Equalities
		Health Impact	Health Inequalities	Determinants of Health	
1	0	0	0	0	0
2a	-6.5	+20	+15	-1	+18
2b	-5.5	+3	-7	+1	+22

The assessment and scoring suggest that both proposals for centralisation of all acute care and rehabilitation would have an overall positive impact on the population compared to the do-nothing scenario, reducing the inequalities in the current/do nothing scenario. Scenario 2a offers the greatest gain in terms of the direct health benefits to patients and the most positive impact on reducing health inequalities.

If the scoring is considered alongside information on the scale of the impact in terms of the volume of patients affected by the proposed changes, the impacts would be magnified further, as the clinical model for 2a is considered more effective and viable than in option 2b. Scenario 2b offers the most flexible rehabilitation pathway and appears to provide the greatest extent of positive impacts in terms of equality of access, particularly in respect of those in the population with protected characteristics. However, it should be noted that some of the equality groups would constitute a relatively small volume/scale of stroke patients (e.g. pregnant/maternal women and those from BAME groups), thus additionally their carers and visitors. Similarly, the number of strokes from areas that might be affected more by changes to travel are lower than in some of the more urban areas.

Overall, the IIA demonstrates both quantitative and qualitative evidence that the proposed scenarios could have major benefits for the Warwickshire and Coventry populations including vulnerable groups. The key benefits relate to the ability of the changes to achieve:

- Everyone within 72 hours of the onset of stroke to have the benefit of assessment in a Hyper Acute Stroke Unit ('HASU');
- Increased timeliness and equitable access to hyper acute, acute and rehabilitative care for all Coventry and Warwickshire residents, removing inequalities in the current provision;
- Improved workforce development opportunities, and recruitment and retention of Stroke specialist staff;
- Reduced levels of mortality and morbidity for people who have suffered a Stroke;

- Reduce levels of dependency for people after suffering a stroke;
- Improved cognitive function for people after suffering a stroke;
- Improvements in stroke prevention for all patients reducing the current inequalities.

Whilst the centralisation will invariably negatively impact on patients and visitors travel and access, particularly from the North and South of Warwickshire, the expected health benefits, greater proportion of time recovering at home and a reduction in inequalities from the exemplar service provision across the area in the proposals should more than offset them.

Headlines from the feedback from the groups identified as most affected by stroke echoed the feedback by the Stroke group engagement meetings and were as follows:

Transport	Location	Services
Transport is a problem if people have to travel further;	Quality of care more important than location;	Things cannot stay as they are;
Concern about increased travel time to UHCW in an ambulance;	All services should be at UHCW where best care is delivered;	There is the need for consistency in service provision;
Extra travel wouldn't be too much of a problem;	GEH provides better care;	Concerns around capacity as UHCW is already busy;
Concern about cost of transport and car parking;	Centralisation is a good idea; better if they come back to their local hospital afterwards;	Better training for carers needed;
Parking is difficult at UHCW;	Specialist unit first and then to a local hospital is a good idea;	Best treatment and facilities are the most important;
Concern about increased travel for visitors;	Access to specialist first and then to a local hospital;	Community care needs consideration;
Public transport from Nuneaton to Coventry is difficult, particularly for the elderly;	Access to specialist stroke unit in their local area, which are better for people especially the elderly;	Sharing of patient notes between hospitals do not work;
Voluntary transport is variable, particularly at weekends;	Specialist stroke unit in Nuneaton needed;	Poor communication between hospitals, with the need to repeat yourself; and
Long-term outcomes are more important than travel;	Do not change the existing services;	Patients need to be discharged only with sufficient support.
Car parking is difficult and expensive at UHCW and Warwick;	It doesn't make sense to bypass the local hospital if time is critical;	
Concern about poorer outcomes for patients if they have to travel further;	Care closer to home is best, to help local carers and relatives;	
Need to think about how patients travel home.	Centralisation at UHCW may not be best for everyone.	

5.10 Quality Assurance

In line with best practice the Coventry & Warwickshire Stroke project has undertaken the following quality assurance reviews and processes:

- Health Gateway Review 0;
- National Clinical Advisory Team Review;
- West Midlands Strategic Clinical Network Assurance;
- West Midlands Clinical Senate Review;
- Achievement of the five tests for service change will be tested in the final assurance meeting with NHS England;
- Two Integrated Impact Assessments (IIA) as the model has evolved; and
- Privacy Impact Assessment (PIA).

Each of the quality assurance reviews and processes are detailed below.

5.10.1 Health Gateway Review 0

In October 2014 the project commissioned an OGC Health Gateway 0 Review to help assure the process being undertaken. This review resulted in a rating of 'amber' (i.e. successful delivery appears feasible but issues that appear resolvable require management attention). Each of the 4 actions recommended by the OGC Health Gateway Team were subsequently addressed as follows:

- Critical path to be clearly identified – a clearly defined critical path document was produced and monitored;
- Project governance structure to be reviewed and strengthened – this resulted in clearer delineation between Commissioner and Provider roles;
- Robust risk management strategy and plan to be developed – this task was completed, and a detailed risk register maintained and shared with all parties; and
- Necessary resources required for successful delivery of the Business Case to be secured – the necessary support and resources were secured.

5.10.2 National Clinical Advisory Team Review

The project has been supported by an External Clinical Advisory Group (ECAG) comprising the following members:

- Dawn Good, Head of Stroke Services, Nottingham University Hospitals NHST;
- Dr Christine Roffe, Consultant Stroke Physician, North Staffordshire Combined HCT;
- Professor Tony Rudd, Consultant Stroke Physician, Guy's & Thomas' NHSFT and National Clinical Director for Stroke;
- Matthew Ward, Head of Clinical Practice, West Midlands Ambulance Service; and
- Rob Wilson, Cardiovascular Manager, West Midlands Strategic Clinical Network.

The ECAG was specifically invited to review the longlist of scenarios in 2014 which resulted in a more detailed exploration and development of the post-acute element of the care pathway. In addition to this, Professor Tony Rudd has visited each of the three local acute

provider sites to see the Stroke wards and meet with key staff and in doing so, provide support and guidance in the development of the clinical model.

5.10.3 West Midlands Strategic Clinical Network Assurance

From the outset of the project, the Associate Director for the West Midlands Strategic Clinical Network has been represented on the Stakeholder Board and as such, has had oversight of the development of local plans. Additionally, the regional Stroke lead for the Strategic Clinical Network has provided his support and input on request.

5.10.4 West Midlands Clinical Senate Review

A review of the clinical model was undertaken by the West Midlands Clinical Senate in line with NHS England's stage 2 assurance process. As a result, the Senate convened an Independent Clinical Review Panel chaired by Dr Nick Harding, Chair of Sandwell & West Birmingham CCG and comprised of a further 22 panel members including the national Clinical Director for Stroke, Professor Tony Rudd.

Following a review of submitted information, the Panel convened a 3-day review in January and February 2016, of which the first two days were spent with members of the Coventry and Warwickshire Stroke programme. Members of the programme met with the Panel on day 2 and included the Senior Responsible Officer; the Clinical, Finance and Project Management leads; and Stroke medical/clinical leads from the current four provider organisations.

Following the review and the updated clinical case for change document, the Clinical Senate submitted their report in May 2016 which concluded that the case for change "contains strong and compelling national and international evidence for improved stroke care and that its final iteration should result in an enhanced patient care pathway and is likely to improve patient outcomes". The Senate approved the clinical model and case for change, whilst identifying 11 recommendations to be addressed.

Project leaders met with the Senate to review completion of the 11 recommendations in July 2018. The Senate concluded that adequate work had been done to meet the recommendations. A copy of the letter from the Clinical Senate Chair is attached (Appendix 12).

5.10.5 "Five Tests" for Reconfiguration

Support from GP Commissioners

Through the governance of the project, GP clinical commissioners have been engaged with and provided support to the Clinical Review Group. The CCG Federation convened as the stroke Project Board acting as the oversight and decision-making body for the project. The CCG Federation is chaired by the clinical chair of one of the CCGs and attended by the other two clinical chairs. The CCGs evolved the Federation into a Joint Strategic Commissioning Committee in 2017. The CCG federation reviewed and approved the Pre-Consultation Business Case and proposed model on 13th February 2019.

Strengthened Public and Patient Engagement

As evidenced in section 5.2, there has been wide and deep engagement across the whole community with stroke survivors and their carers. A Patient and Public Advisory Group chaired by the Stroke Association has met regularly as part of our assurance process and advised on the process for our engagement and the appraisal of options. On-going engagement will be carried out to support the implementation of the commissioned pathway and public views will be fed into these plans.

Clarity on the Clinical Evidence Base

The clinical model which the CCGs seek to commission is based on national evidence used in developing the Midlands and East Stroke Services Specification, is in line with stroke service developments nationally and is supported by Professor Tony Rudd – the National stroke lead. Local services have been audited and assessed against best practice and local clinical engagement has supported the shaping of the model. Evidence from other areas stroke service improvements have also been used to test the design of the proposed clinical model. Sections 3.6, 3.7, 4.1, 4.3 and 4.5 of this document draw together clinical evidence base that underpinned the development of the proposed model.

Consistency with Current and Prospective Customer Choice

The CCGs as commissioners are committed to the provision of patient choice and to ensuring that patients service options are of both adequate quality and accessible.

Overall, the proposed future pathway increases patient choice of the right quality and volume of services although it is acknowledged that there will also be some changes to the locations for the provision of some services that will result in a reduction in choice:

- The provision of HASU services remains unchanged in terms of location of the service but, offers expansion in the level of cover that enables patients in North and South Warwickshire to have greater access to a HASU within 72 hours of onset of symptoms. An additional 699 patients per year are anticipated to have access to HASU/ASU as a result, which clinical evidence suggests will significantly improve individual outcomes.
- There will be increased provision and choice of ESD and CSR; currently patients within North and South Warwickshire do not have access to the right range of specialist rehabilitation services. The expansion of these community services is expected to give an additional circa 860 patients access to ESD and CSR, improving the quality of the outcome of their care through increasing access to services.
- The proposed future pathway limits the locations for provision of ASU from 3 sites (GEH, SWFT and UHCW) to one site (UHCW). The CCGs acknowledge that this reduces choice for this service but, on balance the expected improvement in service quality and outcomes through both the increased access to and quality of specialist care is considered to outweigh the reduction in choice.

Alongside this the outcomes of the engagement with patients and the public, has shaped the model to ensure that all patients will get access to specialist services when they need

them, but are returned to their own home, or into a facility close to home where they require further medical or nursing care, as soon as they are medically able.

The 5th Test

From 1 April 2017 NHS England introduced a new test for proposed service changes. This test requires that in any proposal that includes plans to significantly reduce hospital bed numbers, commissioners are expected to be able to evidence that they can meet one of the following three conditions:

i. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or

ii. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or

iii. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

The proposed service model does not reduce the overall number of hospital beds; it realigns the use of some beds based on robust modelling of the proposed improvements in patient pathways and a significant expansion of community services.

5.10.6 Data Protection Impact Assessment

A Data Projection Impact Assessment (Appendix 13) has been undertaken based on the services being delivered by existing providers and the proposed new model. All providers are currently subject to an existing Information Sharing Agreement. The assessment has been reviewed by the CCG Information Governance Advisory Group. The Group concluded that no immediate further actions are needed and that once the model has been agreed and as implementation arrangements develop, the assessment should be revisited.

5.11 Conclusion

Whilst the development of the Pre-Consultation Business Case has been a Commissioner-led process, it has extensively involved key stakeholders through a multi-agency project governance structure.

There is an existing, well-established evidence base for the most effective clinical models for providing stroke care, which the programme has drawn on in establishing the elements of the pathway that need to be in place for Coventry and Warwickshire.

Clinical and operational leaders alongside members of the public, including stroke survivors and carers, have played a key role in the development and evaluation of the potential scenarios for service delivery. Crucially, public engagement has also supported the co-production of the process for the non-financial appraisal of the options.

To develop the proposed model a range of options have been considered. Initial development work focused on the acute stroke pathway only (HASU/ASU, supported by ESD). Following an assessment of the clinical viability of the options on the long-list, it is evident that there is only one clinically viable scenario for acute care: centralisation of HASU/ASU services at UHCW.

ESD and community stroke rehabilitation are key services required for a high quality stroke pathway. Both need to be provided in patients homes and community settings across Coventry and Warwickshire and require some investment and development; they are not optional parts of the care model. Development work for these services has focussed on modelling the workforce implications to develop the optimal service delivery model affordable within Commissioners planned investments in stroke care.

There were a number of potential ways in which bedded rehabilitation could be provided. A long list of potential scenarios was developed and clinically assessed for viability, with two viable options remaining. A full non-financial appraisal of these options by all key stakeholder groups, identified the preferred option as the provision of bedded rehabilitation at two sites, Leamington and Nuneaton.

A clinical and operational risk assessment of the different models and a financial appraisal of indicative costs supported the outcome of the non-financial appraisal.

Our work to identify and evaluate the options for provision of the future clinical model for stroke care has therefore identified the preferred option for Coventry and Warwickshire as:

- *Centralised HASU/ASU at UHCW*
- *ESD and community rehabilitation in all areas.*
- *Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton.*

6.0 FUTURE CLINICAL MODEL

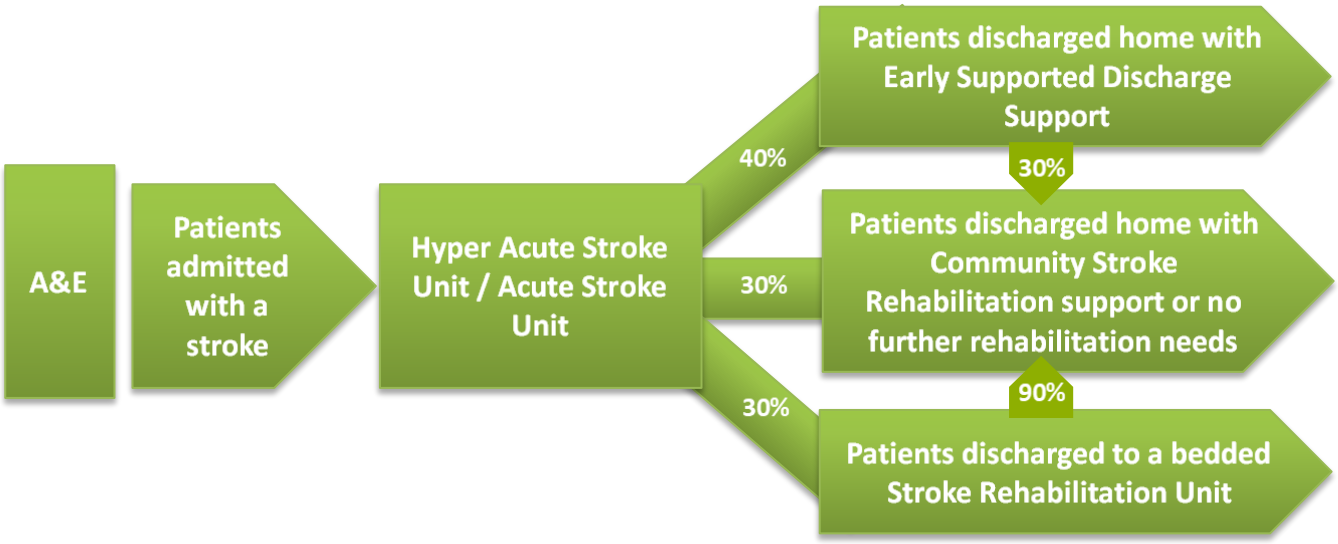
A significant amount of work has been undertaken by clinicians from across the health economy to design a new model for stroke services in Coventry and Warwickshire that will meet the clinical best practice outlined in the Stroke Services Specification developed by NHS Midlands and East and more recent updates to national clinical guidelines.

This section sets out the future clinical model and vision.

6.1 Future Clinical Model & Pathway

Patients will be seen more promptly and in the right place by specialist, skilled professionals, where they will receive the highest quality care. Once the acute episode is complete, patients will either transfer to an inpatient community rehabilitation bed or return home or to their usual place of residence with the appropriate level of community support from both health and social care services. The three CCGs are working in partnership with their partners in local authorities and the third sector to develop seamless services that support people to be as independent as possible and receive appropriate support when they need this.

At a high level, the future pathway will be as follows:



The future pathway has the following key features:

- Provision of a single centralised hyper acute stroke unit (HASU) and an acute stroke unit (ASU) at UHCW, with the necessary infrastructure, support and workforce to assess and diagnose all patients suspected of having had a stroke from across Coventry and Warwickshire, within 72 hours of onset;
- An Early Supported Discharge service;
- Community stroke rehabilitation services, and
- Bedded stroke rehabilitation services for those patients that require more intensive support after discharge from the ASU.

- All patients suspected as having a stroke will be admitted to the HASU/ASU for assessment and treatment, patients will then follow one of 3 routes depending on their clinically assessed need:
    - Discharged home with community stroke rehabilitation support, or potentially requiring no further support. Analysis of historic activity identifies this route applies to 30% of patients
    - Discharged home with Early Supported Discharge. Analysis of historic activity identifies this route applies to 40% of patients; 30% of these patients will need further rehabilitation and therapy input to reach their goals and increase their independence and will go on to receive community stroke rehabilitation support
    - Discharged to a bedded Stroke Rehabilitation Unit. Analysis of historic activity identifies this route applies to 30% of patients. 90% of patients within this cohort will, on discharge from bedded rehabilitation, go on to receive community stroke rehabilitation to achieve their optimal rehabilitation.

It is proposed that the HASU length of stay will be up to 72 hours in line with the NHS Midlands and East Stroke Services Specification. ASU length of stay will be eight days, after which patients will transfer to a bedded rehabilitation facility if they are not ready to return home.

Components of the new pathway are outlined through the rest of this section, all of which are explicitly in line with the NHS Midlands and East Stroke Services Specification.

6.1.1 Early prevention and Atrial Fibrillation

Each CCG has plans in place to improve primary and secondary prevention of stroke, including:

- Identification of patients with Atrial Fibrillation (AF) in primary care; and
- Increased anticoagulation rates for those diagnosed with Atrial Fibrillation.

During August and September 2017, primary and secondary care professionals involved with the AF and anticoagulation pathway started regular meetings to discuss, plan and agree collaborative working practices to deliver an integrated anticoagulation pathway.

The CCGs are already commissioning primary prevention improvements where there are opportunities for the better management of AF, hypertension and diabetes. Opportunistic screening for AF is underway to increase the identification of patients to bring prevalence up to the expected 2%. Work is progressing across Coventry and Warwickshire to put contracts in place with General Practice. It anticipated that contracts will be in place across the region by 31st March 2020.

In addition, a full programme of work across the diabetes pathway is underway, with an emphasis on stroke. From April 2018 the national programme for prevention of diabetes has been rolled out.

6.1.2 Pre-Hospital Care

All patients identified as having a stroke within the first 72 hours of onset will be transferred by emergency ambulance for a hyper acute assessment at UHCW. Ambulances will need to collect patients from wherever they have their stroke, as well as from Warwick and George Eliot Hospitals as some patients may self-present at their local A&E Department.

6.1.3 Hyper Acute Stroke Unit

For all patients suspected of having a stroke, the HASU will provide expert specialist clinical assessment, clinical imaging and the ability to offer intravenous thrombolysis for those who need it 24 hours a day, 7 days a week, typically for no longer than 72 hours after admission. At least 600 cases per year are typically required to provide sufficient patient volumes to make a hyper acute stroke service clinically sustainable, to maintain staff expertise and to ensure good clinical outcomes. As is shown in the activity modelling in section 7, the proposed HASU patient flow will easily meet this target.

6.1.4 Acute Stroke Unit

Acute stroke care will immediately follow the hyper acute phase, mostly after the first 72 hours of admission. The ASU will provide:

- Continuing specialist day and night care;
- Daily multi-disciplinary care;
- Continued access to Stroke Specialist Consultant care;
- Access to physiological monitoring; and
- Access to urgent imaging as required.

In-hospital rehabilitation should be assessed immediately after the person has had a stroke and commence as soon as possible.

6.1.5 Early Supported Discharge

ESD will enable appropriate stroke survivors to leave hospital ‘early’ through the provision of intense rehabilitation in the community at a similar level to the therapy care provided in hospital. The ESD service will operate 7 days a week, able to deliver immediate response to all hospital discharges and patients at risk. The service is therapy led, with medical support provided by the Stroke Consultant where required.

The team will provide intense rehabilitation at home for up to six weeks, thereby reducing the risk of re-admission for stroke related problems, increasing independence and quality of life, with support to the carer(s) and their family. Based on analysis of 3 years of activity data and the Coventry ESD service outcomes it is assumed that 40% of patients will be appropriate to receive ESD services.

Local CCGs will commission ESD using a standard ESD specification across Coventry and Warwickshire, thus ensuring equity of access, service quality and performance standards.

6.1.6 Community Bedded Stroke Rehabilitation

Community bedded stroke rehabilitation is recommended for stroke patients who are medically stable enough to not require daily medical care from stroke physicians, but have ongoing care and rehabilitation needs that prevent them from returning home. The point prevalence audits, bed audits on the UHCW stroke unit and clinical discussions have concluded that this cohort equates to 30% of the patients in an acute stroke unit at any point in time.

Local CCGs will commission community bedded stroke rehabilitation using a standard specification across Coventry and Warwickshire, thus ensuring equity of access, service quality and performance standards.

The provision of this service will be predicated on 'pulling' appropriate patients from the acute stroke unit, providing goal focused rehabilitation and facilitating an onward discharge either home or into an onward residential or care setting, should that be required. Based on local activity analysis, 90% of the patients admitted to bedded stroke rehabilitation will be discharged with community stroke rehabilitation to achieve their optimal rehabilitation.

The facility will require the wider health and care system to support onward flow and thus ensure capacity to continuously improve patient flow from the acute stroke service.

The criterion for the bedded rehabilitation facility has been determined as follows:

- Nurse led care provision, with multidisciplinary therapy interventions;
- Initial admission for up to six weeks of care and stroke rehabilitation;
- Maximum extension of a further four weeks reviewed on an individual case basis;
- Minimum of a weekly review of progress and identification of onward care and therapy needs;
- In-reach support from the ESD service to identify and facilitate the onward pathway of care, including access to the ESD/Community Neuro-Rehabilitation service; and
- Support from Social Care to support onward discharge to home, residential/nursing home placement, ensuring that the maximum period of a 10 week admission is not breached.

6.1.7 Community Stroke Rehabilitation

Stroke survivors' rehabilitation will continue out in the community after time spent in a bedded rehabilitation unit, or after their acute inpatient stay on an ASU. These services enable stroke survivors to develop a greater quality of life and independence following a stroke. Patients will access community stroke rehabilitation services following standard discharge from a stroke unit or following ESD.

The service will ensure regular review of rehabilitation goals with stroke patients, their carer(s) and families and regular review of whether the full rehabilitation potential has been achieved, so that patients can be suitably discharged from the service.

Local CCGs will commission community stroke rehabilitation using a standard specification across Coventry and Warwickshire, thus ensuring equity of access, service quality and performance standards.

6.1.8 Long-term Recovery

Stroke survivors and their carer(s) should be enabled to live a full life in the community in the medium and long-term (i.e. greater than three months). The ESD and community stroke rehabilitation teams will review all stroke patients at 6 months post stroke and offer long term access to rehabilitation for patients with a stroke-based need for multi-disciplinary team intervention. Support will be required from local services to ensure that stroke survivors receive tailored support to assist in their re-integration into the community and maximise the quality of life experienced by stroke survivors, their carer(s) and families.

6.2 Workforce

An important part of mobilising and implementing the proposed model is creating the workforce that will be required by providers to deliver the pathway.

Workforce modelling has been completed with providers as part of the development of the options for service delivery and the subsequent financial appraisal of those options. Staffing levels and skill mix have been based on the NHS Midlands and East Stroke Service Specification, which gives clear guidance on the minimum staffing levels for the various core specialist skills required for high quality stroke care. For those staff groups not prescribed in the Midlands and East Stroke Service Specification, workforce requirements were agreed based on published national guidelines for stroke services and local clinical experience. With regard to ESD and community stroke rehabilitation, local clinical experience of patient complexity, the impact of rurality and recruitment challenges have been used to adapt the proposed skill mix. The workforce model was reviewed with West Midlands CVD Network and their recommendations were used to further shape the proposed model.

The rehabilitation services (community and bedded) have been modelled to provide a 7 day service, in particular it should be noted that therapy services will operate 7 days a week, including providing immediate response to all hospital discharges and patients at risk. The capacity for specific elements of rehabilitation services will vary across the 7 days and has been modelled to match the known profile of demand. This will facilitate the flow from acute and rehabilitation beds over the weekend into the community whilst offering priority visits and intervention to these groups of patients at weekends.

It is acknowledged that as a result of local tailoring, the proposed skill mix for ESD and community stroke rehabilitation includes some deviations from the NHS Midlands and East Stroke Specification. Where the proposed workforce model is not fully aligned to the Specification the adjustments are based on responding to the clinical expertise and experience of the local clinicians.

There are strong rationales underpinning the decisions to change the skill mix profile which include:

- The proposed model has been designed to mirror that of the successful Coventry pilot described in section 4.3; a key factor in this decision is the successful outcomes the team is delivering. The most recent SNNAP results (July-Dec 18) measuring modified Rankin scores, shows that the team delivers input to a much higher percentage of moderate and severely impaired patients as compared to national levels.
- The ESD and CSR teams do not currently include nursing posts as nursing vacancies are currently high in the acute pathway, rehabilitation and community nursing both locally and nationally. Band 4 Assistant Practitioner and Band 3 Rehabilitation Technician Posts have been created within the model and their roles will include traditional nursing activities such as tissue viability and continence management.
- The model includes senior therapist posts; reasons for this include:
    - Having experienced clinical specialists on the ground and available to risk assess, manage arising daily concerns and support less experienced and unregistered staff is an essential foundation for any future plans to develop services further to provide enhanced ESD
    - Providing banding progression through all therapy disciplines was felt to be a clear and sure way of attracting, recruiting and retaining the high numbers of therapy disciplines required.
    - Band 8b psychology posts have been sustained in the model to provide governance and guidance to Band 8as as this support is not available within the existing structures outside of the stroke teams.

