Commissioning intentions

DETAILED STOCK TAKE AND WORK PLANS 2020/21

Our detailed commissioning stock take and next steps

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

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

Primary Care

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Providing high quality education and self-care resources to help support patients with diabetes.	• Health and Care Partnership (HCP) Diabetes Strategy Group and five Task and Finish Groups have been established following our highly successful diabetes Protected Learning Time (PLT) event in November. These groups have individual terms of reference to support and to drive development of place-based diabetes services, aligning to our Out of Hospital (OOH) work. • Our Desmond education providers are delivering sessions within a variety of community venues across our geography; a further eight educators have accessed educator training to support increased capacity and sessions. • Partnership arrangements are in place with Public Health Teams, our other two Clinical Commissioning Groups (CCGs) and NHSE to support re-procurement of the NHS Diabetes Prevention Programme (DPP) across Coventry and Warwickshire. • We are meeting with Type 1 education leads from across Coventry and Warwickshire to review their educational programmes and activity and discuss capacity, pathways and clinical outcomes. • A programme of professional education around diabetes prevention and management has been developed and implemented for General Practitioners (GPs), nurses, Health Care Assistance (HCAs), podiatrists and pharmacists. • We are working with care home providers to support an at scale diabetes educational programme and resources/materials for every care home. • A Diabetes Dashboard has been developed to monitor the wider impact on a range of system-wide and patient health outcomes. This has been designed to view CCG, Primary Care Network (PCN) and individual practice data, and has been overlaid onto our PCN map and onto a Long Term Conditions (LTC) hotspot map to provide a comprehensive overview.	• A greater proportion of patients will have access to and benefit from the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) education programme. • Patients will be provided with necessary skills and education to help them with a greater understanding of their condition, reducing GP appointments and increasing self-management skills. • Patients will have increased access to the Diabetes Prevention Programme (DPP) to reverse progression towards Type 2 diabetes, and improve a range of health outcomes through behaviour change. • Patients with Type 1 will have access to education and specialist advice to support increasing their achievement of the three treatment targets and annual review outcomes. • Our workforce will be upskilled and have increased knowledge to support the management of their diabetes populations. • Identification of where clinical need and service provision, across our PCN needs to be focussed, and to help inform the task and finish strategy groups as pathways and models of working are developed.	• Monitor Desmond provider performance against expected activity. • Continue to meet with Primary Care Networks (PCN) and General Practice (GP) leads to discuss their population needs and support development of the dashboards. • Monitor increasing rise in prevalence, currently above national average, and utilise the dashboards to ensure services deliver against population need and increased capacity with increased demand. • Continue to monitor the outcomes associated with this intervention, with a focus on increases in both the achievement of the three treatment targets and completion of all eight care processes.

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Supporting GP practices to develop a sustainable workforce and avoid staffing issues.	• A full workforce plan for 2019/20 has now been developed, with five work streams including retention, recruitment, welcome back to work, First Five and Portfolio careers. • GP Mentor programme is progressing well, and activity/mentoring sessions are currently being actively sought. This initiative will remain in place for 2019/20 and be extended to support the First Five GP programme. • The First Five GP clinical lead is in place and actively developing a programme of work. • The Practice Manager and Practice Nurse Mentoring programme will be launched in September 2019. • Health Education England (HEE) have been sent the evaluation of the GP Mentor Development programme - which was very positive. • The next Mentor Evaluation/Review session is scheduled for September 2019. • CCG and Training Hub representatives will support the new Local Workforce Advisory Board (LWAB) structure by attending the Workforce Operational Delivery Group and the delivery work streams. • Practice Manager Training evaluation has been submitted to NHSE as requested and all funds have been spent. • Work is under way to complete the maturity self-assessment in readiness for the new Training Hub Contracts. • Training Hubs are meeting regularly and working well together.	• Work with our member practices and key partners to understand the current and forecast workforce capacity and pressures. • Ensure that the CCG works closely with NHS England and member practices to attract and retain workforce within the local area. • Continue to work with practices and other partners to deliver the STP workforce initiatives including international recruitment, GP retention, nurse prescribing, staff training and recruitment.	
	• HCA training continues to be funded. • Signposting and customer service training is being rolled out across Coventry, offered to all practices. Training should be complete by July, with mop up sessions in September 2019. • #careforyourcareer website is due to go live by end of June, with several vacancies being advertised on there. • The Training Hubs have been commissioned to roll out the Portfolio Careers work stream. • HEE funding has been secured for 2019/20.		

