Coventry & Warwickshire Sustainability & Transformation Plan (STP)

Foreword: Summary of our STP

In this October submission we have set out our progress since the submission in June and our ambitions and plans for sustainable Health and Care Services in Coventry and Warwickshire.

Our STP is based on achieving clinically and financially sustainable services, reducing the amount of people needing hospital care, alongside system and service changes. Discussions continue around the future system form and the steps required to develop into the Accountable Care System to which we aspire. Work is also progressing around identifying and appraising options for service reconfiguration and/or consolidation where appropriate, especially with back office functions, to increase productivity and efficiency.

As senior leaders across Coventry and Warwickshire we have agreed the need for a single vision, aligned to that of our Health and Wellbeing Boards, and we have developed bold transformational plans to deliver the sustainable, safe services we know are necessary and that will reduce the risk of ill health for our citizens.

We have purposefully taken time to ensure that we have developed a good foundation for this transformation, have engagement of key stakeholders and that our plans are based in both practical and financial reality.

Our key transformation programmes are still evolving and have been modified since June to reflect our extended ambition and following input from clinical, strategic and financial leads across the health and care economy, through an independently chaired group known as a Design Authority. This group offers a sense check, challenging the scale of our ambition and plans and identifying interdependencies. Clinical and financial sustainability have been key criteria in doing this and so George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust are working together to prepare an outline case for an alternative way of working across the two Trusts, aimed at delivering clinically and financially sustainable services.

Our Transformation Workstreams, Proactive & Preventative Care, Urgent & Emergency Care, Planned Care (including Maternity & Paediatrics and Cancer) and Productivity & Efficiency are supported by a number of supporting Enabling Workstreams, covering Workforce (staffing), Estates (buildings and land), IM&T (use of technology) and Communications & Engagement. Public Health and Mental Health are integral to all and so are embedded within all the transformation workstreams, rather than operating as a separate entities. A large part of our transformation will require developments in primary care (e.g. non hospital and General Practice settings), both in staffing and what services are provided, and so we are in the early stages of developing a Primary Care Development supporting workstream. We have also been clear that we must maintain momentum on, and/or accelerate existing transformation projects and have incorporated these into our plan.

We are clear that these programmes will address the three aims, as set within the Five Year Forward View and the national framework for Sustainability and Transformation Plans.

As annexes to this submission we have included more detail around our plans and commitments but we recognise that we must now continue at pace to complete the population of the Programme Management arrangements, build our staffing plans and finalise the appropriate governance and engagement arrangements necessary for full delivery of our commitments.

We welcome the review of our submission and any comment and support at the earliest opportunity, to assist us in delivering this single vision to improve health and care services for our citizens and communities across Coventry and Warwickshire.

Professor Andrew Hardy

UHCW Chief Executive Officer/C&W STP SRO

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Our STP fundamental premises

Our STP vision is aligned to the identified and understood wider challenges and priorities for the Coventry & Warwickshire Health and Care economy, as agreed by our Health and Wellbeing Boards:

To work together to deliver high quality care which supports our communities to live well, stay independent and enjoy life.

Our focus is on making sure safe and sustainable services are delivered to our citizens in ways that benefit them and support the STP vision and all partners have agreed that form will not be a barrier to the delivery of such services.

To do this we will:

- Reduce the projected future demand growth, through prevention and proactive care of the population, remodeling urgent and emergency care and reviewing and amending the planned care offering, as the total financial challenge by 2020/21 is cost that is not currently being incurred by the system, the vast majority of this cost being due to future activity growth
- Reduce unit cost of provision, by delivering care at lower cost setting/s or by becoming more efficient in current setting/s
- Improve efficiency within and across organisations, through delivering collective productivity opportunities
- Potentially make specific organisational changes (as outlined later in this document) that mirror changes in clinical pathways and services and move us towards an Accountable Care System
- Ensure opportunities and changes are assured in both business and clinical contexts through a Design Authority with an independent chairman
- Embed public health and mental health within all our transformation programmes
- Develop a workforce and Primary Care/General Practice appropriate to these transformed services
- Develop and implement sustainable infrastructure solutions (Estates and IM&T) through which we can deliver these services
- Engage with key stakeholders, staff and our communities as we continue to develop, refine and implement our plans, building on the firm platform we have developed through our Health & Wellbeing Boards

We are committed to providing joined-up care wherever possible through integration of both the Health and Social Care aspects of our commissioning and service provision, as this is fundamental to reducing current demand and curtailing projected future demand growth, as well as improving citizen/community experience.

Changes since June submission

The June STP submission outlined the footprint's health and wellbeing gap, care and quality gap, and finance and efficiency gap.
A number of opportunity areas were identified to address these challenges, however the identified savings did not close the forecast financial do-nothing gap.
Following the June submission, we have continued to work together, with external support, to develop the September financial submission and this October submission. This has included:

An update of the financial do-nothing gap based on recent national guidance

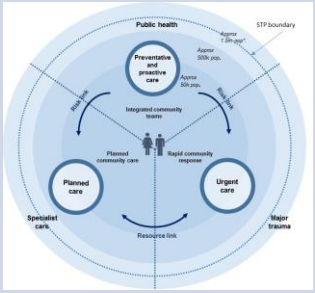
An update of the business-as-usual efficiency plans for commissioners and providers

Development of transformation workstreams that align with the strategic direction agreed by commissioners (Health and Social Care) across Coventry and Warwickshire

George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust working together to prepare a strategic outline case for a service model across the two Trusts aimed at delivering clinically and financially sustainable services

Formation of an independently chaired Design Authority with clinical and managerial representatives across the footprint to:

- Embed joined up stakeholder engagement at all levels within the STP programme
- Act as a sounding board for the emerging whole system vision
- Provide whole system and clinical input into the design of the new system
- Design and agree the appropriate programme structure and remit of workstreams
- Sense–check the impact assessment of transformation opportunities
- Identify key interdependencies across workstreams and ensure that these are appropriately addressed
- Provide independent challenge (via the Chair) and facilitation of "difficult conversations"



Impact assessment of the opportunities identified under each workstream, including the phasing of benefits and costs

Formation of a Finance Group including the Chief Finance Officers, or equivalent, from each organisation to test and challenge modelling assumptions and output

Development of a high-level delivery plan and programme structure to facilitate work at pace and scale including developing work programmes, PID-type outlines, leadership and delivery teams for every workstream

Further coming together and joint working of Health and Wellbeing Boards with Health and Wellbeing Concordat in place

Coventry & Warwickshire STP: Plan on a page

Our Vision

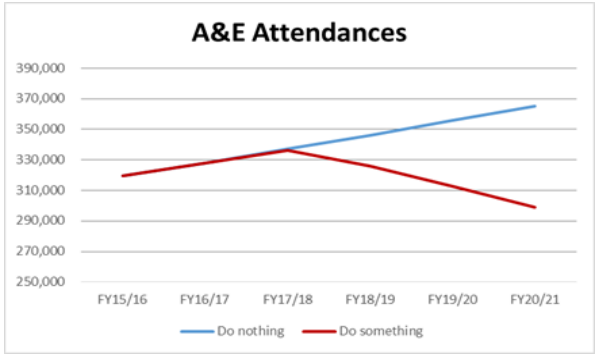
To work together to deliver high quality care which supports our communities to live well, stay independent and enjoy life.

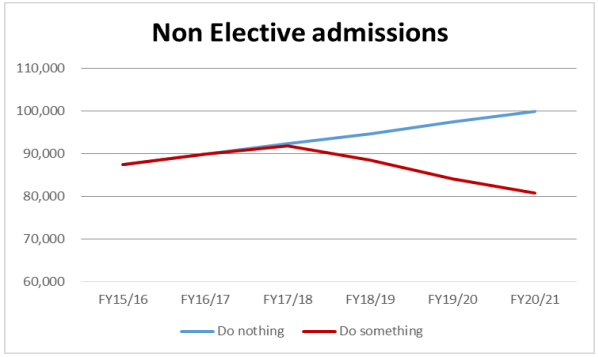
TRANSFORMATION WORKSTREAMS	Proactive & Preventative care (P&P)	Urgent & Emergency care (U&EC)	Planned care (PC)	Maternity & Paediatrics (M&P)	Productivity & Efficiency (P&E)

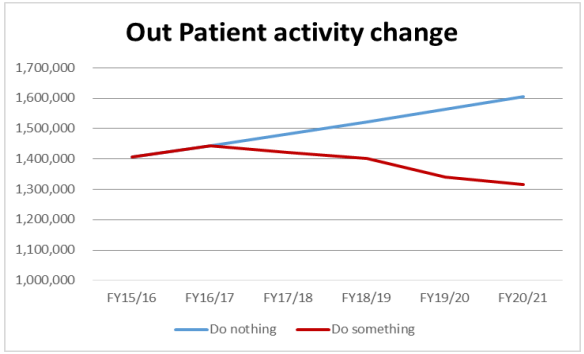
Public Health and Mental health are a part of everything we do and will feature across all workstreams

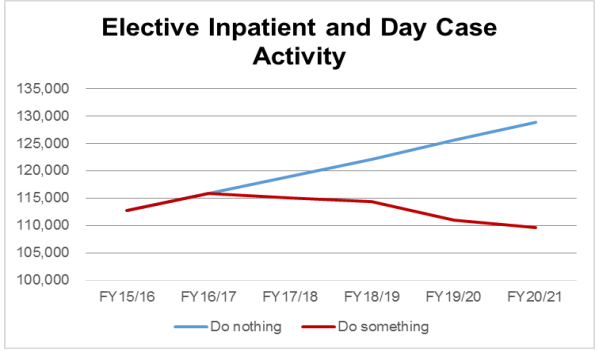
ENABLING WORKSTREAMS	Workforce	IM&T	Estates	Communication & Engagement	Primary Care Development

	Interventions / Opportunities
P&P	Prevention Existing Out of Hospital plans Crisis response Extended scope of proactive care
U&EC	Enhanced ambulatory care Establish a urgent & emergency care network (NHS111/Out of Hours; Senior clinician at front door) Inputting into other workstreams (in particular proactive and preventative) Stroke pathway
PC	Pathway redesign (as part of Right Care work) Reduction in lower value procedures (as part of Right Care day case work) Consolidation of elective specialties
M&P	Consolidation of Maternity and Paediatrics services
P&E	Back office collaboration Consolidation of clinical support services









Coventry & Warwickshire STP: Plan on a page deliverables

	Outline plan – key transformation deliverables in more detail
2016/17	**P&P:** Prevention design & delivery plans. Expansion of existing Better Care Fund activities. Out of Hospital up to contract award. Crisis response developed up to commercial arrangements. Extended scope of proactive care delivery plan. **U&EC:** Enhanced Ambulatory Care & Frailty Service developed and mobilisation commenced, including new workforce model. Service options, defined pathways, IT strategy and workforce plan for U&EC. Develop approach and plan for public education around U&EC. Consultation on new stroke pathway. **PC:** Redesign MSK pathway. Develop delivery plan for other PC pathways. Review "lower value" procedures and develop delivery plan & financial impact model. Develop PC service consolidation options. Design PC policies, procedures & procurement programme. **M&P:** Options appraisal for M&P. **P&E:** Back-office , clinical support & other areas for collaboration impact analysis. **Enablers**: Local Digital Roadmap development and Business Case for Electronic Patient Record (EPR). Development of new operational model for Estates (single estate type solution). Primary care development in line with GP 5YFV. Options for Accountable Care System (ACS) explored.
2017/18	**P&P:** Prevention mobilisation and implementation. Mobilisation & implementation of Out of Hospital programme. Crisis response implementation (potentially as part of out of hospital). Extended scope of proactive care mobilisation and implementation. **U&EC:** Start mobilisation of U&EC plans and standardise approach to referrals/bookings. Single digital Emergency Care record. Implement plan for public education around U&EC. Implement new stroke pathway. **PC:** Pilot implementation of "lower value" procedures programme & develop thresholds. Business Case, assurance, consultation around PC consolidation. Mobilise and commence implementation of PC policies, procedures & procurement programme. **M&P:** Business Case, assurance process and consultation for M&P. **P&E:** Business Cases for consolidation of back-office /clinical support functions. **Enablers**: Assurance for EPR and, if approved, move to procurement. Mobilisation /implementation of new estates model. Continued Primary care development in line with GP 5YFV. ACS proposals and plans in place - ? shadowing.
2018/19	**P&P:** Continued Prevention implementation. **U&EC:** Public education around U&EC. **PC:** PC policies, procedures & procurement programme. Implement "lower value" procedure thresholds. Implement PC consolidation. Achieve Right Care savings. **M&P:** Mobilisation/implementation for M&P. **P&E:** Consolidation of Back-office functions & standardisation of procedures. **Enablers**: UHCW procure and deploy an integrated EPR solution. Accountable Care System in place.
2019/20 2020/21	**P&P, PC and U&EC:** as above **M&P:** M&P implemented. **P&E:** Implementation of clinical support functions consolidation and any other areas identified. **Enablers**: Develop the final business case for EPR to be deployed to other Coventry health organisations yet TBC. Warwickshire organisations potentially moving onto same integrated solution as Coventry leading towards an Electronic Citizen Record (ECR).

