Coventry and Warwickshire
Integrated Care System

The future of health and care

in Coventry and Warwickshire

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Introduction

Integration means bringing services, people and organisations together.

Coventry and Warwickshire is an “Integrated Care System” (ICS). This means all of the organisations which support local people with their health and care, from the NHS and Local Authorities to community groups and the voluntary sector, all want to work better together to improve health, care and wellbeing for everyone who lives here.

Across Coventry and Warwickshire we provide health, care and wellbeing services and support to over one million people. One of the most important things our new ICS has done is develop a strategy to set out how we will all work together. This work was done by the Integrated Care Partnership, a group of representatives from local government, NHS, voluntary and community sector, housing, Healthwatch, universities and others.

This strategy explains what we think we can do over the next five years as an ICS, the difference we can make by working together, and how we will do it. It tells the story about where we want to get to, and what it is that we are all trying to change and improve together. We won’t make things better by just changing health and care services. By all working together we can start to improve some of the things that affect people’s health and wellbeing, such as unsuitable housing or financial pressure. These are known as the “wider determinants of health” and affect our most vulnerable communities most. If we can improve the wider determinants of health, we can improve everyone’s health and wellbeing and reduce some of the inequality which people experience. We also created an Integrated Health and Care Delivery Plan, which goes into detail about how we are going to do what we’ve said we want to do in our Strategy.

This document brings together our Strategy and Plan, to give you an overview of the future of health and care in Coventry and Warwickshire.

The Covid-19 pandemic tested our services like never before, but it also showed us what can be achieved when local organisations and communities work together. We now have new challenges to face and as you read through this document you will see how we plan to do it together.

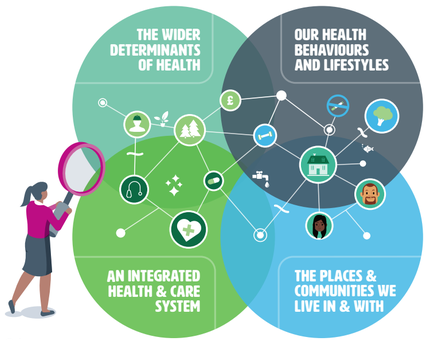
Opportunities

available to the Coventry and Warwickshire Integrated Care System

Our Population Health Framework

Underpins the Integrated Care Strategy and this plan, and connects our work as partners both within the health and care system and across the wider Integrated Care System.

The Framework recognises that we have an opportunity to improve population health and wellbeing in its broadest sense by focusing not only on transforming the health and care system but also on addressing the wider determinants of health.



Building on strong foundations

In the Coventry and Warwickshire Integrated Care System we are building on a long and productive history of collaboration and partnership working framed by our local Health and Wellbeing Concordat.

Partnerships and Collaboratives

We believe that transforming our health and care system by working together at all levels is the best way to improve the health and wellbeing of our population overall and to reduce inequalities.

Our 19 Primary Care Networks, four Places and six Collaboratives are demonstrating the value that partnership working can bring, including by integrating services, shifting to a greater focus on prevention and proactive care and enhancing productivity.

£1.9 billion

Financial Resource

We spend £1.9 billion on health services in Coventry and Warwickshire. By coming together through the Integrated Care Board we have the opportunity to work together to optimise the use of these resources in a way that supports our shared vision and priorities.

Workforce

Our health and care workforce is our greatest asset and the linchpin of our system. Delivering the bold transformation ambitions described in our Integrated Care Strategy and this plan will depend on their efforts, energy and dedication.

Local People and Communities

We have strong communities, with hundreds of thousands of people providing unpaid care to support their loved ones, or freely giving their time and skills through volunteering. Working in partnership with people and communities is central to our approach.

District and Borough Councils, our two local Healthwatch organisations and our Voluntary, Community, Faith and Social Enterprise partners will play a key role in shaping how we develop engagement that empowers people and communities, and ensures that services are responsive to local needs and preferences.

Leadership

Our system benefits from a diverse and talented group of clinical and professional leaders who ensure that we learn from and implement the best examples of how to do things, innovate, and use data and evidence in order to continually improve.