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Improve access to flexible, seven day services and same-day urgent care by helping practices work together.	• Coverage of practices and their patient population has continued to grow during 2018-19, with full coverage expected to be in place by September 2019 • A number of GP Extended Access Hubs are operating across Coventry and Rugby to enable patients to access a GP appointment in evenings and at weekends. NHS 111 is also now able to book appointments into the service following appropriate triage.	• Patients are able to access a GP appointment in the evening and at weekends, including bank holidays.	• Work is on-going to support the development of clusters of practices that will work together more at scale. • The CCG is currently working with the provider and PCNs to review the location of the Hubs to ensure access for patients and utilisation is maximised, whilst ensuring services are delivered in line with current and new national requirements.
Help practices form strong networks and work collaboratively to deliver their services "at scale".	• Rugby: has established one Primary Care Network (PCN) with a Clinical Director. The network agreements schedules were completed and CCG assured by 30th June. • Coventry: has established seven PCNs; all have a Clinical Director and Co-ordinator; all have regular scheduled meetings and Network Leads also attend joint meetings with OOH teams working with their networks and a monthly Primary Care Development group - to support further development networking and collaboration across networks and with the CCG . All Network DES schedules were completed and assured by 30th June.	• Patients will benefit from a wider range of skilled staff and better access to a range of services.	• Continue to develop network working within practices across Coventry and Rugby, supporting closer working and mutual support.
Improve dementia diagnosis and post diagnostic support.	• The CCG continues to focus on improving dementia diagnosis rates (DDR), working closely with Coventry and Warwickshire County Councils, care homes and primary care. A detailed action plan has been created; detailing actions that will contribute to raising numbers of screening/ diagnoses made, for example, a Locally Enhanced Scheme has been launched with GPs who have been trained to undertake Cognitive Function Assessments in order to diagnose dementia. • A mapping exercise is underway to map older populations, care homes and GP practices so that targeted assessments and support can be rolled out in areas where dementia prevalence is likely to be higher. The CCG is also investigating what benefit and advantages Admiral Nurses would bring to the area.	• More individuals with dementia will receive a definitive diagnosis of dementia and be able to access a range of appropriate post diagnosis support enabling them to live independently for as long as possible. •This work will ensure that flexible and timely access to post diagnostic support is available to support carers who provide essential care for a person with dementia.	• Target care home provision for people living with no diagnosis. • Target GPs where there are higher numbers of estimated people living with dementia. • Proposals being taken through Governance Board around utilising nurses to undertake cognition assessments on behalf of GPs. • Continue to work with partners across Coventry & Warwickshire to carry out a system-wide review into the offer to carers. • Dementia Pop-up Clinics are being set up across up to five GP Practices. The Pop-up Clinics will be run by the Dementia Navigators (Alzheimer's Society) once a month and will be an opportunity for GPs and patients to get some support / guidance around memory concerns. This scheme is looking to expand out further.

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Improvement of primary care estate – buildings, number of practices, technology available etc.	• We commissioned the Design Buro to refresh our primary care estates utilisation exercise. This has now been completed and the findings are being used to inform the STP Estates Strategy, due to be drafted in July 2019 • Projects in cohort 1 and 2 of the Estates Technology and Transformation Fund (ETTF) are either in train or completed. We secured funding from NHS England to undertake options appraisals on those projects within cohort three of the ETTF. These are due to be completed at the end of June 2019. The outcome will help determine the next steps for cohort three schemes. • We continue to hold the monthly Local Estates Forum (LEF), and attend the STP Estates Strategy Group (ESG) to ensure that we are working with partners to look at potential opportunities for collaborative working across public estate. • Separately we have launched more technological solutions to support care, including the Castle End of Life register, and worked to ensure that practices receive the GP IT support they need.	• Facilities will be designed with greater flexibility to accommodate Multi-disciplinary Teams and an increased online access will make it easier for patients to be seen quicker.	• We continue to hold the monthly Local Estates Forum (LEF) and attend the STP Estates Strategy Group (ESG) to drive this intention and to ensure that we are working with partners to look at potential opportunities for delivering out of hospital and Multi-disciplinary Teams (MDTs) across the primary care estate.

Out of Hospital

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Develop Multidisciplinary Teams working across groups of practices to support the care delivered to frail and vulnerable adults.	• Out of Hospital is now in its second year of its transformational programme to develop and implement a new service model for community services. • An Integrated Single Point of Access (iSPA) has now been operational for over 12 months which centrally receives, clinically triages and responds to all referrals. This includes a Rapid Response Service. • Community staff and caseloads have now been aligned to each of the Primary Care Networks as the first step towards full implementation and roll out of Placed Based Team and MDT working. • The contract has placed great emphasis and responsibility on the provider for co-production of the new care model, to include engagement with patients, carers, staff and system partners.	The new model will help to: • Prevent ill health and improve the quality of life for people with long term conditions. • Effectively manage long term conditions such as diabetes, heart disease and COPD. • Identify people at risk of ill health or hospital admission who are 'frail'. • Avoid hospital admissions for at risk patients with increasing frailty . • Better coordinate the care of people with complex problems and support them to live independently for longer. • Better coordinate the care of people with complex problems via joined up hospital and community services.	• Further development of the iSPA to ensure that it remains responsive to system demands. • Development and implementation of full Placed Based Team and MDT working, aligned to Primary Care Networks. • Introduction of risk stratification and population health tools to enable Placed Based Teams to plan and deliver services based on its population's health and wellbeing needs. • Implementation of an Electronic Patient Record to enable improved access to information to support health, primary care and social care professionals in the integrated care co-ordination and care planning, where people only need to tell their story once. • Patient pathway development, specifically for long term conditions, to enable patients to be better equipped to self-manage their conditions and receive the care in the correct setting when needed.