The tables that follow show the current stroke workforce in place in each of the providers and the proposed workforce developed to meet the needs of the future service model.

The current stroke workforce is as follows:

Role	Band	UHCW	SWFT	GEH	CWPT
Consultant		4	1	1	0
SpR		2	2.34	1	0
Stroke Specialty doctor (Fast Bleep/TIA clinics)		2	0	0	0
SHO		4	0	1	0
Dietetics	*7*	0	0.65	0.9	0
Dietetics	*6*	1	0	0	0.37
Speech & Language Therapist	*7*	0.8	0.6	0.5	1.45
Speech & Language Therapist	*6*	1	1.3	0.5	0.67
Speech & Language Therapist	*5*	0.6	0.6	0	0
Speech & Language Therapist	*4*	1	0	0.4	0
Physiotherapy	*7*	0.8	2	0	0.8
Physiotherapy	*6*	3	2	1	2.88
Physiotherapy	*5*	3	2	1	1
Physiotherapy	*2*	0	1.5	0	0
Occupational Therapy	*7*	1	1.28	0	1.64
Occupational Therapy	*6*	2.8	1.4	0	1.81
Occupational Therapy	*5*	2	1.5	0	1
Occupational Therapy	*2*	0	1.3	0	0
Therapy assistants/MTO	*4*	0	0	0	2.9
TIA support worker	*3*	1.02	0	0	0
Therapy assistants	*3*	2.79	2.3	1	4
Therapy assistants	*2*	2	0	0	0
Psychology	*8b*	0.5	0.5	0.5	0.84
Psychologist	*8a*	0	0	0	0.8
Psychology assistant	*5*	0.5	0	0	0
Pharmacy	*8a*	0.5	0	0	0
Stroke co-ordinator/Clinical Lead	*8a*	1	0	0	0.83
Stroke CNS/TIA CNS	*7*	0	1	2.6	0
Stroke CNS	*6*	1.4	2	1	0
Stroke secretary	*4*	2	0	0	0
Stroke data officer	*3*	1	0	0	1
Stroke data officer	*2*	1	2.02	0	0
Nursing	*7*	1	2	1	0
Nursing	*6*	2.8	4	4.8	0
Nursing	*5*	28.42	25.81	11.11	0
HCA	*3*	3.18	2.6	1.93	0
HCA	*2*	16.33	23.2	10.49	0
Ancillary	*2*	0	1.46	0	0
Total number of staff					**244.52**

The proposed workforce model is as follows:

Role	Band	HASU/ ASU	Bedded Rehab	ESD	Community Rehab
Consultant Physician (thrombolysis trained)		8			
SpR		3	2	0	0
Stroke Specialty doctor (Fast Bleep/TIA clinics)		2	0	0	0
SHO		4	0	0	0
Dietician	*6*	1	1	0.4	0.5
Dietician	*5*	0.5	1.63	0	0
Dietician	*3*	0	0.5	0	0
Speech & Language Therapist	*7*	0.8	2	1.6	1.05
Speech & Language Therapist	*6*	2	2	1	1.87
Speech & Language Therapist	*5*	1	2	0	0
Speech & Language Therapist	*4*	1	0	0	0
Speech & Language Therapist	*3*	0	0.5	0	0
Physiotherapist	*7*	1.8	2	2.3	2
Physiotherapist	*6*	4	4	1.8	7.1
Physiotherapist	*5*	3	2	4	3
Occupational Therapy	*7*	1	2	1.8	1.84
Occupational Therapy	*6*	3.8	4	2.3	5.8
Occupational Therapy	*5*	2	2	3.8	3
Assistant Practitioner	*4*	0	0	0	6.85
TIA support worker	3	1.6	0	0	0
Rehab Assistant	*3*	4.2	6	10.8	6
Rehab Assistant	*2*	2	0	0	0
Psychologist	*8b*	0	0	0	1.84
Psychologist	*8a*	1	1.2	1.4	1.2
Psychology Asst	*5*	0.5	0	0	0
Pharmacist	*8a*	1	0	0	0
*Stroke Services Team Leader**	*8a*	1	0	0.9	0.9
*Stroke Clinical Nurse Specialist**	*7*	1	0	0	0
Stroke Fast Bleep Holders	*6*	6	0	0	0
Medical Sec	*4*	2	0	0	0
Data Clerk/Admin	*3*	1	2	2.5	0
Admin	*2*	1	1	0	0
Ward Sister	*7*	1.2	2	0	0
Ward nurse	*6*	5	2	0	0
Ward nurse	*5*	38	29.5	0	0
HCA – ward	*3*	8.2	3.2	0	0
HCA - ward	*2*	21	19.2	0	0
Orthotics		0	0.24	0	0
Total number of staff					**306.12**

*These roles will be working on opposite shifts to provide 7-day specialist cover to HASU/ASU

6.3 Conclusion

To deliver the NHS Midlands and East Stroke pathway and to achieve the step change improvement that has been achieved by other health economies in areas of best performance, we need to change the way that stroke services are collectively provided across Coventry and Warwickshire.

The new networked stroke pathway proposed has been designed based on the best practice evidence available, incorporating HASU, ASU, bedded rehabilitation, ESD and community rehabilitation support services. It will ensure that all stroke survivors can access the right standard of stroke specialist ESD and community stroke rehabilitation, providing evidenced based care to reduce the level of disability of those who survive a stroke.

The proposed future service model for stroke care described in this Business Case will meet the projected population demands and support providers to achieve the best practice standards for anyone on the stroke pathway.

The new networked workforce model and pathway when commissioned will place the local providers in the best position to overcome the current recruitment challenge and gap between the number of stroke specialist staff we need and those employed.

The NHS Long Term Plan and National Stroke Programme set out national ambitions for improvements and new developments in stroke services such as mechanical thrombectomy, to further increase stroke survival and rehabilitation outcomes. Crucially, the proposed new clinical model for stroke in Coventry and Warwickshire will establish a service structure and pathway that gives the foundations for these improvements in stroke care to be delivered.

7.0 FINANCIAL AND ACTIVITY IMPACT

Finance and activity modelling have been undertaken to estimate the likely impact on patient flows, costs and potential savings from the potential new models. The results of this work provide evidence to demonstrate that the proposed new model is affordable.

7.1 Financial Appraisal of Remaining Options

Following an assessment of the clinical viability of the potential options for a new model of stroke services, it was evident that:

- there is only one clinically viable scenario for acute care: centralisation of HASU/ASU services at UHCW
- ESD and community stroke rehabilitation are key services required for a high quality stroke pathway. Both require some investment and development across Coventry and Warwickshire; they are not optional parts of the care model.
- There is more than one possible way to provide bedded stroke rehabilitation.

Based on the options development and appraisal the financial case has been prepared on the basis of a do-nothing comparison to a centralised model for HASU/ASU. Modelling for ESD and community stroke rehabilitation has been based on a clinical assessment of the workforce needed to provide these services. A smaller financial options appraisal was undertaken to develop indicative costs for the following options for bedded rehabilitation:

Option 1 - Bedded rehabilitation at SWFT in Leamington Spa and GEH in Nuneaton.

Option 2a - Bedded rehabilitation provision in the Coventry area, not on an NHS hospital site, with specialist therapy in-reach; one bedded rehabilitation unit at SWFT in Leamington Spa and one bedded rehabilitation unit at GEH in Nuneaton.

A lack of clarity on how clinical and operational risks could be mitigated and market availability of beds have made this option difficult to quantify. Pathway costs are subject to significant variation dependent on the location, spread of patients and the exact service support put in. Best estimates of the costs range from this option saving £135k on Option 1 to incurring an additional £200k per annum, assuming that therapy support needs doubling and with medical support going into the facilities. Given the risks identified in section 5.8, the actual pathway required to deliver this option could be beyond this cost base.

Option 2b - One bedded rehabilitation unit at SWFT in Leamington Spa, one bedded rehabilitation unit at GEH in Nuneaton and one bedded rehabilitation unit at the Hospital of St Cross in Rugby.

This pathway when costed was £788k per annum more than Option 1.

The results of the risk assessment (section 5.8) provide a strong steer from the clinical and operational leaders of stroke services that:

- Option 2a has significantly higher levels of clinical and operational risk than Option 1.
- Option 2b poses higher risks of an inability to recruit and a significant risk of having an adverse impact on wider NHS provider sustainability in the health system, than both Option 1 and Option 2a

The above financial appraisal provides a high level, indicative financial test only. Option 1, as the clinically most viable option and preferred option from the non-financial options appraisal, has been used as the basis for the financial case that follows.

7.2 Bed Modelling

Bed capacity modelling has been undertaken to establish the number of beds that should be required to manage demand through the current service model (do nothing state) and for the proposed future clinical model. Modelling for the proposed new clinical model has also been tested to ensure achievement of SSNAP measures.

Activity for 2017/18 was used to form the baseline for modelling, with growth of 1.07% assumed annually. Appendix 14 details the assumptions applied to the activity to complete the modelling and their source/evidence base. Cross boundary activity involving Coventry and Warwickshire's bordering providers (University Hospitals of Leicester, Worcestershire Acute Hospital and Birmingham Heartlands Hospitals) was also analysed to identify any potential impacts. The resulting cross-boundary flow of activity was found to be minimal.

The results of the activity modelling on the required bed numbers are shown in the table below:

Bed and Service Provision: Current vs Future State

Bed/Service provision	Current	Future	Difference (Beds)
Hyper Acute Stroke beds	6 beds at UHCW	12 beds at UHCW	+ 6 beds
Acute Stroke beds	30 ASU beds at UHCW 12 ASU beds at SWFT 18 ASU beds plus 1 assessment bed at GEH (Total 61 beds)	31 ASU beds at UHCW	- 30 beds
Community Stroke Rehabilitation beds	6 inpatient rehabilitation beds at Rugby site, UHCW for Rugby patients aged 65+ 20 inpatient rehabilitation beds at Leamington site, SWFT for SW patients only (Total 26 beds)	17 for C&R CCG (preferred option 9 in SWFT/8 in GEH) 12 beds in SW (SWFT) 10 beds in NW (GEH) (Total 39 beds)	+ 13 beds (N.B. different specification of beds)
Total bed numbers	**93 beds**	**82 beds**	**- 11 beds**

In establishing the future bed base, the following assumptions about the patient flow through the proposed future clinical model were made:

- HASU length of stay would continue to be up to 3 days;
- Acute length of stay is expected to reduce from the current 18 days (spell average) to 11 days at day 1 of introduction of the full pathway, reducing further to 7 days from

year 2 of the new pathway being implemented. The implementation plan for the proposed new model introduces and embeds the new community rehabilitation services in phase 1, to make the necessary changes to patient flow to reduce length of acute stay in advance of centralising the HASU and ASU services.

- Following their stay on the ASU, patients will be discharged as follows:
    - 40% of patients will be discharged with a standard ESD package
    - 30% of patients will transfer to bedded rehabilitation provision
    - 30% of patients will be discharged with community stroke rehabilitation.
- Community stroke rehabilitation will also support 30% of the patients completing ESD and 90% of the patients discharged from bedded rehabilitation.
- Bed occupancy rates have been agreed with clinical input from providers to enable the pathway to manage peaks in demand and to deliver the patient flow necessary to sustain the existing HASU/ASU bed ringfencing policy. The occupancy rates applied are as follows:
    - HASU – modelled assuming 85% occupancy
    - All other Stroke related beds – modelled assuming 90% occupancy

The proposed new clinical model results in a redistribution of the current stroke bed capacity and an overall reduction of 11 beds in the total number of stroke beds required. These beds will be reallocated to other hospital specialisms, recognising the demand pressures for other acute hospital beds in the system from demand growth and given the need to ensure that patient flow is maintained.

7.3 Activity Impact

A detailed model of patient flow through the system was constructed with clinical engagement and using points prevalence audits to test and refine assumptions (Appendices 14-16). The tables below show a comparison of activity flows through the Coventry and Warwickshire acute hospitals through the current versus the proposed future pathway, for each of the acute provider organisations. This illustrates the potential impact that the centralisation of HASU/ASU is likely to have on both patients and providers.

Activity Impact

	UHCW		GEH		SWFT	
	Current	Future	Current	Future	Current	Future
Suspected stroke patients – arriving by ambulance	2,077	3,091	437	-	577	-
No of patients assessed in A&E	2,336	3,345	659	224	820	246
Patients transferred to UHCW HASU	-	-	-	120	-	109
No of patients Treated in HASU/ASU	1,053	1,752	281	-	418	-
No of patients to receive bedded rehab			-	170	-	179

Early supported discharge and Community Stroke Rehabilitation	Coventry and Warwickshire
No of patients to receive ESD	465
No of patients to receive CSR	803

Due to the likely increase in patient journeys identified within the proposed new model we have directly engaged with NHS West Midlands Ambulance Service (WMAS) to enable them to model patient journeys under the proposed future model. This modelling completed by WMAS has identified that implementation of the proposed new model will result in an additional 2.78 ambulance journeys per day. WMAS have confirmed that this increase could be planned into their annual workload. The WMAS modelling report can be found in Appendix 15.

Specific review and agreement of the proposed model was sought from NHS England Specialised Commissioning to ensure that the changes proposed would not impact on the services commissioned by them. A letter of support in principle from Specialised Commissioning has been received.

7.4 Financial Modelling

The financial implications of the proposed new model have been assessed through joint work between commissioners and providers. The results have been discussed at STP level and the following principles have been agreed by both commissioners and providers:

- The bedded part of the stroke pathway (i.e. HASU/ASU and bedded rehabilitation) will continue to be covered by tariff under the current tariff cost envelope.
- The three CCGs will invest the required amounts in the additional ambulance transfers, elements of prevention and the community stroke rehabilitation pathway.

The agreement that tariff will cover the bedded elements of the proposed new pathway has been used to set an overall financial envelope. This will be recast for the latest tariff at the time of implementation. The three local acute providers have agreed to operate the model within this envelope and to jointly mitigate and manage any risks associated with this element of the pathway, having assessed the costs of delivery and scope for efficiencies.

It is important to note that there will be no savings to Commissioners from the planned stroke bed base realignment outlined above. Tariff will continue to be paid on the nationally set basis.

The level of investment required from CCGs into the community elements of the pathway has been calculated based on the activity modelling and costing of the proposed workforce models and associated service delivery costs. Further details on the commissioner investments are provided in section 7.4.2

In line with the agreements and assumptions identified above, estimates have been produced by Commissioners and Providers of the impact on income, activity and costs under the current model and the future model options, both at system and individual provider level. These estimates have been based on 2017/18 planned activity and prices to enable a consistent approach to be taken.

The table that follows compares the costs for both CCGs and providers of the current and preferred option.

	Current Investment by CCGs	Proposed Model	Change from Current Investment	UHCW	GEH	SWFT	CWPT	Other
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Acute HRGs	10,440	9,312	-1,128	9,312				
Rehabilitation	2,478	3,980	1,502		1,990	1,990		
Bedded facilities			0					
Acute Outpatients	642	642	0	642				
Acute elements	**13,560**	**13,934**	**374**	**9,954**	**1,990**	**1,990**	**0**	**0**
Community - ESD and Rehab	1,663	4,775	3,112			2,669	2,106	
Ambulance extra journeys		171	171					171
AF Net investment		128	128					128
Community elements	**1,663**	**5,074**	**3,411**	**0**	**0**	**2,669**	**2,106**	**299**
Total cost of pathway/model	**15,223**	**19,008**	**3,785**	**9,954**	**1,990**	**4,659**	**2,106**	**299**

Notes:

- The original investment envelope was £13.1m (2017) but this has been revised upwards due to changes in the national tariff.
- Current Acute HRG spend based on 19/20 plan and as such within Provider and CCG baselines
- Community costings – taken from Provider costings

7.4.1 Inpatient Bedded Care Costs

The cost of hospital bedded care will remain the same for CCGs with the three acute providers agreeing to deliver within the current funding. All three acute provider Boards have confirmed in writing their sign up to this agreement and to jointly managing and mitigating any risks arising.

The financial impact of the proposed model was assessed through joint work with providers to agree the likely impact. The table that follows shows the position from the acute provider perspective:

	Cost of Proposed Model
	£000s
Acute Inpatient	9,312
Rehabilitation	3,980
Acute Outpatients	642
Acute elements	**13,934**

	Funding Envelope
	£000s
HRG Tariff	10,440
Rehabilitation	2,478
Acute Outpatients	642
Funding by CCGs	**13,560**

Difference	**374**

Please note that the following assumptions have been made in this analysis:

- Total acute costs for UHCW, GEH and SWFT are paid on a cost and volume basis at national tariff.

- Staffing has been costed on updated pay levels.
- A risk share arrangement is in place for under/over activity based on length of stay.
- The Trust income changes (and therefore the CCG costs) have been calculated based on the effects of the change to Atrial Fibrillation anticoagulation therapy only. Evidence indicates that there is the potential to avert 230 strokes over three years across the three CCGs (NHS England Atrial Fibrillation QIPP Report 2012/13). NICE estimates the average cost of acute and community care for one stroke at between £12,228 and £40,000 per year. However, there are additional costs associated with delivering this part of the pathway in terms of prescribing and patient identification, which make this a small net cost overall.

Further assumptions have been included relating to length of stay as described in the following section.

Length of Stay Assumptions

The centralised service model improves Commissioner and Provider financial sustainability.

The baseline activity data used for modelling reflects a current average length of stay per spell of 18 days. Given the current limitations on availability of stroke rehabilitation beds, the current acute spell length is believed to include some rehabilitation level bed days, which is therefore inflating the reported average acute stay.

The proposed new model of care sets a target of 11 days for the average acute length of stay (i.e. HASU/ASU total stay). This is based on a prudent expectation of the acute length of stay reduction that will be achieved through establishing comprehensive ESD and community stroke rehabilitation. The reduction in length of stay helps to lower the bed requirement for acute stroke from the existing bedded quantum at the three sites to the equivalent of 12 additional beds at UHCW.

For Commissioners, the provision of alternative rehabilitation options will reduce the average length of stay needed within an acute setting by creating services which actively ‘pull’ patients who are medically stable and in need of rehabilitation into non-acute settings which are more appropriate and closer to home.

The 11 day average acute length of stay is noted as being a prudent estimate when compared with other similar models in England evidencing a 7 day average length of stay. As discussed in section 4.3, evidence from the evaluation of other systems in England that have already centralised stroke admissions supports the assumption that investment in community services will deliver a reduction in length of stay. Further, local evidence from the implementation of the ESD and community stroke rehabilitation in Coventry has already demonstrated a significant reduction in acute length of stay for Coventry patients. The three local acute providers report current average acute stroke lengths of stay of between 12 and 14 days. It is therefore recognised that a proportion of the overall reduction in length of stay required has already occurred and gives credence to the deliverability of the business case.

The development of this Business Case coincides with the release of 11 decant beds at UHCW, which were created to enable fire stopping works at the Trust. These beds will accommodate the bed requirement transfer to UHCW. The prudent assumptions on the

expected length of stay further mitigate the capacity risk at UHCW. To transact this, commissioners have agreed an unbundling methodology with UHCW.

It is important to note that there will not be any overall bed closures for the system; beds not required for stroke care will be transferred to other specialties as required by demand.

7.4.2 Commissioner Costs

As stated above, it has been agreed by all three Commissioners that they will fund the additional costs required in the community elements of the pathway.

As with the acute costs, joint work with providers has been undertaken to calculate the cost of these changes, based on activity modelling and costing of the consequent workforce model and associated service delivery costs. The resultant total investment and split between each of the three CCGs has been agreed and signed off by CCG Governing Boards as follows:

- NHS Warwickshire North CCG 17th July 2019
- NHS Coventry and Rugby CCG 17th July 2019
- NHS South Warwickshire CCG 17thJuly 2019

The table below compares the costs for both CCGs and community providers of the current and proposed model.

	Current Investment by CCGs	Cost of Proposed Model
	£000s	£000s
Community - ESD and Rehab	1663	4,775
Ambulance additional journeys		171
AF Community investment		128
Community elements	**1,663**	**5,074**

Additional cost of community model	3,411
Additional cost of Acute model	374
Less savings on CHC packages	-700
Net additional CCG investment required	**3,085**

Agreed split by CCG:

CRCCG	300	1,283
SWCCG	440	547
WNCCG	1,008	1,254
	1,748	**3,085**

This analysis indicates that the CCGs will be required to invest a further £3.1m in the community pathway. The agreed split of investment between the CCGs is as shown in the table above. Proposed investment levels are within CCG financial plans for 2019/20 (on a part year basis) and 2020/21 (on a full year basis). The five-year financial plan being developed will also include the impact of this service provision.

The proposed new stroke pathway is expected to improve patient outcomes, leading to a reduction in the costs of long term packages of care. Savings of £700k have been assumed

across Coventry and Warwickshire. These savings have been assumed as a source of funding for the additional community-based costs (including Atrial Fibrillation anticoagulation therapy) of the proposed pathway, reducing the additional CCG investment requirement.

The estimate of costs has been based on the following assumptions:

- It is based on a current cost breakdown received from providers. Current staffing levels will be altered in line with business case assumptions. It has been assumed that income will cover costs under the proposed model.
- ESD: up to 40% of all Coventry and Warwickshire patients would receive this service. This is consistent with what is known about the numbers of patients receiving the current Coventry service and take-up rates. Further details of the modelling used to predict ESD demand can be found in Appendix 16.
- Community stroke rehabilitation: costs have been included for the provision of a service throughout Coventry and Warwickshire which meets the Midlands and East Service Specification.
- Ambulance service: additional funding will be required as a centralised model will increase the number of emergency transports into the specialist centre following a 999 call and also the number of non-emergency journeys as a result of repatriation for rehabilitation. The estimated activity impact of this and associated costs have been worked up by WMAS.

In line with the Implementation Plan for the proposed new model, the cost of the community pathway has been assumed to start at an earlier stage than the bedded pathway, to enable the pull of patients through the system to be created and embedded before implementation of the acute centralisation.

7.4.3 Impact on Social Care Costs

The financial impact of improved stroke management on Social Care costs has not been included in the costings due to there being:

- no increase in the number of stroke patients that social care will be supporting; the new model will change the flow of patients through the system, not the volume and should reduce patients' level of dependency through the enhanced rehabilitation. Therefore, there are not expected to be any additional costs incurred by the Local Authorities
- there being net anticipated savings to the Council from improved patient outcomes that are not necessarily attributable to the CCGs.

It should be noted that similar stroke models piloted in other parts of the country have observed significant reductions in post-stroke Social Care packages. In Essex, a shift took place from 8.9% of strokes requiring a Social Care package before implementation of the new stroke pathway to 2.7% after implementation. It is estimated that this could save around £2m across all 3 CCGs if this percentage reduction is applied to the projected strokes in this business case.

7.4.4 Financial Risks and Sensitivity Analysis

A number of financial risks have been identified which are described in the table below.

Risk Number	Risk	Description	Value estimate (£m)	Provider (£m)	Commissioner (£m)	Recurrent?	Level of Risk	Basis	Mitigating actions
1	Risk Share	The proposal is that tariff is risk shared for acute length of stay at under 11 days.	1.4	1.2	0.3	R	High	Currently above 11 days as a system	Agreement has been reached that Providers will take the risk on the bedded part of the Stroke pathway. Work with Clinical leads undertaken with expectation that pathway can deliver better than 11 day length of stay. Contract approach and clauses should mitigate. Acute Length of stay will reduce with introduction of bedded rehab, which accounts for a substantial part of current Acute length of stay.
3	Bed Opportunity Cost	The movement of bed usage may not result in an income neutral equivalent service being re-provided within the Trusts.	0.4	0.4		NR	High	Trust Estimate on possible income loss	ESD already in place for CRCCG, 6-9 months implementation is anticipated at most. Clear communication of issues during implementation phase with recovery actions. Contract approach will be to pay for reasonable levels of transition with limits on reasonable adjustment set. Delay on implementation of the next phase would be the ultimate mitigation.
	Provider Efficiency	Sensitivity analysis shows that there is a risk of additional beds in both HASU/ASU needed for peak times	1.2	1.2		R	Medium	Assumption based on additional 5 days LOS, 6 beds at £200k per bed.	Peak times will be managed through overflow and through occupancy being allowed to be greater than 85%. Sustained period of peak flow unlikely.
9	CCG Community Savings	CHC Community package investment and AF Prevalence assumptions	0.7		0.7	R	Medium	Based on NICE guidance, but without certainty as to where savings occur.	Prudent assessment of impact of AF already in place. Community package impact will be taken out of budgets as part of investment plan, but prudent assessment of valuation taken.
11	Tariff Changes	Tariff has been based on 2019/20 tariff levels and these will change impacting on commissioners/providers. As an STP this should only move the deficit.	0.0			R	Medium	Tariff changes each year. Could change as contract basis may change. Not financially valued.	Zero impact confirmed for Health Economy
TOTAL			3.7	2.8	1.0				

As described in section 7.2 above, bed capacity has been modelled on the basis of running the proposed new model with bed occupancy of 85% in HASU and 90% in all other beds, in line with accepted best practice. Sensitivity analysis has been undertaken to test the resilience of the resultant bed numbers, modelling the impact of an increase in acute length of stay and variations in the total volume of strokes through the model. In terms of acute length of stay it has already been shown that the creation of dedicated rehabilitation beds alone should reduce the required number of beds to the level for 11.5 length of stay. An increase in the overall total number of strokes is a more likely risk to the model. Planning bed capacity based on the occupancy rates used means that occupancy should be low enough to offset the sensitivity around this in the short to medium term. Increased numbers should only be needed for very high peak times as outlined within the risk table. The health economy will need further conversation if this does peak in a sustained way above this level.

The results of the sensitivity modelling are shown in Appendix 17. This has been included within the risks.