Performance

By benchmarking our performance against other areas, both regionally and nationally, we know that we perform favourably against a number NHS targets and priorities.

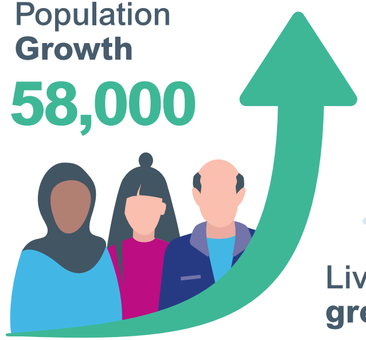
These include elective recovery, with achievement against the 6 week diagnostic test waiting time targets and reduction of long waits in relation to the referral to treatment waiting list. In mental health, Coventry and Warwickshire also perform well on the number of annual health checks undertaken for patients with a learning disability and with severe mental illness.

Challenges

facing the Coventry and Warwickshire Integrated Care System

Population **Growth**

58,000



Predicted increase of GP registered patients by 2027/28, making the population **1,111,898.**

In the last two years GP registered patient growth has been the highest in percentage terms of any ICB, **0.94% per annum** over the last two years, and **0.97% in the last 12 months.**

Living longer with **greater need**

	Healthy Life Expectancy (years)	Years spent in **poor health**	Total life expectancy
Coventry			
	61.1 (males)	16.9 years	78 years
	64 (females)	18 years	82 years
Warwickshire			
	62.1 (males)	17.6 years	79.7 years
	64.1 (females)	19.3 years	83.4 years

Financial **strain**

£125 Million

Expected efficiency ask equating to 6.5% of the **£1.9 billion** NHS opening budget for 2023/24.

Health **inequalities**

The gap in life expectancy between most and least deprived **is widening.**

Coventry

10.2 year gap (males) | 7.5 year gap (females)

Warwickshire

7.7 year gap (males) | 6.7 year gap (females)

Performance impacted by increasing **demand** and **complexity**

in primary care, mental health services and emergency presentations, alongside referrals for routine care.

Place-based **variation**

Life Expectancy

Willenhall **71.3** years

Warwickshire South **87.8** years

Workforce **Challenges**

Staff turnover (NHS 14%/Social Care 26.9%), **vacancy rates** (NHS 11%/Social Care 9.8%) and **absence rates** all create significant challenges to capacity, service delivery and staff wellbeing.

Deprivation

137,208

people live in the top **20% most deprived areas nationally**; equating to **14.6%** of the total Coventry and Warwickshire population.

Of the 137,208 people

> 99,153 reside in **Coventry**

> 38,055 reside in **Warwickshire**

Cost of living

Coventry is in the top decile **(10%)** of Local Authorities in the Cost of Living Vulnerability Index.

There is variation across Warwickshire's districts and boroughs, with Nuneaton and Bedworth ranking the lowest for overall vulnerability.

Not being able to afford essentials – food, rent or mortgage payments, hot water and heating – **has significant negative consequences for physical and mental health and wellbeing.**

Putting people at the heart of our strategy

What our communities told us...

From 20 August until 30 November 2022 a group assembled by the Integrated Care Partnership undertook engagement work with local communities, the ICS workforce, stakeholders and the voluntary and community sector to understand local priorities for health and care.

The information gathered was used to shape and inform the development of the priorities, areas of focus and enablers that are shared across the Integrated Care Strategy and the Integrated Health and Care Delivery Plan.

26 engagement sessions took place in various community settings

What we heard...

244 people completed the online survey

8 virtual sessions online

72 paper copies of the survey were completed

Access to Services

Booking an appointment with a GP practice

'GP appointments not available and patients asked to ring following day after 8am. This carries on for days.'

Access to dentistry

'Women in the refuge [are] unable to access dentists.'

Accessing clinicians

'I get very distressed and anxious when having to call the surgery, I don't like to explain my personal health problems to the receptionist.'

Face to face appointments

'We need face to face appointments - the doctor tells you to take a picture of your skin condition - how can this be a true reflection of my condition as my skin colour is black and you can't see a rash on black skin in a photo.'