Maternity, child and young people services

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Working together with local commissioners and providers to implement the recommendations of the National Maternity Review 'Better Births'.	• The Local Maternity System (LMS) is delivering the key milestones via the Maternity Transformation Plan. • Three work streams are in place to deliver the Transformation Plan: - Quality and Safety - Choice and Personalisation - Health and Wellbeing	• Safer, kinder, more family friendly and Personalised care. • Ensures patients feel more involved in the decisions about their care. • Ensures support is centred around a patient's individual needs and circumstances. • 35% of women will receive continuity of care.	• Continue to implement the recommendations from Better Births, the West Midlands Neonatal Review and the LMS Transformation Plan.
Ensure women at risk of premature delivery receive the right care in the right place at the right time leading up to the birth of their baby.	• Collaborative working between University Hospitals Coventry and Warwickshire (UHCW), George Eliot Hospital (GEH) and South Warwickshire Foundation Trust (SWFT) has demonstrated that working collaboratively as a system ensures that Coventry and Warwickshire women and babies are not transferred out of area.	• Where safe to do so babies delivered as close to home as possible. • Improves infant mortality by reducing the number of stillbirths and neonatal deaths by 20% by 2020 and 50% by 2025 from the 2015 baseline.	• Implement the recommendations from Better Births, the West Midlands Neonatal Review and the LMS Transformation Plan.
Ensure we have the right amount of neonatal cots (level 1 to 3 cots), based on patient need. Reduce separation of mothers and babies through increased use of Transitional Care.	• The Choice and Personalisation work stream of the LMS has established a Clinical Steering Group that is developing a range of potential scenarios for the future clinical model for maternity and neonatal services. • NHSE Specialised Commissioning and the Operational Delivery Network are members of the LMS.	• Women and babies receive care in the right place at the right time.	• Implement the recommendations from Better Births and the West Midlands Neonatal Review.
Deliver against national requirements related to Special Educational Needs and or Disability (SEND).	• Plans in place for a Care Quality Commission (CQC) and Ofsted inspection.	• All children will have an up-to-date Education Health and Care Plan (EHCP) that clearly states their needs and outcomes to ensure they receive the best care to meet their needs.	• Through the SEND partnership and the Designated Clinical and Medical Officers review processes to improve timeliness and quality of EHCPs.
Review provision of: • Occupational therapy • Physiotherapy.	• Monitor the impact of the revised service specifications and access thresholds to ensure improved outcomes for children and young people.	• Improved access to therapy services • Early identification and intervention • Improved patient outcomes • Reduced waiting lists	• Agree key performance indicators and monitor via the contract.

Urgent and emergency care

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Make it easier for patients to understand and access the right type of urgent care service in an emergency.	• Worked with NHS England, NHS Digital and University Hospitals Coventry and Warwickshire (UHCW) to develop Rugby Urgent Treatment Centre and consider options for Coventry Walk-in Centre. • Implemented direct booking into local GP Extended Access appointments for relevant patients. • Worked with other regional CCGs to improve triage capabilities within NHS 111 to safely reduce demand on ambulances and Accident and Emergency departments (A&E).	• A more responsive, joined up service which will be easier to navigate for patients. • Patients will receive the optimum level of services in the appropriate setting regardless of how they access the service.	• Monitor demand and feedback for Rugby Urgent Treatment Centre. • Develop Coventry Walk-in Centre according to local need. • Enable direct bookings into UTC appointments via NHS 111. • Support local implementation of the NHS app including the ability for patients to access appointments online. • Support national and regional 'Choose Well' and NHS 111 marketing campaigns during the winter season. • Review and promote agreed smart phone app(s) to support patient and carer navigation of the urgent care system.
Reduced reliance on urgent and emergency care over time, with integrated teams/communities proactively managing people at higher risk.	• Rolled out Place Based Teams (PBTs) across Coventry and Rugby.	• Greater proportion of patients will receive treatment and care in a place that is more convenient for them. • There is more support available to help patients to manage conditions themselves.	• Roll out an enhanced service to all GP Practices in Coventry and Rugby to support the identification and case management of patients at higher risk of requiring urgent and emergency care.
Integrated rapid response and support once people are in the urgent / emergency care system, with better links to urgent social care services.	• Single points of access established to cover Coventry and Rugby to give access to Place-based Teams as well as all rapid response community services. • Invested in West Midlands Ambulance Service to work more closely with PBTs using their Strategic Conveyance Cell (SCC).	• More patients will receive treatment and care in a place other than A&E and which is more convenient. • There is more support available to help patients to manage conditions themselves. • Patients avoid unnecessary admissions to hospital because more suitable care is available and more easily accessible. • Services can help prevent hospital admissions and facilitate early discharge, improve patient safety and improve choice by enabling patients to stay in their homes.	• Integrated Single Point of Access referral routes and pathways to be evaluated and improvements implemented where highlighted. • Evaluate West Midlands Ambulance Service's Strategic Conveyance Cell (SCC).