7.5 Conclusion

The financial analysis indicates that the CCGs would be required to invest £3.1m to deliver the proposed model of care. The three CCG Governing Boards have agreed to invest this level of funding and included their respective proposed investments in financial plans for 2019/20 (on a part year basis) and 2020/21 (on a full year basis).

Working together, the three acute providers have agreed to deliver the hospital bedded elements of the pathway within the national tariff and a joint risk share arrangement is in place for under/over activity based on length of stay. Some modest financial savings will accrue to the CCGs as a result of the new model (£0.7m from the impact of improved anticoagulation therapy for AF and reduction in long term NHS funded packages of care through the improved rehabilitation offer).

This is considered an appropriate investment to make to increase quality, improve outcomes and access and address the key issues outlined in this business case.

After the consultation process and as part of mobilisation, further work will be undertaken on the timing of the required investments.

8.0 IMPLEMENTATION

This section outlines the next steps for the CCGs to proceed to implementation of the proposed future clinical model for Stroke services.

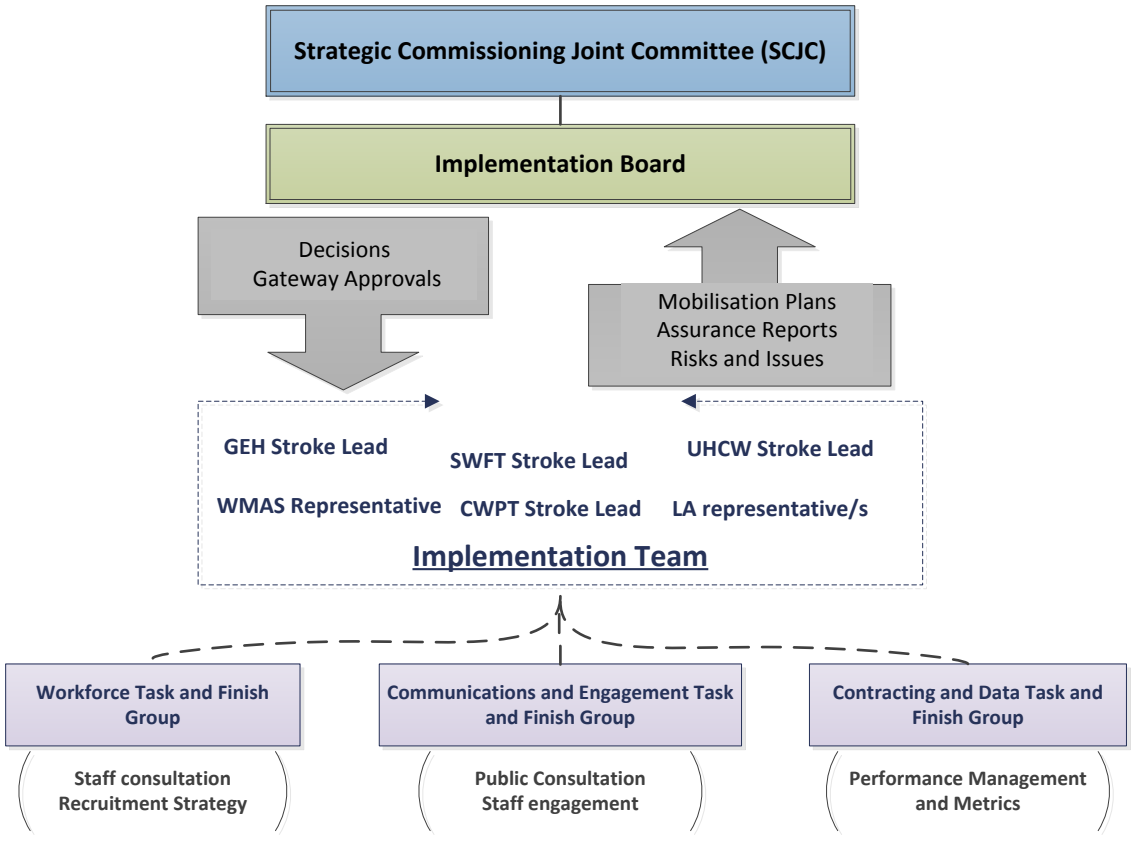
8.1.1 The Process Following Consultation

Once the final pathway has been identified following public consultation, the project will move into the contracting and implementation phase. As Commissioners commence the contract process, they will focus on the governance arrangements with accountability routed through the Strategic Commissioning Joint Committee (SCJC) formed from the three CCGs of Coventry and Warwickshire.

Implementation will be overseen by the formation of an Implementation Board, chaired by a Chief Executive of one of the provider organisations (to be nominated), with membership comprising at least one Executive from each of the provider and commissioner organisations.

It is expected that the governance structure for the implementation process will be as set out in the diagram below.

Governance Structure – Implementation Phase



The Implementation Board will meet every two months. Providers will agree arrangements for project management support and leadership at the start of the implementation phase. The Implementation Board will have responsibility and accountability for signing off progression through the implementation gateways defined. The governance responsibilities associated with implementation are in addition to the existing and ongoing duties commissioners and providers have for monitoring and performance managing the delivery of patient services.

It is proposed that the already established Stroke Clinical and Operations Group will reconfigure to become the Implementation Team, with day to day responsibility and accountability for managing the delivery of the new networked clinical model. The C&W Stroke Implementation Team membership will comprise a minimum of a Stroke project lead from each provider organisation and representation from West Midlands Ambulance Service, both Coventry and Warwickshire Local Authorities and any other key stakeholders identified as critical to the delivery of the future pathway.

In line with best practice project management, the Implementation Team will be responsible for ensuring that mobilisation plans (including timelines) are provided and adhered to, providing formal assurance reports and escalating any risks and issues to the Implementation Board and SCJC as appropriate. They will also be responsible for monitoring achievements against the benefits plan which will include; the regular performance review of patient flow through the system, outcome data, staffing skill mix effectiveness and ensuring that defined gateways are achieved before transitioning to the next phase of implementation. This is a complex programme of implementation, delivered in phases with defined "go/no go" gateways. On the basis of the performance and progress review, the Implementation Team will make recommendations to the Implementation Board for approval regarding progress and/or suggested amendments to the implementation plans.

Individual providers will be responsible for establishing their own internal governance structure and mobilisation plans for their specific elements of the model.

8.1.2 Commissioning of Future Stroke Pathway

The Commissioners have undertaken an options appraisal of the available contractual mechanisms and procurement routes in order to recommend the most effective way of commissioning the integrated stroke pathway. In assessing the contract mechanisms and procurement routes the commissioners considered the following factors:

- Local needs and profiles;
- Sustainability;
- Continuity;
- Value for money
- Affordability;
- Stability
- Deliverability, and
- Procurement Law and Guidance.

After assessing the options, the Commissioners intention is to move to a Lead Provider arrangement with mandated sub-contractors as this should give the best opportunity for an integrated model of care and an integrated workforce across the future pathway

CCG Commissioners recognise that there is further work required to underpin the future contracts with robust outcome measures, performance indicators and clinical protocols in order to support the principle of integrated care, continuous improvement and ensure

patients flow seamlessly through the pathway. These will be developed in collaboration with providers.

8.1.3 Implementation

Implementing the proposed new clinical model represents a significant change to current services and as such will be a complex process.

We are currently in the early stages of implementation planning as the focus to date has been on comprehensively engaging with all key stakeholders to design the most appropriate service delivery model. Therefore, and, acknowledging that greater detail will be provided during and following consultation, the present outline implementation timeline is provided below. A high-level project plan Gantt chart illustrating the key tasks and project gateway decision points is attached at Appendix 18.

Business Case	
Business case complete	June 2019
NHS England Assurance process commences	June 2019
Consultation period	October 2019 –January 2020
Governing Bodies consider consultation results and decision made (BC updated with consultation outcomes)	January 2020 - February 2020
Contract signed	March 2020
Proposed Mobilisation and Implementation should pathway be agreed	
Community pathway mobilisation/ implementation	
Recruitment commences to ESD and CSR posts	March 2020
Mobilisation of ESD and CSR	May 2020
ESD and CSR fully implemented	Jan 2021
Acute pathway mobilisation/ implementation	
Recruitment commences to acute posts	March 2020
Adequate acute staffing in post. Go/No Go gateway decision	Jan 2021
UHCW: additional HASU/ASU beds implemented	April 2021
SWFT: ASU beds closed / SWFT CSRB implemented	
GEH: ASU beds closed / GEH CSRB implemented	
Complete pathway implemented	**April 2021**

8.1.4 Workforce

The workforce model for the proposed new clinical model is based on ensuring that the system has the right skills to manage patients complex and varying needs, in the right setting. It has also been developed based on understanding the current local and national recruitment pressures, to seek to optimise where we are targeting workforce expansion. For example, recognising that we currently have high levels of nursing vacancies in the acute stroke pathway, Band 4 Assistant Practitioner and Band 3 Rehabilitation Technician posts in the ESD and community stroke rehabilitation services will include traditional nursing activities such as tissue viability and continence management, so that our nursing recruitment can be focussed on enhancing the acute team.

The workforce required for the future clinical model represents a significant increase in the numbers of staff in the stroke services workforce in Coventry and Warwickshire. It is recognised that this will present a significant challenge given the current difficulties faced in recruitment and is therefore identified as a key implementation risk, with mitigation plans

agreed. Critically, the implementation plan has been designed to include key clear gateway criteria for progression with the implementation of aspects of the proposed new clinical model, many of which are based on levels of recruitment to new posts achieved.

A Workforce Group has already been established as part of the STP-wide Workforce action to manage recruitment. The group will work closely with colleagues in the Cardio Vascular Disease Network and Health Education England in recruiting to and shaping the workforce. This group will take the following actions to manage the recruitment process and deliver our workforce plans:

1. Assess the **current skill mix and competencies** of the workforce against the recognised national competency frameworks, to give a clear indication of where new skills should be recruited and which new posts should be prioritised. Further to this the effectiveness of the workforce skill mix will be regularly reviewed as part of the routine review of the achievement of expected outcomes and benefits and responding to any staff turnover.

2. With regard to **nursing recruitment challenges**, we will recruit more experienced nurses from within the existing workforce. We will use targeted recruitment processes and work closely with local universities to highlight opportunities within stroke services. We will give opportunities for the development of existing staff who would like to progress into more specialist band 6 and 7 roles within the nursing team. We will put a development plan in place to offer newly qualified and less experienced nursing staff opportunities to gain experience within the specialist wards as part of a rotational training process. We will offer targeted training to ensure that the necessary competencies are readily available in both the acute and community nursing workforce. We will rotate band 5 nurses through ASU, bedded rehabilitation and community services to give them a broad understanding of the pathway and develop the skills required to deliver care in a seamless way. We will offer rotational opportunities at band 6 and 7 for nurses to enhance the ability to retain this important workforce.

3. Within **therapy services**, nationally there is no current shortage of staff at band 5, there are however challenges in retaining staff at this level and a consequential high turnover, due to limited progression opportunities, particularly noted in some fixed community posts. The presence of clinical specialism within the therapy offer can act as a draw and a clear range of skills and specialists to learn and develop from. Consideration will be given to providing rotational opportunities between services once the model is embedded and this should increase competency, neuro skill and retention at a band 5 level, at least in some posts. We will need local specific actions to recruit experienced band 6 and higher posts. We will run an internal STP wide development programme around the stroke pathway to attract and retain experienced workforce. The band 6/7 physiotherapy and occupational therapy posts in the new structure will be clearly differentiated, to allow current post holders to be clearly slotted into the roles and to attract new employees. We anticipate a shift of band 6/7 experience and clinical experts from acute services into community services as the rehabilitation offer increases in the community, this will allow flow through for

lower banded staff to move into their first Band 6 or 7 position in an environment of increased governance and support in bedded units and we would expect this trend to continue and allow a sustainable workforce from OT and PT perspective.

4. For **medical recruitment**, the role of Consultant Stroke Physician is recognised nationally as being a shortage specialty and recruitment to the proposed establishment will be a challenge. Promoting a new "stroke pathway of excellence" for the area with a minimum 1:6 on-call rotation should make the posts more attractive to new consultants in particular. The opportunity to have varied input across the whole pathway will also be attractive. Recognising the challenge in recruiting, despite our attractive service model, this has been identified as a key risk to implementation. We have designed our implementation plans to mitigate the risks to delays in implementing the future clinical model, through phased implementation of the model. We will work with HEE and the local Deanery to agree additional training placements locally at F1, STR and SPR level.

5. We will include **new and extended roles** in the pathway in the medium term. We will seek to develop extended scope practitioners, including extended scope nursing roles, therapy roles, physician's associates and extended scope pharmacists. Having the HASU/ASU on a single site will make the mentoring and support of these roles less complicated and will offer opportunities to develop skills based, rather than qualification-based job roles. This approach could also be applied to more junior roles with the introduction of nursing associates and assistant practitioners, both within nursing and therapies, to extend the scope of skills delivery. Additionally, we will use apprenticeships to develop HCA and therapy assistant roles.

6. We will put in place **retention and reward strategies** across the health economy to help retain the workforce. This approach will help to secure additional short-term staffing, whilst the new pathways are established, and staff gain confidence in the delivery model.

Timescales for recruitment

Subject to the consideration of the outcome of public consultation and assuming that CCG Boards approve the implementation of the proposed model in February 2020, recruitment to the new workforce model would start in March 2020. The high-level project Gantt chart attached at Appendix 18 sets out the timescale for recruitment for the key workforce groups.

It is important to note that whilst the implementation of the proposed new model will be phased, with ESD and community stroke rehabilitation introduced first and centralisation of HASU/ASU occurring after these rehabilitation services are fully mobilised, recruitment to key posts within the new HASU/ASU model will start immediately after CCG Board approval, i.e. in March 2020. This is a key requirement for mitigating the risk of delays in recruitment given the national shortages of specialist staff in specific key areas such as Stroke Consultants. Recruitment to the ESD and community stroke rehabilitation teams would also start in March 2020.

A whole health economy wide induction process for those people joining the pathway, both for existing staff and for those new to the team, will be required. This will have the dual benefits of enabling everyone to have a common understanding of the pathway and where they fit within the services and support the development of an integrated networked approach across the team that is not dependent on the employing organisation, but on the delivery of the pathway.

8.1.5 Risk Analysis

This is a complex service reconfiguration and as such work has already taken place to identify the potential risks to delivery of the proposed new clinical model and to develop appropriate mitigation plans. The key risks identified are as follows:

Workforce: The inability to recruit the necessary staff and reconfigure existing staff as required by the new clinical model.

In mitigation implementation will be phased with clear thresholds for gateway progression to ensure that the service is safely mobilised and embedded. The establishment of a clinical network workforce model is seen as a key benefit for recruitment as well as quality of care and whilst initially being applied to Consultants, the principle will be reviewed with respect to its value for other major staff groups such as nurses and AHP staff. Mobilisation of the rehabilitation services will be front-loaded enabling extra time to complete Consultant recruitment before the centralisation of the HASU/ASU services. Whilst the intention is to recruit to a networked model of Stroke Consultants, recognising the recruitment challenge, alternative mitigating workforce strategies have been outlined by the providers to enable progression to centralisation should only 50% of the new consultants required be recruited. Core to these is the separation of the rehabilitation beds Consultant cover from the HASU/ASU. Establishment of a Workforce Workstream is underway to oversee the workforce challenges and proposals, also acting as the link with the West Midlands Deanery and West Midlands Health Education. The specific situation at the time of each gateway review will be considered by the Implementation Board and the relevant mitigation plan will be enacted should recruitment not be progressing as planned.

Capacity: Whether sufficient capacity at UHCW can be developed and sustained to be able to manage any peaks in demand for the HASU and ASU services and any delays in patient flow.

In mitigation, capacity planning has been completed using the latest available data and clinically agreed assumptions on the impact of the new model on patient flow. Bed occupancy of 85% for the HASU and 90% for the ASU has been assumed and sensitivity analysis completed which demonstrate that the system is resilient to expected peaks in activity. In addition, implementation will see rehabilitation services implemented first to enable the impacts on acute length of stay to embed prior to the centralisation of the HASU/ASU service. Review and oversight of the implementation of the new service model will be managed by an Implementation Board that includes all providers within the networked model, to ensure alignment and joint ownership of any issues and actions.

9.0 CONCLUSION

This document has described how stroke services are currently provided across Coventry and Warwickshire, the current gaps and inadequacies with these and our proposal for change.

It is clear from the analysis of current services that there is considerable unwarranted variation in the range and quality of service provision for patients across each CCG footprint in Coventry and Warwickshire. For example, access significantly differs to inpatient rehabilitation beds, specialist community rehabilitation and ESD dependent on where patients live within the STP footprint. Current services do not meet the Midlands and East Stroke Specification and fail to deliver against a range of key service performance indicators. National and local skill shortages have a significant impact on workforce availability and the ability to recruit and retain sufficient staff to operate high quality services across three sites.

Given this range of current, significant access, quality and workforce issues, work is clearly required to improve local stroke care across Coventry and Warwickshire so that more patients can survive their stroke and achieve their optimum level of recovery.

Considerable collaborative work has been undertaken over the last 4 years with all stakeholders to design, develop and appraise new clinical models for future stroke services. We recognise that stroke services across Coventry and Warwickshire can be better delivered to provide improved health outcomes for patients, by being set up in line with established best practice guidance.

The Business Case has identified the preferred option which is:

- A centralised HASU/ASU at UHCW which will receive all stroke patient presentations
- One bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa;
- One bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton;
- ESD and community stroke rehabilitation at home areas available across all of Coventry and Warwickshire;

In addition, actions have been agreed to improve the identification of people with Atrial Fibrillation and further improve their anticoagulation therapy for people to reduce the occurrence of stroke.

The proposed new clinical model will create a pathway of excellence for stroke services, improving the quality of services and removing the current inequities in service provision and access for our population. We believe that through delivery of this business case we will create services that contribute to a higher quality, more effective health and care system, and allow the further development of the NHS long term plan Integrated Stroke Delivery Network and mechanical thrombectomy.

Developing stroke services
in Coventry and Warwickshire
Public Consultation - Full Document
XX October 2019 - XX January 2020

NHS Coventry and Rugby CCG, NHS South Warwickshire CCG
and NHS Warwickshire North CCG

Contents

Foreword

Welcome to our public consultation on developing stroke services in Coventry and Warwickshire.

The consultation document explains why we need to change the way stroke services in Coventry and Warwickshire are delivered, how the proposals for change have been developed and our preferred proposals for an improved stroke service.

We started by considering changes to hospital services, but it became clear that we needed to review the whole patient pathway, including rehabilitation services (such as physiotherapy) and stroke prevention, in order to make the biggest difference to the health outcomes of stroke patients.

From the work we have done it is evident that services across our area differed from place to place and also did not meet some of the principles of good care set out in national guidance.

It was also clear from public feedback that high quality specialist stroke services were valued by people, but there was also a desire for localised rehabilitation services where possible.

We have listened to all feedback from the extensive public engagement over the last four years and taken it into account in the final proposals we are bringing to you for public consultation.

We are clear from what people have said through the engagement so far, that should the proposals be approved, the home-based rehabilitation services must be in place before any changes to hospital services are made.

We are now looking for your views as we need your assistance to help us gain feedback on our final proposals. Our objectives are about developing a pathway of excellence for stroke care which results in real improvements in health outcomes for local people.

Our proposals would need more investment in specialist rehabilitation services (such as physiotherapy), medicines and more ambulance transfers than the services available now. But we feel that it is important to make this £3.1 million investment in order to reduce the chances of having a stroke and the disability resulting from a stroke.

Thank you for taking the time to read this document. Please complete the questionnaire at the end of this document, attend one of our consultation events or complete the online survey at www.strokecovwarks.nhs.uk. Your contributions and opinions really do count and will help in making the decisions about future stroke services in the area.

About us

We are three NHS Clinical Commissioning Groups (CCGs): NHS Coventry and Rugby, NHS South Warwickshire and NHS Warwickshire North. The CCGs plan and buy the majority of NHS healthcare services across the area and are overseen by NHS England.

The key partners in this consultation are:

- **University Hospitals Coventry and Warwickshire NHS Trust (UHCW)**
- **South Warwickshire NHS Foundation Trust (SWFT)**
- **George Eliot Hospital NHS Trust (GEH)**
- **Coventry and Warwickshire Partnership NHS Trust (CWPT)**
- **Warwickshire County Council**
- **Coventry City Council**
- **West Midlands Ambulance NHS Foundation Trust**

UHCW, SWFT and GEH currently provide acute stroke services. Rehabilitation services are currently provided by Leamington Spa Hospital, Hospital of St Cross in Rugby, CWPT and GEH. Rehabilitation services provided from a hospital bed or at home are to support stroke survivors to regain their health following a stroke. Rehabilitation may include a package of care such as physiotherapy, speech therapy and emotional support at home.

Acknowledgements:

This public consultation is the culmination of a long journey to develop a pathway of excellence for stroke services in Coventry and Warwickshire. We have been through a process of co-production of proposals that includes pre-consultation engagement and planning work with the help of our local patients, carers, clinicians, community groups and our dedicated Stroke Patient and Public Advisory Group. This work has led to the proposed options for the future of this important service. The input we have received has made a real difference in the production of our plans and we would like to thank everyone that has contributed.

About stroke

Stroke, a preventable disease, is the fourth single leading cause of death in the UK and the single largest cause of complex disability.
(Source: Stroke Association (2018) State of the nation: Stroke statistics).

A stroke is a rapid loss of brain function that occurs when the blood supply to part of the brain is cut off, leading to brain cells either being damaged or destroyed. Whilst largely preventable, stroke is one of the main causes of deaths in the UK and is also the leading cause of adult disability.
Strokes are medical emergencies and urgent treatment in the first 72 hours is essential because the sooner a person receives an effective diagnosis and treatment for a stroke, the less damage is likely to occur.

There are two types of stroke:

- An **ischaemic stroke** resulting from a blockage in one of the blood vessels leading to the brain.
- A **haemorrhagic stroke** resulting from a bleed in the brain.

In addition, a **transient ischaemic attack (TIA)** or 'mini-stroke' is a sign that a person is at risk of going on to have a full stroke.

Although people often assume that only older people have strokes, in fact young and middle-aged people also experience strokes. A stroke can have a huge impact on the quality of someone's life, irrespective of age.

Why we are developing proposals to change stroke services

There is strong and growing evidence, that quick specialist assessment and treatment significantly improves a person's chance of surviving with the least complications and disabilities following a stroke. When we reviewed our services we discovered that we have some gaps against these specifications. We want to change these services so that all patients get the best outcomes.

The CCGs are clear on the improved outcomes they want to see delivered through this change. By ensuring a consistent, high quality service offer, improvement will be made against the following three key clinical outcomes:

1. Reduced levels of mortality for people who have suffered a stroke
2. Reduced levels of dependency for those who have suffered a stroke
3. An improvement in cognitive function for people after suffering a stroke

We also want to ensure that we are in the best position to develop the Integrated Stroke Delivery Networks described in the new NHS Long Term Plan published in January 2019. These networks would, over the next five years ensure our services meet the NHS seven-day standards, National Clinical Guidelines for Stroke and higher intensity models of stroke rehabilitation. We would also be prepared for adoption of the latest medical advances such as mechanical removal of a blood clot in the brain (this is called a thrombectomy). The increased use of this process (from 1% to 10% in the future) is predicted to mean that 1,600 more people a year in England, would be able to live an independent life after their stroke.

(Source: NHS Long Term Plan - stroke care).

We have used this important clinical evidence to help develop our plans:

1. The National Stroke Strategy
Key changes were identified in stroke care and has contributed to a reduction in the numbers of patients dying within 10 years of having a stroke.
www.strokecovwarks.nhs.uk

2. Evidence that hyperacute interventions such as brain scanning and thrombolysis are best delivered as part of a networked 24/7 service.
https://doi.org/10.1371/journal.pone.0070420

3. Areas that have centralised hyperacute stroke care into a smaller number of well-equipped and staffed hospitals have seen the greatest improvements in patient care (**https://doi.org/10.1136/bmj.g4757**)

4. The NHS Long Term Plan, **https://www.longtermplan.nhs.uk**

5. The Midlands and East Regional Stroke Services Specification sets out expected standards to achieve the best outcomes for patients, in particular in relation to:

   - **Pre-hospital care**
   - **All patients suffering from a stroke receive appropriate hyperacute care within the first 72 hours**
   - **Full access to Early Supported Discharge services and specialist community stroke rehabilitation**
   - **Greater focus on prevention**
   - **Long term care.**

To view the complete Midlands and East Stroke Service Specification, please go to **www.strokecovwarks.nhs.uk/Documents/Documents**

Current stroke services

Current stroke services in Coventry and Warwickshire are providing a good standard of care but they are not meeting the latest national and regional guidance and evidence. They could be better. There are also different services available in different areas and we want to address this through our proposed improvements.

The main gaps we have identified from working with the professionals and patients, carers and the Stroke Association are:

- Not everyone who could benefit (ie within the first 72 hours of having a stroke) is being taken to the hyperacute unit at University Hospital Coventry and Warwickshire.
- Although we have tested out a model of the best practice specialist rehabilitation services in one area, we don't have these available for everyone after their stroke.
- We struggle to recruit specialist stroke doctors and there is growing evidence that there are not enough specialist stroke nurses. Our stroke doctors, nurses and therapists are not organised in a way to deliver a joined-up, seamless service for patients. Introducing a better integrated and networked stroke service will help us to recruit, develop and retain the right number of stroke specialists.
- Although we are already preventing stroke by identifying patients with AF in primary care and increasing anticoagulation rates for diagnosed patients, we know we aren't identifying everyone. We could reduce stroke risk by optimising drug therapy and early intervention could save around 100 local people a year from having strokes.
- People want more local co-ordinated action and information on how to prevent strokes, so that they can easily find out how to help themselves and loved ones.
- Having looked at our services, we are also clear that we are not in the best place to develop services in line with the ambitions in The NHS Long Term Plan which are nationally set.