Ordering prescriptions

'The email prescription service only works for people who can get online.'

Access to urgent care services

'Very long waits for ambulances and in A&E departments – sometimes more than 12-15 hours.'

Digital Inclusion

Ensuring services are inclusive

'Too much by mobile – who is going to pay for my WiFi?'

'Some of the elderly Asian people [in my community] do not know how to use a computer or book appointments online.'

'Being able to get an appointment and talk face to face and not these phone calls and online chats, that's how things are missed.'

Need for more online services where appropriate to relieve pressure

'Provide email and online consultation bookings for patients who can use online. There are many things we want to talk to the doctor about that are not extremely sensitive, and often it is easier to write things than talk to receptionist.'

Groups and communities involved in engagement

- South Asian Community Groups
- Learning Disability Groups
- Men's Health Support Groups
- Care Home Staff
- Ante-natal Support Group
- Charities
- Elderly Support Groups
- Faith Groups
- Mental Health Support Groups
- Black and African Caribbean Groups
- Cancer Support Groups
- NHS and Social Care Staff
- Refugee, Migrant and Asylum Seeker Groups
- Housing Support Groups
- LGBTQi+ Support Groups

Trust in Services

'Too much red tape, being told you don't meet an arbitrary invisible criteria when you are begging for help.'

'There is no link up, no who do you go to. It's assumed families will do it... I'm single? And I haven't even EVER seen any medical person regarding having dementia.'

35 individuals conversations

686 individuals participated in the sessions

Our vision for the future of Health and Care in Coventry and Warwickshire

> We will enable people across Coventry and Warwickshire to start well, live well and age well, promote independence, and put people at the heart of everything we do.

Improve outcomes in population health and health care

Tackle inequalities in outcomes, experience and access to services

Enhance productivity and value for money

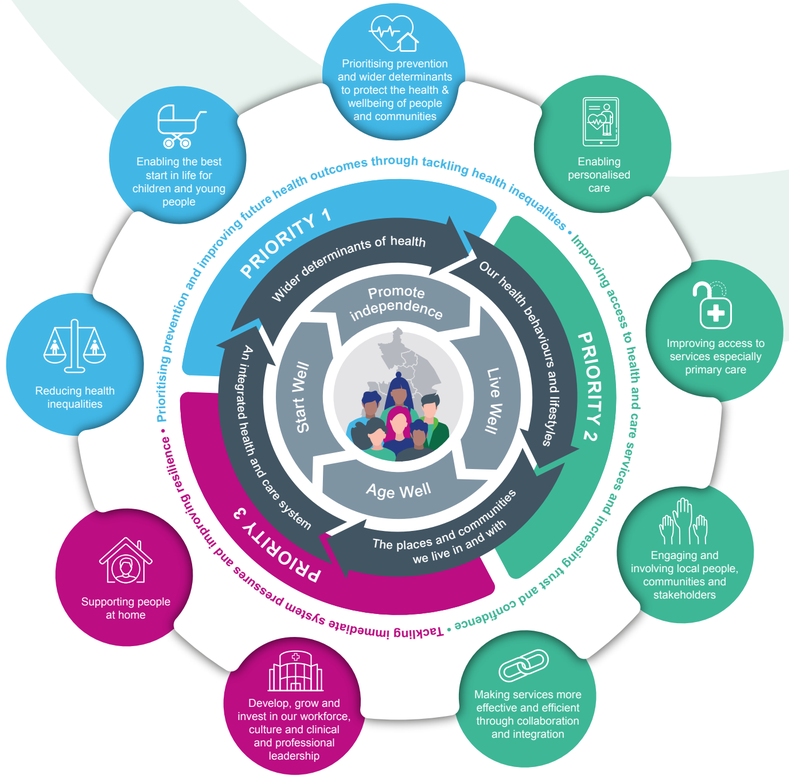
Help the NHS support broader social and economic development

The health and care system will contribute to delivering this by…

1. Prioritising prevention and improving future health outcomes through tackling health inequalities
2. Improving access to health and care services and increasing trust and confidence
3. Tackling immediate system pressures and improving resilience

Enabled by…

4. Creating the conditions for change to happen
5. Transforming our system



Through everything local communities told us their priorities are, what we know about the health needs in our area and the challenges we know are facing us, we developed priorities that will help people to start well, live well and age well, promote independence and put people at the heart of everything we do.