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Provide better, clearer and easier-to-access alternatives to A&E to help patients receive the best care for their need when it isn't a life-threatening emergency.	• Implemented a case management approach to support patients attending A&E frequently partly due to other underlying health or social issues. • Invested in West Midlands Ambulance Service to work more closely with PBTs using their Strategic Conveyance Cell (SCC).	• A greater proportion of patients will receive treatment and care in a place that suits them with a greater emphasis on provision of support to help patients to manage conditions themselves. • Providing Nursing Home staff access to clinical support via NHS 111.	• Deliver case management support for local residents calling 999 most frequently partly due to wider underlying health or social issues. • Implement solution to enable direct booking from NHS 111 into GP Extended Hours. • Ongoing development of regional NHS 111 Clinical Assessment Service to increase the numbers of calls safely signposted to alternative services other than 999 and A&E.
Improve stroke services across the area to reduce the number of strokes suffered, improve immediate care for those that do have a stroke and provide better support and rehabilitation after a stroke	• Undertaken pre-consultation engagement with public, patient groups, local authorities and other key stakeholders. • Used engagement feedback to develop a clinically viable proposal that provides the services people need. • Worked with the specialist colleagues within the Cardio Vascular Disease Network to refine the staffing model that underpins the rehabilitation services • Worked with NHS England to gain their assurance and approval to progress to public consultation • Worked with the public, patient groups and other key stakeholders to develop accessible public consultation documents • Developed an indicative plan for implementation	• Improved access to specialist services in a "hyper acute" stroke unit. • Provision of new community rehabilitation services at home for 70% of stroke patients • Improved outcomes following a stroke due to improved access to rehabilitation • Improved anticoagulation for AF patients leading to the prevention of approximately 230 strokes in 3 years • Reduction in mortality rates as a result of strokes • Help people continue to live independently, where it is safe to do so, following a stroke	• Formally consult with patients, the public and other stakeholders on the proposed future model of service • Consider the outcomes of public consultation, agree any changes needed and formally approve implementation • Establish the Governance structures to manage and oversee implementation • Engage and formally consult with staff working within the services that are being developed
Increase the numbers of patients treated in hospital under Same Day Emergency Care.	• Initial engagement with UHCW regarding how best to optimise the level of Same Day Emergency Care.	• More timely assessment, diagnosis and treatment. • More patients returned home same day avoiding the need for full hospital admission. • Free bed capacity to allow quicker admission of more acutely ill patients.	• Implement a review of patient pathways in and out of the Emergency Department. • Agree and implement an action plan to increase SDEC activity.
Implement revised national urgent and emergency care standards.	• National review underway.		• Implement changes as required by NHS England.

Planned care

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Reducing unnecessary hospital outpatient attendances.	• A number of workshops have taken place with a view to ensuring patients are seen in the most appropriate location, reducing the complexity in accessing the right service in the right place and reducing unnecessary hospital attendances. Workshops have taken place during 2018 and early 2019 in MSK, Ophthalmology, Urology, Dermatology, (Inc. Plastics) General Surgery, ENT (Ear, Nose and Throat) and Gastroenterology. • The outcome of these workshops informs the transformation programme specific for each specialty that are part of a continuous service improvement programme.	• Reduction in unnecessary patient visits to hospital. • Reduced travel and car parking charges for patients. • Improved patient satisfaction.	• Joint Transformation plans in development and in the process of being agreed by providers and commissioners. Transformation programme underway to establish sustainable Ophthalmology, Dermatology and Urology pathways. • Single Point of Access/First Contact Practitioner implementation to support the primary care/acute and community MSK pathway.
Ensure commissioning policies are reviewed and aligned across both CCGs.	• Work continues through the 2019/20 financial year to review existing commissioning policies on a Coventry and Warwickshire footprint level. • A programme of horizon scanning continues throughout the year to identify new guidance being introduced by other commissioners that may benefit Coventry and Warwickshire patients.	• Ensures equity of access for patients and a consistent approach to policy development across the Coventry and Warwickshire footprint.	• Revise commissioning policies where they differ from those identified in the national consultation. Ensure policies are policed and managed more effectively with a range of partner organisations.
To ensure social prescribing model is meeting the needs of our communities.	Over the last 12 months, the CCG has proactively worked with the other Warwickshire CCGs and Warwickshire County Council to progress work to develop a Warwickshire Wide Social Prescribing model. This has involved a number of Workshops with the voluntary sector and wider stakeholders. With the recent introduction of Primary Care Link Workers, engagement is being undertaken with Primary Care to look at opportunities for how these roles will align and integrate within the wider model. Within Coventry a similar process of engagement has recently commenced.	• The social prescribing model will support people with a wide range of social, emotional or practical needs, and many schemes are focussed on improving mental health and physical wellbeing.	The work to develop Social Prescribing models within Coventry and Warwickshire will continue, with the aim of informing commissioning intentions and recommissioning of services.