By 2020 we would begin improved post-hospital stroke rehabilitation models with full roll out over the period of the Long Term Plan.

By 2022 we would deliver a ten-fold increase in the proportion of patients who receive thrombectomy after a stroke, so that each year 1,600 more people will be independent after their stroke.

By 2025 we would be amongst the best performers in Europe for delivering thrombolysis to all patients who could benefit.

In summary we have considered the evidence, what local people and professionals have told us and taken advice from experts, to come to a conclusion that we need to make improvements that would require change now.

How we have developed our proposals

Clinical involvement in developing proposals for the future

We have looked at national and regional evidence and best practice for delivering stroke services and have taken advice from a range of experts at different stages of the development, this included Professor Tony Rudd, National Clinical Director for Stroke.

We have worked with local doctors, specialist nurses and therapists - including GPs and stroke consultants, nursing and therapy specialists and tested our proposals with a panel of national experts in stroke care, as part of the review led by the NHS West Midlands Clinical Senate. This work led us to understand what the best clinical model is for stroke patients in Coventry and Warwickshire.

Dr Gavin Farrell, Consultant Clinical Neuropsychologist, Head of Neuropsychology Services Central England Rehabilitation Unit, and Chair of the Stroke Clinical and Operations Group explains:

"The whole redesign of the stroke pathway came about when NHS East and Midlands published the new stroke specification, and we have been working over the last few years as a senior group of people, senior doctors, nurses, therapists and commissioners across Coventry and Warwickshire to implement the recommendations of the specification.

Really, the specification was designed to increase the level of provision for stroke and increase the ability for people with stroke to get to the acute hospitals as quickly as possible and to get the specialised interventions they need, and in addition to providing that level of stroke intervention in order to help survival. It was also specified how to increase the level of rehabilitation after leaving hospital. So, back home in the community to give people the level of rehabilitation they need for as long as they need it."

Claire Quarterman Clinical Lead for the Early Supported DischargeTeam and Community Rehabilitation Team, and a member of the clinical and operations group says:

I have been part of a clinical and operational working party discussing stroke services we currently offer to patients, trying to really think about how can we improve and make service equitable, accessible for patients across the region. So, that everybody no matter where they live in the region, when they have a stroke get access to the best possible acute care and then following on from that the rehabilitation that they require, to live as best a life as they can.

Throughout the development of the proposals clinical involvement has been continuous. The clinical and operations group of local stroke service providers has provided clinical expertise into the development and evaluation advising on:

- Potential scenarios for improved service delivery.
- Staffing models of each aspect of the proposed options.
- Ability to implement scenarios and more latterly proposals.

Patient and public involvement in developing proposals for the future

At the same time as getting information from clinical experts over the last five years, we have held an extensive programme of pre-consultation engagement with the public including stroke survivors and carers. Just as we created a local group of clinical experts, we also created a group of stroke patient and carer experts. This group, known as the Patient and Public Advisory Group (PPAG), is chaired by a representative from the Stroke Association. It includes people who have experienced a stroke, carers and family members of those who have experienced a stroke and Healthwatch representation.

Initially, we asked local stroke survivors and carers about how we could improve hospital stroke services and through this work tested out some scenarios. A clear outcome of this work was a message that they wanted us to plan improvements in hospital services, but also to look at preventing more strokes and rehabilitation after the stroke.

It was at this stage that we established the Patient and Public Advisory Group to act as a critical friend to guide and feedback on the engagement process. We also went back with the patient and public feedback, to look at how we might design an overarching stroke service that included preventing more strokes, providing the right type of hospital care and then more specialist rehabilitation for those who have had a stroke.

How we developed possible ideas for hospital care when people first have a stroke

In 2014/15 we began talking with local stroke survivors and carer groups, as well as other members of the public who could be affected by a change to gather their views on how we could improve stroke services sharing with them reasons why change was necessary - such as the national shortage of expert stroke doctors and the new evidence about timeliness and organisation of care that improves the chances of recovery.

After the discussions we asked people whether:

- We should do nothing and leave services as they are.
- We should centralise the hyperacute and acute service at University Hospitals Coventry and Warwickshire. All patients across the city and county would go to the Hyperacute and Acute unit rather than as currently, some go to their local hospital – George Eliot Hospital or South Warwickshire Foundation Trust.
- All patients go to University Hospitals Coventry and Warwickshire Hyperacute unit for 2-3 days. After this, people from the Warwickshire North area transfer to George Eliot Hospital and people from South Warwickshire area transfer to South Warwickshire Foundation Trust.
- All patients go to University Hospitals Coventry and Warwickshire Hyperacute unit for 2-3 days. Then Warwickshire North and South Warwickshire patients transfer to one other hospital, either George Eliot Hospital or South Warwickshire Foundation Trust, with the closure of stroke facilities at the other hospital.

At that time, we were only looking at the hospital services and we collated the feedback from engagement we did with them on this. However, the groups asked that we also look at stroke rehabilitation and how people can prevent a stroke. Along with other views, they were clear that travelling to a specialist centre when you first have a stroke was acceptable if your rehabilitation could be closer to home.

Areas of concern included:

- Transport and travel
- Travel time by ambulance
- Having enough staff and beds at University Hospitals Coventry and Warwickshire
- Parking at University Hospitals Coventry and Warwickshire

Commissioners in Coventry and Warwickshire considered all feedback and worked with clinicians, senior managers and local authority colleagues to address the concerns.

At the same time, the commissioners who buy health and care services reviewed the available evidence and guidance, and developed some principles for the potential scenarios for hospital services which included:

- All scenarios must meet the requirements of the NHS Midlands and East Regional Stroke Service Specification, and therefore provide:

  A Hyperacute Stroke Unit (HASU) – should remain at University Hospitals Coventry and Warwickshire as the specialist hospital and trauma centre;

  Acute Stroke Unit (ASU) care: one to be next to the Hyperacute Stroke Unit at University Hospitals Coventry and Warwickshire as a minimum;

  An Early Supported Discharge (ESD) service should be available for everyone who needs it after their stroke.

- Stroke rehabilitation beds would be provided locally for the post-acute phase of care: for those patients who no longer require acute stroke care, but have ongoing care and rehabilitation needs that prevent them from returning home. All high risk TIAs (mini stroke) would be seen at UHCW as a location near to the HASU is critical.

Based on these principles, a list of scenarios for the provision of hyperacute and acute services was developed by the clinical leads as follows:

- **Scenario 1 -** Hyperacute Stroke Unit at University Hospitals Coventry and Warwickshire / 1 Acute Stroke Unit at University Hospitals Coventry and Warwickshire

- **Scenario 2 -** Hyperacute Stroke Unit at University Hospitals Coventry and Warwickshire / 3 Acute Stroke Units at University Hospitals Coventry and Warwickshire, South Warwickshire Foundation Trust & George Eliot Hospital

- **Scenario 3 -** Hyperacute Stroke Unit at University Hospitals Coventry and Warwickshire / 2 Acute Stroke Units at University Hospitals Coventry and Warwickshire and South Warwickshire Foundation Trust

- **Scenario 4 -** Hyperacute Stroke Unit at University Hospitals Coventry and Warwickshire / 2 Acute Stroke Units at University Hospitals Coventry and Warwickshire & George Eliot Hospital

These scenarios were then assessed to see if they met various clinicial conditions including:

1. Scenarios are capable of meeting the NHS Midlands and East Stroke Service Specification.
2. Scenarios must be clinically viable in terms of both workforce and number of patients treated; the latter is critical for staff to maintain their stroke specialist knowledge and skills.
3. Scenarios must be no less than 10 bedded units, as the findings from the visits to stroke units already identified as providing the best practice was that this was the minimum for the service to be clinically sustainable.

It was agreed that the only clinically viable option for the acute phase of the stroke pathway would be to centralise hyperacute and acute services at University Hospitals Coventry and Warwickshire with ESD. There is clear evidence that hyperacute stroke/acute stroke units need to treat a minimum number of cases to be able to recruit specialist staff and maintain their skills. There isn't enough stroke activity in Coventry and Warwickshire to sustain more than one hyperacute service.

Outcome of the engagement work to look at the different ideas for hyperacute and acute stroke services

Feedback from public engagement in 2014/15 led to the extension of the stroke patient pathway to include stroke community rehabilitation and proposals to improve stroke prevention. During 2016 the clinical group developed specialist stroke home based community rehabilitation and a proposal for how to prevent more strokes. A second stage of formal engagement was undertaken to understand the views of the proposals:

- 5000 questionnaires were circulated across Coventry and Warwickshire
- 23 public meetings took place
- 27 newspaper articles were published
- 3 radio interviews were undertaken
- Social media reached 800,000 people
- Over 300 people completed questionnaires to feedback their views.

People were asked if they agreed with the proposal to prevent more strokes by:

- Make the most effective use of the treatments available
- Centralising the service for everyone who suffers a TIA and is at high risk of a stroke.

173 respondents agreed with the proposals to prevent more strokes, 70 disagreed.
People were also asked what they thought about the proposal for a stroke rehabilitation service. The proposal includes Early Supported Discharge where people would receive rehabilitation at home. For those not well enough for Early Supported Discharge, community based beds would be available in hospital at South Warwickshire Foundation Trust (SWFT) in Leamington Spa and the George Eliot Hospital (GEH) in Nuneaton.

- 160 people agreed with the developed proposal for stroke rehabilitation
- 133 people disagreed with the developed proposal for stroke rehabilitation.

Key concerns were raised during the engagement relating to travel and the requirement for Coventry and Rugby residents to travel to the George Eliot Hospital in Nuneaton or South Warwickshire Foundation Trust to receive bedded stroke rehabilitation.

In response, the Clinical and Operational Group considered alternative scenarios for delivering bedded rehabilitation for the population of Coventry and Warwickshire (for more information please see the business case at): **www.strokecovwarks.nhs.uk/Documents/Documents**

Review of ideas for inpatient rehabilitation services

This further work identified that there were a number of potential scenarios for providing bedded rehabilitation. A long list of potential scenarios was developed by the Clinical and Operational Group. These scenarios were assessed against their ability to:

- Meet national guidance and the requirements of the NHS Midlands and East Regional Stroke Service Specification
- Demonstrate at least the minimum levels of delivery of: quality; being safe; being sustainable and better outcomes for patients.

Following these clinical assessments two viable stroke rehabilitation options remained:

Option 1

Early Supported Discharge Service (ESD) and community rehabilitation in all areas of Coventry and Warwickshire. Bedded rehabilitation at South Warwickshire Foundation Trust (SWFT) in Leamington and George Eliot Hospital (GEH) in Nuneaton

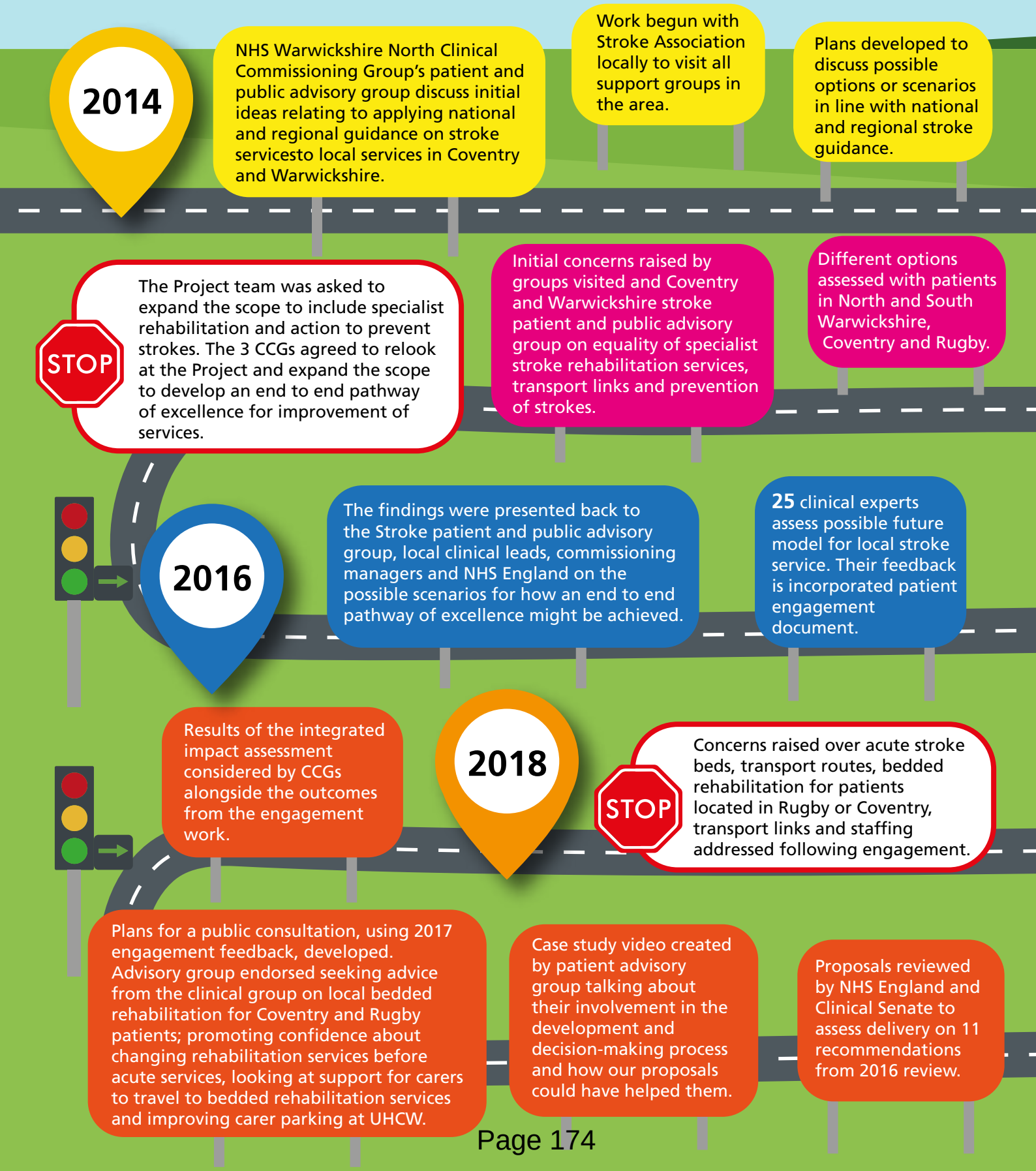
Option 2

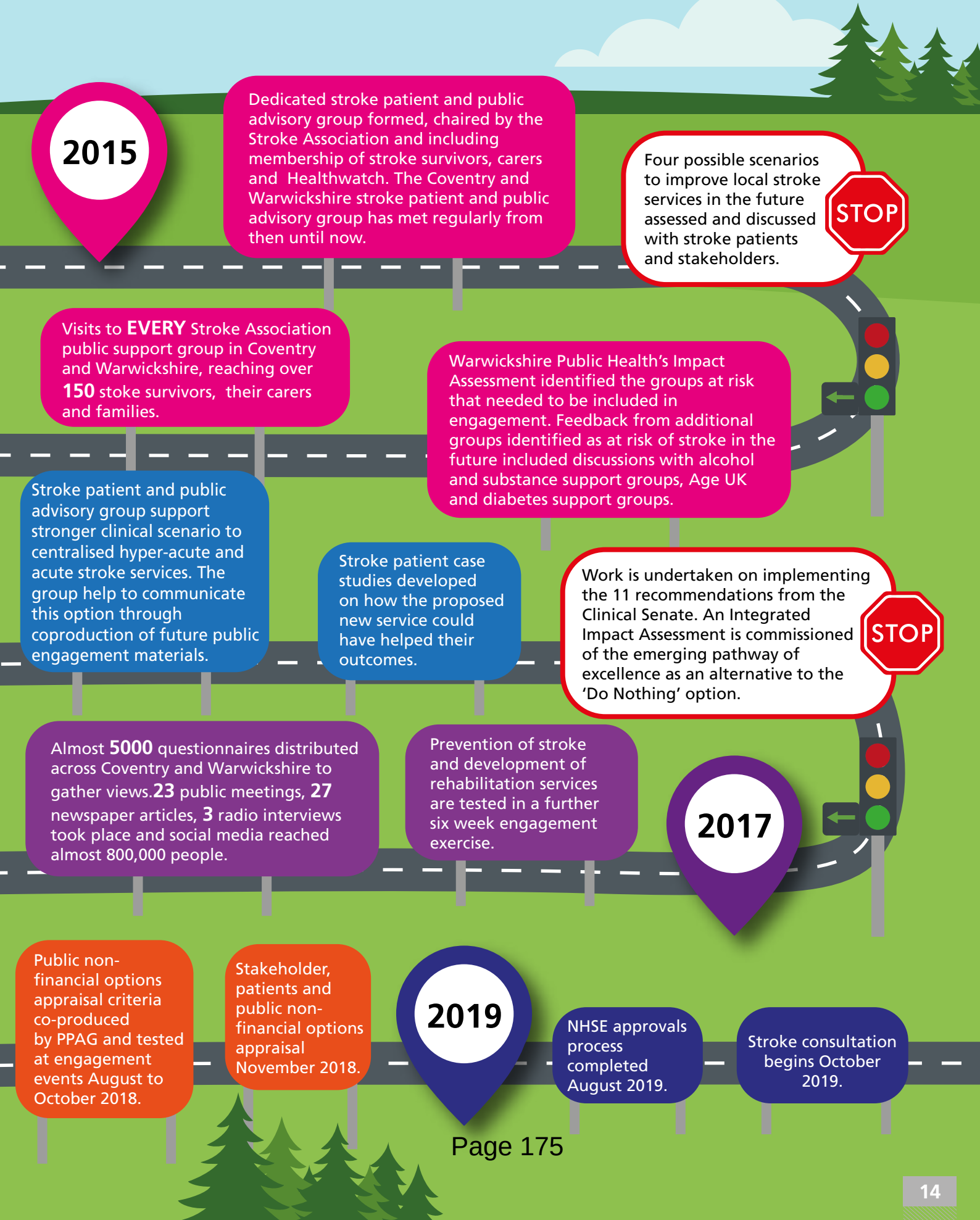
ESD and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry with specialist therapy in-reach. Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton

These options were then taken forward for full non-financial appraisal by all key stakeholder groups.

Details of the options appraisal are provided in the Redesigning Stroke Services in Coventry and Warwickshire Engagement Report August to November 2018 and in the business case at: **www.strokecovwarks.nhs.uk/Documents/Documents** and under the heading non-financial options appraisal later in this document.

Patient and public engagement has informed the development of proposals for an improved stroke service since 2014 to the present (please see the infographic below).




2015
Dedicated stroke patient and public advisory group formed, chaired by the Stroke Association and including membership of stroke survivors, carers and Healthwatch. The Coventry and Warwickshire stroke patient and public advisory group has met regularly from then until now.
Four possible scenarios to improve local stroke services in the future assessed and discussed with stroke patients and stakeholders.
STOP
Visits to EVERY Stroke Association public support group in Coventry and Warwickshire, reaching over 150 stoke survivors, their carers and families.
Warwickshire Public Health's Impact Assessment identified the groups at risk that needed to be included in engagement. Feedback from additional groups identified as at risk of stroke in the future included discussions with alcohol and substance support groups, Age UK and diabetes support groups.
Stroke patient and public advisory group support stronger clinical scenario to centralised hyper-acute and acute stroke services. The group help to communicate this option through coproduction of future public engagement materials.
Stroke patient case studies developed on how the proposed new service could have helped their outcomes.
Work is undertaken on implementing the 11 recommendations from the Clinical Senate. An Integrated Impact Assessment is commissioned of the emerging pathway of excellence as an alternative to the 'Do Nothing' option.
STOP
Almost 5000 questionnaires distributed across Coventry and Warwickshire to gather views.23 public meetings, 27 newspaper articles, 3 radio interviews took place and social media reached almost 800,000 people.
Prevention of stroke and development of rehabilitation services are tested in a further six week engagement exercise.
2017
Public non-financial options appraisal criteria co-produced by PPAG and tested at engagement events August to October 2018.
Stakeholder, patients and public non-financial options appraisal November 2018.
2019
NHSE approvals process completed August 2019.
Stroke consultation begins October 2019.

Concerns expressed during patient and public engagement and how we have addressed them

Consistent areas of concern included:

- Transport and travel including travel time by ambulance
- Capacity at University Hospitals Coventry and Warwickshire
- Parking

Commissioners considered all feedback and worked with clinicians, senior managers and local authority colleagues to address the concerns.

We have constantly considered patient and public feedback in the development of proposals for an improved stroke service. Commissioners throughout the development of the new model have listened and responded to concerns expressed by patients and the public, these have included the following:

Travel

People are worried that there won't be enough ambulances to take additional patients if the hyperacute unit and acute unit are centralised at University Hospitals Coventry and Warwickshire.

The detailed modelling we have done means that we know that we would need more investment into ambulance services. Extra funding has been identified to commission adequate ambulance service provision.

People are concerned about how they would travel to visit family and friends.

It is important that patients and relatives have the right information at the right time and we have reviewed and refreshed the information pack, currently being piloted, to provide stroke patients with information on public transport, patient and voluntary transport and private transport. This includes useful information from bus timetables to the local area, how stroke survivors aged 50 plus and/or their carers can attend NHS related appointments all the way through to social and wellbeing activities for low cost.

We're changing bus routes - the number 65 hourly bus service, operated by Arriva, is now extended to service Tamworth Hospital to George Eliot Hospital, Nuneaton. This gives a new direct service from several North Warwickshire communities.

Keeping information accurate - transport planners regularly send the latest public transport timetables to named representatives on stroke wards to make sure information is up to date.

Getting more from bus transport - bus operators have agreed the principles of a bus pass plus across Coventry and Warwickshire, costs are to be agreed.

Posters detailing voluntary car schemes in Warwickshire advertise in local hospitals and are available on stroke units.

For information on travel and transport please visit: **warwickshire.gov.uk/activetravel**

Capacity at University Hospitals Coventry and Warwickshire

People are concerned about beds, they worry that moving the acute stroke services at George Eliot Hospital and Warwick Hospital would mean there would not be enough beds for stroke patients in hospitals.

Faster discharge where appropriate - the new model offers Early Supported Discharge and community rehabilitation. This means that patients can continue their recovery at home and in the community. The new model has taken into account population growth and busiest times.

Our review of established services show that because of shorter stays in hospital for the majority of stroke patients (70%), fewer acute beds will be needed. Community stroke rehabilitation beds have been allocated for patients who are not fit enough for Early Supported Discharge and community rehabilitation. Please see 'staffing tables by Provider' detailed in the business case at: **www.strokecovwarks.nhs.uk/Documents/Documents**

People are aware and concerned about national shortages in specialist stroke consultants and difficulties in recruitment

Bringing the workforce together - a more centralised model for the acute stroke service would optimise the specialist workforce available and improve recruitment, retention, education and training and workforce sustainability (for further detailed information please visit the business case at): **www.strokecovwarks.nhs.uk/Documents/Documents**

People are concerned about busy times at A & E and delay in reaching the Hyperacute Stroke Unit or the Acute Stroke Unit.

Getting you to where you need to be - clinicians have developed a protocol to ensure patients are handed over quickly to the hyperacute stroke unit and do not get delayed in the Emergency Department. To inform the protocol, clinicians looked at peak and surge demand times (busiest times) and developed plans to make sure patients would reach the right service even at these times.

People are worried about the difficulty in parking at UHCW

A new car park would provide an additional 1,600 car parking spaces (awaiting planning decision).

Review of ideas for community rehabilitation beds

At a meeting in August 2018, the Stroke Patient and Public Advisory Group worked to co-produce a set of desirable criteria and the process to be used to assess the options for bedded rehabilitation. The group also confirmed their support for the preferred option for acute and hyperacute stroke services to be centralised at University Hospital, Coventry.

The assessment criteria co-produced by the Patient and Public Advisory Group and subsequently tested at further public engagement events in Autumn 2018 were:

- Services should be equitable, consistent and always available
- Services should focus on the best possible outcomes and recovery
- Services should be personalised with a package of care that is right for each individual patient
- We should create an environment where experiences, knowledge and information can be shared to benefit stroke survivors and their carers
- Professional who are delivering services should understand the stroke patients' feelings and the consequences of having a stroke
- All stroke services should work together with a smooth transition at all points in the stroke patients' care.

At the patient and public engagement events in autumn 2018 the preferred option for stroke hyperacute and acute services was also revisited, as well as discussing the options for stroke rehabilitation. The findings from these engagement events then fed into a formal public and stakeholder non-financial options appraisal event for bedded stroke rehabilitation services.

To ensure a mix of people offering a range of perspectives attended the meeting, invitations were sent to people of different ages, religions, ethnicity, gender etc. More than 40 people attended, including staff members who would be involved in delivering a future improved service. They were asked to consider the relative importance of each of the criteria and score each option out of 10 for how well they met (or did not meet) each of the desirable criteria. There was overwhelming support for the option of one bedded rehabilitation unit at Leamington Spa Hospital and one at George Eliot Hospital (to view the full report on the non-financial options appraisal please visit: **www.strokecovwarks.nhs.uk/Documents/Documents**)

The Clinical and Operational Group then completed a financial option appraisal (for more detail please see the business case at: **www.strokecovwarks.nhs.uk/Documents/Documents**)

Our proposal for local stroke services

Over the last four years we have worked with clinicians, stakeholders, patients and the public collaboratively which has led to a proposed new clinical model for stroke services. The new model will provide a pathway of excellence for stroke services, removing the current differences in services and access for the population of Coventry and Warwickshire (for more detail please see the business case at **www.strokecovwarks.nhs.uk/Documents/Documents**.)

Acute or emergency stroke services

- Acute stroke services would be located at University Hospitals Coventry and Warwickshire with stroke rehabilitation provided closer to people's homes.
- All patients across the city and county would go to the hyperacute and acute stroke unit at University Hospitals Coventry and Warwickshire
- Patients would be diagnosed and treated there until they are ready for rehabilitation closer to home, either in a bedded rehabilitation unit or in their own home with clinical support.
- The acute stroke units at Warwick Hospital and the George Eliot Hospital in Nuneaton would no longer operate because all patients would be treated in one specialist centre.