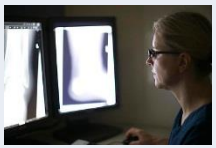
Benefits for our communities

Our STP is aligned to the priority areas and benefits identified by our Health and Wellbeing Boards through the Joint Needs Assessment activity and the joint Health and Wellbeing Concordat and is summarised by the STP vision: *To work together to deliver high quality care which supports our communities to live well, stay independent and enjoy life.*

There are many benefits that will be realised by our communities, ranging from those of widespread application (e.g. increased community capacity and resilience, promoting independence and long term population health benefits from smoking cessation) to the specific and individual (e.g. post stroke rehabilitation at home rather than in hospital, ability to more easily have a home birth, better support to die at home rather than in hospital).

Some detailed examples of community/individual benefits from our transformation plans are:

Proactive & Preventative Care	Better general health with reduced risk of illness Increased independence with reduced/delayed hospital and/or care admissions Less frequent hospital attendances for patients with long term or complex conditions Shorter length of stay in hospital More rehabilitation, after-care, long term condition care and end of life care at or closer to home More personalised care and better individual/family/community experience
Urgent & Emergency Care	Standardised single point of access with timely redirection to most appropriate care All stroke patients receive initial care in specialist hyper-acute/acute stroke unit Reduced length of hospital stays and more rehabilitation, after-care at or closer to home Improved urgent care closer to people's homes Better patient experience
Planned care	Elimination of *post-code lottery* effect for many elective procedures/treatments Fewer hospital attendances pre and post treatment Elimination of interventions know to be of lower clinical/lifestyle value than alternatives Better patient experience
Maternity & Paediatrics	Sustainable services that meet current guidance and findings of recent national and regional reviews Increasing home births and introduction of community hubs
Productivity & Efficiency	Reduction in use of agency staff with "knock on effect" on improved quality of care and patient experience Financial sustainability that will underpin ongoing service sustainability



STP response to key areas of focus within Five Year Forward View (1)	
Strengthen and invest in primary care	Already work going on across the footprint to develop GP services in line with the GP Forward view. A primary care development workstream will focus on developing GP services at scale and pace closely aligned to other STP activity to facilitate transfer activity from hospitals into care closer to home. Patients will have better and extended access to GP services. A number of services, for which patients currently have to travel to hospital, will be available within their local community or even in some instances at home. Our aim is to provide high quality, easily accessible, clinically and operationally sustainable GP and primary care services for our communities.
Deliver A&E and ambulance standards, simplify the U&EC system making it more accessible.	Review and reform of the Coventry & Warwickshire A&E/Urgent Care Board/s to provide clear and strong collaborative leadership in this area. Working closely with other STP workstreams to reduce demand for U&EC services through crisis intervention within the community to help keep people at home rather than in being admitted as an emergency into hospital. Work to look at how best to provide clinically sustainable U&EC/A&E provision in the immediate future and going forward, given the current national shortages in the U&EC workforce. Developing and publicising clear and simple routes of access to U&EC services will be a priority, so citizens have clear direction and simple ways to access the U&EC services.

STP response to key areas of focus within Five Year Forward View (2)	
Improve mental health and cancer services, and for people with learning disabilities.	Our Mental Health provider is already part of a regional programme of service improvement (MERIT Vanguard) and will continue this work to improve mental health services for our citizens. Given its significance, we are going to treat Cancer services as a completely separate wave of clinical pathway review from other specialties. This will mean that we can start to make improvements in our cancer services earlier than otherwise. Build on previous and current Better Care Fund activity on improving the situation for citizens with learning disabilities, particularly in moving those who are receiving care out of the area into appropriate care closer to their family and friends.
Prevent illness, empower people to look after their own health and prevent avoidable hospital stays.	Focus will be on areas identified as having a significant impact on the health of our citizens, such as obesity, smoking (especially in pregnancy), falls prevention and building community capacity and resilience, so citizens are better able to look after their own health and stay in good health and enjoy life. Integrated Out of Hospital care will mean our citizens are only treated in hospital when this is absolutely necessary and for the shortest time possible.
Improve the quality of hospital services, including maternity services, and deliver the RTT access standard.	Address issues of quality and sustainability around particular hospital services across Coventry & Warwickshire to make sure there are safe, clinically and financially sustainable services available. Clinically and financially sustainable Maternity and Paediatric services available across the whole of Coventry & Warwickshire meeting current guidance and best practice, as highlighted by recent national and regional reviews into these services, for example supporting more mothers who choose to, to be able to give birth at home.
Create a financially sustainable health system for the future.	Going forward our focus is on making sure safe and sustainable (clinical & financial) services are delivered to our citizens in ways that support the STP vision : ***To work together to deliver high quality care which supports our communities to live well, stay independent and enjoy life.***

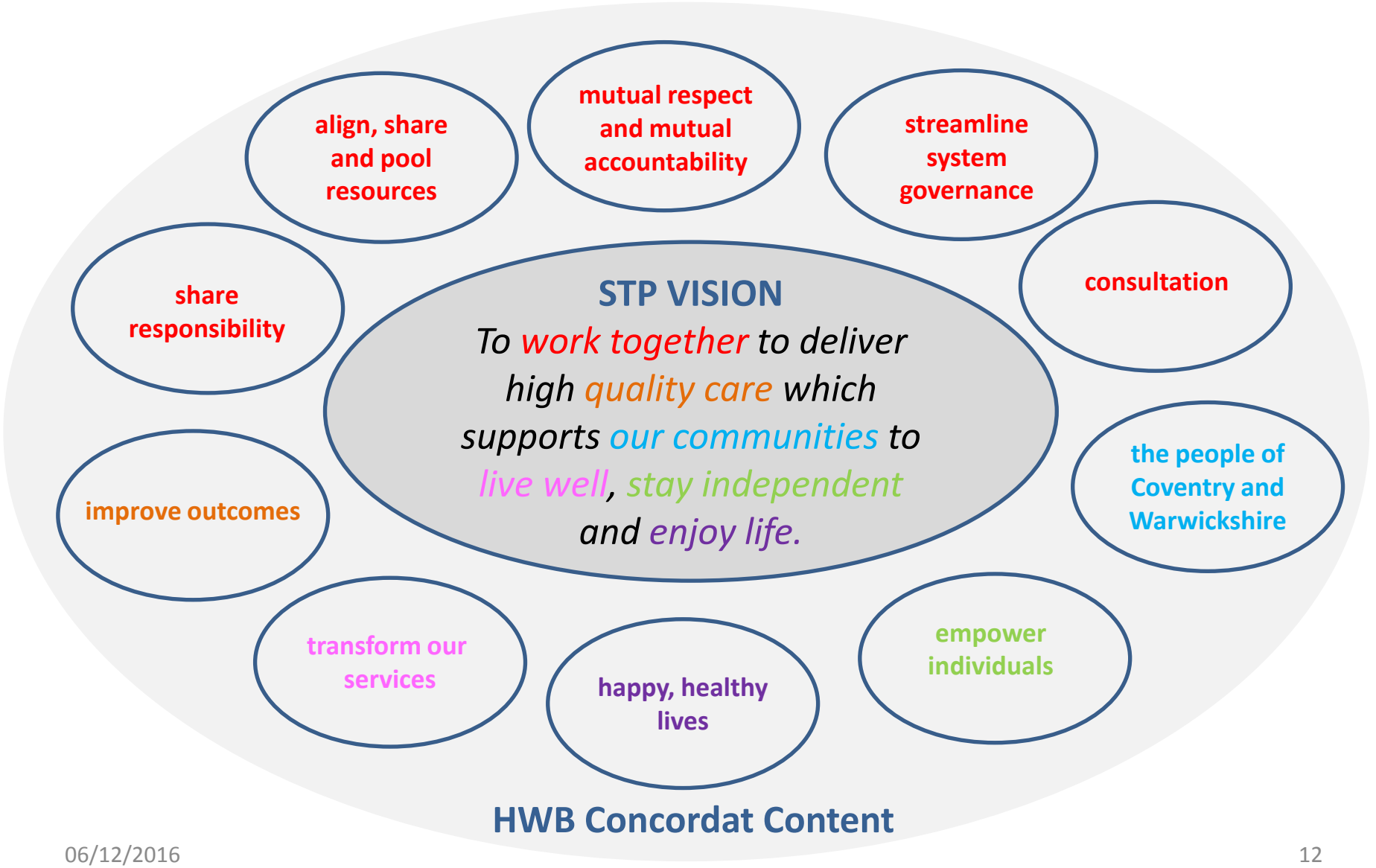
Local Consensus: STP Vision and Health & Wellbeing Board Alignment

Over the last 6 months Warwickshire County Council and Coventry City Council Health and Wellbeing Boards have developed jointly and agreed a concordat out of which the STP vision was developed.

The Health and Wellbeing boards are regularly engaged in the STP development with the content of this plan being considered at a dedicated joint session on 13th October 2016, at which both Council Leaders and all STP organisation leaders were present. Following this event, work is already underway revising the P&P workstream remit to better address the following Health and Wellbeing Board question:
How do we create the real SHIFT to a new model where prevention is everybody's business and the whole system is engaged in reducing and preventing demand on the health and social care system?

Councillor Izzi Seccombe, Chair of the Warwickshire Health & Wellbeing Board and Leader of Warwickshire County Council, said: "This is a momentous step for Coventry and Warwickshire working together around the health and care needs of our people and our shared place and I am excited to be going forward together."
Councillor Kamran Caan, Chair of the Coventry Health & Wellbeing Board and Cabinet Member for Public Health and Sport at Coventry City Council, said: "People and communities are at the heart of everything we do and creating a partnership like this is going to help shape better futures for those that we want to support. This agreement allows us to work closer together to create a better system that improves the health, wellbeing and overall happiness of people and families across Coventry and Warwickshire."

Local Consensus: STP Vision and Health & Wellbeing Board Alignment



Revised C&W STP Financial Summary

The total 'do-nothing' NHS financial challenge facing the healthcare system by 2020/21 is forecast to be £267m.

In addition, the two Local Authorities would face a deficit of £33m by 2020/21 (across social care and public health only).

The STP plan assumes no cost shunting of CHC costs from health to social care, but there are £8.6m of CHC savings in health plans by 2020/21.

The plan assumes that any costs to Local Authorities in relation to closely associated new burdens, for example in respect of the Better Care Fund, Care Act Funding Reform and Transforming Care initiatives are fully funded and that any funding of these developments will not impact adversely on STP income stream assumptions.

Local authority budgets present a managed gap, however, the actions necessary to achieve this are significant and their seriousness and their risks are less visible by the fact that the position is balanced.

Provider and commissioners have identified business-as-usual recurrent efficiency savings of £141m.