These priorities each have key areas which we will focus on over the next five years. These areas are where we think we can make the most difference and address what matters most to people in Coventry and Warwickshire.

Priority 1:

Prioritising prevention and improving future health outcomes through tackling health inequalities

What do we want to achieve

As a system we want to prioritise preventing ill-health and work together to support every person who lives in Coventry and Warwickshire to remain as independent and healthy as possible from early years through to the end of life.

This means focusing especially on those whose health outcomes and experiences are worse than others and addressing the factors in their lives – from birth onwards – that make this the case.

What are the overall aims of the system by 2028

Reducing health inequalities

All partners in the Coventry and Warwickshire ICS will work to identify and tackle the inequalities faced by our local population to ensure that Coventry and Warwickshire is a place where everyone starts, lives and ages well.

Action to tackle health inequalities will be embedded strategically and operationally across all organisations within our health and care system and will be a golden thread running throughout this plan.

We will build a culture and data architecture that supports us to prioritise those in greatest need – reducing inequalities will be a core consideration in the prioritisation and allocation of resources.

Service delivery and preventative activities will be driven by data around both existing health inequalities and the wider determinants of health.

Services will be planned and delivered in an inclusive way through co-production with people and communities.

Work programmes and services will systematically be assessed for their contribution to the health of our population.

Enabling the best start in life

Children and Young People

Effective partnership working is embedded between organisations and sectors around a clear set of shared priorities and outcomes for children and young people, maximising the impact of local resources and expertise, and avoiding duplication and missed opportunities.

Through the above, seamless, integrated and evidence-based care and support is delivered at the right time, enabling every child and young person living in Coventry and Warwickshire to have the best start as a foundation for a happy, healthy, safe and productive life.

Children and young people who are more vulnerable or who require additional support, including looked after children and children with special educational needs and disabilities, receive the additional care and support that they need to thrive and make a strong start in life.

To deliver the system responsibilities in relation to the expectations of the Children and Young People Core20PLUS5 model.

Children and young people feel safe and are protected from violence, harm, harmful practices, abuse and neglect at home, online and in the community.

Maternity and Neonates

Safe, personalised, kind, professional and family friendly maternity and neonatal services are embedded across our system, through which every woman has access to; information to enable them to make decisions about their care, and support that puts them and their baby at the centre based around their individual needs and circumstances.

To provide assurance by the surveillance and triangulation of clinical outcomes that robust, quality maternity and neonatal services are in place to support women, babies, and families.

To continually drive service improvement and transformation to reduce health inequalities, and maternal and perinatal mortality and morbidity, listening to women, families and frontline staff to ensure that their voices are at the heart of service improvement.

Prioritising prevention

A system wide commitment to supporting prevention is embedded, recognising value for money in prevention and early intervention.

Prevention is the first step in every clinical pathway and opportunities for primary, secondary and tertiary prevention are maximised across all pathways.

Prevention is explicitly embedded and resourced across all plans, policies and strategies for our population. This includes addressing the impact of the wider determinants of health across the life course, ensuring residents live in affordable and good quality homes, have access to good jobs, feel safe and connected to their communities, utilise green space and are enabled to use active travel.

Resources are allocated to reflect our focus on prevention and the wider determinants of health – this will include a systematic shift in resources 'upstream' towards prevention, with Place based Health and Wellbeing Partnerships acting as the delivery vehicle for the wider determinants of health.

We work as a system to manage all aspects of health protection, taking appropriate measures to protect the most vulnerable.

What will be different by 2028

We will **reduce the gap in life expectancy** between people living in our most deprived communities compared with the least deprived by **5% in five years** – by 6.5 months for males, and 4.5 months for females in Coventry, and 5 months for males and 4 months for females in Warwickshire.