Rehabilitation stroke services

- There would be an Early Supported Discharge Service (ESD) (where patients are given support to leave hospital as soon as they are able to) and community rehabilitation in all areas of Coventry and Warwickshire for patients after they leave the acute stroke unit.
- Patients who need rehabilitation in hospital would receive care and treatment at Leamington Spa Hospital and the George Eliot Hospital in Nuneaton.

Tell us your views

Your views are important to us and you can feed back to us in the following ways:

1. Complete the questionnaire on the next pages and post it back to us to. You can post the questionnaire free to: Freepost **NHS QUESTIONNAIRE RESPONSES**. Please ensure you use capital letters as shown in the address, so the Post Office machines can scan the address.

2. Complete the online survey at: **http://www.strokecovwarks.nhs.uk**

3. Attend one of our events at the times and in the locations below:

Date	Time	Venue
7 November 2019	6pm-8pm	Foundation House, Masons Road, Stratford-upon-Avon. CV37 9NF
12 November 2019	6pm-8pm	Atherstone Memorial Hall, Long St, Atherstone. CV9 1AX
21 November 2019	1pm-3pm	Benn Partnership Trust, Railway Terrace, Rugby. CV21 3HR
25 November 2019	6pm-8pm	Queens Road Baptist Church, Queens Road, Coventry. CV1 3EG
5 December 2019	6pm-8pm	Benn Partnership Trust, Railway Terrace, Rugby. CV21 3HR
12 December 2019	11am-1pm	The SYDNI Centre, Cottage Square, Leamington Spa. CV31 1PT
6 January 2020	11am-1pm	Townsend Hall, 52 Sheep St, Shipston-on-Stour. CV36 4AE

Consultation survey

Q1: Have you experienced a stroke or transient ischaemic attack (TIA)?

- ☐ Yes, I have experienced a stroke or TIA
- ☐ No, I haven't had a stroke or a TIA
- ☐ Prefer not to say

Q2: Are you are carer, friend or relative of someone who has had a stroke or TIA?

- ☐ Yes, I am a carer, friend or relative of someone who has had a stroke or TIA
- ☐ No, I am not a carer, friend or relative of someone who has had a stroke or TIA
- ☐ Prefer not to say

Q3: To what extent do you agree or disagree with our proposal to locate all acute or emergency stroke services in Coventry?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree / disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q4: Please tell us about the impact our proposal to locate all acute or emergency stroke services in Coventry would have on you:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q5: Please tell us about the impact our proposal to locate all acute or emergency stroke services in Coventry would have on your family/ friends/carer:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q6: To what extent do you agree with patients who have had a stroke being given support to leave hospital as soon as they are able to (early supported discharge?)

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree / disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q7: Please tell us about the impact that early supported discharge services would have on you:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q8: Please tell us about the impact that early supported discharge services would have on your friends/family/carer:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q9: To what extent do you agree or disagree with rehabilitation being available in hospital at Leamington Spa Hospital and the George Eliot Hospital in Nuneaton?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree / disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q10: Please tell us about the impact that having hospital rehabilitation at Leamington Spa Hospital and the George Eliot Hospital in Nuneaton would have on you:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q11: Please tell us about the impact that hospital rehabilitation at Leamington Spa Hospital and the George Eliot Hospital in Nuneaton would have on your family/friends/carers:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q12: Is there anything you would like to add regarding stroke services in Coventry and Warwickshire which has not been covered by earlier questions (for example, can you suggest another option?)

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Equalities monitoring - optional

We recognise and actively promote the benefits of diversity and we are committed to treating everyone with dignity and respect regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. To ensure that our services are designed for the population we serve, we would like you to complete the short monitoring section below. This is optional and the information provided will only be used for the purpose it has been collected for and will not be passed on to any third parties.

Q13: Please tell us which area of Coventry or Warwickshire you live in.

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Q14: Please tell us your postcode below

Please use all capital letters eg CV34 4DE

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Q15: What is your gender?

- ☐ Male
- ☐ Female
- ☐ Prefer to self-define .....
- ☐ Prefer not to state

Q16: If female, are you currently pregnant or have you given birth within the last 12 months?

- ☐ Yes
- ☐ No
- ☐ Prefer not to state

Q17: What is your age?

- ☐ Under 16
- ☐ 16-24
- ☐ 25-34
- ☐ 35-59
- ☐ 60-74
- ☐ 75+
- ☐ Prefer not to say

Q18: What is your ethnic group?

- ☐ English/Welsh/Scottish/Northern
- ☐ Irish / British Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background, please describe

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Mixed/Multiple ethnic groups

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed/Multiple ethnic background, please describe

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Asian/Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladesh
- ☐ Chinese
- ☐ Any other Asian background, please describe

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Black/African/Caribbean/Black British

- ☐ African
- ☐ Caribbean
- ☐ Any other Black/African/Caribbean background, please describe

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Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group, please describe:

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Q19: Do you look after, or give any help or support to family members, friends, neighbours or others because of either:

- ☐ Long-term physical or mental health problems/disability
- ☐ Problems related to old age
- ☐ No
- ☐ Prefer not to say
- ☐ Other, please describe

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Q20: Are your day-to-day activities limited because of a health condition or illness which has lasted, or is expected to last, at least 12 months? (Please select all that apply)

- ☐ Vision (such as due to blindness or partial sight)
- ☐ Hearing (such as due to deafness or partial hearing)
- ☐ Mobility (such as difficulty walking short distances, climbing stairs)
- ☐ Dexterity (such as lifting and carrying objects, using a keyboard)
- ☐ Ability to concentrate, learn or understand (Learning Disability/Difficulty)
- ☐ Memory
- ☐ Mental ill-health
- ☐ Stamina or breathing difficulty or fatigue
- ☐ Social or behavioural issues (for example, due to neuro diverse conditions such as Autism, Attention Deficit Disorder or Aspergers' Syndrome)
- ☐ No
- ☐ Prefer not to say
- ☐ Any other conditions or illness, please describe

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Q21: What is your sexual orientation?

- ☐ Bisexual
- ☐ Heterosexual / straight
- ☐ Gay or Lesbian
- ☐ Prefer to self-define
- ☐ Prefer not to state
- ☐ Don't know / not sure

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Q22: Are you?

- ☐ Single - never married or partnered
- ☐ Married/civil partnership
- ☐ Co-habiting
- ☐ Married (but not living with husband/wife/civil partner)
- ☐ Separated (still married or in a civil partnership)
- ☐ Divorced/dissolved civil partnership
- ☐ Widowed/surviving partner/civil partner
- ☐ Prefer not to say
- ☐ Other, please describe:

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Q23: What is your religion and belief

- ☐ No religion
- ☐ Baha'i
- ☐ Buddhist
- ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ☐ Hindu
- ☐ Jain
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Prefer not to say
- ☐ Other, please describe

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You can post the questionnaire free to: Freepost **NHS QUESTIONNAIRE RESPONSES**. Please ensure you use capital letters as shown in the address, so the Post Office machines can scan the address.

Engagement team
c/o NHS Arden&GEM
Westgate House
Market Street
Warwick
CV34 4DE

For more information about this consultation and our proposals, please go to **http://www.strokecovwarks.nhs.uk/**

This consultation document is available in different formats and languages on request. Please contact us for further information on:
Tel: 0121 611 0611
Email: agem.communications@nhs.net

Agenda Item 5

Coventry and Warwickshire Partnership NHS Trust

Item 5

Report to Joint Coventry and Warwickshire Scrutiny Committee
14 October 2019

Coventry and Warwickshire Partnership NHS Trust

Reconfiguration of Acute and Urgent Care Services in Coventry and Warwickshire

This paper seeks to brief the committee of a programme on patient service development and reconfiguration to develop a high performing Mental Health Acute and Urgent care pathway in Coventry and Warwickshire.

The programme is one of the workstreams of the Mental Health programme of the Coventry and Warwickshire Health and Care Partnership (HCP).

HCP

A number of key principles inform our programme:

1. To ensure that Patients receive appropriate treatment and support as close to home as possible thus maintaining continuity of care and improving the patient experience

2. To ensure Carers receive appropriate and timely support and guidance

3. To deliver on the components of the NHS Mental Health Five year forward view that support the reduction in need for inpatient treatment by offering timely access to alternative service provision in the community wherever possible

4. To improve patient flow through the in-patient pathway and facilitate timely discharge

5. To optimise patient choice and work towards recovery thus enhancing patient experience

6. To maximize the use of Digital technologies including tools to support management and oversight of in-patient beds in real time

7. To reduce the out of area spend and reinvest resource into more sustainable local services.

Coventry and Warwickshire Partnership NHS Trust

The following projects have been initiated to enhance our community based urgent care response to offer triage, assessment and treatment of patients with mental health issues in a responsive and timely manner.

Crisis Resolution and Home Treatment Service

With investment of £1.8mil over the next 18 months the current service will be significantly upgraded to provide 2 key elements of community based service:

1. Three locality based hubs offering 24 hour per day crisis triage and assessment of patients presenting with mental health crisis

2. Three locality based home treatment teams offering intensive community treatment for up to six weeks.

Safe Haven Projects

These services offer walk in support to people in mental health crisis/difficulties.

2 pilot projects currently operate in the evening in Leamington Spa and Nuneaton.

A further pilot service is planned to open in the evenings in Coventry from mid December 2019.

The service is run by Mental Health matters a third sector partner organisation.

Street Triage Teams

This is a joint Health / Police project predicated on the fact that a significant part of police urgent call outs involve members of the public who present as a result of transient or ongoing mental health difficulties.

In Coventry, the West Midlands Police and CWPT operate a service where a mental health clinician accompanies a police officer on appropriate call outs. Initially operating only at night the success of this service has been such that it has been extended to day time operating hours.

Recently, Warwickshire Police and CWPT have collaborated on a pilot street triage project in North Warwickshire which has been well received. The aspiration is to extend this to South Warwickshire in due course.

Coventry and Warwickshire Partnership NHS Trust

Psychiatric Liaison Services (AMHAT Service)

Psychiatric Liaison Services operate in the three Acute Hospitals in Coventry and Warwickshire. The role of this service is to provide patients who present with mental health difficulties in Emergency Departments with timely assessment and treatment and to avoid unnecessary admission to the general hospitals. Recent investment into these teams will see the services at UHCW Hospital and Warwick Hospital expand to full 24 hour a day services by January 2020. A bid is currently under consideration by NHS England for similar funding to extend the service at George Elliot Hospital to 24 hours per day.

Psychiatric Clinical Decision Unit

This 6 recliner chaired unit is sited at the Caludon Centre and provides the opportunity for the extended assessment of patients with mental health issues once they have presented to Psychiatric Liaison Services or the Street Triage Services. This service has been operational for 6 months and is currently under review.

Mental Health Liaison and Diversion Service

This nurse led service is well established in Coventry and operates in police custody blocks/ court holding cells offering assessment and support to people in custody. Recent funding from the Department of Justice will facilitate the expansion of the service into Warwickshire.

In tandem with the urgent care expansion programme highlighted above CWPT is undertaking reconfiguration of the acute mental health inpatient services which are delivered at 3 sites:

1. Manor site, Nuneaton
2. St Michael's Hospital and Woodloes House, Warwick
3. Caludon Centre, Coventry.

Over the last two years Coventry and Warwickshire Partnership NHS Trust have been undertaking a review and redesign of our acute mental health services for adults and older adults who require in-patient care, including assessment and treatment.

We are seeking to secure improvements in the clinical effectiveness and quality of care for our service users, in line with our Clinical Strategy, and supported by our Estates Strategy.

Coventry and Warwickshire Partnership NHS Trust

This will ensure that we provide high quality end-to-end care that is wrapped around the clinical needs of our patients in an environment which is fit for purpose, e.g. meets all statutory and regulatory requirements including; anti-ligature, fire safety and eliminating mixed sex accommodation (EMSA).

As we have been reviewing and developing our plans over the last two years we have engaged with our staff and key stakeholders including:

1. A number of internal roadshows for CWPT staff as part of the staff consultation process

2. Discussions with the CCGs, including a specific session on 31st October 2018

3. Presentation to the Health Overview and Scrutiny Committee in March 2019.

As at August 2019 our plans are on hold pending completion of necessary estates improvements at the Caludon Centre (Coventry) and further dialogue and engagement.

Once we have a definitive timetable for completion of the estates work further communication and engagement activity will be undertaken to inform our plans. In particular, efforts will be made to secure the views of service users, their families and carers and other key stakeholders. We recognise that meaningful stakeholder engagement is essential for the development and finalisation of the plans.

Overview of current model

Our patients access the most appropriate in-patient bed available across Coventry and Warwickshire based on their clinical need (irrespective of where they live). We do not operate a locality model and there are no plans to change this. Our priority continues to be ensuring that our patients access the most appropriate services and, wherever possible, this is achieved without placing patients out of area.

We currently have a number of in-patient units across Coventry and Warwickshire, which respond to clinical needs in the following ways:

1. Adults who require acute mental health in-patient services could be admitted either to the Caludon Centre in Coventry or St Michaels Hospital in Warwick

2. Adults who have a more intensive level of acute mental health need will be admitted to a Psychiatric Intensive Care Unit (PICU):

    a) the male PICU is located at the Caludon Centre in Coventry
    b) the female PICU is located at St Michaels Hospital in Warwick

    This means that when our patients are at their most acutely unwell they may have to be transported across counties to a different site (either from St Michael's Hospital in Warwick to the Caludon Centre in Coventry or vice versa)

3. Older adults (i.e. 65+) who require acute mental health in-patient services could be admitted to St Michaels Hospital in Warwick or Woodloes House in Warwick

4. Adults with a dementia diagnosis who require in-patient services will be admitted to the Manor in Nuneaton.

Developing specialist sites

As noted above, our plans are on hold pending completion of necessary estates work at the Caludon Centre (Coventry) and, once we have a definitive timetable for completion of these works, further communication and engagement activity will be undertaken to inform our plans. However, in the interim we have provided below an overview of the key elements of the plan and the clinical rationale.

We are planning to continue to reconfigure services into specialist sites to ensure that patients are able to access the right people, in the right place and the right skills all in one place. We will continue to provide mental health in-patient beds across three sites in Warwick, Coventry and Nuneaton.

1. Adults (both males and females) requiring acute mental health in-patient services will be admitted to the Caludon Centre in Coventry for assessment and/or treatment.

2. Adults who have a more intensive level of acute mental health need will be admitted to a Psychiatric Intensive Care Unit (PICU):

a) The female PICU will be relocated from the St Michaels (Warwick) to the Caludon Centre (Coventry), with the creation of 4 additional female PICU beds.
b) The male PICU will continue to be provided at the Caludon Centre (Coventry). No changes to this are proposed.

Providing treatment wards and PICUs on the same site will help to enable seamless, responsive care and minimise disruption as clinical needs change and will help to eliminate the need to transport patients between sites when a patient is at their most acutely unwell.

3. Older Adults who are more vulnerable to physical health deterioration and with a primary diagnosis of a mental health disorder, requiring acute mental health in-patient services, will be admitted to St Michael's Hospital (Warwick). Whilst we will no longer admit patients to Woodloes House (Warwick), these beds will be relocated to St Michael's Hospital (Warwick).

   Therefore, there will be no decrease in the number of older adult beds available in Warwick whilst also ensuring an equal number of male and female older adult beds are available.

4. Older adults with a dementia diagnosis will continue to access in-patient services at the Manor site (Nuneaton). There are currently no proposed changes to this service/location.

Workforce planning

To ensure that our workforce continues to be aligned to the configuration of our services we necessarily review staffing levels across all of our services on an ongoing basis, including for each of our specialist services and at each of our three in-patient hospital sites.

Our future workforce planning will include the need to ensure that staffing levels meet the required levels to reflect any increase in the number of older adult beds at St Michael's Hospital (Warwick) and female PICU beds at the Caludon Centre (Coventry).

As we plan to continue to provide in-patient services at all three hospital sites we have no plans to reduce overall staffing levels at any of our hospital sites and are committed to maintaining safe staffing levels across all of our services.

Coventry and Warwickshire Partnership NHS Trust

Summary

In summary, we are continuing to review and develop our plans to provide a clearer and more focused set of services across our principal mental health inpatient sites, the Caludon Centre in Coventry, St Michael's Hospital in Warwick and the Manor site in Nuneaton.

Our plans are clinically driven to support the appropriate specialisation and effectiveness of services across Coventry and Warwickshire as a whole. This approach will also reduce the need to send some patients out of area to receive their treatment.

An essential element of our plans is to continue to ensure that the majority of our patients are treated and supported in local community settings. We are systematically developing, enhancing and promoting the pathways, to continue to improve the quality and effectiveness of patient care and to attract, develop and retain the best possible workforce.

We recognise that meaningful stakeholder engagement is essential for the development and finalisation of the plans and we will actively engage with service users, their families and carers and other key stakeholders as our plans develop.

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Agenda Item 6

Item 6

Coventry and Warwickshire Joint Health OSC

14 Oct 2019

Update on the Future of Health Commissioning Arrangements in Coventry and Warwickshire

Recommendation(s)

1. Members are asked to receive the report for information and assurance.

1.0 Key Issues

1.1 As your local health commissioners, we are considering how we can best support the move to an Integrated Care System (ICS) and how our organisations will need to change to accomplish this. Therefore, this change relates to the future Clinical Commissioning Groups' (CCGs) organisational form to fit within the emerging national and local context and discharge our statutory duties effectively – not about reconfiguration of any services commissioned.

1.2 In May 2019 the Governing Bodies of all three Clinical Commissioning Groups recommended merger to their Members, which is a matter reserved for Members themselves. The Members in South Warwickshire supported that recommendation; the Governing Bodies in NHS Coventry and Rugby CCG; and NHS Warwickshire North CCG requested further assurances and the Members wished to wait for those assurances prior to voting on the recommendation. This is now anticipated to take place in November 2019.

1.3 This report provides members with an update on our progress in deciding the future configuration of local health commissioning in Coventry and Warwickshire and provide you with assurance that we will still deliver our statutory duties and functions.

2.0 Options and Proposal

2.1 We aim to be clear about the direction and timing of a proposal for moving towards a single commissioning function.

2.2 We are continuing our engagement with stakeholders throughout this period and beyond, and this meeting provides a further opportunity for our engagement and discussion with you on this matter.

3.0 Financial Implications

3.1 The financial requirement for Clinical Commissioning Groups is to reduce internal running costs by 20% in the next year.

4.0 Environmental Implications

4.1 None.

5.0 Timescales associated with the decision and next steps

5.1 The CCGs continue to provide additional information, including how the new options might look in practice, and to answer questions received from stakeholders and the public, Members, the Local Medical Committees (LMCs), and CCG staff.

5.2 Throughout October and November 2019, the CCGs will continue the dialogue with their respective members, to keep them updated on the progress on the additional information requested by the Governing Bodies.

5.3 The next steps will be determined by the outcome of the votes.

5.4 Should there be a consensus for full merger, the detailed application will be developed for consideration by NHS England. The outline timetable is included in the report and an application would be submitted by the end of September 2020 for merger to be effective from 1 April 2021.

Background papers

1. Transition Case for Change – May 2019

	Name	**Contact Information**
Report Author	Liz McLean	liz.mclean3@nhs.net Tel no: 07980 845839
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TRANSITION CASE FOR CHANGE

PROPOSAL FOR CLINICAL COMMISSIONING IN COVENTRY & WARWICKSHIRE

Abstract

This document aims to outline the Case for Change for the future working arrangements of NHS Coventry & Rugby Clinical Commissioning Group (CCG), NHS South Warwickshire CCG, and NHS Warwickshire North CCG, currently acting as commissioning partners in the Coventry & Warwickshire Sustainability and Transformation Partnership (STP)
It describes the context and identifies the engagement feedback and overall narrative for the process of considering the options for change. It recommends a preferred option. It also includes information addressing the 11 tests required by NHS England for mergers of CCGs as defined in April 2019.

It is drafted for an intended audience of high-level, informed stakeholders.

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DOCUMENT HISTORY COVER SHEET

DOCUMENT TITLE	**CCGs Case for Change**
VERSION / DATE CREATED	**16 May 2019**

VERSION	DATE	SAVED BY	NOTES
0	05 05 19	LM	Initial Draft
1	9.05.19	GE	Inclusion of comments from GE
2	12.05.19	LM	Inclusion of comments from GE, AG, & Region
3	14.05.19	LM	Inclusion of comments and material from AG, AH, S'OH, CH, PS, AW
4	15.05.19	LM	Inclusion of provider feedback & restructuring
5	15.05.19	LM	Inclusion of comments from AG, GE
6	16.05.19	LM	Addition of further ONS data
FINAL	16.05.19	LM	Paper approved for submission to Governing Bodies by AG and GE
7	22.05.19	LM	Correction to total number in figure 2, p9

Table of Contents

1. Introduction

The NHS Long Term Plan (LTP) was released in early January 2019. Of note for the local population is the requirement for a plan to address local health inequalities, and clarity of a new service model for the NHS. This new model will comprise of Primary Care Networks (PCNs), facilitated by a new type of General Medical Services (GMS) network contract. Every Sustainability and Transformation Partnership (STP) area in the country is to be, or be part of, an Integrated Care System (ICS) by 2021.

With less than two financial years to deliver this change, discussions have centred around the development of the local PCNs and the transition of the three individual clinical commissioning groups (CCGs) to a single strategic commissioner as required by the LTP. This has led to several scenarios for strategic commissioning being put forward which are explained in this document. Proposals for PCNs and updated Primary Care Strategy are the subject of other documents.

This document describes current challenges and commissioning arrangements and sets out the thinking for changing the way the CCGs could work together in the future to underpin the transition into an ICS. It explains the possible alternative options; including their advantages and disadvantages.

Governing Body members are asked to discuss the options set out in this paper and the recommendation of the option which will best fit and most rapidly begin to deliver the requirements of the LTP within the timescale required nationally. The approved recommendation will be put to a vote of the members in line with the required constitutional arrangements for each CCG.

2. Background

The NHS Long Term Plan (LTP) sets out an intention to continue to develop Integrated Care Systems across England and that, by April 2021, ICSs will cover the whole country. NHS England describes an ICS as an arrangement in which NHS organisations, in partnership with local councils and others, take collective responsibility for planning and commissioning care, managing resources, delivering NHS standards, and improving the health of the population they serve.

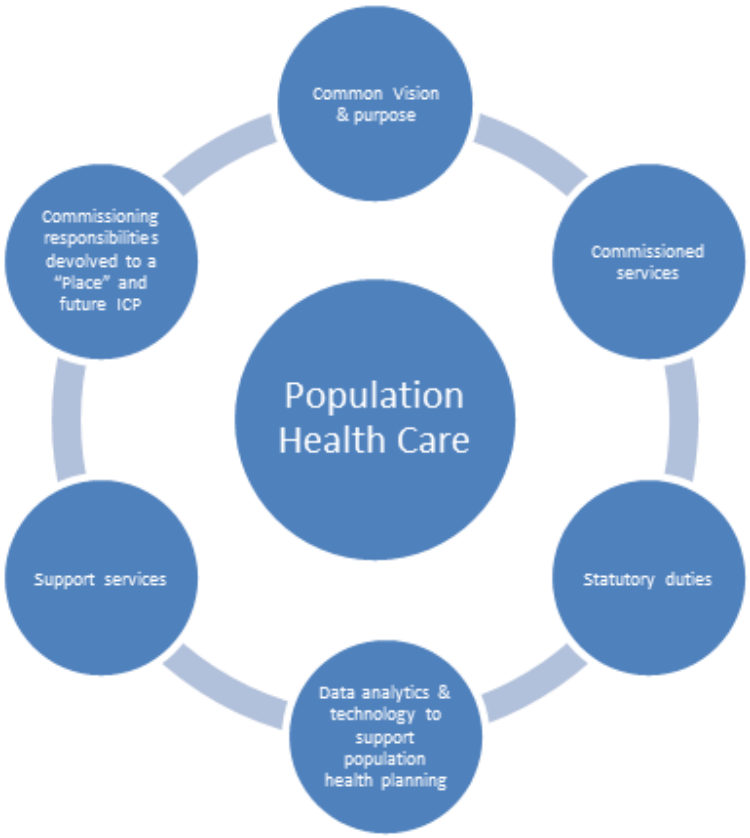

Figure 1: Population Health Care delivery

The LTP (p.29) describes how the commissioning environment will continue to evolve and that it is in this context that CCGs will operate in future.

> '*Each ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.'*

Across England there is a growing appetite for formal CCG mergers. Several, for example in Birmingham & Solihull and around Bristol, became new statutory bodies on 1 April 2018. This reduced the total number of CCGs from 211 in 2013 to 195 in 2018. The drive and ambition to respond is leading to rapid change with many other CCGs implementing new structures by

1 April 2020. Many have already set up shared management teams and innovative structures across STP areas to help tackle the issues they face and facilitate the shift from competition to collaboration.

A range of solutions are being implemented around the country from:

- formally merged CCGs,
- further integration with local government,
- smaller Place-based systems involving commissioners and providers in a Place and providers taking on commissioning responsibilities.

No 'one size fits all' approach is mandated by NHS England.

The ICS needs health commissioning to change to support development of two critical capabilities:

- Better, faster service integration by better alignment of commissioning resources e.g. pathway redesign, contracting expertise, case management etc. with providers around discreet populations known as a 'Place';
- Streamlined, single commissioning resources for a population approach focusing on assurance, financial management, strategic change, and outcomes-based commissioning. CCGs have been told, by NHS England, to reduce their running costs by 20% as part of these new structures by 2020/21

In the future, the strategic commissioners will contract with a single organisation or partnership of organisations to manage a single budget and deliver a range of services for the local population, focusing on the population's health and wellbeing. This means that CCGs will have a more strategic role in overseeing the local health system, focusing more on overall performance and less on individual services. Providers will take on delivery commissioning currently carried out by commissioners, such as sub-contracting for and monitoring the performance of individual services.