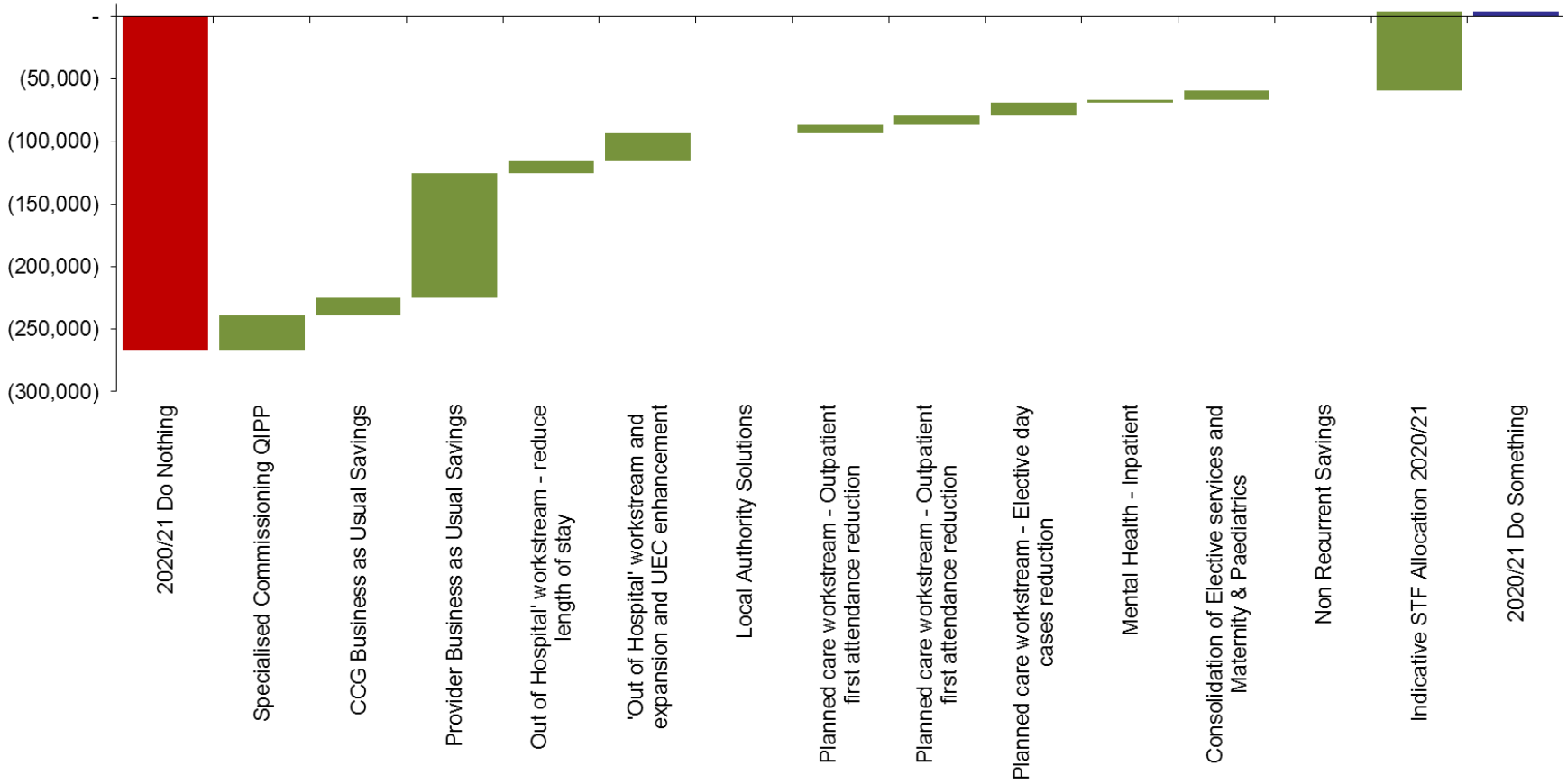
Analysis of the opportunities developed by the Design Authority, workstreams and external support, have identified the potential savings of £66m* towards the do-nothing financial challenge.

The system is also expected to receive £63m STF funding in 2020/21 to support transformation.

As a result the footprint now has a financial plan that creates a financially sustainable health and care system by 2020/21, underpinned by high-level workstream plans, with key assumptions tested and agreed by the Finance Group and the Design Authority.

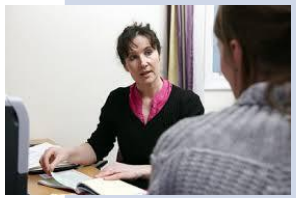
*These financial benefits are driven by better managed demand, better utilisation of the health and care assets and improved efficiency within and across organisations and are net of re-provision costs incurred by providing alternative care and support outside the current care setting.

A financially sustainable health and care system by 2020/2021



Curtailing Demand Growth: Target Cohorts

Programme Workstream	Cohorts
Proactive & Preventative	Prevention: Frail and elderly; smokers, particularly in pregnancy; all at higher risk related to obesity Out of Hospital: Top 15% most complex patients Crisis Response: People with complex needs in health and social care Proactive care: All people with LTCs (not within the top 15%)
Urgent & Emergency Care	Enhanced Ambulatory Care: People who are frail, largely with complex needs (aligned with top 15%) Establishing U&EC network: All remaining population
Planned Care	Pathway redesign: Out patient attendances Lower value procedures: Elective day case activity, stricter thresholds applied consistently (eliminate post-code lottery) Consolidation of elective specialties: Some entire services but mainly Out Patient & Day Case, which and when TBC



Curtailing Demand Growth: Demand & Financial Impact

Our STP key demand and finance targets	
Proactive & Preventative Care	A reduction of 21k attendances and 10k admissions against do-nothing growth, corresponding to a £34.7m saving (includes both out of hospital, acute mental health and Urgent and Emergency Care).
Urgent & Emergency Care	A reduction of 21k attendances and 2k admissions against do-nothing growth. Note the savings are included within Proactive and Preventative care above.
Planned Care	A reduction of 189k attendances and 12k admissions against do-nothing growth, corresponding to £24.5m in savings.
Productivity & Efficiency	Total net saving of £7.1m (note this includes maternity and paedatrics at this stage). In addition there is £141.2m of Business as Usual efficiencies assumed within the model. **A total financial impact of £207.5m by 2020/21 (excluding social care)**

Programme Structure & Workstreams

STP Board

Comprised of the heads of each organisation, with Healthwatch in attendance.
It is responsible for decision making and providing strategic direction.

Finance Group	Design Authority	Transformation Workstreams
The Finance Group is comprised of the Finance Directors of each organisation and its role is the development of the STP financial template, including: • Finalising the do nothing and BAU gaps • Supporting intervention modelling	The Design Authority is comprised of clinicians and strategy leads from across the footprint and its role is to: • Identify transformation opportunities • Identify and address key interdependencies • Sense check financial impact assessments	There are five transformation workstreams • Proactive & Preventative care • Urgent & Emergency care • Planned care • Maternity & Paediatrics* • Productivity & Efficiency The role of these workstreams is to develop the identified opportunity areas *will eventually become part of Planned Care

Public Health and Mental health are a part of everything we do and feature across all workstreams

Enabling Workstreams		GEH/UHCW
• Workforce • Estates • IM&T • Communications & Engagement	The role of these workstreams is to work alongside the transformation workstreams to identify what is required to enable progress of each opportunity area	Preparation of a Strategic Outline Case on a collaborative service model aimed at delivering clinical and financial sustainability

A Primary Care Development workstream is being added

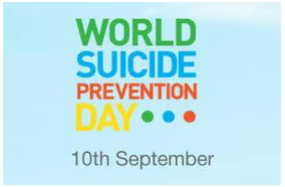
Transformation Workstreams (summary)

Workstream	Content	Some Examples	Outcomes
Proactive & Preventative 	Prevention Existing Better Care Fund activity Existing Out of Hospital plans Crisis response Extended scope of proactive care	Public Health activity Social Prescribing & Community support Neighbourhood teams Early intervention	Reducing activity growth related to smoking and obesity for 70% of smokers and all high risk related to obesity Reducing Non-elective(NEL)/A&E activity for top 15% most complex patients Reducing length of stay Reducing NEL/A&E activity for all people with LTCs (not within top 15% most complex patients)
Urgent & Emergency Care 	Enhanced ambulatory care Establish a U&EC network (Senior clinician at front door) Inputting into other workstreams (in particular proactive and preventative) New stroke pathway	Frailty services Improved primary care access Urgent Care centres Paramedic @ home Public education Integrated 111/Out of Hours Stroke pathway redesign Possible A&E reconfiguration	Reducing NEL admissions for people who are frail (largely aligned with 15% most complex) Reducing NEL/ A&E activity for the remainder population
Planned Care 	Pathway redesign Reduction in lower value procedures Consolidation of elective specialties	Musculoskeletal pathway Other pathways redesigned Review of “out-dated”/lower value procedures Patient education	Reducing OP activity for all OP attendances Reducing elective day case activity Removal of duplication Reducing unit cost for identified elective specialties Standardised referrals/pathways across the footprint
Maternity & Paediatrics 	Response to recent national and regional reviews Ongoing sustainability across footprint (eventually part of Planned Care)	Expanded home birth provision Address Workforce challenges Sustainable services	Unit cost analysis of options. Bottom up analysis of configuration options. Service reconfiguration to meet national/local review recommendations and bring ongoing sustainability Realise financial savings
Productivity & Efficiency 	Back office collaboration Consolidation of clinical support services	Procurement, Pay roll Pathology network, Radiation protection, Estates, IM&T	Savings from back-office and clinical support collaborations/consolidation Sustainable clinical support functions

Enabling Workstreams (summary)

Workstream	Activity	Outcomes
Workforce	Addressing current workforce issues New roles New models of training	Workforce changes associated with STP plans in place New roles developed with appropriate training in place A safe and sustainable workforce
Estates 	Consolidation of estate and making best use of existing estate Primary care estate New estates operating models Identifying opportunities to share/use other partners' estate	Reduced costs Reduced requirement for capital and additional estate Fit for purpose primary care estate Sustainable estates workforce Care closer to home Estates changes associated with STP plans in place
IM&T 	C&W Digital Roadmap Electronic Emergency/Urgent Care Record (UCR) Electronic Patient Record (EPR) → Electronic Citizen Record (ECR) Consolidation of IM&T workforce/back office Digital/electronic innovations in treatment & care	Electronic Citizen Record (ECR) Population Health Management approach Reduction in duplication Better, safer care & improved user experience Innovative, digitally enabled transformations in care Reduced demand through increased independence Empowered workforce and service users
Communication and engagement 	Ongoing communications (public, service users, staff) Ongoing dialogue with partners and stakeholders Informal communications and dialogue Statutory communications/consultations Media	All stakeholders, staff and public informed Constructive and collaborative approach to change Efficient dialogue about change through productive informal networks Compliance with all statutory requirements Increased support/understanding and reduced challenge
Primary Care Development 	This is a new enabling workstream that is in its very early stages of development. We envisage that whilst it will be focussing on the STP enablers within GP Practices (Workforce, Estates, IM&T), linking into the other appropriate enabling workstreams. It will also act as an enabling workstream in its own right, ensuring that appropriate services are developed alongside and aligned to the transformation workstreams, to help ensure their success. The system is committed to ensuring that the investment in Primary Care will be at least as great as the growth in CCG income in line with planning requirements.	

Role of Mental Health & Public Health



We don't have separate Public Health and Mental Health workstreams
Both Mental Health and Public Health have established programmes of work around the prevention agenda and the 5YFV for Mental Health.
Our Mental Health Provider (CWPT) is already part of a Mental Health Vanguard and so is already underway with major transformation and service improvement schemes.
We consider public health and mental health to be key parts of our "people focussed" transformation workstreams (Proactive & Preventative Care, Urgent & Emergency Care, Planned Care, Maternity & Paediatrics).
We therefore have these specialties embedded within the transformation workstreams, informing their decisions and plans, rather than as separate, silo workstreams.
This is demonstrated by the involvement of mental health and public health leads and practitioners in the workstreams and their project/working/task & finish/clinical reference groups.

Priorities going forward

Workstreams	Priorities
Preventative & Proactive Care 	Integrated teams or communities (approximately 15-20 across the footprint covering 50k population) bringing together services that meet the needs of the population they cover Focus on prevention, keeping people well, reducing demand & pressure on more expensive parts of the system Primary care at the core, with social care, mental health, community services, and acute services out-reach and in-reach, forming a network of care and support Maximisation of the capacity and strengths that the person and their family bring and what is already available within the community Proactive in-reach into the acute by integrated teams, pulling people out of acute care and support recovery and rehabilitation.
Urgent & Emergency Care 	Simple access without duplication, reflecting the national direction for U&EC facilities and move towards integrated delivery Reduced reliance on U&EC over time, with integrated teams proactively managing people at risk Integrated rapid response and support once people are in the urgent / emergency care system, with urgent social care response incorporated Implement new stroke pathway
Planned Care 	Patients supported in most appropriate setting and helped to access care in a planned way through education and earlier intervention where appropriate More services (including early diagnostics/outpatients) moved into the community coordinated by integrated teams, when there are benefits to patients/system Inpatient services delivered at scale, at high quality and achieving economy of scale Potential consolidation of some specialised services at a larger footprint level
Productivity & Efficiency 	Consolidation of services/back office functions/clinical support to achieve economies of scale/reduce waste Working together to optimise the workforce, joint negotiation of agency contracts and sharing of best practice Developing a shared collective estate to improve productivity and facilitate a standard offer for facilities management and collective contract negotiation to reduce running costs and ensure full utilisation

Risks

Overarching Risks
No history or track record of delivering large scale transformation across the footprint
Potential for reversion to silo approaches
Individuals continue representing organisation *versus* STP/footprint
Continued misalignment of governing regulations, priorities, expectations, processes, cultures and internal governance between the respective organisations
Challenges associated with acute provider network development and potential reconfiguration decisions
Challenges of limited public engagement thus far and need to rapidly address this
Current operational and financial challenges *versus* need to prioritise STP work
Funding and access to capital resource
Sourcing appropriate capacity to implement the programme of work
Understanding the longer term commissioning footprint/arrangements for a range of specialised services
Lack of sufficient transformational support for preventative initiatives, primary care, new models of care and out of hospital solutions
Capacity and funding pressures in Social care
Timeliness of delivery given the need to see benefits sooner
For areas requiring public consultation there is an inherent delay