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Establishment of a telephone Advice & Guidance system.	• Agreement reached to replicate the Consultant Connect service that has been launched in Warwickshire North.	• Potential for significant reduction in unnecessary hospital visits. • Consultant Connect system encourages GPs and Consultants to have conversation re: management plans with patient present and at the centre of the decision making process.	• Service has been launched with Gastroenterology following extensive IT and infrastructure reconfiguration to enable the system to work within UHCW. This will be rolled out across multiple specialties replicating the system in WN and SW.
Work with our Local Authority partners to progress the implementation of the Carers Strategies which were refreshed during 2016/17.	• The CCG continues to be part of the Warwickshire Carers Strategy Delivery Board, which oversees and leads on the development of strategies to deliver improved support for carers. • Partners continue to work with the new Carer Wellbeing Service to ensure that they are reaching carers across the county. Specific communications were developed and circulated by the CCG for carers who are looking after someone who is end of life.	• Ensures those acting as carers for family members or friends are given the right support. • Provides wellbeing checks to carers.	• CCG will be increasing engagement with carers who look after somebody with dementia by holding regular meetings with a carer and patient reference panel 2019-20. This will allow local carers to feed into the dementia strategy and future commissioning intentions of the CCG.
Work collaboratively with Public Health to embed healthier lifestyles in planned care services.	• *Rugby* Fitter Futures Warwickshire (FFW) has been commissioned to reduce obesity, improve healthy eating, improve mental wellbeing, increase physical activity levels. • Improve access to Smoking Cessation services and support through meeting NICE guidance for SC in secondary care (PH 48) and promote use of E-Cigarettes in harm reduction.	• A greater proportion of patients are being supported to achieve a healthier lifestyle.	.• Support stronger integration and signposting between CCG commissioned services and WCC/CCC Public Health services through our commissioning and contracting approaches. • Ensure a strong focus on reducing inequalities and evidencing our impact across our commissioning activity by promoting workplace wellbeing for our staff and those of our provider organisations. • Celebrating good practice around prevention and wellbeing. • Strengthening our approach to Making Every Contact Count across our commissioned activity. • Championing system-wide initiatives including #onething and The Daily Mile.

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Engage with our local stakeholders and communities to improve cancer screening uptake.	• 100% of GP Practices across Coventry and Warwickshire promoting bowel screening through GP Endorsement. • Promoting bowel screening among those patients who fail to return FOB specimens: This will be evaluated as part of a wider research project in partnership with Warwick University. • Developed a cervical screening business case focusing on inequalities across the STP. The proposal is based on targeted interventions to improve uptake across BAME communities and maximising the use of extended hours access. • Owing to the success of the C&W Lung Cancer Protected Learning Time event held in March 2018 a date for a future PLT has been secured. Supporting education and development of primary care staff is fundamental as they are best enabled to prevent cancer, support early diagnosis and enable people to live well with cancer.	• A greater proportion of patients will receive screening opportunities and earlier referral resulting in earlier detection of cancer and increasing survival rates.	• In line with national guidance and locally developed plans, continue to work towards improved patient uptake rates for each of the screening programmes. • Develop a work programme that will focus on an increased number of Stage 1 and 2 cancer diagnosis
Provide quicker access to cancer diagnostics and specialist care compliant with national quality standards.	• Development of C&W wide two week wait referral forms, due to be launched on a phased approach in the coming months. • Cancer waiting times continue to be monitored through the commissioner/provider contractual agreements. • It has been recognised that there needs to be a greater understanding of pathways and operational issues impacting on achievement of the national quality standards. A local group has been established and is in the early stages of developing an STP wide action plan. • In 2018 a new diagnostic test (FIT) was launched across C&W; this test will detect/diagnose potential cancers earlier. • Secured funding to develop a Lung Screening pilot with a targeted group of GP practices in Coventry.	• Earlier access to diagnostic testing; diagnosing cancers much earlier. • Improved waiting times. • Improved outcomes.	• Work towards the achievement of the 28 day faster diagnosis target in line with the NHS Long Term Plan.