Commissioners identified a number of scenarios for the future of health commissioning across Coventry and Warwickshire, and criteria against which to assess them. These have been tested with staff and stakeholders to inform selection and weighing of the assessment criteria, the preferred option and the case for change that is the subject of this paper.

To make this transition successful, there are several important factors to consider:

- What is already in place that demonstrates working in the ICS way;
- What, and where, are potential opportunities for this change to further benefit patients and the public, improving population health through integration, and/or to address inefficiencies or financial challenges;
- Full assessment of the risk vs benefit of potential changes; and
- Availability of the resource required to achieve the changes in an appropriate timescale.

3. The CCGs

The local CCGs were formed in April 2013 taking over responsibility for planning, paying for, and monitoring, local health services from Primary Care Trusts (PCTs). These were new organisations combining the expertise of local family doctors and NHS managers putting local doctors and nurses at the heart of deciding which health services to provide, and where and

how they would be provided.

Each CCG is led by a Governing Body. All general practices in a CCG area are members of that CCG and have clinical representatives elected to their respective governing bodies. The CCG membership retains the authority to set the strategy and direction for the organisation and to hold their governing body to account.

CCGs are responsible for commissioning services including:

- Planned hospital care
- Rehabilitative care
- Urgent and emergency care (including out-of-hours)
- Most community health services
- Mental health and learning disability services.

The CCGs also have delegated authority from NHSE for commissioning general practice primary care services.

The three CCGs have a long history of working together to commission hospital, community, children's and mental health services working in partnership with social care.

4. CCG profiles

NHS Coventry & Rugby Clinical Commissioning Group

Accountable officer: Andrea Green
Address: Parkside House, Quinton Road, Coventry, CV1 2NJ
Local authority: Coventry City Council (for Coventry)
Warwickshire County Council (for Rugby)
2019/20 budget: £729.4 million
Number of staff: 256 (this includes several directly provided services)

NHS South Warwickshire Clinical Commissioning Group

Accountable officer: Gillian Entwistle
Address: Westgate House, Market Street, Warwick, CV34 4DE
Local authority: Warwickshire County Council
2019/20 budget: £404 million
Number of staff: 52

NHS Warwickshire North Clinical Commissioning Group

Accountable officer: Andrea Green
Address: Heron House, Nuneaton, Newdegate Street, Nuneaton, CV11 4EL
Local authority: Warwickshire County Council
2019/20 budget: £282.7 million
Number of staff: 53

The total GP registered list sizes at 1 January 2019 of 813,954 are located across the four Place areas as set out in the table below.

Place	Registered Population	Primary Care Networks	GP practices
Coventry	411,972	7	56
Rugby	110,691	1	12
South Warwickshire	291,291	7	33
Warwickshire North	192,278	4	26
Total	**1,006,232**	**19**	**127**

Figure 2: GP registered list size by 'Place'

Registrations grew during 2018 by 2% in each of Coventry, Rugby and South Warwickshire Places; and 1% in Warwickshire North.

In April 2017, NHS Coventry & Rugby CCG and NHS Warwickshire North CCG became jointly managed organisations with a single executive team and reduction in duplication through a single finance and commissioning function. The CCGs remain distinct and separate bodies constitutionally, with separate chairs and lay members, but holding Committees-in-Common for all Governing Body and statutory committees other than the Primary Care Committees, which are Place-based.

The LTP proposes that typically a population of this size (approx. 1m) would be covered by a single strategic commissioner (see diagram) and also that the current Sustainability and Transformation Partnerships (STPs) will be used as the geographical basis for future ICSs.

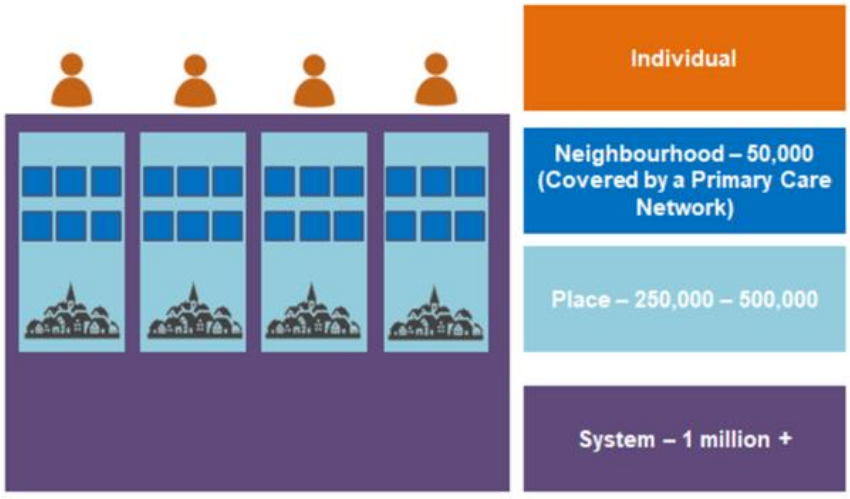

Figure 3: Layers of an Integrated Care System

5. Current joint working arrangements in relation to contracts and services

The area includes three acute hospitals, one of which also provides several specialised services commissioned directly by NHS England; a partnership trust providing core mental

health services for the whole population and community services in Warwickshire operated by one of the acute trusts; and 127 general medical practices, serving a total of approximately 960,000 local residents.

- University Hospitals of Coventry & Warwickshire: general and tertiary (specialised) acute
- George Eliot Hospital: general acute
- South Warwickshire Foundation Trust: general acute and Out of Hospital services for Warwickshire
- Coventry & Warwickshire Partnership Trust: Mental Health and Learning Disability plus Out of Hospital services for Coventry.

Figure 4: Location map

- NHS Coventry & Rugby CCG is the co-ordinating commissioner for UHCW and CWPT and leads negotiations on behalf of all 3 CCGs. It carries out activity analysis and raises challenges on behalf of all 3. It also hosts the IFR team and management of the commissioning policies reform group.

- NHS South Warwickshire CCG is the co-ordinating commissioner for SWFT and leads negotiations on behalf of all 3 CCGs for the trust's acute and other Warwickshire-wide services, including the Out of Hospital contract. The CCG is also lead commissioner for Out of Hours services.

- NHS Warwickshire North CCG is the co-ordinating commissioner for the George Eliot Hospital Trust and other Warwickshire-wide services.

- The Arden-Gem Commissioning Support Unit (CSU) provides services to all three CCGs:

Information Governance, Communications & Engagement, Business Intelligence (DSCRO) and other functions such as HR, estates and information technology. The CCGs vary in their utilisation of these services with Coventry & Rugby commissioning fewer services than the other two.

- West Midlands Ambulance Service NHS Foundation Trust; NHS 111 are contracted by Sandwell and West Birmingham CCG as the co-ordinating commissioner for the area consortium. The staff who manage this process are funded by the three CCGs.

- The CCGs have experience of working together on joint 'at scale' procurements, namely: Any Qualified Provider (AQP) and CSU procurements.

6. Local population

The area of Coventry and Warwickshire is home to a population with wide and diverse needs together with areas of rurality and urban conurbations. Despite the focus of population within the main towns of the county, a significant part of Warwickshire is rural in nature.

In the past ten years, Coventry's population has grown by a fifth, making it the second-fastest growing local authority outside of London. In 2016-17 its growth rate was the seventh highest. Growth is particularly high amongst 18-29 year olds.

The county of Warwickshire has five Districts. The larger population bases are Nuneaton & Bedworth, Stratford-on-Avon and Warwick. Nuneaton & Bedworth is an area of significant urban deprivation, being some of the most deprived in the country. The North Warwickshire District is a more rural area. The Nuneaton & Bedworth and Stratford-on-Avon Districts have experienced the largest numerical population increases, with North Warwickshire, Warwick and Rugby Districts experiencing much lower, but approximately the same numerical increases as each other. Generally, the rate of population growth in the county of Warwickshire is below that experienced nationally (0.83%) but there is variation between the five districts.

	Population / Year			% change		
Area	2015	2016	2017	2015-2016	2016-2017	2015-17
Coventry (City)	344,300	353,200	360,100	2.6%	2.0%	4.6%
Warwickshire (total)	555,200	559,000	564,600	0.7%	1.0%	1.7%
North Warwickshire	62,800	63,200	64,100	0.6%	1.4%	2.1%
Nuneaton & Bedworth	126,600	127,700	128,700	0.9%	0.8%	1.7%
Rugby	104,500	105,300	106,400	0.8%	1.0%	1.8%
Stratford	122,400	123,300	125,200	0.7%	1.5%	2.3%
Warwick	138,900	139,500	140,300	0.4%	0.6%	1.0%

Figure 5: ONS population and growth by District

ONS 2014-based projections suggest the population of the county of Warwickshire is

projected to increase by an overall 11.1% from 2016 to 2039, lower than the equivalent national increase of 15.0%. However, this masks considerable variation when looking at broad age bands:

- 0-14 years expected growth by 4.9% between 2016 and 2039;
- 16-64 years expected growth by 2.1%;
- 65+ years expected to increase by almost half (49.0%); and
- 90+ years is expected to increase substantially.

	2016	2039	Change	% Change
North Warwickshire	63,229	66,184	2,955	4.7%
Nuneaton & Bedworth	127,019	139,012	11,993	9.4%
Rugby	103,815	121,506	17,691	17.0%
Stratford-on-Avon	140,411	157,505	17,094	12.2%
Warwick	122,276	134,076	11,800	9.7%
Warwickshire	556,750	618,456	61,706	11.1%

Source: ONS, 2014 Population Projections

Figure 6: Warwickshire County Council - ONS 2014 population projections

Although age profiles for NHS Warwickshire North CCG and NHS South Warwickshire CCG are broadly similar there is a greater proportion of residents aged between 0-19 (23%) in NHS Warwickshire North CCG and a greater proportion of residents aged 70 years or over (16%) in NHS South Warwickshire CCG. The age profile for NHS Coventry and Rugby CCG is comparatively different due to the large student population residing in Coventry City; 56% of residents are aged 20-59 but the greatest proportion of residents are aged 20-29 years.

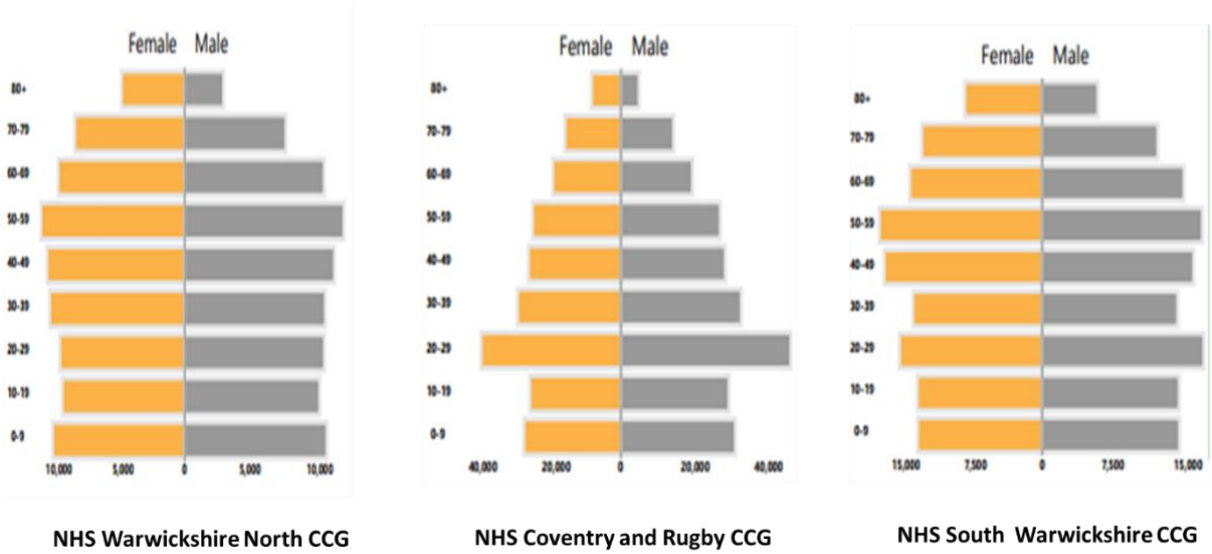

Figure 7: Population Profiles for each CCG

Coventry is one of the fastest growing local authority areas in recent years due to more births than deaths and growing migrant and student populations (attending the two local universities). The number of full time students at the universities has doubled during the last 10-15 years. The growth in over-65s is expected to accelerate and outpace other groups within the next 10-15 years. The city is diverse with around one third of the population and just under half of school aged children from minority ethnic groups. It is a relatively deprived city, ranking 55th out of 326 local authority areas and with significant differences between wards. Almost a third of the children live in low-income families.

Life expectancy is lower than the national average though similar to other areas with the same level of deprivation. There is an inequality gap between the least and most deprived areas, with a difference in life expectancy of 9.4 years for men and 8.7 years for women. The city has higher rates of premature deaths (under the age of 75) from cardiovascular disease, cancer and respiratory disease.

Rugby residents are predominantly in the 'white British' ethnic group and account for approximately 84% of the population (2011 data), and just over 1 in 10 of the population recorded as being born outside of the UK. The variation between wards of most vs least deprived is 5.7 years lower life expectancy for men and 4.0 years life expectancy for women.

South Warwickshire has an older age profile with its 65+ years population size significantly larger than that of both Coventry & Warwickshire as a whole, and nationally. Although its total future population growth is significantly lower, its 65+ years population's growth will be significantly higher than that of both Coventry & Warwickshire as a whole and nationally by 2035. This raises a considerable financial challenge with fewer working age people in the CCG area and increased adult health and social care responsibilities associated with an aging population.

Warwickshire North is an extremely diverse locality, with some neighbourhoods experiencing high levels of deprivation, some with high numbers of BME communities, and several new housing developments alongside more traditional urban town and rural village communities. Like South Warwickshire, both Nuneaton & Bedworth and the North Warwickshire Districts have significant numbers of older people as a proportion of their communities which is significantly larger than that of both Coventry & Warwickshire as a whole and nationally. Its total future population growth is significantly lower but its more rapid growth in those over 65 years will be significantly higher than that of both Coventry & Warwickshire as a whole and nationally by 2020. This raises a considerable financial challenge with fewer working age people in the CCG area and increased adult health and social care responsibilities associated with an aging population.

7. Local health needs

The map which follows shows the index of multiple deprivation (IMD) for the STP area. The IMD in 2015 was 19.87 against a national average of 21.67.

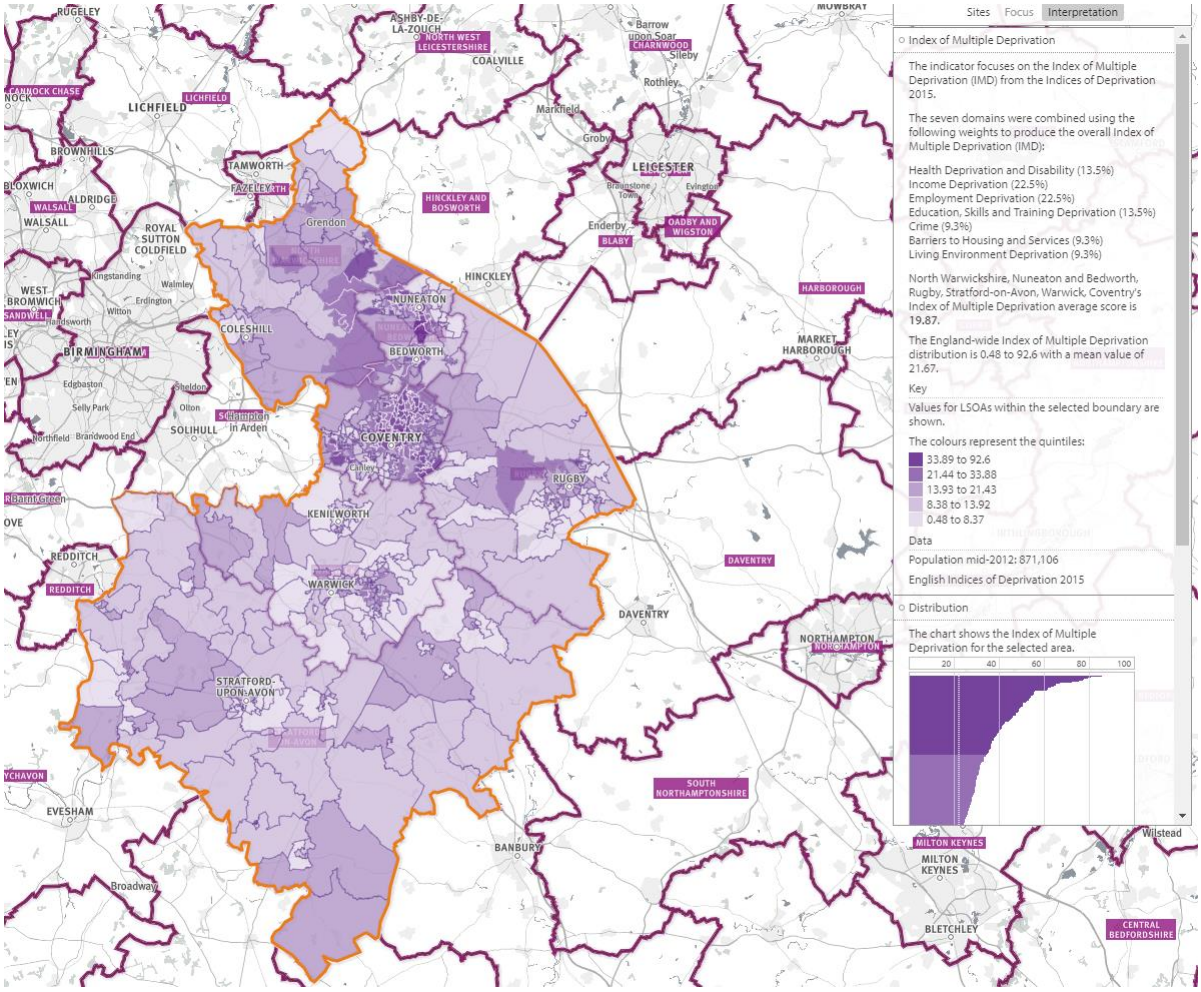

Figure 8: Index of Multiple Deprivations Coventry & Warwickshire

In 2017 a new approach was agreed by the Warwickshire Health & Wellbeing Board, with the focus of the JSNA moving from a theme-based to a Place-based approach reflecting the urgent need for more localised health intelligence. The chart below highlights for the whole of Coventry & Warwickshire some of the specific challenges facing the commissioners currently in addressing health outcomes for patients, benchmarked against national average.

The three CCGs have worked hard individually and together with partner organisations to manage the issues causing these inequalities. However, progress and pace could be improved through increased joined-up working. A more coherent approach to the planning and commissioning of services would help them become more effective and give them a better chance of achieving their objectives more rapidly.

Figure 9: Challenges in health outcomes across all three CCGs

8. Sustainability and Transformation Partnership

In 2016, the Government asked NHS organisations and local councils to formalise their working relationships by forming STPs to deliver NHS England's Five Year Forward View at a local level. The LTP now builds on the Five Year Forward View to completely transform local health and social care across the NHS in England.

This can only be achieved if everyone who has a stake in health and social care - the NHS, Local Authorities, the voluntary sector and other public sector agencies - work together to

achieve change. This change is about providing better quality care, improving health, social care and wellbeing services and making sure that services can be delivered in a sustainable way.

Other than the three CCGs, the members of the local STP 'Better Health, Better Care, Better Value' Board are:

- University Hospitals Coventry & Warwickshire NHS Trust (UHCW)
- George Eliot NHS Trust (GEH)
- Coventry and Warwickshire Partnership NHS Trust (CWPT)
- South Warwickshire NHS Foundation Trust (SWFT)
- Coventry City Council
- Warwickshire County Council
- Healthwatch

The local providers have recently joined together in a Provider Alliance in order to improve patient pathways and reduce duplication in local service provision.

One of the main aims of the STP is to create more effective and efficient organisations, releasing a greater proportion to be spent on frontline services, to the greater benefit of patients. The ambition is to strengthen the voice of commissioning, improve the quality of services across the whole system, meet financial targets and be a stronger commissioner to match local provider partners.

A number of high level goals can be realised, at least in part, by the proposal to change. For example:

- More effective system management underpinned by comprehensive information system;
- More effective and efficient commissioning processes with less duplication;
- Greater focus on outcomes based commissioning;
- Better value through improved efficiency and reduced costs of commissioning function;
- Simpler and more effective governance of commissioning and decision making;
- Stronger service transformation approaches, decommissioning and re-commissioning;
- Aligned budgets (as a minimum) and agreed risk share arrangements.

9. Primary Care Networks

One of the key challenges general practice has faced in the past is the lack of a single, representative provider voice to engage in system level strategic planning and decision making. CCGs have improved this but still not managed to achieve a single voice of general practice. This has led to a perception of lack of representation and influence of general practice at a strategic level.

Nominated GP leaders have worked closely with individual GP contractors, local LMC and GP Federations, to develop a mechanism for securing the One Voice of General Practice. This development provides one aspect of the foundation for future PCN Clinical Directors to play their crucial role in shaping and influencing the ICS and in ensuring that general practice feels fully engaged.

Member practices have already formed geographically aligned Primary Care Networks

(PCNs) typically serving natural communities of around 30,000 to 50,000, though some are significantly larger reflecting local conditions. They will now progress through the NHSE maturity matrix for PCNs and identify population health priorities, including focused action to reduce variation, and extend the range of services available in out of hospital settings.

The developing Primary Care Strategy will aim to ensure that the PCNs in each of the four Places can:

- Co-ordinate out of hospital care.
- Facilitate and promote peer review and sharing of good practice
- Provide additional resilience
- Develop arrangements to join up extended hours
- Improve outcomes for patients by delivering the seven mandated national service specifications contributing to NHS Long Term Plan
- Innovate and collaborate to deliver system benefits
- Utilise investment in new roles to expand general practice workforce
- Support PCN Accountable Directors
- Agree an approach across Coventry and Warwickshire to achieve sustainable GP one voice within the ICS and at Place.

10. Delivery at Place

The Coventry & Warwickshire Health and Wellbeing Place Forums led by local authorities and working with all system partners have developed a model for the future of health and care for the population in Coventry and Warwickshire. They also agreed that within this area there would be four “Places”; these are Coventry, Rugby, Warwickshire North and South Warwickshire.

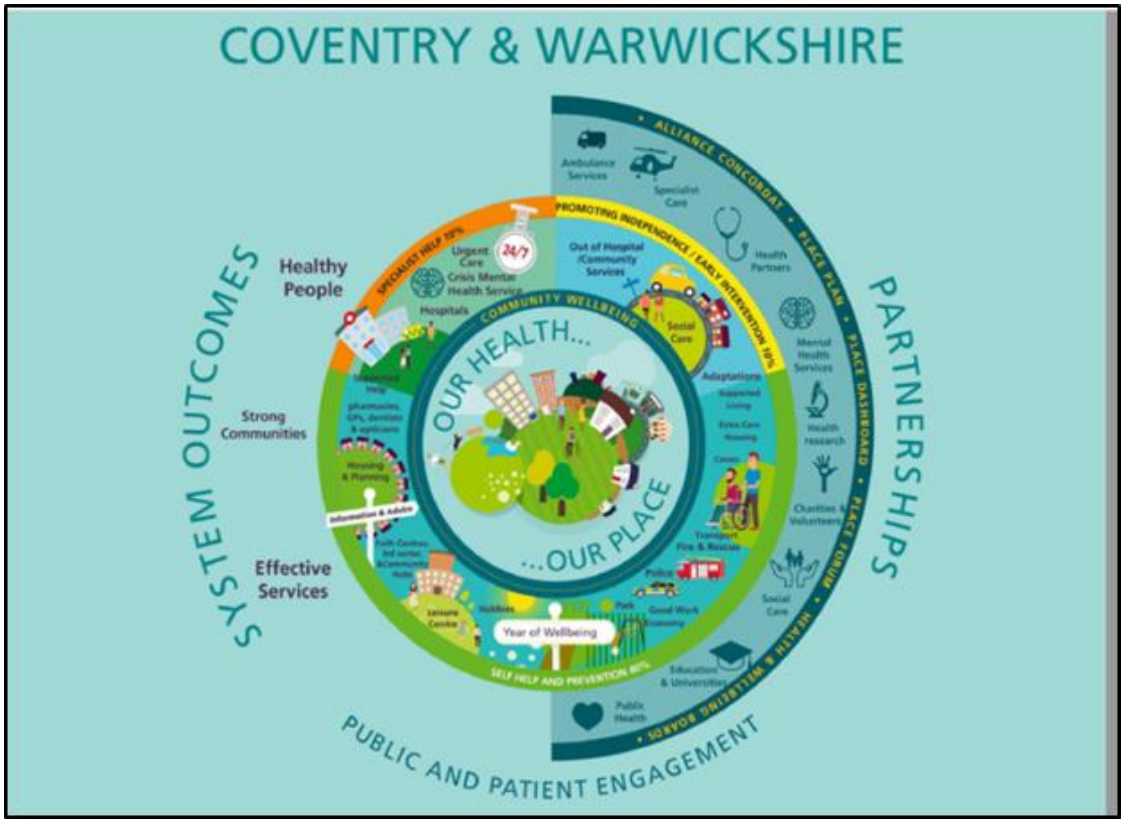

Figure 10: System of care

This model puts people at its heart and builds the system around them. It places much more emphasis on what the system will offer to people around promoting independence, early intervention, self-help and prevention, as this is where the most beneficial and long-lasting outcomes and positive impacts on health and wellbeing can be made. The new model looks to move services closer to where people live, removing some of the barriers to access. It helps to remove unnecessary trips to hospital and the stress that goes with it i.e. parking, appointment times. Finally, it builds on existing partnership working by bringing those commissioning and providing services into even stronger alignment.