Next steps

Immediate
Recruit dedicated STP Programme Director
Resource and set up appropriate programme management and support arrangements for delivery of the STP programme
Develop the Primary Care Development enabling workstream
Ensure appropriate resourcing of all the workstreams
Agree further detail of workstreams, programmes and detailed implementation plans, milestones and outcomes for each
Work with Design Authority, Clinical Reference Groups, patients/service users and partners across statutory and other sectors on these plans
Health & Wellbeing Boards to consider further and advise on future system model/s - (ACS/ACO), risk sharing and pooling resources (extent of System Control Total/s) – based on outcomes that benefit our communities
Start broader engagement and communications after workstreams have confirmed the narrative sufficient to inform the listening exercise
Further key stakeholder engagement in line with workstream plans
Enabling workstreams develop their detailed plans as transformation workstreams plans are developed further and finalised
Complete actions in plans with most proximate milestones

and as plans develop
Formal consultations
Implement at scale and pace
Evaluate and revise as necessary

Statements of Support

The boards of statutory organisations within the STP have considered the plan and signed up to it in advance of this submission as indicated below

	Methodology	Key dates
CR CCG	Extraordinary Governing Body	19th October
SW CCG	Governing Body	19th October
WN CCG	Extraordinary Governing Body	19th October
CWPT	Delegated Authority to CEO granted in accordance with Standing Orders on 27th September	Week commencing 17 October 2016
GEH	Extraordinary Trust Board	20th October
SWFT	Delegated Authority to CEO in accordance with the FT Standing Orders for Emergency Powers and Urgent Decisions, to enable CEO to consult with at least two NEDs	Week commencing 17 October 2016 with report back to Board on 27th October
UHCW	Extraordinary Trust Board	19th October
CCC	HWB Board consideration, Letter of Support	Joint C&W HWB Boards development session 13th October HWB Board on 17th October
WCC	HWB Board consideration, Letter of Support	Joint C&W HWBB development session 13th October

STP Workstream Annexes

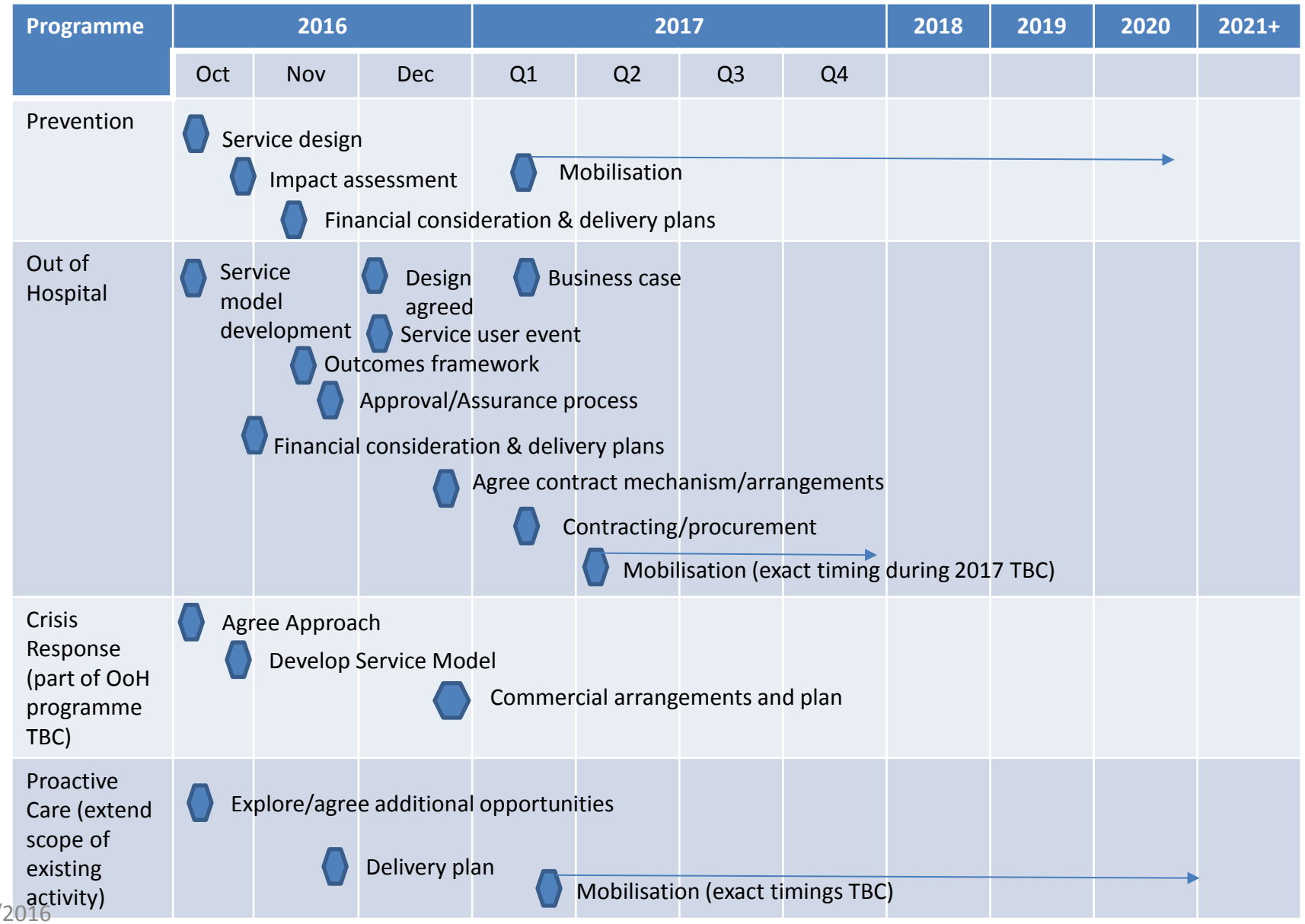
Proactive & Preventative Care

Roles and Responsibilities	
Workstream Lead	Gail Quinton (Executive Director – People, CCC)
Finance Lead	Liz Murray (Deputy Chief Finance Officer, SW CCG)
Workstream Team	Gill Entwistle (Accountable Officer, SW CCG), Anna Hargrave (Director of Strategy and Engagement, SW CCG), Andrea Green (Accountable Officer WN/C&R CCG), Matt Gilks (Head of Contracting and Procurement, CR CCG), Pete Fahey (Director of Adult Services, CCC), Chris Lewington (Head of Strategic Commissioning , WCC), John Linnane (Director of Public Health, WCC), Liz Gaulton (Deputy Director of Public Health, CCC), Justine Richards (Director of Strategy & Business Development, CWPT), Charles Ashton (Medical Director, SWFT), Jayne Blacklay (Director of Strategy & Development/ Deputy Chief Executive, SWFT), Michelle Norton (Director of Nursing, GEH), David Eltringham (Chief Operating Officer, UHCW)
Enablers & Interdependencies	Primary Care Development: Sustainable and at scale primary care Contractual and commercial consideration Communications and engagement: pre-consultation and consultation (where required) IM&T: identification and development of IM&T requirement to deliver the opportunities Workforce: development of integrated care team/s Estates: identification and provision of estates requirement (e.g. community hubs, primary care facilitates)
Programme/Project Leads	Out of Hospital Programme – Gill Entwistle (Accountable Officer, SW CCG) Prevention Programme – John Linnane (Director of Public Health, WCC)

Proactive & Preventative Care

	Content
Prevention 	A radical upgrade in prevention work that will deliver long term sustainability. The focus will be on the following areas: • Working with GP practice lists and proactive early intervention for people as they age, preventing injury (including falls) , ill-health and poor outcomes related to the risk of frailty • Enhancing and upscaling weight management programme across the STP footprint, with a focus to reduce diabetes, cancer incidence and other long term conditions • Implementing targeted smoking prevention programmes across the footprint
Out of Hospital 	• Integrated teams or communities (approximately 15-20 across the footprint covering a population of 50k) that bring together services that meet the needs of the population they cover • A focus on keeping people well, reducing demand and pressure on more expensive parts of the system • Budgets controlled by integrated teams who can make a choice in spending on highest value, lowest cost resource • Primary care at the core, with social care, mental health, community services, and acute services out-reach and in-reach, forming a network of care and support • Maximisation of the capacity and strengths that the person and their family bring and what is already available within the community • Proactive in-reach into the acute by integrated teams, pulling people out of acute care and support recovery and rehabilitation
Crisis response 	• Integrated teams coordinate all community assets to support those declining patients, preventing crisis from escalating and rapidly respond to crisis to avoid hospitalisation. • Where patients do have to go to hospital, the team will have the ability to track them and will work closely with the ward to allow them home even if they have not yet fully recovered, after which they will provide sufficient care and support at home or in the community
Proactive 	• Enhanced self-care for all with LTCs • Proactive management of those with LTCs through integrating health, social care, mental health and other services required

Proactive & Preventative Indicative Timeline



Proactive & Preventative Care

Risks	
1	Delivery of the radical upgrade in prevention needed to close the health and wellbeing gap requires strong commitment from across the STP partners and extends beyond Public Health commissioned programmes
2	Adequate and ongoing support for system-wide approaches to empowering communities, targeting 'at risk' populations.
3	Ensuring all health and social care settings are health promoting, with improved staff health and wellbeing and prevention embedded into all strategies and developments
4	The providers are unable to develop and agree a sustainable new care model for out of hospital
5	Out of hospital care model unable to deliver outcomes and/or within financial envelope
6	Drifting timescales due to other pressures in critical 2016/17 Q3/Q4 period
7	Engagement gaps create barriers
8	Provider governance insufficiently robust in developing out of hospital system

Engagement

A robust Communications & Engagement Plan for the Out Of Hospital Programme is in place. It is a key element of how we manage this large piece of work and ensures we proactively keep teams and external stakeholders informed of the work we are doing. It also supports us manage the media as and when is appropriate.

Based on the CCGs' need to inform and involve key internal team members, the governing bodies and wider staff groups, they have been and will continue to be given the opportunity to contribute, wherever possible to the development of some aspects of the programme documentation and assessment process and to influence, wherever appropriate, implementation of the programme.

There are already well-established channels of communication and engagement, the project will continue to strive to gain wider stakeholders' understanding of the process, to manage and inform their perceptions and to derive a common view of what is happening, using consistent messages.

There is a commitment to present positively the CCGs' process working with providers across the health and care economy, attempting to anticipate, manage and contain the risks in this process, wherever possible.

Proactive & Preventative Care

Finance	
Finance	For the purpose of the Finance template, Proactive and Preventative Care includes Solution 4 (Out of Hospital' workstream - reduce length of stay); Solution 5 (Out of Hospital workstream and expansion and UEC enhancement and Solution 10 (Mental Health - Inpatient)
	The Net effect of these solutions is £34.7m by 2020/21

Outstanding Items & Next steps	
Capacity & capability	A targeted approach and a workforce development programme to build capacity and confidence in behaviour change and risk modification MECC training mandated for all health and social care staff, with enhanced training in supporting behaviour change for key staff groups Enabling the promotion of wellbeing and disease prevention through digitalising referrals and access to information and support
Smoking cessation	Smoke free sites, workplace wellbeing initiatives, embedding advice and referral across contacts
Obesity - Behaviour change approaches in workforce development, workplace wellbeing	Staff health and wellbeing maximised through improved workplace health programmes including a healthy physical environment – Workplace Wellbeing Charter
Falls, frailty and isolation	Promoting physical activity across the life course, through the Age Friendly City initiative, community capacity building, embedding social prescribing approaches into health and social care contacts and robust approaches to frailty and falls prevention
Out of Hospital	Providers agree a new care model which delivers outcomes (Dec 2016)
	Commissioners complete new contract model design and testing (Dec 2016)
	Contract award process (Q4 2016-17)

Proactive & Preventative Care: Examples/case studies

Prevention

- Addressing 'wider social determinants', linked to work with communities enabling 'self help' through Warwickshire's Public Health grants to Districts & Boroughs and Lillington needs assessment and Coventry's Marmot City programme focussing on health inequalities
- Integration of promotion of Mental Wellbeing alongside physical and mental health through Warwickshire's Mental Wellbeing Strategy and Coventry and Warwickshire's 'zero suicide' strategy
- Operating across the life course through Warwickshire's 'Smart Start' Programme, Coventry's Acting Early, family focussed and targeted adult lifestyles services and Age Friendly Cities programmes
- Reflecting current evidence in Coventry and Warwickshire's JSNAs, HWB boards, and service developments
- Supporting personalised approaches reflecting individuals' knowledge, skills and motivation through Warwickshire's 'Fitter Futures' programme, Coventry's Be Active Be Healthy service and wider Public Health commissioning.
- STP partners have submitted an expression of interest for the 2017 roll out of the National Diabetes Prevention Programme – decision awaited from NHS England