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Deliver a year-on-year improvement in the one year survival rate; maximise involvement in survivorship programmes.	• Through earlier diagnosis and staging we are supporting patients to self-manage their conditions in the long term with additional information, advice and support through planned Health and Wellbeing programmes as part of their care pathway.	• A greater proportion of patients will survive and learn to effectively self- manage their condition.	• Patients will be supported through health and wellbeing events, primary care cancer reviews allowing them to self-manage their long-term cancer diagnosis.
Ensure all elements of the recovery package are commissioned (Holistic Needs Assessment and Care Planning, Health and Wellbeing Events, Treatment Summaries and Cancer Care Reviews).	• A Coventry and Warwickshire wide Living with and Beyond Cancer (LWBC) programme plan is in place. • A multi-stakeholder breast cancer mapping workshop has been undertaken to allow local providers and commissioners to collaboratively agree how the Recovery Package aligns with the breast cancer pathway. • A Coventry and Warwickshire wide Steering Group is in place and is supported by Task and Finish groups focusing on implementation of the Recovery Package . Funding has been secured and posts have been recruited to in each of the local Trusts. • Approximately 40 practice nurses have been trained to deliver holistic cancer care reviews.	• Patients living with and beyond cancer have improved quality of life, and improved health and wellbeing. • Patients more confident in their ability to self-manage their health, and make appropriate use of health care resources, leading to a reduction in GP and A&E attendances. • Patients live longer due to healthier lifestyle and better management of the consequences of treatment, e.g. CVD. • Implementing the Recovery Package supports the wider implementation of Person Centred follow up of care, leading to fewer patients in face to face follow up, allowing reallocation of resources to focus on patients with complex needs.	• Continue to implement the LWBC Programme Plan and work towards national requirements. By 2021, where appropriate every diagnosed person will have access to personalised care. • Ensure Breast Cancer? Person Centred Follow Up is in place and develops plans to roll out to colorectal and Prostate. • Continue with Cancer Care review practice nurse training. • Support local Trusts with the delivery of the Recovery Package.

Mental health and learning disabilities

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Improving access to Child and Adolescent Mental Health Service (CAMHS) services.	• Follow up waiting times continue to reduce. • Tier 3.5 Business Case developed and mobilisation underway. • Expansion of the Children's and Young Peoples Acute Liaison Team to improve access and assessment from five days to seven days. • Pilot additional support for CAMHS/LD and Autistic Spectrum Disorder children and young people in crisis. • Pilot outreach support for children, young people and families waiting for an Autistic Spectrum Disorder diagnosis and those who have recently been diagnosed with Autistic Spectrum Disorder (ASD). • Developed a bid for additional funding from NHSE to expand the trailblazer offer within SWCCG to cover WNCCG and CRCCG to have an STP wide offer. • Developed a pilot for a bespoke service for up to 10 CYP to work within the community to prevent A&E attendance with a view to support back into mainstream schools. • Warwickshire Community Partnerships in place across the county to improve access to information and support for parents and children and young people. Partnership work is underway to expand the offer to communities.	• Earlier access and interventions • Improved crisis diversion • Reduced unnecessary demand for specialist care by ensuring more appropriate care is available and easy to access.	• Further integrate pathways with family/ community hubs. • Monitor and evaluate impact of transformation schemes on outcomes for young people. • Review referral to treatment pathway to ensure reduced waits are sustained. • Promote revised Dimensions Tool as a means of parents and families describing need to referrers and the Rise service directly, as well as identifying means of self-directed help and support. • Deliver pilot bespoke service for up to 10 CYP to work within the community to prevent A&E attendance with a view to support back into mainstream schools. • Continue implementation and development of Tier 3.5 Service. • Implementation of Trailblazer service (MH support for CYP in schools), providing bid is successful.

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Embed the Suicide Prevention Strategy and reduce suicide rates.	• Safe Haven trial sites launched in Warwickshire (July 2019). • Bid in with NHS England to expand crisis support including Safe Haven for Coventry. • Suicide Prevention and Mental Health First Aid training provided to health and community partners. • Communications and public engagement activities to raise awareness throughout 2018/19 and 2019/20. • Stay Alive App commissioned for Coventry and Warwickshire residents to access for free. • Work underway to establish 'Real Time Surveillance' of self-inflicted deaths to improve timeliness of data and support to those affected by potential suicides.	• Raised awareness and access to self-help resources. • Increased bereavement support. • Reduced levels of suicide.	• Monitor Safe Haven provision across Warwickshire to provide meaningful alternative to crisis. • Expand 'It Takes Balls to Talk' to reach additional community assets such as barbers and workplaces. • Deliver evidence-based mental health awareness and suicide prevention training to both NHS and non-NHS stakeholders. • Continue with coproduction elements with those with lived experience on projects and monitor the outcomes and feedback of 'Crafty Blokes' (being run by Coventry Men's Shed).
Expansion of IAPT (Improving Access to Psychological Therapies).	• IAPT has expanded focused on long-term conditions (LTCs) such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). • Employment Advisors help people find and stay contracted from Mental Health Matters.	• Increasing access rate for people with common mental health conditions receiving psychological therapies, with 50%+ of people achieving recovery.	• Maintain and develop high quality services. • Further expand IAPT therapies through group based therapies, digital therapies, expansion of LTCs and a strong interface with CAMHS. The above will be supported through the co-location and alignment of IAPT therapists to Primary Care Networks.