We will reduce the under 75 **mortality rate from all causes considered preventable** by **5% in five years**, with the aim of achieving the largest reductions in Coventry, Nuneaton and North Warwickshire.

We will increase the percentage of children achieving a **good level of development at the end of Reception** by 5% points in both Coventry and Warwickshire by 2028, focusing particularly on children from **households with the lowest incomes**.

> I will be supported to live a healthy, happy and fulfilled life, being equipped with the knowledge and resources needed to prevent ill health and maintain my independence at home, whilst knowing that effective services are in place for me to access should the need arise. This will include having access to support relating to the wider aspects of my life, including housing, employment and finances.

Priority 2:

Improving access to health and care services and increasing trust and confidence

What do we want to achieve

Our mission over the next five years is to improve access to and trust in health and care services across Coventry and Warwickshire.

This means helping people to get the proactive support they need in the community, including harnessing digital technology to enable people to access information, support and care easily and confidently. We also want to give people more choice and control over the way their care is planned and delivered, based on what matters to them.

We need to find more and better ways to work together, involving people and communities in this as well as partners such as the fire service, police and our many voluntary and community groups. We are committed to redefining the shape and scope of our local health and care system, starting with local neighbourhoods and empowering local communities to lead the way.

What are the overall aims of the system by 2028

Enabling personalised care

Personalised care is embedded at all levels of our system meaning that people accessing health and care services in Coventry and Warwickshire have better experiences and achieve improved health and wellbeing outcomes.

People are consistently empowered to be equal and active participants in their health and wellbeing by having more choice and control over the way that their care and treatment is planned and delivered based on what matters to them and their individual diverse strengths, needs and preferences.

Reduced health inequalities as health and care services are increasingly planned and delivered based on what matters to people, taking account of their circumstances, challenges and assets. In addition, personalised care approaches are targeted at people living with complex health conditions, often linked to the wider determinants of health, who are most at risk of experiencing health inequalities.

Our local health and care workforce feel equipped to use personalised care approaches in their day to day work.

Improving access to services especially primary care

Primary Care

Everyone who needs an appointment with their GP practice gets one within the appropriate period of time depending on urgency, and patients are offered an assessment of need, or signposted to an appropriate service, at first contact with their GP practice.

Our local general practice workforce continues to increase in numbers and broaden in terms of roles and skills, including through all PCNs maximising opportunities to employ or have access to additional roles through the national Additional Roles Reimbursement Scheme.

Infrastructure development supports and enables improved access, through improved IT and telephony systems, and estates. Funding opportunities are maximised in support of this.

Our GP practices and PCNs play an integral part in the design of Integrated Neighbourhood Teams and the delivery of fully integrated, Place-based out of hospital care through these Teams.

Patient experience of access to general practice improves as reflected in the results of the national GP Patient Survey.

Urgent and Emergency Care

Urgent and Emergency Care ('UEC') services are stabilised and transformed so that patients are seen more quickly regardless of how they access care – whether that be the length of time that they wait for an ambulance, the waiting time at A&E, or the period of time that they stay at hospital.

UEC service resilience is strengthened through increased capacity both in terms of hospital bed and ambulance availability, in turn improving patient experience and outcomes.

Hospital discharges processes are improved with a focus on early and timely discharge to prevent patients from deconditioning, whilst promoting patient independence through reablement.

Fully integrated urgent care models are operational in each of our four Places, making it easier for people to access the right care and guaranteeing same day care for those patients who need it, in turn reducing UEC demand and releasing emergency care capacity to those who need it most.

Elective Care

Outpatient services are transformed with patients having the choice of personalised, digital and face to face appointments as close to home as possible from a range of NHS and Independent Sector (IS) providers who offer equitable waits to be seen and Patient Initiated Follow Up (PIFU) appointments.

Planned elective waiting lists are reduced and stabilised to pre-Covid levels such that patients wait no more than 18 weeks from referral to treatment.

Patients with cancer receive earlier diagnosis through a range of transformed screening programmes and enhanced community based diagnostic capacity which ensure increased uptake, provide straight to test pathways and reduce inequalities of access across the population.