Out of Hospital

- Over 75s programme in south Warwickshire, developing holistic care plans and increased engagement in the at risk over 75s population to identify needs earlier and avoid emergency admission
- Hydration project in south Warwickshire to target patients with catheters and promote good hydration to prevent community visits
- Falls prevention programme across Warwickshire to target people to build resilience before falls
- Integrated Neighbourhood teams established in Coventry, city wide, to support frailty patients aligned to GP clusters, involving MDT working (Primary Care, 3rd Sector, Mental Health and Community services)
- Implemented a care navigator programme in south Warwickshire for older people and those with dementia, to support and empower patients and their carers to take more control and enable better understanding of services available in the health and care system

Urgent & Emergency Care

Roles and Responsibilities	
Workstream Lead	Glen Burley (CEO, SWFT)
Finance Lead	Kim Li (Director of Finance, SWFT)
Workstream Team	Membership will be aligned to the new C&W A&E Board but currently stands as David Moon (CFSO, UHCW), Charles Ashton (MD, SWFT), John Thompson (Director of Operations, GEH), Steve Jarman-Davies (Director of Performance and Planning, CR CCG), Sharon Binyon (MD, CWPT) Participation from Social Care, Primary Care and the Ambulance service is being sought.
Enablers & Interdependencies	Interdependent with Proactive & Preventative workstream Contractual and commercial consideration Communications and engagement: pre- consultation and consultation (where required) IM&T: identification of IM&T requirement for integrated U&EC network Workforce: requirement for delivering ambulatory emergency services and UEC network Estate: TBC but right-sizing of A&E at UHCW and primary/community care estate
Programme/Project Leads	Stroke Pathway Lead - Andrea Green (AO, CR CCG/WN CCG)

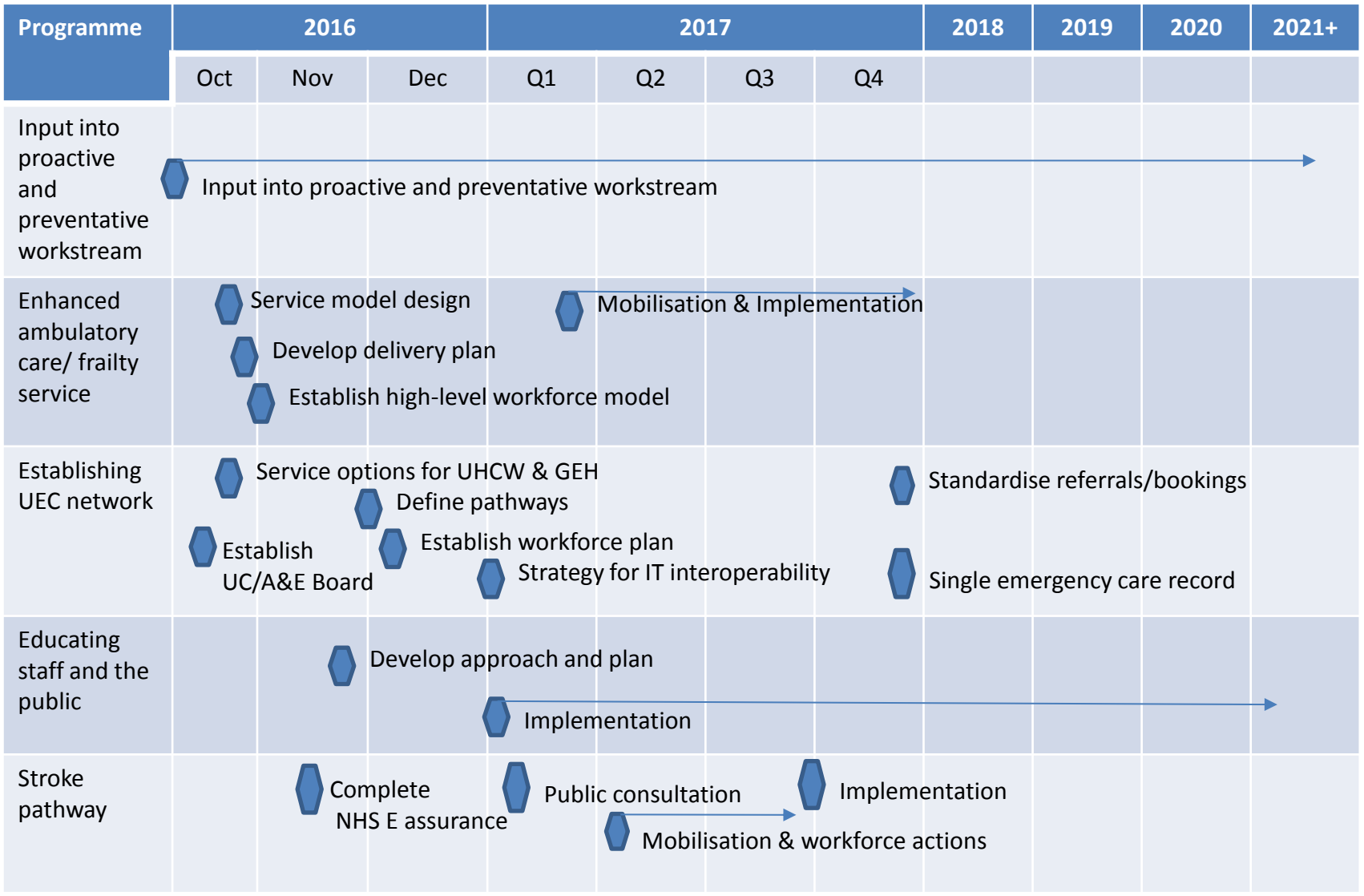
Urgent & Emergency Care

	Content
Input into Proactive & Preventative 	• Co-developing the new model of care, including crisis response in the community • Support to identify the patient cohorts that need targeted intervention • Provide acute clinical input and work alongside primary care, social care, mental health and community services to provide integrated care
Enhanced ambulatory care & frailty services 	• Enhanced ambulatory care in hospital to provide quick assessment and avoid admissions • 1-day frailty service can be an efficient way to provide rapid assessment and care for frail patients without admitting them into hospital - there is the potential to scale up the frailty pilot at South Warwickshire

Establishing a U&EC network 	• Aligned with national U&EC review, develop an integrated urgent and emergency care network, with:
	  • Streamlined and integrated access points, through 111, GPOOH, 999 and walk-in centres
	  • Senior decision makers earlier in the process – a single front door staffed by senior clinicians
	  • Clarify definition of services and acceptance criteria for each access point across EDs, UCCs, and other sites in the footprint
	• Review sustainability of the current urgent and emergency care system, including the review of access points at GEH and UHCW

Educating staff and public 	• Empower and enable patients to self care • Invest in communication and engagement for the public to provide the information and support needed to better utilise the health and care system • Enhanced engagement and education for staff to utilise the system appropriately (with the ability to direct patients to appropriate, alternative services)
Stroke Pathway 	• Achieve the outcomes outlined in the Midlands and East regional stroke service specification • Consolidate service with one hyper acute stroke unit and additional rehabilitation beds across the other providers with ESD teams to enable patients to get back into their homes as soon as possible where appropriate. Community Stroke Rehab also commissioned across the patch to enable this

Urgent & Emergency Care Indicative Timeline



Urgent & Emergency Care

Risks	
1	The 'right sizing' of urgent and emergency care capacity is dependent on optimisation of activity through the Proactive and Preventative work-stream. Operating these two work-streams in parallel will require demand assumptions.
2	The 111 and GPOOH elements of the urgent and emergency care pathway have already been commissioned and hence are a 'given' solution and need to be effectively connected into any revised pathway.
3	Operational pressures relating to A&E performance will challenge the ability of the group to focus on strategic solutions.

Engagement
Good engagement from secondary care sector.
There will need to be greater engagement with primary care colleagues to ensure that in-hours and out of hours solutions are integrated into the pathway.

Finance	
Finance	Please note that the financial impact of Urgent and Emergency Care is included within Solution 5; in Proactive and Preventative Care in the financial template.

Urgent & Emergency Care: Example/case study

Stroke

- Stroke consolidation from GEH/SWFT to UHCW is to take place with patient flows going to the hyper acute stroke unit which is in place at UHCW
- UHCW will be the only Acute Stroke Unit
- To aid patient flow, additional capacity will be provided via additional rehabilitation beds across the other providers with ESD teams to facilitate returning patients into their homes where appropriate
- Community Stroke Rehab will also be commissioned across the patch to enable this

Benefits:

All elements of the future service will achieve the outcomes outlined in the Midlands and East regional stroke service specification, which seeks to ensure that improved patient outcomes are achieved, as is the quality of life after a stroke; and patients experience a better service.

Next steps:

All three local CCGs have now approved the Pre-Consultation Business Case and discussions are taking place with NHS England to seek their approval of the case and to proceed with a public consultation.

ACTIVITY	DATE
Business Case Approval / Consultation	
NHSE approval of Pre-Consultation Business Case	November 2016
Public Consultation exercise	December – February 2017
Public Consultation outcome confirmed	March 2017
Implementation	
Interim commissioning arrangements in place (as required)	April 2017
Procurement of new services / pathway (as required)	April - July 2017
Newly procured services / pathway mobilised	July 2017+