In order to best support this new model, there need to be changes to how services are prioritised, planned and commissioned. There needs to be a move away from an income-driven commissioning style, where local providers compete for CCG resources, and a move to an outcomes-based commissioning approach. This means focusing less on paying for performance based on targets and processes, and more on the impact that services have on the health and wellbeing of people living in Coventry and Warwickshire.

Coventry and Warwickshire CCGs have agreed a model of care (depicted in the diagram below). These contracts require community providers to organise their community service offer around GP registered patient lists of around 30k - 50k populations, and to establish integrated teams working in collaboration with general practice and social care.

The action taken to implement Out of Hospital care provides a solid foundation for breaking down historical barriers between primary, community and social care services, and for providing assessment and support for 'higher risk' patients to remain independent later in life. This is achieving system benefits and responding to the requirements of the NHS long term plan by establishing an Integrated Care System with general practice at its core.

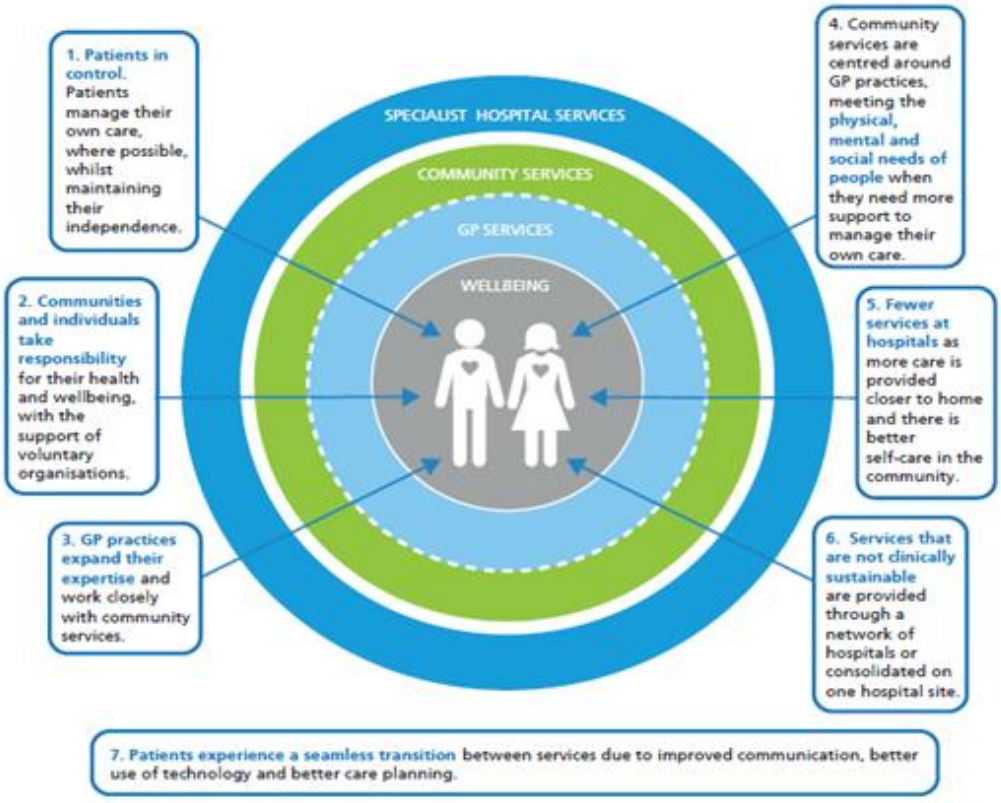

Figure 11: Integrated Care system model

11. Vision

Throughout the engagement with key stakeholders across the STP area, we have learnt that the following objectives are consistently important to them in the CCGs pursuing a single commissioning voice:

- Overall improved health and better outcomes for patients;
- A more sustainable local NHS;
- Better integration of provision and commissioning at Place
- Better integration with the local authorities, especially for social care and preventing poor health outcomes;
- Consistency for patients;
- Ensuring that all patients can access the same high quality service, regardless of where they live in the area;
- A strong and strategic NHS commissioning voice to match that of the provider organisations and local authority;
- A larger and stronger pool of clinical expertise; and
- Building on the existing partnerships the three CCGs currently have.

While finalising proposals, feedback from staff and stakeholders recognised that 'Place' is a key issue. The area of Coventry and Warwickshire is made up of many different natural communities and a key consideration will be how a new organisation can respond to that, whilst still delivering high quality services and addressing and reducing health inequalities.

12. Integrated Care Systems

Despite the legislative framework moving increasingly towards a quasi-competitive market, the policy objective in recent years has been to increase integration and a statement that ICSs will effectively end the purchaser / provider split, bringing about integrated funding and delivery for a given geographical population.

The LTP is clear that local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere. The most recent definition describes their function as

> *"… bringing together local organisations to redesign care and improve population health, creating shared leadership and action."*

In an ICS, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering standards, and improving the health and wellbeing of the population they serve. For example, ICSs are expected to improve health and care by:

- Supporting the coordination of services, with a focus on those at risk of developing acute illness and being hospitalised;
- Providing more care in a community and home-based setting, including in partnership with council social care, and the voluntary and community sector;
- Ensuring a greater focus on population health and preventing ill health;
- Allowing systems to take collective responsibility for how they best use resources to improve health results and quality of care, including through agreed cross-system spending totals.

As the national direction of travel moves away from competition and toward collaboration and integration, commissioners and providers will work more closely together making shared decisions. This will necessitate a different type of commissioning organisation, that aligns strategic commissioning functions to a system level, and tactical commissioning activities to a place level, integrated with provision.

The LTP outlines that:

> *1.51.* ***We will continue to develop ICSs, building on the progress the NHS has already made. By April 2021 ICSs will cover the whole country****, growing out of the current network of Sustainability and Transformation Partnerships (STPs).*
>
> *ICSs will have a key role in working with Local Authorities at 'place' level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health (other than for a limited number of decisions that commissioners will need to continue to make independently, for example in relation to procurement and contract award).*
>
> *Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area.*
>
> *CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.*

Developing the model outlined above will be a continuous journey, with many achievements and small milestones along the way. There are three major stages as outlined in the figure below. These major stages are:

A. **Current:** This first describes the current position and the progress already made within the STP system.

B. **Greater alignment:** The second describes the proposed next step and includes greater alignment between the CCGs (through the bringing together of functions, leadership and governance), alongside greater alignment of the appropriate commissioning activities to integrate with providers at each Place.

C. **Integrated care at system and Place level:** the third describes a foreseeable end-state

D. **Legislative changes**: to underpin local requirements but currently unclear. Proposals for possible changes to legislation were published on 28th February 2019. The earliest time for legislative change is 2022 and CCGs have been encouraged to move forward with implementing the LTP and not wait for legislation.

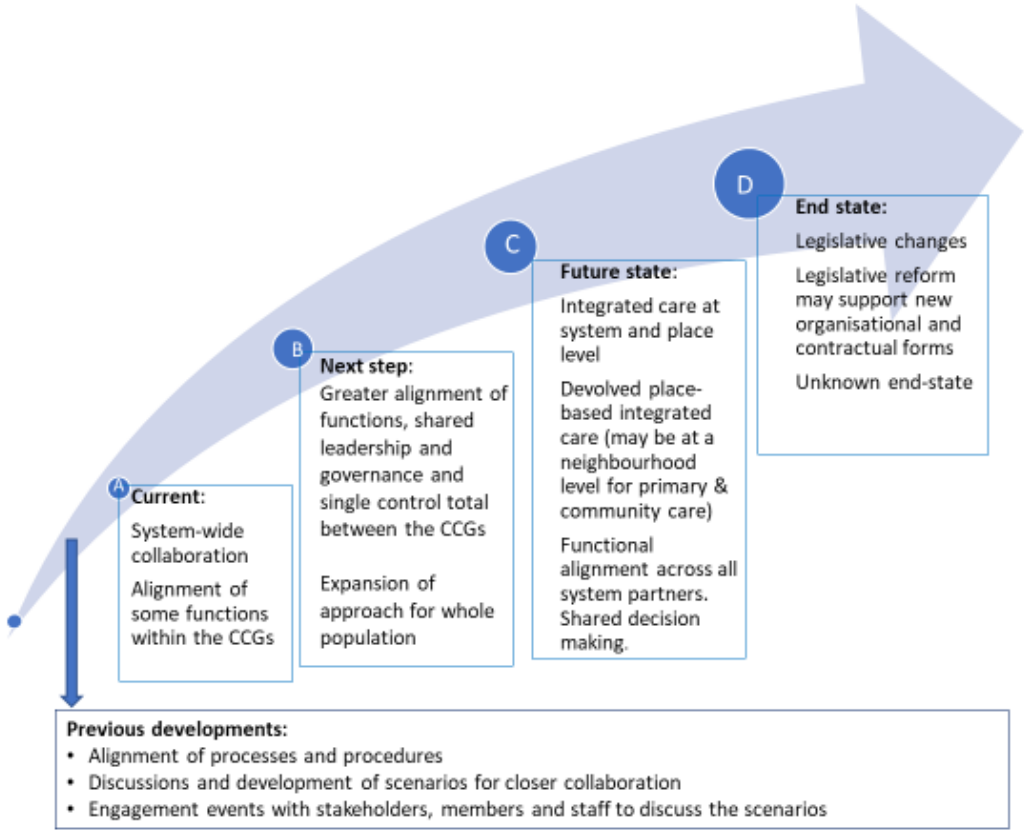

Figure 12: Major stages in moving to strategic commissioning

13. Future arrangements

There is a need to establish appropriate governance arrangements with transparency over where decisions are made when the change in structure is being implemented ahead of any legislation change. Shared management structures have demonstrated many advantages to date, including greater capacity and resilience, economies of scale and an enhanced skills base. The move to joint working and shared responsibility helped those CCGs who were currently struggling to tackle common issues with NHS providers or social services.

The benefits of aligning the boundaries of NHS commissioning areas with existing administrative boundaries at other levels are widely acknowledged. The proposed boundary is aligned and coterminous with both the existing Local Authorities and CCGs. There is no requirement to adjust boundaries or change the relationship of any GP practices to the developing PCNs.

The four Place health delivery systems are coterminous with City, District and Borough Council boundaries and the four groups of PCNs. Local Providers focus on delivery of services to their Place-based populations and, in the case of UHCW, provide some tertiary services to the whole population.

14. Expected benefits of greater alignment

Greater alignment of the health and care organisations will allow creation of a health and social care system that works better for patients and their families and which makes best use of scarce resources. Through minimising the structural barriers that exist between organisations

there is removal of competing priorities of individual organisations and development of aligned objective to improving the quality of health services across the whole of the ICS.

The ultimate goal of this greater alignment is to improve the health of the population, provide better quality care for patients, improve ways of working and return the system to financial balance, by a more effective and efficient use of assets and resources. This will be achieved through transforming clinical services across both primary and secondary care, and also improving organisational alignment and system performance across other areas, including shared functions and shared governance.

There is no technical reason as to why the benefits outlined above cannot be achieved by three separate organisations. However, the practicalities of this arrangement, and learnings from other systems, suggests that this would be extremely difficult to achieve. Without a single leadership team, it will be challenging to achieve the transformative change required to improve the quality of care provided, whilst ensuring financial stability to the system.

This is supported by a wealth of learnings from other systems, where organisations (both commissioners and providers) have attempted to collaborate but where separate leadership has created material, and in some cases insurmountable, barriers to alignment.

Alignment will have, a positive impact on financial stability, through:

- Reduction in duplication – the appointment of joint/single roles will realise savings
- More efficient use of resources across the system
- Improved relationships across the total Coventry and Warwickshire footprint
- Aligning the financial objectives of all organisations removes incentives to act in the interest of individual organisations and encourages activity which benefits the entire system.

15. Current progress

A temporary, dedicated transition team has been convened to manage the transition to a future state, develop and implement a detailed plan e.g. communications, risk and issues and management.

We are confident that the proposal follows a natural progression, building on joint working arrangements and collaborations such as:

- Lead commissioner contract arrangement/joint clinical commissioner groups
- Better Care Fund arrangements through the *Better Health, Better Care, Better Value* Partnership
- Hosted team arrangements
- System Resilience Groups/A&E Delivery Boards

Furthermore, there are already in place some of the following shared functions across two or more of the existing CCGs:

- Single senior management team in two CCGs
- Committees in common e.g. all Governing Body committees included the Governing Bodies of two of the CCGs, but with the exception of the Primary Care Committee
- Joint Strategic Commissioning Committee
- Individual Funding Requests

- Clinical Policy Group.

The strategic delivery plan across the three CCGs is set out in the table below:

Programme	Deliverables for 2019/20	By
Strategic Commissioning	Strategic Framework for the C&W HWB partnership	30 September 2019
	Strategic Commissioner Strategy & yr1 commissioning intentions (including financial strategy)	30 September 2019
	Agreed governance and reporting for strategic commissioning team	30 June 2019
	Strategic Commissioning Process for MCYP; Planned Care; and MH	Throughout 2019/20
	Develop the strategic commissioning clinical leadership function/s	30 June 2019
	Establish an assurance framework that can be used to inform readiness of Place for ICP contract	30 September 2019
	Undertake a baseline assessment of readiness and work with the Places (both provider and delivery commissioning) on a development plan that enables the progression to an ICP contract	31 November 2019
	Develop the system 5-year plan	Autumn 2019
Place Based Transformation Programme	Develop Place based commissioning transformation resources focused on priority areas – MH; Frailty; Planned Care; Maternity and Paediatrics; CIP/QIPP/Value Boards	31 May 2019
	Support the delivery of Place Based 5 year plans	30 June 2019
	Develop Commissioning at Place transformation and continuous improvement methodology with Provider Alliance	30 September 2019
	On behalf of the 4 Places deliver system wide enabling programmes	Throughout 2019/20
Place Based Governance	Develop, for each Place, an agreed Governance mechanism governance for reporting into existing CCGs for 2019/20	31 May 2019
	Ensure governance enables effective participation in the ICS development and enables CCGs to deliver statutory responsibilities	31 May 2019
	Design governance for place-based commissioning	31 December 2019
Population Health Management	System wide clinical leadership development – stage 1	31 March 2020
	Baseline assessment of analytical capacity and capacity for PHM	31 May 2019
	Develop the C&W methodology/approach in line with regional approach and obtain agreement with BHBCBV Board	30 June 2019
	Develop PHM capacity and capability resources in line with the regional approach	31 March 2020
Primary Care Transformation Programme	Mechanisms in place for NHS organisations in each place to work with PCNs	30 June 2019

Figure 13: Joint development plan

16. Future aspects of working together in Place

The move towards system and Place working is intentionally blurring the commissioner/provider split in the NHS and integrated care provider partnerships at Place will in future do some commissioning. This is recognised in many developing ICS systems across England.

By improving alignment with providers, commissioners will be better able to deliver large-scale service and clinical transformation projects across acute, community and primary care, which benefit the whole system rather than individual care settings. The diagram below shows how this alignment would work.

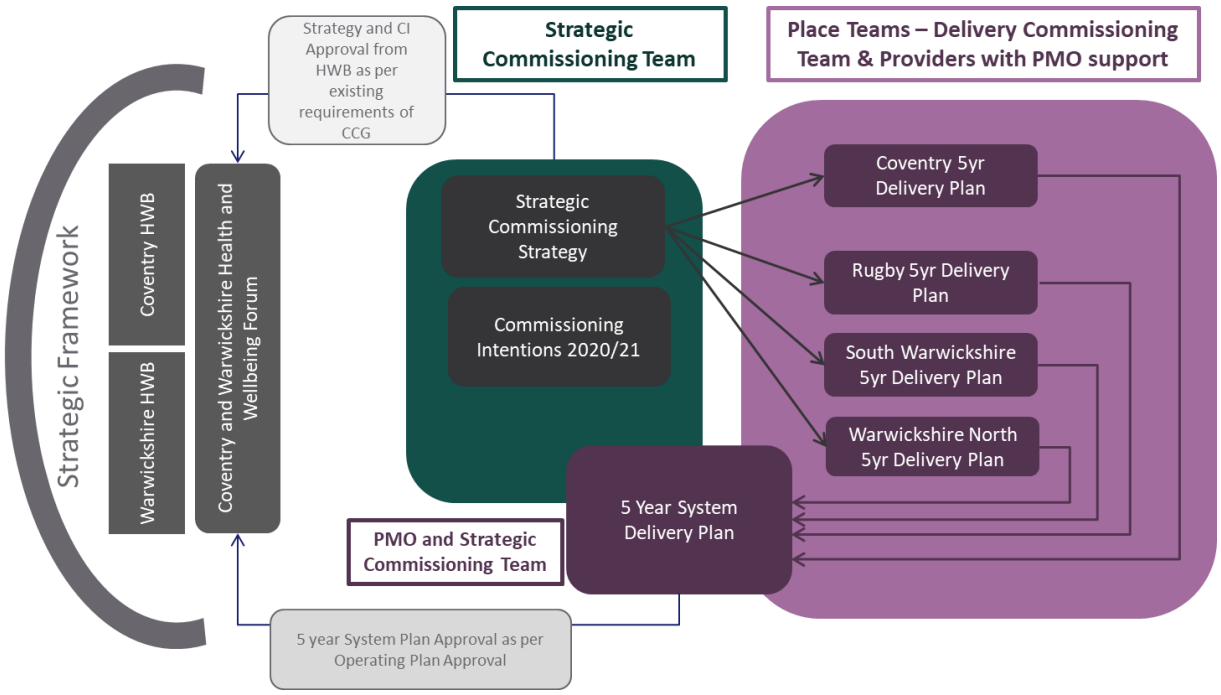

Figure 14: Strategic map

By streamlining commissioning, it will also:

- Remove duplication of functions to enable resources and assets to be used more effectively;
- Reduce misalignment, divergent priorities, and conflicts, which waste unnecessary time and resources;
- Allow the sharing of approaches, capability and best practice with one another.

Furthermore, the LTP, supports the aspirations of Place-based care by committing to the creation of Integrated Care Systems (ICSs) by 2021. The collaboration is a first step on this trajectory, and one that will importantly lead to considerable benefits both in terms of the quality of care and the overall financial stability of the local system in its own right.

17. Financial position

CCGs are required to comply with NHS England's rules on financial performance. Each year, CCG financial plans are checked to make sure they comply with national business rules.

In this financial year (2019/20), the financial positions for each CCG are shown in the table. The combined Coventry and Warwickshire financial plan is an overall deficit of £15m (1.2%).

	2019/20						
	Programme	Running Costs	Primary Medical	Total Budget	In-Year Surplus	Cumulative Surplus/Deficit	
	£m	£m	£m	£m	£m	£m	%
Coventry & Rugby CCG	647.9	10.3	71.2	729.4	0.4	6.4	1.0%
South Warwickshire CCG	354.5	5.8	38.4	398.7	1.9	-3.4	-1.0%
Warwickshire North CCG	252.3	4.0	26.4	282.7	0.0	-18.0	-7.1%
Total C&W Commissioners	**1254.7**	**20.1**	**136.0**	**1410.8**	**2.3**	**-15.0**	**-1.2%**

Figure 15: Financial position 2019/20

CCGs have received confirmed revenue allocations for 2019/20 and 2020/21 and indicative allocations for 2021/22 to 2023/24 setting out expected growth. Should a decision be taken to move to single Commissioner the allocations for each 'Place' would be based upon the published allocations, providing the sum of these does not exceed the single allocation notified to the new CCG.

A process has commenced to identify the Rugby share of the Coventry & Rugby allocation based upon current expenditure and a fair share of any uncommitted reserves.

CCGs need to show how a recurrent 20% reduction in running costs will be achieved in 2020/21, releasing resource to each Place. The CCG Running Costs Allowance is based on a standard national amount per head of population and for 2019/20 amounts to £20.1m for the three CCGs. This amount will not change if the CCGs merge.

18. Stakeholder engagement

The Health and Social Care Act 2012 clearly sets out a legislative requirement for NHS Clinical Commissioning Groups to involve their stakeholders at an early stage and throughout change programmes, at varying degrees. It is important that this legislation and guidance is noted, to avoid any future legal challenge or democratic scrutiny, both of which can be costly in terms of time and money. It must also be ensured that due and proper regard is given to the Public Sector Equality Duty, as set out in the Equality Act 2010.

The vision, priorities, and ways of working, must be shaped, conveyed and implemented through an on-going relationship with all stakeholders, based on mutual respect and openness. Efforts will be made to ensure that partnerships are sustained, well managed and transparent.

There is already a very strong commitment to public engagement and stakeholder involvement, demonstrated by the care taken in ensuring that there are opportunities for local people to influence decision making, and appraisal of the various scenarios. An effective engagement approach will be maintained going forward, based on the existing communications and engagement strategies for all stakeholders. This is possible due to the ability to maintain local structures that allow for a more distributed model of leadership and a focus on local priorities.

Those charged with the authority to set the direction for clinical commissioning are local GPs as is articulated in the CCG Constitutions. GPs are connected to the NHS and see every aspect of it; they are also connected to their local populations. Their input into the process of how to get more from local NHS clinical commissioning is critical to achieving the ambitions set out.

The members and governing bodies of all three CCGs have been informed and involved from the outset and contributed to the planning at each stage. The Governing Bodies confirmed this as the correct strategic direction of travel, but like other stakeholders, there are issues that have been raised (see below). These views and insight will be more important than ever during transition towards a new model and need to be taken into account. Stakeholders have so far raised issues that need to be discussed during the programme of involvement and used as the basis for further conversations that will influence and inform future decisions.

Issues raised for discussion included:

- Need to retain patient-focused pathways of care.
- The role of a single commissioner in an ICS and links to the new PCNs and Place.
- Delivery of a single Commissioning Voice.
- Clarity on the financial impact and management across Coventry and Warwickshire as a whole and at Place.
- How NHS England deadlines for merger applications fit with the need for local engagement and democratic processes.
- Maintaining good relationships at all levels with hospitals and other health and care providers.
- Clarity on the combined vision and priorities for the new organisation, not just its size and shape.
- The need for consistent commissioning strategies across the Coventry & Warwickshire footprint delivering localised implementation at Place.

19. Stakeholder events

Some scenarios were developed to determine the best way of commissioning health services going forward, making the most of the CCGs resources and working more closely with providers and the community and voluntary sector. Stakeholder events were held with staff, representatives of the GP membership, the CCG governing bodies and key stakeholders, including representatives from patient groups and the community and voluntary sector, as well as colleagues working in health and social care.

In the period since December 2018 there have been a number of briefings and engagement events with staff, Members and Governing Bodies. Other events have also been held with key stakeholders between March and May 2019.

The purpose of the engagement activity was to bring together a wide range of key stakeholders from across Coventry and Warwickshire, including colleagues working in health and social care, voluntary and community organisations, councillors, carers and patients and their representatives with the aim of:

- Providing clarity that this piece of engagement was specifically around the future of health commissioning as it pertains to meeting the needs of a future integrated care

system for Coventry and Warwickshire.

- Giving attendees some background information and putting things in context to help them understand why we are considering changing health commissioning.
- Capturing their initial thoughts and reactions to this information to input into the case for change document, due to be presented to the CCG governing bodies in late May 2019.

These events were not:

- A platform to persuade people of our thinking; it was a listening exercise as part of the engagement process
- Aimed at the wider public; rather, they were targeted and focused events with CCG staff and membership, and representatives from various key stakeholder groups from across Coventry and Warwickshire
- A platform to make decisions but a chance for people to further inform thinking.

A wide range of stakeholders were invited to the events. To ensure that the stakeholders were fully representative, we took into account the demographics of our population, previous engagement equality findings and recommendations in how to engage seldom heard and protected characteristic groups.

To ensure there was representation from across Coventry and Warwickshire stakeholders were identified and invited to nominate representatives to attend the events. These external stakeholders included:

- Patients and patient representatives – individuals who had contributed to previous engagement activities, including underrepresented groups of people identified as part of other wider communications and engagement strategies
- Voluntary and community sector representatives including those representing underrepresented groups
- MPs and local Councillors
- Both local Healthwatch organisations

Those who were unable to attend any of the events were offered the chance to contact the team to share their views or request a link to an online survey, although to date no such requests have been received.

Governing bodies

The three CCGs' governing bodies were given an opportunity to feed into the case for change during a governing body development session. Following a presentation to provide background and context, a series of questions was asked. Responses and feedback were captured via an online tool (mentimeter.com).

Members

The same information was presented to each CCG's membership and feedback was captured using an online tool (www.mentimeter.com) where possible. For NHS Coventry and Rugby CCG, CCG representatives attended a Protected Learning Time (PLT) event for the Coventry membership, and a Delivery Group meeting for Rugby.

NHS Warwickshire North CCG holds monthly membership meetings and the April meeting was used to deliver a brief presentation and then capture feedback using the same online tool.

NHS South Warwickshire CCG conducted a meeting with their membership at a Members' Council engagement session in March 2019. One of the key themes from this meeting was that a "larger, stronger GP voice" needed to be added to the assessment criteria, which was agreed.

Local health and wellbeing leads

Letters were sent to the Chief Executives of all the local providers, as well as leaders for local GP federations/alliances and Local Medical Committee Chairs, Deputy Chairs and Secretaries. The letters outlined the approach and requested feedback, in writing, to the proposals and timelines, as well as any other feedback or concerns they had.

Staff

NHS Coventry and Rugby CCG and NHS Warwickshire North CCG staff attended an all-staff team brief, led by the Accountable Officer, on 30th April 2019. An update was given on progress since the last briefing in December 2018, then attendees were asked to provide their feedback and views using the mentimeter tool. Likewise, NHS South Warwickshire CCG held an equivalent staff engagement session on 7th May 2019.

Patients

NHS South Warwickshire CCG spoke with members of its 3PG group - comprised of patient representatives, GPs and the CCG Lay Member for Patient and Public involvement. Feedback from this event suggested that the presentation and subject matter were very complex and needed to be simplified for wider audiences. This was adjusted ahead of the stakeholder events. It was also felt that "patient voice" needed to be added to the assessment criteria alongside "larger, strong GP voice" and this was actioned.