Patient pathways, including those that provide tertiary and specialised services, have been reviewed and transformed and deliver improved outcomes and patient experience, reduced inequalities and enhanced productivity and value for money.

Mental Health

To deliver an all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

A system-wide approach to promoting mental wellbeing and resilience is embedded, underpinned by evidence-based interventions to reduce mental health inequalities linked to access, patient experience and outcomes.

Broader access to care, moving away from risk and care clusters to quicker access to interventions based on presenting needs (rather than diagnosis), and with trauma-informed Community Mental Health Teams aligned to Primary Care Networks and patients.

People who have experienced problems with their mental health are empowered to take greater control over their own care and supported to manage their own conditions more effectively.

Learning Disability and Autism

To achieve the Partnership Statement from the Building the Right Support Action Plan (August 2022) meaning that in Coventry and Warwickshire:

- Adults, children, and young people with a learning disability and autistic adults, children, and young people will be equal citizens in their communities;
- People with a learning disability and autistic people will live in their own homes and have the right health and social care support in place to meet their needs and live an ordinary life. This includes access to education, employment, and other opportunities which help people to fulfil their aspirations.

To deliver the Coventry and Warwickshire Joint Strategy for Autistic People 2021-2026, which commits the partner organisations to commissioning high quality autism services and support, as well as working closely with one another to build local communities that are more inclusive and welcoming for autistic people, and to improve the lives of and opportunities for autistic children, young people, and adults

Engaging and involving local people, communities and stakeholders

Involvement functions and networks across the ICS connect through a single ICS Involvement Network and work cohesively with each other and our population to support the ICB and the Integrated Care Partnership ('ICP') to deliver the vision set out in our Integrated Care Strategy.

Involvement functions across the health and care system support the ICB and partner organisations to ensure that appropriate public involvement or consultation is embedded in all aspects of their work, and involvement activities are delivered in line with best practice and relevant statutory duties.

A range of routes are available and clearly communicated for individuals and communities to be involved in the governance of different parts of the ICS and the work of the ICB, the ICP and individual partner organisations.

Culturally competent health and care services are co-produced with the communities who use them and are communicated effectively, resulting in improved experiences and increased trust in the health and care system.

Making services more effective and efficient through collaboration and integration

Integrated Neighbourhood Teams ('INTs') are embedded across our four Places, bringing together the expertise and resources of health, care and Voluntary, Community, Faith and Social Enterprise ('VCFSE') partners. The INTs provide a focal point for connecting wider Place based integration involving the full range of partners (housing, employment, etc).

People with more complex needs, including those with multiple long term health conditions, receive more proactive, personalised care closer to home with support from a multidisciplinary teams working across professional boundaries as part of INTs.

People stay healthier for longer within their local communities as a result of a focused and joined-up approach to prevention, and are supported to maximise their independence, wellbeing, quality of life and potential for recovery after an episode of ill health.

People and communities are equal partners in how INT services are designed and delivered, ensuring that services are responsive to local needs and preferences.

People thought to be in the last 12 months of life receive co-ordinated, proactively planned and personalised care for the end of life and are supported to be cared for and die in the place of their choosing, with bereavement support available to those important to them.

What will be different by 2028

We will increase the uptake of **Personalised Care and Support Plans** (PCSPs) each year, with a focus on individuals experiencing **health inequalities**.

We will increase the **total number of appointments in general practice** by 7.5% by 2028, with a focus on practices in the most deprived areas.

By 2024 we will co-produce a Framework for what **good engagement looks like** with our local population. We will also co-produce a system wide **engagement metric** to understand the current sentiment of our local communities towards health and care, and this metric will show an increase year on year in positive sentiment. By **2026 the Framework will be in use at both ICB and Collaborative level**, with 100% of significant service change decisions made under the Framework to put people at the heart of everything we do.

We will meet the faster diagnosis standard by March 2024 so that **75% of patients** who have been urgently referred by their GP for **suspected cancer are diagnosed or ruled out within 28 days**. We will then continue to meet any further national targets set over the next five years.

> I will find it easier to access the health and care services that I need wherever I live across Coventry and Warwickshire. Those services will feel more like one service, I will have more say over the services I receive and greater trust in their quality, effectiveness and safety.