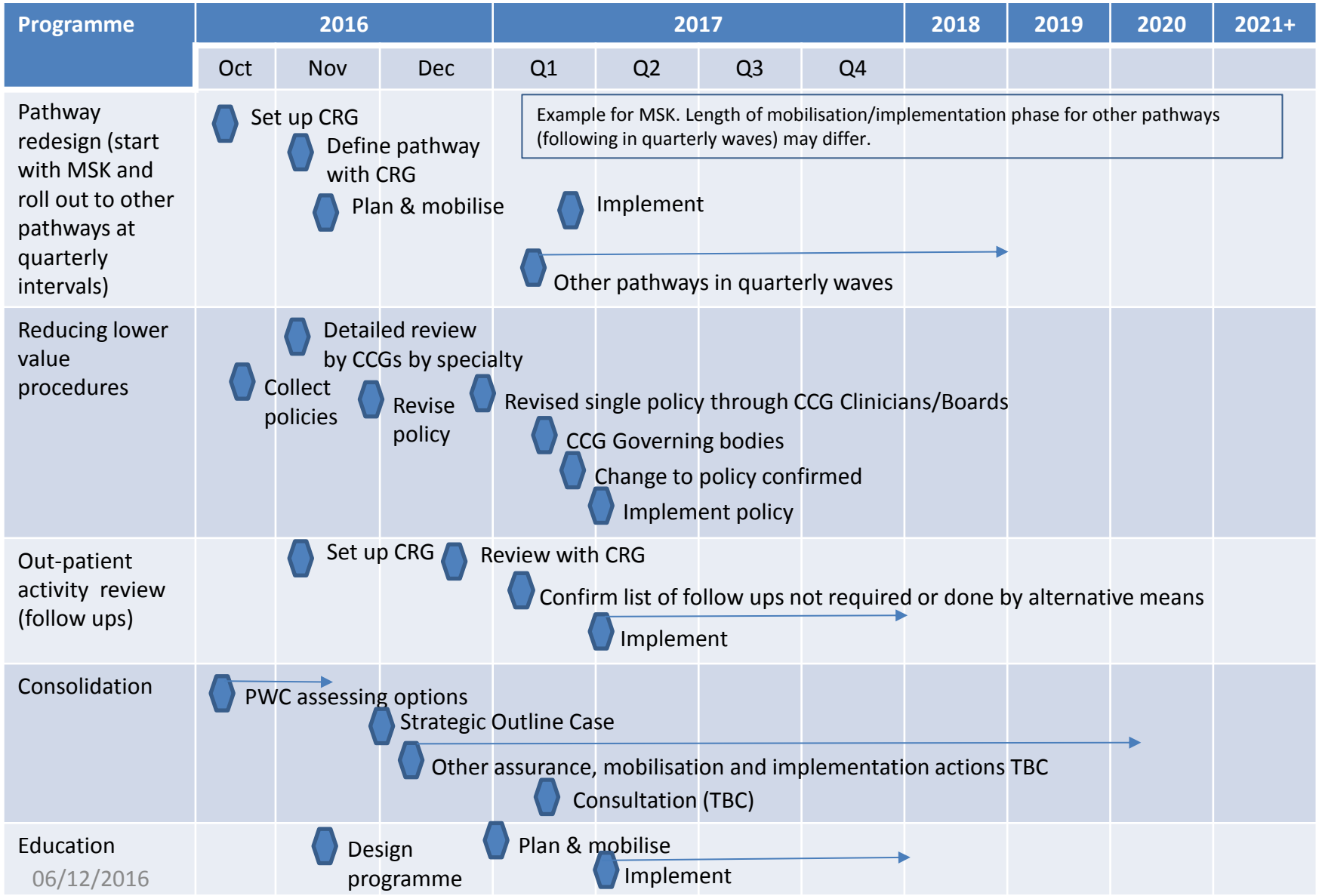
Planned Care

Roles and Responsibilities	
Workstream Lead	Debbie Pook (Chief Operating Officer, WN CCG)
Finance Lead	David Moon (Chief Finance & Strategy Officer, UHCW)
Workstream Team MSK team	Adrian Canale-Parola (GP, Chair CR CCG), Janet White (Programme Director – Strategy, UHCW/STP Programme Manager), Jayne Blacklay (Director of Strategy & Development/Deputy Chief Executive, SWFT), Dave Weston (GP, Warwickshire LMC), Simon Illingworth (Associate Director of Operations, SWFT), Ali Scott (Director of Performance and Contracting, SW CCG), Steve Jarman Davies (Director of Performance and Planning, CR CCG), Jane Fowles (Consultant in PH, CCC/CR CCG), Patrick Ryan (Head of Business Development, UHCW), Peter O'Brien (GP and Clinical Lead for InSpires Locality), Liz Mathers (GM, GEH), Kathryn Millard (Public Health Consultant, WCC), Gerard Dillon (Arden CSU) **PLUS a Clinical Reference Group**
Enablers & Interdependencies	Primary Care Development: Sustainable and at scale primary care Contractual and commercial consideration Communications and engagement: pre- consultation& consultation (where required) IM&T: potentially no requirement (TBC) Workforce: development detailed workforce plan (including impact of service reconfiguration) Estates: identification of estates requirement for new service model
Programme/Project Leads	MSK – Simon Illingworth (Associate Director of Operations, SWFT) Lower Value Procedures – Kay Holland (Contract Lead, CR CCG)
Policy Development Group	Commissioners and clinicians from the 3 CCGs with support from Arden GEM CSU

Planned Care

	Content
Pathway redesign (as part of Right Care work) 	Pathway redesign from prevention through to reablement and rehabilitation to reduce variance and reach peer median or top quartile performance Introduction of 'social prescribing', AHP support and effective referral management centres Significant improvement in outpatient performance, in particular reduction in follow-up attendances 1-stop diagnostic service to reduce outpatient attendances and ensure patients are fully prepared for surgery
Reduce lower value procedures	Reduce number of lower value procedures to focus resource on higher value procedures which offer greater benefits to patients Develop and apply stricter thresholds for procedures to ensure resource is being targeted to areas that are clinically evidenced and give the most value to patients Detailed review of all specialties across the footprint to identify all opportunity areas
Consolidation of elective specialties 	Service consolidation/reconfiguration to address care and quality challenges and significant workforce constraints, to bring sustainable services over the next five years Consolidation of inpatient and day case elective care onto a single centre (or centres) to achieve higher efficiency and lower cost Further exploration of a number of specialties including Ophthalmology, Urology, Plastic Surgery, ENT and Oral Surgery This work will be interdependent with Maternity and Paediatrics work, Urgent & Emergency Care reviews
Education, Policies, Procedures and Procurement 	Use of schools, GPs and wider Public Health to educate the public on prevention and wellness Implement standardised policies on intervention and referral levels Standardise disposables such as drugs etc. at lowest costs

Planned Care Indicative Timeline



Planned Care

Risks	
1	Timely Project Management support and availability of appropriate clinicians for level of clinical engagement required
2	Development of enabling services in primary care/GP practices, especially workforce at scale and pace required

Engagement

Clinicians (GP and acute hospital), managers (from general management and therapy backgrounds), commissioners, providers, public health directors and STP Programme Manager have been involved in developing the workstream and starting to take forward the MSK work.

Clinical reference groups and patient engagement will be critical in taking forward the workstream activity and the first Clinical Reference Group is due to take place on 4th November.

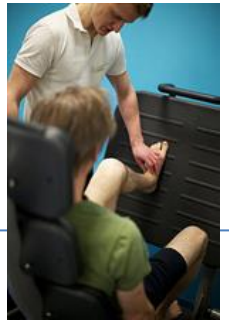
Outstanding Items & Next steps

Project and Admin Support	Clear project support required to facilitate multiple work streams
Governance Structure	Need to ensure clear lines of accountability, responsibility and systems and processes in place to be able to hold each other to account

Finance

Finance	For the purpose of the Finance submission, planned care includes Solution 7 (Outpatient First reduction), Solution 8 (Outpatient follow up reduction) and Solution 9 (Elective Day Case Reduction)
06/12/2016	The net effect of these solutions is £24.5m by 2020/21

Planned Care: Example/case study



MSK

- There are numerous “referral management” pathways in place for MSK across the country and there is limited assessment as to their effectiveness
- Locally, there is relatively poor understanding around the numbers of patients seen or the outcomes delivered by existing referral management schemes
- A single study, into an existing referral management pathway in the North West & reviewed by the MSK workstream team, suggested
  - *There was a lower conversion rate to surgery for those patients referred to MCAT service than those sent straight to secondary care*
  - *There was an increase in demand for diagnostics for patients seen through MCAT service compared to those referred direct to secondary care*
  - *It took longer to gain a working diagnosis for patients seen by MCAT team, compared to those sent directly to secondary care*
- On the basis of the above we are focussing as follows:
  - On Hips and Knees only initially
  - This would not stop existing pathways for other procedures being delivered by referral management centres/pathways
  - There was some evidence that it could reduce secondary care demand
  - Hips and knees would be more manageable in terms of change management across the region
  - We could collect data more easily and review the impact of the changes by focussing on these two areas
  - We can expand to other conditions as necessary next year
- Next steps
  - a clinical reference group on 4th November
  - develop a standardised hip and knee pathway for the footprint
  - include aftercare management in this pathway
- Initial Outcomes
  - Common referral pathway across the footprint
  - Reduction in the number of the patients unhappy with the outcome of surgery from an estimated 17% to something lower (% TBC)
  - Movement towards reduced secondary care demand

Maternity & Paediatrics Options Appraisal (eventually part of Planned Care)

Roles and Responsibilities	
Workstream Lead	Meghana Pandit (Chief Medical Officer/Deputy CEO, UHCW)
Finance Lead	Su Rollason (Director of Finance & Strategy, UHCW)
Workstream Team	Jo Dillon (Children's Commissioner, CR CCG), Carmel McCalmont (Associate Director of Nursing,- W&C, UHCW), Alison Talbot (Head of Midwifery, GEH), Wendy Jones (Head of Midwifery, SWFT), others as required
Enablers & Interdependencies	Workforce: an option must be deliverable by using the existing workforce, training of the existing workforce or through the addition of resources which can be obtained from other providers. Any option which relies on the acquisition of additional staff at grades/with skills that cannot be recruited due to lack of supply regionally and nationally should not be progressed as it would be unlikely to deliver safe and sustainable services. Productivity & Efficiency: Any transformation opportunity included within the STP programme cannot lead to an increase in costs to the system. Options likely to lead to an increase in cost overall should not be progressed.

Maternity & Paediatrics Options Appraisal

Content	
Initial Options & Benefits	The workstream has identified a number of options for further financial and workforce modelling, as well as a high level options appraisal by the workstream team. The benefits of these options are development of community hubs, increasing home births, reducing inequity and achieving workforce sustainability. The following questions have since been applied to the options:
Is an option deliverable?	In light of the challenges facing Trusts in securing a sustainable workforce - an option must be deliverable by using the existing workforce, training of the existing workforce or through the addition of resources which can be obtained from other providers. Any option which relies on the acquisition of additional staff at grades/with skills that cannot be recruited due to lack of supply regionally and nationally should not be progressed, as it would be unlikely to deliver safe and sustainable services.
Can an option be delivered at or below current provision costs?	Analysis conducted by UHCW clinicians has concluded that in order to deliver the RCPCH 'option 2 (termed option 4 in the STP analysis)' there would need to be an increase in the number of consultants needed to cover both sites from 31 funded posts currently to 39 or 40 (at least in the short run) in order to deliver a safe level of care. The increase in the number of consultants required reflects the fact that 11 of UHCW's consultants do not currently have the requisite skills to cover a SCBU. Overtime it is likely that the combined team would build their skills reducing the total number of consultants required - but it was felt that this would not be to a level below the existing number.
Remaining options	2 options, each with a single sub-option remain and the workstream is now working on further analysis and modelling of these options. No communications outside the STP teams has yet happened as these ideas are still evolving but no decisions made. These will be fed into the Planned Care consolidation activity.

Maternity & Paediatrics Options Appraisal

Risks	
1	Reaching a final agreement on options to be appraised
2	Agreeing options appraisal process and way forward

Engagement
Given the early stage of this work there has not yet been any engagement outside the STP workstream as these ideas are still evolving with no decisions made.
We realise that this particular workstream will require extensive, thoughtful communication and engagement through both pre-consultation and formal consultation stages and are planning for this.

Outstanding Items & Next steps
Reconvening group to revisit options and reach a final agreement on options to be appraised (impetus for this may come from GEH/UHCW collaboration SOC)

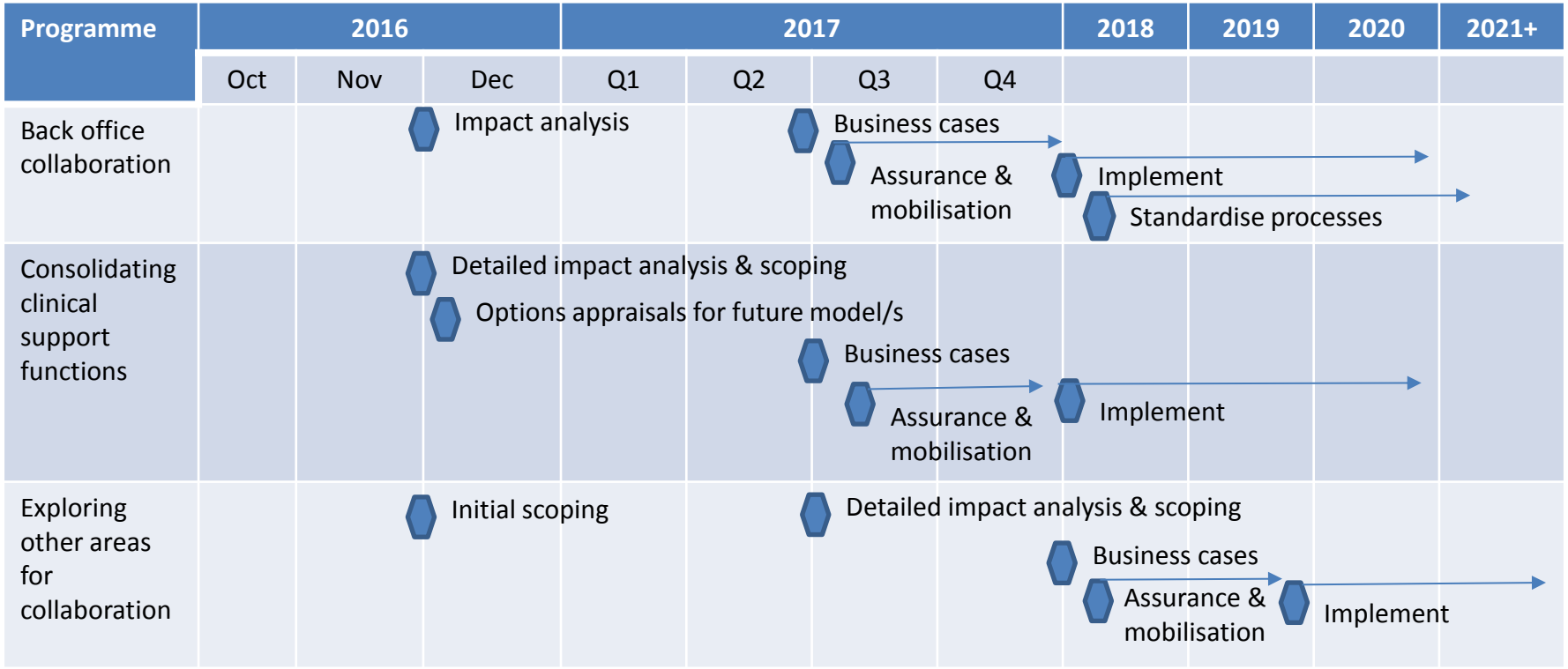
Finance	
Finance	Please note that the financial impact of Maternity and Paediatrics is within Solution 11 (Consolidation of Elective services and Maternity & Paediatrics) included in Productivity and Efficiency