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Increase access to annual health checks for patients with SMI (severe mental illness), progressing towards 60% uptake by 2020.	• Health checks for patients under the care of CWPT delivered in 2018/19; primary care model developed and due to be implemented during summer-autumn 2019. • Smoking cessation training delivered to CWPT and Mind staff to raise awareness and encourage brief interventions with this cohort. • 'Supporting Health and Physical Exercise' (SHAPE) trial through the Recovery and Wellbeing Academy for people with SMI under the care of CWPT. • Healthy Living Pharmacies training to improve knowledge, skills and confidence of staff to support people with SMI and 12 month trial of health interventions provided through pharmacies (healthy lifestyle conversations and medicines use reviews). • CWPT have strengthened the physical health check lifestyle tool, with enhanced benefit to the Early Intervention in Psychosis (EIP) cohort. • 'Get Set to Go' programme being delivered by Springfield Mind for Warwickshire residents, providing peer support to encourage uptake of physical activity opportunities among people with SMI.	• Patients to have improved awareness of and access to annual health checks, reviews and lifestyle interventions.	• Implement a whole system pathway for promoting uptake and delivery of physical health checks in people with severe mental illness and, importantly, improving the engagement with healthy lifestyle support for this cohort. This will be mobilised through the increased integration, place-based working and personalised care planning which is developing across the system.
Service users experiencing a first episode of psychosis or ARMS (at risk mental state) wait less than two weeks to start a national Institute of Clinical Excellence (NICE) recommended package of care.	• The capacity of Care Coordinators has been increased to assist consistent achievement of the access standard. • As a system we have also received support from the National Intensive Support team, who completed a deep dive in January 2019.	• Case load per Care Coordinator has reduced, alongside an extension in the average length of treatment.	• Strengthen and improve the quality standards for patients to access Cognitive Behaviour Therapy (CBT); specialists' employment support; family interventions; carers' education and support programmes; physical health checks and increase use of outcome measures.
Increase access to specialist perinatal mental health services.	• Mobilised transformation funding to enhance and build capacity within this service.	• Supported the expansion of capacity and capability of an evidence-based multidisciplinary service. The inclusion criteria have been extended to now accept mothers with children aged 0-12 months.	• Consider opportunities to sustain the Early Years Practitioners and BME link support worker as part of an integrated pathway of care.

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
All Out of Area Placements (OAPs) to be eliminated by 2021.	• Out of Area Placement Coordinator recruited to CWPT on secondment basis. • Analysis undertaken: benchmarking and assessing current position in OAPs and Length of Stay. • Trajectory to reduce OOAs agreed by CWPT.	• Ensures that treatment and care coordination is delivered to patients locally, increasing clinical outcomes and recovery.	• The Out of Area placement budget is to be devolved to CWPT, who will use resource to commission alternative provision to prevent usage of out of area placements and ensure delivery of the OOA trajectory plan agreed with CCGs and NHSE.
Increase investment in Crisis Resolution and Home Treatment teams (CRHTTs).	• Scoped a Health and Care Partnership (HCP) submission to enhance crisis resolution and home treatment provision across Coventry and Warwickshire.	• Full fidelity to the Crisis Resolution Home Treatment Team model by 2021 (or sooner if possible). • Fast Response Hub (FRH) based in each of the three localities (Coventry, Warwickshire North and South), staffed by a robust and skilled MDT team operating 24/7 365 days a year to provide triage, assessments and response functions with open access/ no restrictions. • Establishment of crisis home treatment teams linked to the Fast Response Hubs.	• Implementation of the Crisis Resolution and Home Treatment Team funding bid (subject to approval from NHSE).
Invest in alternatives to admission or A&E as part of a comprehensive crisis pathway.	• Engaged with provider and service users to scope opportunities for Safe Haven provision in Coventry.	• Meaningful alternative to crisis available to deescalate, prevent admissions and provide a calming environment.	• Delivery of a Safe Haven in Coventry, 6-11pm 365 days, complementing the Safe Haven provision across Warwickshire.
Increase provision in Mental Health (MH) Liaison.	• Scoped a NHSE Transformation bid for UHCW to have Core 24 MH liaison standards, where patients will have access to MH liaison to receive a psychosocial assessment, risk assessment and safety plan.	• The liaison mental health to operate as an on-site, distinct service on a 24/7 basis. • Commissioned to deliver care in line with the recommended response times. • The service is resourced in line with or close to the recommended liaison mental health staffing levels and skill-mix.	• Implementation of the MH Liaison funding bid (subject to approval from NHSE).