20. Criteria for reviewing scenarios

Various scenarios were considered and through the process of the stakeholder engagement these were refined. When asked, out of 174 people, only three (all staff members) said they were not happy/satisfied with the scenarios identified. At the Warwickshire North stakeholder event, only one attendee felt they had sufficient information to respond to this question. In particular, the majority wanted more information on how each scenario would be costed. They also preferred "Don't have enough information" to "don't know", from a wording standpoint.

The initial criteria used by SWCCG with members were subsequently combined with the criteria used elsewhere, with some additions. These were:

- Progress already made towards a single commissioning voice;
- Realisation of possible efficiencies;
- Potential to address the financial challenge; and
- Level of disruption and speed of change.

After adaptation the following criteria were finally used to evaluate various scenarios:

- Improved clinical quality
- More effective use of resources
- Better access to services

- Development of services
- Ease of delivery
- Improved strategic fit
- Meeting training, teaching, research needs
- Improved environmental quality
- Meeting national/regional policy

Broadly speaking, most of those engaged agreed that all the appraisal criteria were important. Improved clinical quality, more effective use of resources and better access to services were agreed as the highest priorities across all engagement sessions, with the remaining options changing depending on the audience. Generally, meeting national and regional policy was seen as the least important criterion for the majority of stakeholders, with improved environmental quality often in second-to-last place.

Using best practice criteria for assessing more general scenarios, members were asked to rank which of these criteria should be prioritised, and whether these should be sensitised for this subject matter, or if anything was missed by using this set of criteria.

21. Stakeholder responses

The key messages which emerged from the engagement programme were as follows (in no particular order of priority):

Support for change

The vast majority of those engaged were in agreement that there was a need for change to both an integrated care system (ICS), and also that health commissioning needed to change to help enable development of the ICS. However, there was some feeling that much of this had been discussed and promised before and not taken hold in various forms including previous iterations of CCGs (e.g. Primary Care Trusts, Strategic Health Authority). So there was some scepticism that it would work this time around, particularly when it came to integrated the health and social care agenda, finances and accountability.

A full merger was the most preferred scenario

At each session most agreed that a full merger made the most sense and would be the best scenario for achieving the objectives set out in the future model of health and wellbeing for Coventry and Warwickshire, though it was widely recognised it would not be an easy, quick or cheap process. Local provider's feedback to date has also been broadly supportive of a full merger.

Joint management team across three CCGs first before moving to full merger

At each session some questions were raised over whether, due to the tight timeframes, there was a possibility of doing a "best of both worlds" approach, which would involve first moving to a joint management team to build the foundation of the new commissioning structure before moving to a full merger.

Building robust "Places" – and not losing local identity – is critical to success

All agreed that success or failure of the health and wellbeing system was dependent on building and supporting strong "Places". Loss of local voice and identity were highlighted as being of large concern when thinking about moving to a strategic commissioning structure.

Involving the local population and their representatives is seen as another critical measure of success

Local people, and those that represent them (whether that be in the community and voluntary sector or elected officials), were eager to be involved as much as possible in the future development of systems to improve the health and wellbeing of the local population. Transparency, openness and the opportunity to feed into and influence planning and delivery were considered of vital importance.

Supporting staff is vitally important

Any change to the status quo will introduce uncertainty, worry and potential changes for staff. All stakeholders agreed the importance of supporting them during any change couldn't be overstated. Understandably, amongst staff groups job security was a chief concern.

"Do nothing" is not a viable scenario

Only one person felt that "do nothing" was a viable scenario. All others considered it was not; either due to pressures from NHS England or for achieving the aspirations of the future model of health and wellbeing for the area.

A full report will be available on the website of each of the three CCGs.

22. Criteria to select final options

	OPTIONS		
	1: Do nothing	**2: Single Management**	**3: Full merger**
Criterion	**Three statutory bodies**	**Three statutory bodies & joint commissioning**	**One statutory body**
Improved clinical quality	No change	All the clinical expertise in the STP area would be available to the whole STP area	All the clinical expertise in the STP area would be available to the whole STP area
More effective use of resources	No advantage	More stable arrangement than no change	Stable arrangement.
			Single legal entity.
		Single executive team - loss of some senior posts	Single executive team – loss of some senior posts
Better access to services	No advantage	No advantage	Single voice for strategic commissioning of local services
Development of services	No advantage	No advantage	Single voice for strategic commissioning of local services
Ease of delivery	No change	No advantage	No advantage
		Timeframe 3-6 months	Timeframe 9-22 months
Improved strategic fit	No advantage	Some economies of scale	Maximises potential for economies of scale
			Eliminates commissioning duplication and inconsistent approaches
			Allows single financial and service strategy
			Strong basis for negotiation and approach to STP
Meeting training, teaching, research needs	No advantage	No advantage	No advantage
Improved environmental quality	No advantage	No advantage	No advantage
Meeting national / regional policy	Does not achieve requirement	Joint alignment to STP / ICS	Full alignment to STP / ICS for providers / provider alliance and local authorities to engage with
		Retains three commissioning bodies and three sets of statutory requirements to be delivered	Move from three sets of statutory requirements to one
		No advantage – influence across STP not maximised	

23. Options for the future direction of health commissioning arrangements

As a result of the discussions and consideration of the criteria the following options are set out below for Governing Body consideration:

○ Option one: No change

Three separately accountable CCGs and current, separate management arrangements.

Until recently, each of the three CCGs had separate management teams, planning processes, priorities, budgets, and reporting responsibilities. Within the last two years NHS Warwickshire North and NHS Coventry & Rugby CCGs have shared an executive team and aligned work programmes focussed on the relevant lead acute provider for the CCG. This has enabled some streamlining of staff time involved.

While there are lead commissioning arrangements in place for contracting purposes, providers in the STP area work with the views of three CCGs, as does Warwickshire County Council. Coventry City Council has the benefit of working solely with Coventry & Rugby CCG, though the CCG works with both Local Authorities.

Management and governance arrangements are duplicated. The CCGs have two accountable officers, two chief finance officers, two executive teams and hold two sets of committee meetings in public. But they have three sets of offices, complete all their legal responsibilities separately three times (such as accounts), commissioning plans, production of three annual reports and maintenance of three websites.

Implementing this option would maintain the status quo and would not fulfil the vision of becoming a strategic commissioner nor the development of an ICS. It does not offer any benefit in terms of economies of scale nor deliver the required reduction in costs. It does not improve recruitment and retention and creates the potential to lose clinical leadership and key staff. There would remain three commissioning voices, with potentially divergent associated commissioning priorities. This would appear to duplicate decision making at Place and potentially hinder progress.

This option has therefore been discounted.

○ Option two: Retain three CCGs but with a single management structure

A single joint management team established following the immediate appointment of a single Accountable Officer for the three CCGs with retention of the three existing statutory bodies

In this arrangement, the current CCGs would remain separate organisations that share some staff and structures to help them work more efficiently. This model would deliver marginal benefit in cost reduction in areas such as joint committees or holding committees-in-common to undertake aligned priorities and responsibilities. Each CCG would retain its own constitution, governing body and membership arrangements for all statutory functions. The CCGs would work toward this arrangement by appointing a single Accountable Officer and Chief Financial Officer in the first instance. The timescale for this has already been approved

by the Governing Bodies and recruitment will commence shortly.

Implementing this option would require the CCGs to co-design and implement new non-statutory governance arrangements. Comparing this option to the current arrangements in Option 1, there are no material advantages. Implementing this option would incur little disruption for staff and have no significant impact on the current level of duplication. Meetings-in-common would need to be held in a rotation of the three sets of CCG offices which might disadvantage some stakeholder and public attendance.

○ Option three: Merger of the three CCGs

A single commissioning voice, management team, constitution, and governance arrangements following merger; with a single, joint management team established following the immediate appointment of a single Accountable Officer for the three CCGs up to the date of merger

This option establishes an entirely new CCG, with a single management team, governing body and one set of statutory duties to be delivered, coterminous with the whole STP area and including both Local Authorities. It would provide the foundation of the future ICS and do so within the timeframe required nationally.

The arrangement would be stable, permanent and align to existing local authority health scrutiny and Health and Wellbeing Board arrangements. This alternative would allow more effective partnership work within the STP, including with NHS England, on areas outside of the CCG's scope e.g. specialised commissioning.

Implementing this option would require the early recruitment of an Accountable Officer and a Chief Financial Officer to appoint a single executive team and to design and implement new statutory governance arrangements leading on the merger application to NHSE England and delivery of the merger programme arrangements.

Compared to current arrangements, this arrangement would be significantly more sustainable and substantially reduce duplication because there would be one statutory body, rather than three; a single legal entity for providers, third sector and local authorities to engage with; and a single set of reporting and policy approaches to deliver consistency for the people of Coventry and Warwickshire.

These arrangements would make all the clinical expertise available in the area available to the whole of the area, with the single CCG working together with the recently established Provider Alliance which itself covers those within the STP footprint.

24. Conclusions

1. It is considered that, due to the lack of any demonstrable benefits, Option 1 is discounted entirely.

2. Option 2 is a viable option but fails to deliver a single commissioning voice and retains three statutory organisations and overheads in management and requirements.

3. Option 3 creates a single management structure whilst moving the organisations to full

merger. It gives the best chance of achieving the national target of becoming an ICS by 2021 and delivers the requirements of full coterminosity with the STP area and boundary alignment with the local authorities. It also provides the greatest potential for achieving the financial reduction in management costs required by the NHS Long Term Plan and the ability to develop a strategic commissioning function to support a single co-ordinated approach to the commissioning and delivery of health care at Place.

25. Recommendations

1. That the Governing Body support Option 3
2. That CCG member practices are asked to choose (by voting) either Option 2 or Option 3

26. Delivery timeline

Following the Governing Bodies' decision on the recommended option, planning to deliver the this will continue in the meantime.

The CCGs will proceed to engage with members and stakeholders during the next few months to ensure that the planning is robust. If it becomes clear during the engagement that the preferred option is not sustainable and/or does not deliver the required benefits a further report will be brought back to the Governing Bodies with a revised recommendation and next steps.

If Option 3 (Full Merger) is supported there will be a requirement to formally apply to NHS England for formal merger to take place. Annex 1 sets out the NHSE / NHSI criteria for assessing CCG mergers. Whilst there are many other documents that will need to be developed or refined to support the case for change for merger, these criteria will need to be assured within that case. Formal application would be required in September for transition on 1 April following.

In each of the change options (Options 2 and 3), the three Governing Bodies will have a single Accountable Officer and will work towards a single management team. This approach offers clear executive leadership and economies of scale.

There is every intention of retaining strong clinical leadership under changed arrangements and envisage retaining a robust executive function incorporating the Accountable Officer role. However, adjustments will be needed such as determining the required skills and capacity in accordance with NHSE guidance. This would include the establishment of the correct balance of clinical, lay member and executive roles.

It is recognised that clinical leadership has two distant parts; those involved in strategy, governance and accountability (e.g. Governing Body members), and those driving delivery, patient centred care pathways, implementing new evidence, building relationships with clinicians in provider organisations. The approach will be to get the balance between these two roles and ensure those clinicians with the right skills are in the right roles.

In developing the new operating structure, there would need to be decisions on how to establish the function of Clinical Chair and the wider clinical engagement and leadership structures. Since these are well-regarded/trusted mechanisms in each of the existing CCGs

it has significance in terms of continuity. The new leadership will need to finalise the proposals, but the intention would be to agree the core principles with the respective memberships to underpin new arrangements in a merged organisation.

These plans will be firmed up and made available for scrutiny after the final decision on the option is reached. Steps will also be taken to mitigate any risks associated with changes for example using necessary shadow committees/arrangements where committee structures are to be altered.

27. Membership engagement

As set out in the CCGs' constitutions, the memberships of each organisation are required to agree changes to their organisation. The following membership engagement principles will be followed:

- Engagement will continue to build on the clinical led model; where local GPs are at the heart of the conversation, being visible and their presence sustained
- Engagement will have a shared focus for the future, where the goal is to be a strong strategic commissioner
- The arrangements by which GPs are engaged will be flexible and will be able to adapt to small and larger networks
- Engagement with GPs will be supported by a common message, with common materials so that all GPs throughout Coventry and Warwickshire receive consistent, timely and relevant information
- There will be a commitment to using and building upon existing networks for engagement, so that there is minimum disruption to business as usual
- An evidence-based approach will be used
- The overall approach to engagement should be informed by the Local Medical Committees.

28. Future financial management

It is too early to draw together the detail of this plan but there are several components of the financial control arrangements which will be essential in delivering proper stewardship and accountability for public funds in a new structure or new CCG.

These are set out below in such a way which incorporates a transition phase if required:

- ***Audit Committee***: If Option 2 is adopted, jointly agreed terms of reference and holding meetings in common. Robust audit arrangements would be expected to be adopted by a new CCG in order to ensure clear oversight of financial governance.
- ***Chief Finance Officer and Finance Team***: financial planning, management and reporting is provided in-house with AGEM Commissioning Support Unit providing financial systems and transactions support. There is a need to ensure continuity with regard to these arrangements. The appointment of a single Chief Financial Officer will be undertaken prior to the remaining leadership team. The structure and functions of the finance team for the new arrangements will be determined following that appointment.
- ***Financial policies***: adoption of a common set of prime financial policies. These policies would become the prime financial policies for a new CCG. Harmonisation of

the scheme of delegated financial limits used by the individual CCGs would be adopted by a new CCG.

- ***Financial planning***: the three CCGs developed joint working arrangements for the completion of the most recent contracting process. This included common assumptions for financial planning purposes and lead commissioner arrangements for contract negotiation processes.
- ***Financial system/budgetary controls***: the CCGs operate a common financial system (ISFE) and use the business intelligence reporting functionality from ISFE to support budgetary control and financial management. Further work will be undertaken to continue to harmonise detailed working practices to ensure financial control operates effectively under new arrangements.
- ***Internal audit***: Coventry and Warwickshire Audit Services (CWAS) currently provides internal audit and counter fraud services to all three CCGs. CWAS would deliver a jointly agreed single audit plan as approved during any transition phase by each Audit Committee. This approach is expected to facilitate a smooth transition of internal audit arrangements into the first year of a new CCG which may then choose to re-procure internal audit and counter fraud services in future.
- ***External audit***: external audit arrangements would need to be confirmed or procured depending on the option selected.

In the longer term, the establishment of new models of care and structures will see deployment of resources in new settings. In addition, the future commissioning function will continue to evolve, with a wider range of potential partners including local authority and other statutory agencies, and there is an expectation that greater efficiencies will be available over time as these new structures develop.

ANNEX ONE

NHS England tests on a decision in principle for the formation of one CCG[1]

The application procedure for CCGs proposing to merge has been revised in light of the NHS Long Term Plan, and the learning from previous mergers. The revised procedure sets out the legal requirements, and how CCGs should work together to prepare merger applications. The revised procedure builds in benefits realisation from the outset, so that the proposed benefits of joint working and merger (streamlined commissioning across systems, efficiencies, financial savings, etc) are clearly articulated and measured. As CCGs merge and cover larger areas, they will need to show how they will retain local focus and involve members and communities.

In accordance with the legal requirements and the NHS Long Term Plan, NHS England will consider the following criteria in deciding whether to approve a proposed merger:

I. Alignment with (or within) the local STP/ICS

To provide the most logical footprint for local implementation of the NHS Long term Plan, and to provide strategic, integrated commissioning to support population health.

II. Co-terminosity with local authorities

There is a presumption in favour of CCGs being coterminous with one or more upper-tier or unitary local authorities. They should also show how they have/will put in place suitable arrangements with local authorities to support integration at 'place' level (population of between 250,000 and 500,000).

III. Strategic, integrated commissioning capacity and capability

In line with the legal requirements, the existing CCGs must demonstrate that they have/will develop the leadership, capacity and capability for strategic, integrated commissioning for their population. This will include population health management, new financial and contractual approaches that encourage integration, and developing place-based partnerships. In accordance with the legal requirements, the application must demonstrate how any commissioning support services to be procured will be of an appropriate nature and quality.

IV. Clinical leadership

In line with the legal requirements, the existing CCGs must demonstrate how the proposed new CCG will be a clinically led organisation, and how members of the new CCG will participate in its decision-making.

V. Financial management

In accordance with the legal requirements, the existing CCGs must show how the new CCG will have financial arrangements and controls for proper stewardship and accountability for public funds.

[1] Procedures for clinical commissioning groups to apply for constitution change, merger or dissolution NHS England & NHS Improvement April 2019

VI. Joint working

Ideally, a merger should build on collaborative working between the existing CCGs and represent a logical next step from current arrangements. The merger application should show progress on joint working to date and must show how the existing CCGs intend to resource and manage the merger process itself.

VII. Ability to engage with local communities

Assurance is required that the move to a larger geographical footprint will not be at the expense of the proposed new CCG's ability to engage with - and consider the needs of - local communities.

VIII. Cost savings

Where possible, the existing CCGs should show how collaboration and joint working to date has contributed to cost savings; they must also show any further cost savings projected to result from the merger, and when, and how cash released will be re-invested.

IX. CCG Governing Body approval

The merger application must show evidence of approval for the merger by the Governing Body of each of the existing CCG governing bodies.

X. GP members and local Healthwatch consultation

Evidence is required that each of the existing CCGs have engaged with, and seriously considered the views of, their GP member practices, and local Healthwatch, in relation to the merger. The merger application must record the level of support and the prevailing views of each existing CCG's member practices and local Healthwatch, and the existing CCGs' observations on those views.

Abbreviations used in this document

BME	Black and minority ethnic
CCG	Clinical Commissioning Group
CRCCG	NHS Coventry & Rugby CCG
GMS	General Medical Services (contract)
ICS	Integrated Care System
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LTP	NHS Long Term Plan (10 year Plan)
PCN	Primary Care Network (of GPs)
STP	Sustainability & Transformation Partnership
SWCCG	NHS South Warwickshire CCG
WNCCG	NHS Warwickshire North CCG

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Item 6 Briefing Note

Date: 14 October 2019

To: Joint meeting of the Coventry and Warwickshire Health Overview & Scrutiny Committees

From: Gillian Entwistle – Chief Officer, NHS South Warwickshire CCG
Adrian Stokes – Interim Accountable Officer,
NHS Coventry & Rugby CCG and NHS Warwickshire North CCG

Subject: Update on the Future of Health Commissioning Arrangements in Coventry and Warwickshire

1. Purpose of report

To provide an update on our progress in deciding the future configuration of local health commissioning in Coventry and Warwickshire and provide you with assurance that we will still deliver our statutory duties and functions.

2. Recommendations

Members are asked to **receive** the report for information and assurance.

3. Information / Background

3.1. As your local health commissioners, we are considering how we can best support the move to an Integrated Care System (ICS) and how our organisations will need to change to accomplish this. Therefore, this change relates to the future Clinical Commissioning Groups' (CCGs) organisational form to fit within the emerging national and local context and discharge our statutory duties effectively – not about reconfiguration of any services commissioned.

3.2 The NHS Long Term Plan (LTP) was released in early January 2019. Of note for the local population is the requirement for a plan to address local health inequalities, and clarity of a new service model for the NHS. This new model will comprise of Primary Care Networks (PCNs), facilitated by a new type of General Medical Services (GMS) network contract. Every Sustainability and Transformation Partnership (STP) area in the country is to be, or be part of, an Integrated Care System (ICS) by 2021.

3.3 With less than two financial years to deliver this change, discussions have centred around the development of the local PCNs and the transition of the three individual

clinical commissioning groups (CCGs) to a single strategic commissioner as required by the LTP. This has led to several scenarios for strategic commissioning being put forward which are explained in the Transition Case for Change document (Appendix A). Proposals for PCNs and updated Primary Care Strategy are the subject of other documents.

4. What we have done so far

4.1. Over the course of the last 24 months the three CCGs in Coventry and Warwickshire have been taking steps to transform how they work together and with the system in order to support the development of an ICS. The NHS LTP reinforced our direction of travel and expectation that we will need to create a more streamlined commissioning arrangement within Coventry and Warwickshire to enable a single set of commissioning decisions at system level associated with local commissioning decisions at the four Places (Coventry, Rugby, South Warwickshire and Warwickshire North).

4.2. Over the period January to May 2019 we have worked with our staff, member practices and external stakeholders to identify the potential options for a single commissioning function, and the criteria that we should use to assess the different options and applied those criteria to the options. We have undertaken a number of workshops for stakeholders to support this process and have provided a number of ongoing opportunities for members, staff and the public to share their views, ideas and concerns about the future of health commissioning.

4.3. Whilst the NHS LTP indicates that there will typically be one CCG per ICS; how we create our single, streamlined commissioning function is for local determination. The outputs of our engagement throughout the first part of 2019 informed the case for change (Appendix A) which was presented to each of the three CCG Governing Bodies in May. Of the three options presented, each Governing Body recommended to their Members the option of full merger.

4.4. Working within the provisions of their Constitutions, the strategic direction and hence, the question of organisational merger, is a matter reserved for GP Members and therefore Members were required to vote on their preferred way forward. The case we are considering does not change any of the services provided to patients, rather the organisation of the commissioning capacity and mechanisms by which we, as statutory bodies undertake our functions/duties.

4.5. In May, South Warwickshire CCG Members voted in support of the recommended option to merge the three statutory bodies.

4.6. In light of further assurances required by their Governing Bodies, and feedback from partner organisations, the Members of NHS Coventry and Rugby CCG and NHS Warwickshire North CCG were asked to vote on whether they supported the CCGs exploring closer working, either through a single management team or through merger. The memberships each voted to support the further exploration of closer working options and the work in providing further information has been

progressing over the intervening months. We expect to seek permission from the Governing Bodies in November to return to the Members and for them to vote.

4.7. We aim to be clear about the direction and timing of a proposal for moving towards a single commissioning function. We will then need to seek approval from NHS England (NHSE) through a formal and detailed application process to proceed to merger if that is the decision reached by Members. For merger from 1 April 2021 this would require a formal application to NHSE by 30 September 2020 at the latest. The CCGs cannot merge if NHSE refuses the application.

5. Local structures, partnerships and priorities

5.1. As described in other documents, work will be carried out at different levels in the future health and care system. There are 18 localities serviced through Primary Care Networks (PCNs); 4 Places through partnerships of public and voluntary sector organisations; Coventry and Warwickshire, where work across the system makes sense. It is at this highest level that our single commissioning function will operate in the future model.

5.2. In each of our Places the local partnership arrangements will begin to take responsibility for quality and cost of health and social care for their populations, as well working in partnership on the communities, lifestyle and wider determinants of health agendas; such as wellbeing and prevention. The place partnerships will develop their own arrangements to deliver the ambitions of the LTP and over time local commissioning will form a significant element of this work as around 80% of health services are likely fall within that remit.

5.3. As we have developed our thinking and as local partnerships have been developing, we have taken into account outcomes from a wide variety of engagement activities that have been undertaken across the health system.

5.4. We believe that to respond to the concerns and priorities identified in our system by our population, stakeholders and partners that the CCGs, as your health commissioners, need to become much more streamlined in our ability to respond as statutory organisations. We consider that the success and pace of priority delivery is bound in relationships and willing support from NHS organisations, Local Authorities and others, and therefore we need to be better able to support this.

5.5. To achieve this, we consider that health commissioning would need to change to:

- **Support service integration** by ensuring our resources are built around the needs of our four places – Coventry, Rugby, South Warwickshire and Warwickshire North;

- **Streamline resources** for assurance; financial management; strategic change and outcomes-based commissioning into a single commissioning function; and

- Meet the requirement to **reduce our internal running costs** by 20% by 2020/21. Achievement of this without structural change will be almost impossible and hamper our ability to deliver our statutory functions.

5.6. To do this successfully, we need to consider a number of important factors:

- What we are already doing that demonstrates working in this way e.g. the Out of Hospital contract

- Where are the potential opportunities for this change to further benefit patients and the public, by improving population health through integration and/or address inefficiencies or financial challenges?

- Fully assess the risk verses benefit of potential changes, and the resources required to achieve the changes.

5.7. If we were to move to a single CCG, we could expect to see the following benefits for staff:

- Sharing the load across system-wide work
- Keeping a focus on place-based expertise and experience
- Much closer working with and within the community
- Combined expertise and resources from across all three CCGs
- Opportunity to work at every level – system, place, and network

5.8. A number of high level goals can be realised, at least in part, by the proposal to change. For example:

1. More effective system management underpinned by comprehensive information systems;
2. More effective and efficient commissioning processes with less duplication;
3. Greater focus on outcomes-based commissioning;
4. Better value through improved efficiency and reduced costs of commissioning function;
5. Simpler and more effective governance of commissioning and decision making;
6. Stronger service transformation approaches, decommissioning and re-commissioning;
7. Aligned budgets (as a minimum) and agreed risk share arrangements.

6. Next Steps

6.1. The CCGs continue to provide additional information, including how the new options might look in practice, and to answer questions received from stakeholders and the public, Members, the Local Medical Committees (LMCs), and CCG staff.

6.2. Throughout October and November 2019, the CCGs will continue the dialogue with their respective members, to keep them updated on the progress on the additional information requested by the Governing Bodies. .

6.3. The next steps will be determined by the outcome of the votes.

6.4. Should there be a consensus for full merger, the detailed application will be developed for consideration by NHS England. The broad timetable for this would be:

Dec 2019	Outcome of vote known
Jan-March 2020	Recruitment to a single accountable officer and chief financial officer Preparation of specific documents required by NHSE for the application, including proposed single constitution and full engagement programme
April – June 2020	Preparation of, and agreement to, application submission in line with NHSE requirements
July – Sept 2020	Formal application made to NHSE prior to Sept 30th deadline
October 2020 – March 2021	NHSE review and assessment period. Secretary of State approval or conditional approval reached; Actions undertaken to resolve conditions if/as required Preparation for transfer of assets and liabilities to the new CCG.
1 April 2021	Go Live

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