Productivity & Efficiency

Roles and Responsibilities	
Workstream Lead	Kim LI (Director of Finance, SWFT)
Finance Lead	N/A
Workstream Team	STP Finance Group members – CFOs, DoFs, Finance Leads from each STP organisation, Jonny Gamble (Financial Planning Accountant, UHCW)
Enablers & Interdependencies	Workforce IM&T Estates

Content	
Back office collaboration	Back office collaboration to reduce the cost of back office functions across the system, for example, through consolidating functions, standardisation and adopting best practice across the footprint IM&T is identified as a key area to explore Other potential targets for collaboration include Finance, HR & PMO
Consolidating clinical support services	Consolidating clinical support services that are duplicated across the footprint can reduce variation, achieve economies of scale and create efficiencies For example, through better utilisation of equipment, more efficient management of workload and better deployment of staff Potential targets for consolidation include pharmacy and pathology (building on existing work)

Productivity & Efficiency Indicative Timeline



Productivity & Efficiency

Risks	
1	Reaching agreement on services/functions to collaborate on whilst these services/functions are supporting the individual workstreams

Engagement
Engagement of Service functions will be critical to ensure buy in and ownership of change

Outstanding Items & Next steps
Awaiting feedback from national benchmarking Identity service function leads to liaise with on scope of collaboration

Finance	
Finance	For the purpose of the Finance submission, Productivity and Efficiency includes Solution 1 (Specialised Commissioning QIPP), Solution 2 (CCG Business as Usual QIPP), Solution 3 (Provider Business as Usual CIP) and Solution 11 (Consolidation of Elective services and Maternity & Paediatrics)
	The net effect of these solutions is £148.3m by 2020/21

Productivity & Efficiency: Example/case study

Pathology Network

- Following the Lord Carter review into Pathology Services, Coventry & Warwickshire health economy acted promptly to the recommendations to form a pathology network: Coventry and Warwickshire Pathology Services (CWPS).
- Formed on 1 April 2008 between UHCW, SWFT & GEH, CWPS provides pathology services to each of the stakeholder organisations, community services and GP practices across the footprint, as well as private organisations and UK MoD.
- It also has contracts with neighbouring community and GP services and provides services for other STP footprints (e.g. Burton).
- The service is provided from three laboratory locations, with an increasing development towards point of care provision, which supports our STP direction of travel.
- CWPS also has SLAs for services it buys from other providers and brings economies of scale by doing this on a footprint basis.
- CWPS is overseen by a Stakeholder Board comprising the Chairs and Chief Executives of the stakeholder trusts and voting arrangements and equity stake holding are laid out in an Accountability Agreement.
- Given this existing strong position, CWPS has contacted other neighbouring footprints to assess any appetite for collaborating/joining CWPS to bring efficiency benefits to other footprints at pace and scale.

Collaboration between GEH and UHCW

Roles and Responsibilities	
Workstream Leads	Andy Hardy (CEO, UHCW/STP SRO) and Kath Kelly (CEO, GEH)
Clinical Leads	Meghana Pandit (Chief Medical Officer/Deputy CEO, UHCW) and Gordon Wood (MD, GEH)
Finance Leads	David Moon (CFSO, UHCW) and Shahana Khan (DoF, GEH)
Workstream Team	Joanne Guy (Head of Business Development, GEH), finance teams from both Trusts, clinical leads from a range of specialties
Enablers & Interdependencies	Workforce, IM&T, Estates
Strategic Outline Case (SOC)	
Workstreams to develop	The preferred option for a service model across the two organisations including the configuration of services and support functions The potential impact of integration on clinical, operational and financial sustainability The options for organisational form and their ability to deliver the potential benefits of the integration The steps required to move towards the preferred model and the potential resources required

GEH & UHCW Collaboration

Strategic Outline Case (SOC)	
SOC will include   	**Strategic case**: A description of the current configuration of services and the quality and financial issues that exist. Articulation of the preferred service model option and how it was designed. **Economic case**: An assessment of the benefits and costs of the preferred service model option. **Commercial case**: A description of the options for organisational form and how they can deliver the benefits of alignment. **Financial case**: Description of the costs of alignment and the impact on organisational sustainability. **Management case**: A high level implementation plan drawing on the implementation plan described above.

Risks	
1.	Lack of clinical buy-in
2.	Political opposition to change
3.	Inability to make estate changes required e.g. theatres at GEH, right-size UH ED
4.	Time to agree the preferred service model
5.	Lack of sufficient capital to respond to agreed changes (e.g. right-sizing of UHCW A&E)

Workforce

Roles & responsibilities	
Lead	Karen Martin, Chief Workforce & Information Officer, UHCW
Team	Fiona Grove (Senior HR Business Partner, Arden GEM CSU - Primary/Community Care), Lorraine Nye (Workforce Business Partner, UHCW - Acute Care), Wendy Bowes (Associate Director Workforce, UHCW), Janet White (STP Programme Manager), Gill Satpal (Head of Employment Services, UHCW), Sarah Copley (WM HEE), Caroline Macintyre (Head of Workforce Assurance, Arden GEM CSU), Caroline Samouelle (Associate Director Organisational Development, SWFT), Ann Pope (Director of Human Resources, SWFT), Sue Wakeman (Director of Human Resources, GEH), Marie Cooksey (Workforce Planning and Information Manager, GEH), Andrew Ashford, (Workforce Information Officer , CWPT), Catherine Sills (WM HEE), Shajeda Ahmed (Associate Director of HR, CWPT)

Content	
Baseline Analysis	We have worked with colleagues from HEE and across the footprint to assess our baseline workforce position.
Current Workforce Requirements	HR/Workforce leaders across the footprint have been asked to identify their current workforce challenges so these can be collated and opportunities for collaborative effort/remedy be identified.
Additional STP Workstream requirements/workforce changes	STP workstream leads have been asked to identify the particular challenges and changes associated with their workstreams so more detailed workforce plans can be developed that we know are aligned to need and delivery timescales. This is very much “work in progress”.
There are workstreams with significant workforce requirements/challenges in their plans (P&P, M&P, PC) but the detail of this is not yet clear. We will be getting early indications during w/c 17th October.	
We know we have much work to do to ensure we have captured the requirements of the “here and now” and workstreams’ future plans and are in a position to respond to them.	

Workforce

Next steps
Maintain and update baseline assessment of ongoing workforce challenges and plans across the footprint
Support transformation workstreams to ensure safe staffing levels and appropriate skills are incorporated into their plans with appropriate milestones
Work with communications & workstream leads to ensure they have plans to involve the workforce, including staff-side representatives and unions
Work with P&E workstream on Carter savings and consolidation of back office functions including review of HR functions as well as HR/workforce aspects of other service consolidations
Support above workstream in its activity around reduction in Agency costs
Support all transformation workstreams in their activity to reduce agency staff use (e.g. requirement around workforce costs in M&P Options Appraisal workstream)
Close working with Primary Care Development workstream around workforce development requirements to support transfer of activity to primary care/GP settings and to meet the existing workforce challenges in this sector
Work across the STP on common recruitment and retention strategies, plans and processes
Optimise a learning environment for current and potential staff across the footprint

Case study/Example
We are currently working with WCC on a reablement project – one workforce across Health & Social Care, planned for implementation in Jan 2017. The workforce model is to include new and extended roles with WCC staff seconded to SWFT.
We are bidding to have a pilot site for Nurse Associate roles within the footprint and there are a number of apprenticeship schemes ongoing, with plans to take advantage of the Apprenticeship Levy from April 2017.
We are exploring rotational working across organisational boundaries within the footprint and are exploring this further in end of life care with Myton Hospice.

Estates

Roles & responsibilities	
Lead	Jenni Northcote (Director of Partnership and Engagement, WN CCG)
C&W STP Estates Group (STP LEF) – decision making and oversight of the STP Estates activity, assess plans from other workstreams and identifies interdependencies and necessary estates actions.	Representation is from WN CCG, SW CCG, C&R CCG, GEH, CWPT, UHCW, SWFT, Coventry & Warwickshire ICT Collaborative, NHS England, WCC, CCC, NHS Property Services, Community Health Partnerships, and Rugby Borough Council. The STP Programme Manager also attends.
Local Estates Forums (LEF)	The STP wide combined LEF (described above) acts as main driver to co-ordinate the STP Estates activities. Coventry & Rugby LEF has been subsumed into the STP LEF, but WN CCG and SW CCG have retained their separate Local Estates Forums. The STP LEF operates with workstreams, programmes and project groups to move the agenda of the STP and CCGs' LEFs forward.
Resource	An STP Strategic Estates Advisor has been nominated, in line with national guidance, to support the STP process, especially in acting as a sounding board / "critical friend" in the completion of the estates requirements. The STP SEA for this locality is from CHP, Riana Relihan.
Workstreams and task & finish groups (workstreams are described in the following slide, a number of Task and finish groups are taking forward discreet pieces of work within the workstreams).	Both of these types of groups are set up and operating in taking forward the STP Estates agenda: Worksteams are continuous and may require updating and ongoing management protocols; task & finish groups are time limited and have an initial objective to respond to.

Estates

Content	
As an enabler to service change	Major change requires new or refurbished estate. Aligning primary, community and acute services will require a very different primary care estate.
As a source of funds: Capital Receipts	Retention in locality to be business case dependant i.e. making the case for re-investment. There remains overarching policy that capital receipts all needs to go to the 'central pot' to facilitate equitable future use. Discussion with DH ongoing to inform further clarity for implementation stage.
'Big' ideas or plans in terms of estates that responds and delivers service transformation for the STP footprint	More than relocation and shifting things about – so a review of the organisational estates plans (including primary care premises plans) is required to re-align with STP priorities. Ongoing treatment of risk has to be quantified and recognised in terms of resource allocation, i.e. statutory compliance, H&S etc.
Responding to the STP Transformation Workstreams	Consolidation of acute provision and other changes across the estate will become apparent as consolidation plans emerge from the a transformation workstreams. Potential impact of the large housing developments and their effect on provision as specific sites in the future. Options around the future estates provision.
Identifying/ Confirming the PLACE and HUB localities	Determining barriers to integrated use and co-location of services at premises. Estates Operating Model (formerly "Single Estate"– best utilisation of estate to support service delivery), review existing local initiatives, complete estates' information collation, develop STP-wide disposal list protocol, STP-wide approach to Planning consultation/S106 applications, review multiple occupier and user premises, integration of children services, and co-location of children's services in key sites, better access to and utilisation of GMS space.

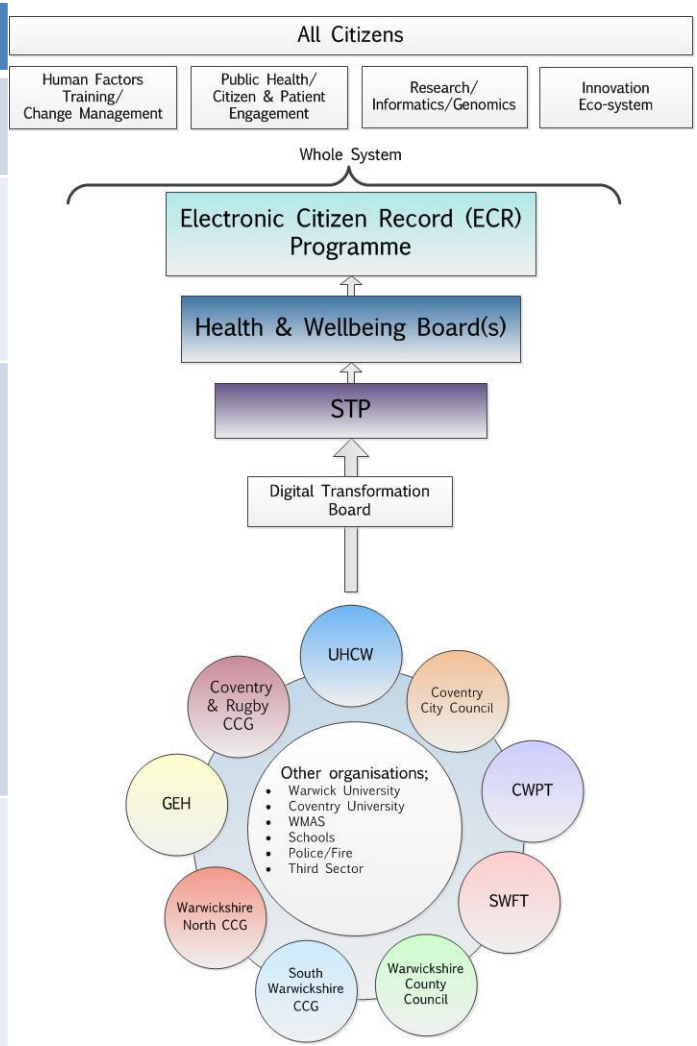
Estates

The main STP service priorities needed to deliver FYFV: The overarching challenges are Closing the Gap on Health & Wellbeing, Transformation to close the Quality & Care Gap, and Achieving Financial Balance and Efficiencies. The key work streams set up are:	
1	Planned Care- Redesign In-Hospital Programme focussing on Maternity and Paediatrics and planned care, initially focussing on MSK
2	Proactive and Preventative Care - Developing existing Out of Hospital Care, including preventative care and early intervention
3	Developing an integrated Urgent & Emergency Care service – including Out of Hours, a new stroke pathway and simplified access to Urgent & Emergency care
4	Productivity and Efficiency – identifying savings opportunities through whole system working
5	Primary Care Development
6	Digital Roadmap/IM&T
7	Workforce
8	System change - Accountable Care System
The STP is setting targets for the service workstreams and delivery of these will require estates as an enabler in some cases, but this will be dependent on Business Cases. A specific efficiency target for estates has therefore not been set and it is recognised that estates may require variable levels of investment.	
1	Review land and site utilisation for University Hospitals Coventry & Warwickshire, South Warwickshire FT and George Elliot sites for potential reconfiguration and rationalisation
2	Establishing a new renal unit in a community facility in Coventry city centre bringing activity off acute site
3	Defining the collaborative estates governance model to support the 'system implementation' and efficiencies (shared resourcing and expertise with combined/ single accountability
4	Review barriers to better premises utilisation by looking at three different categories of community and primary care buildings
5	Resourcing and expertise at both programme and work stream level very limited