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Expansion in access to IPS (Individual Placement Support) for patients with Severe Mental Illness.	• IPS provision is in place across Coventry and Warwickshire delivered by Rethink and integrated with MH secondary care teams.	• Access to specialists employment support to aid and support recovery through hope, connectedness, identity and empowerment.	• To further expand the provision and integration between Rethink IPS workers and CWPT IPUs 10 - 17.
Continue transforming care for people with learning disabilities and/or autism.	• Created the infrastructure to effectively deliver Care, Education and Treatment Reviews locally. An expert by experience hub has been commissioned to strengthen the input from people with lived experience. • Commissioned new community services for people at risk of admission including a pilot intensive support service for children and young people with learning disabilities and/or autism; intensive support for adults with autism and forensic community support for adults. • 24% reduction in use of inpatient services since March 2016, including a 46% reduction in use of CAMHS Tier 4 inpatient services for young people with learning disabilities or autism.	• People are supported to achieve their potential, to remain in their community, to increase independence and meaningful activity, including increased engagement in education for young people. • Delivery of person centred care in the community to reduce avoidable admissions.	• Continue to strengthen multi-agency working and key worker arrangements across health, social care and education with a focus on reducing avoidable admissions and ensuring timely discharge. • Work with commissioning partners and the market to ensure community and inpatient commissioned services are meeting need and enable early identification and intervention to prevent escalation of need. • Work with regional commissioners to jointly commission services and redesign care pathways, including complex care and forensic rehabilitation services and services for people with autism. • Continue to improve the quality of Care Education and Treatment Reviews, including strengthening the role of people with lived experience in reviews. • In Warwickshire, work with the council to review and recommission community support for people with disabilities, ensuring a more personalised rather than service driven approach (including short breaks, day opportunities, Shared Lives, supported living and specialised housing suitable for adults with disabilities). • Work with social care partners to continue to support the development of the local accommodation offer for people with disabilities or autism, including the residential care offer for people with high support needs.

Commitment	What we have achieved so far	How this benefits our patients	Next steps (20/21)
Further development of joint commissioning arrangements for people with disabilities or autism across the Health and Care Partnership (HCP).	• Expanded the scope of the integrated commissioning function for people with learning disabilities and autism across health and social care for Coventry and Warwickshire to include children with Special Education Needs and Disabilities (SEND) (hosted by Warwickshire County Council). • Coventry and Warwickshire are leading the West Midlands commissioning collaborative for people with disabilities. • With Coventry and Warwickshire Partnership Trust (CWPT), jointly developed six outcome based service specifications which will be aligned to a revised pricing and activity matrix.	• Improves the integrated commissioning pathway; including for young people with SEND and those in transition. • Improves the quality of provision for our disabled population by integrating health and social care support around individuals.	• Further develop integrated commissioning intentions across the HCP footprint, and West Midlands as appropriate; coordinated through the integrated commissioning function, including refreshing and aligning statements of intent for people with disabilities. • Continue to implement the recommendations of the collaborative review of Coventry and Warwickshire Partnership Trust (CWPT) learning disability services. • Deliver an integrated plan for the re-commissioning of short break services and day services.
Continue to focus on improving health outcomes for people with Learning Disabilities or autism.	• Agreed a sub-regional health improvement action plan. • Developed an understanding of performance. • Engaged people with lived experience. • Established a Steering Group. • Commissioning resource has been identified to drive delivery with a focus on engagement, targeting poor performing GP Practices and working with the care and support market. • The CCG is working collaboratively across Coventry and Warwickshire CCGs and social care partners to support the review of deaths of patients with learning disabilities. • An annual report has been produced and will inform the priority areas within the health improvement action plan.	• Improved health outcomes for disabled and autistic people. • Reduced premature mortality of people with learning disabilities and/or autism.	• Continue to focus on improving health outcomes for people with Learning Disabilities or autism, including: - Increasing the proportion of people having an annual health check. - Implementing the STOMP (Stop over medication of people with a learning disability, autism or both with psychotropic medicines) and STAMP (Supporting Treatment and Appropriate Medication in Paediatrics) agenda. - Continuing to review deaths of people with learning disabilities and addressing the priorities highlighted by the LeDeR annual mortality review report. • Improve the experience of people with learning disabilities or autism who are accessing mainstream or specialist health, education and social care services by ensuring reasonable adjustments are made for people when they need it.
Improve the support offer for people with autism.	• Undertook a joint needs assessment for people with autism and co-produced a joint all age commissioning statement of intent with people with lived experience. • Piloted community outreach service for children and young people. • Delivered parent training and autism awareness training to the children's and adults' workforce across health, social care, education and justice.	• Improved support offer for people with Autistic Spectrum Conditions (ASC).	• Deliver the commissioning priorities in the joint commissioning statement of intent for people with autism to deliver a clear local offer for people with autism.