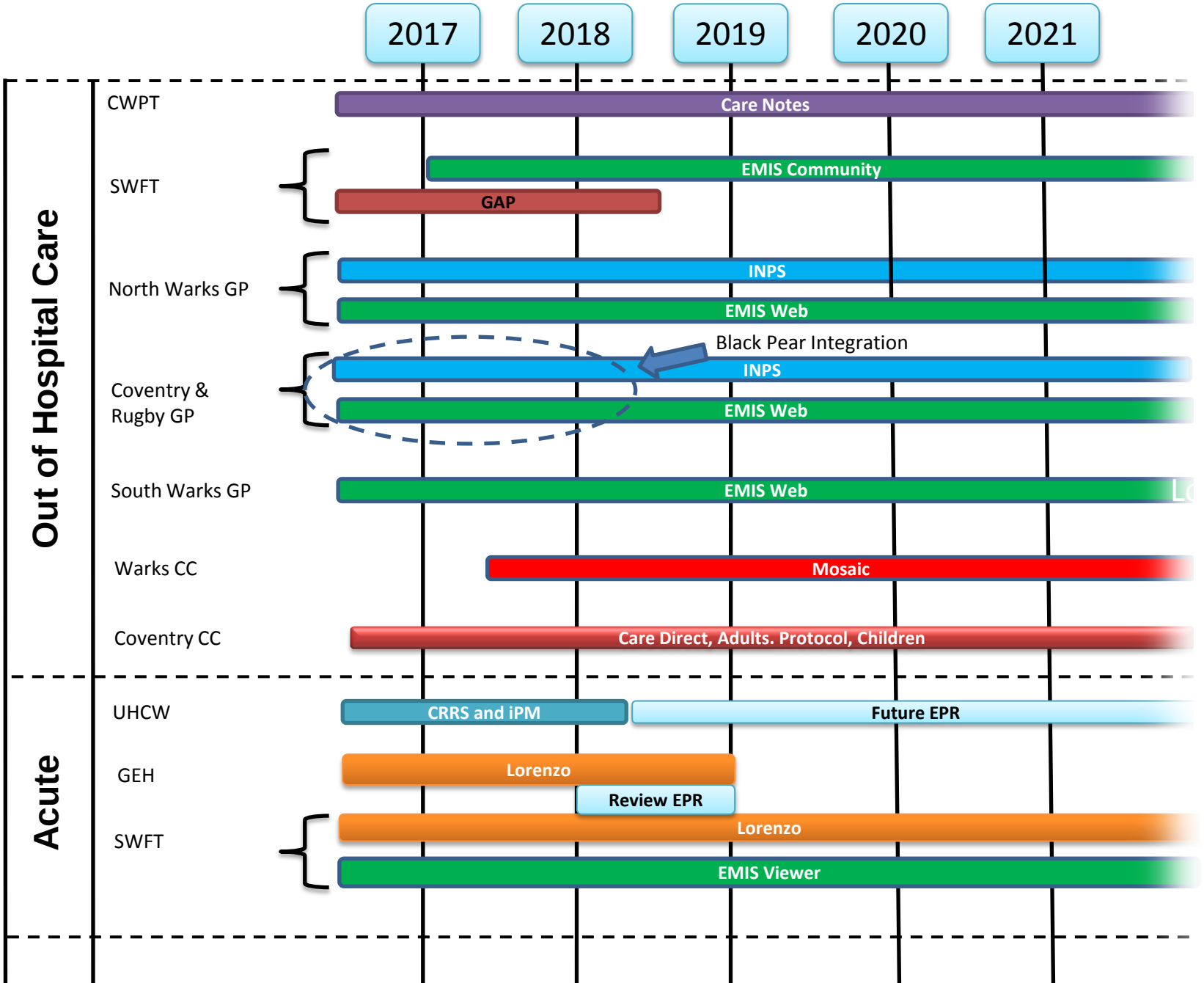
All organisations have existing capital plans, mainly to address outstanding maintenance and to keep facilities safe and fit for purpose (e.g. replacement of theatres at Hospital of St Cross). Given the limited capital available, there are no major estates plans being worked up currently that are specifically connected to the STP. However, the GEH/UHCW Collaboration activity may result in Estates Capital schemes (e.g. right-sizing of UHCW A&E).

IM&T/Digital Roadmap

Roles, Responsibilities & Timeline	
Lead	Steve Jarman Davies (Director of Performance and Planning, CR CCG)
STP IM&T LDR Group	Senior representation (including Directors of ICT) from all STP organisations and WMAS, C&W ICT Collaborative and CSU. The STP Programme Manager also attends. Clinical representation is provided by the LDR lead clinicians (Medical and nursing).
Strategic journey - Coventry	UHCW procure and deploy an integrated EPR solution which is developed to have the potential to fulfil the long term vision – 2018/19 Options for future deployment with Coventry City Council to be considered as the LDR and STP progress and business cases are developed. Develop the final business case and agree to deploy to other Coventry health organisations, including the Coventry and Warwickshire Partnership Trust – 2021/22 **Outcome – Electronic Citizen Health Record for Coventry**
Strategic journey - Warks	Explore a business case to move South Warwickshire Hospital to same integrated solution as Coventry and Rugby and deploy 2021/22 Explore a business case to move Warwickshire Out of Hospital Care to same integrated solution and deploy 2021/22 Explore a business case to move Warwickshire County Council to same integrated solution and deploy 2022/23 **Outcome – Coventry and Warwickshire Electronic Citizen Health Record**



IM&T/Digital Roadmap

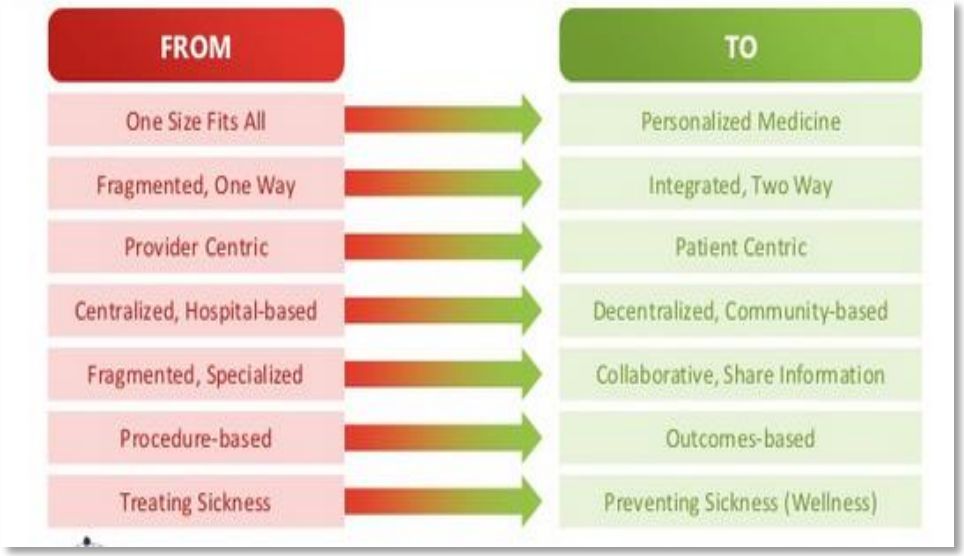


IM&T/Digital Roadmap

Content	
Strategic Vision	In line with the C&W STP, to deliver an integrated health and care system (enabling us to become 'the healthiest community in the UK') Integrated electronic citizen health record To enable the move over time to implement accountable care and outcomes/values-based care models
Key drivers	Improving patient experience Reducing duplication Reducing medication errors Enabling integrated working
Next steps	Technology leads of all organisations to drive delivery of LDR in support of the STP LDR Technology Leads Group, Chaired by the Coventry and Warwickshire CCIO, being set up in October 2016 Terms of Reference of the Group drafted and to be agreed by Digital Transformation Board in November 2016

Modernisation, Transformation and Innovation

- Changing behaviours
- Engage and empower citizens and patients (self-care)
- Changing the way we work
- Clinical decision support
- Effective population health management



Communications & Engagement

Roles & Responsibilities	
Lead/s	Communications – Kerry Beadling (Head of Communications, UHCW) Engagement (Big Conversation) – Andrea Green (Accountable Officer, WN and C&R CCGs) Design Authority (Chair) - Guy Daly (Dean, Health & Life Sciences, Coventry University)
Communications Group (Weekly conference calls & meet as required) STP Communications & Engagement meeting STP Engagement sub-Group	Communications Leads from all STP organisations As above plus Healthwatch (Coventry & Warwickshire, represented by CEO Healthwatch Coventry), chaired by Kerry Beadling CCG and Local Authorities – chaired by Andrea Green
Voluntary Sector (building on earlier workshops around Mental Health, Urgent Care, Frailty & high level STP briefing)	Rob Allison (Director of Policy & Partnership, VAC) Paul Tolley (Chief Executive, Warwickshire CAVA) Janet White (STP Programme Manager – STP) - STP Justine Richards (Director of Strategy & Business Development, CWPT) – Mental Health & Out of Hospital Jim Davidson (Associate Medical Director, UHCW) – Urgent Care & Frailty
Healthwatch (attend STP Transformation Board)	Ruth Light (Chief Executive, Healthwatch Coventry) Chris Bain (Chief Executive, Healthwatch Warwickshire)
Health & Wellbeing Boards (building on briefings with development session on STP on 13th Oct)	Gereint Stoneman (Health and Wellbeing Delivery Manger, WCC) Liz Gaulton (Deputy Director Public Health, CCC)
HOSCs (as required)	Gail Quinton, (Executive Director – People, CCC) John Dixon (Strategic Director of People Group, WCC)
LMCs (members of STP Design Authority)	Maggie Edwards (Executive Officer) & Sarah Mathews, Jamie MacPherson, Terry Eaton, (GPs, Cov LMC) Andrew Kennedy (Chairman) & Dave Weston, Bill Fitchford, Lesli Davies, (GPs, Warks LMC)
STP Design Authority (meet as required)	

Communications & Engagement

Examples/Progress
HWB Boards have been briefed regularly both at joint Coventry and Warwickshire development sessions and at board meetings. In addition, HOSCs have been briefed, when requested.
Building on previous workshops with the Voluntary Sector on Frailty, Mental Health and Urgent Care, a high level briefing on the STP (process and approach) has taken place.
Senior Management teams at organisations within the STP have been briefed and initial staff briefings have been included in various staff newsletters etc. within the individual organisations' staff communications routes.
An initial Communications & Engagement Strategy for the STP was presented to the STP Transformation Board in August.
An Engagement Strategy for Pre Consultation (*Big Conversation: A route-map to delivering the Five* Year Forward View) has been developed and will be going to the STP Transformation Board in late October. This strategy has been developed to respond to concerns raised by our Healthwatch colleagues and conforms to the Healthwatch good engagement charter.
An Engagement Plan for the "Big Conversation"/Pre Consultation between October 2016 and the end of March 2017 has been developed aligned to national priorities (e.g. 5YFV, Better Births, MH 5YFV etc.).
Communications, engagement and formal consultations (staff, patients and public) around specific transformation plans will take place as and when appropriate to these plans.