Priority 3:

Tackling immediate system pressures and improving resilience

What do we want to achieve

We know that if we don't fix some of the immediate pressures facing our Integrated Care System will never be able to move on and invest in the future.

We are seeing increasing demand for health and care services, complexity of need and challenges around the flow of patients through the system, all at a time of significant financial pressure. Many within our workforce are tired, having moved from the pandemic to recovery of services, and now face the additional stress of increased demand, increased vacancies and higher sickness absence.

We need to work together both to reduce immediate demand on services and to secure the system capacity required to meet the current and future health and care needs of our population – which include both physical and mental health care, and social care needs. Traditional approaches aren't working, and increasingly we recognise a need to do something different as we embrace the opportunity of collaborative working through our Integrated Care System.

What are the overall aims of the system by 2028

Supporting people at home

An improved and more responsive coordination and delivery of health and care within an individual's own home when urgent and emergency care is required – this will help prevent people making unnecessary visits to hospitals.

Where ongoing support, health or care or both, is required, people are enabled to continue to live independently – this is reliable, sustainable and responsive to change as people's requirements change.

Where people need to visit hospital for treatment, this is undertaken in a patient-centred and effective manner, with the focus on people returning home as soon as possible.

Where people have had a change in their health as a result of deterioration or a specific episode in their life, they are supported to recover and re-able to maximise their individual health and wellbeing outcomes.

Develop, grow and invest in our workforce, culture and clinicaland professionalleadership

System Culture and Organisational Development

People across our system will have better relationships, feel more connected and better understand the diversity of each other's roles, contributions, value and experiences. Our ICS will have compassionate leaders who proactively align to system, Place and organisational goals.

Attract; Recruit; Retain

We will collaborate in new and novel ways with system partners to attract and recruit people with right skills, values and capabilities, in ways that address structural inequalities and help build stronger socioeconomic outcomes and improved health and wellbeing for all. Our retention priorities will be grounded in a solid evidence base and be context specific.

People Development

Organisations across our system will be supported in new and powerful ways to help their people fulfil their potential in both their professional development and personal wellbeing. Neither background nor privilege will advantage or disadvantage people's professional journeys.

Workforce Innovation

The system will have support to: (1) capture ICS level workforce opportunities at the intersection of workforce redesign, tech innovation and data innovation, and (2) create system level workforce innovations that respond to two needs: the delivery of enhanced efficiency and productivity from current models of care; and the delivery of new services or entirely new ways of working within new models of care and health for our workforce broadly, and for our people services.

What will be different by 2028

- We will aim to achieve top two **quartile performance** nationally each year for the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/ rehabilitation services.
- We will **reduce staff vacancies** in NHS provider trusts workforce by 30% by 2028.

> Everyone works together to make sure I receive appropriate and timely care when I need it, from skilled and valued staff.

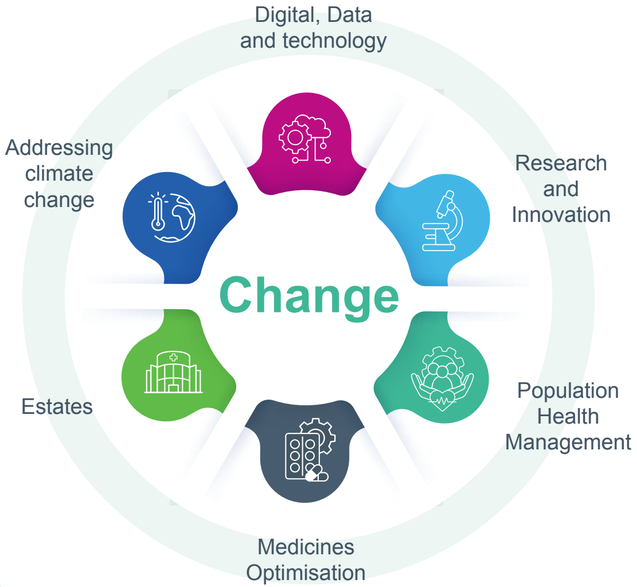
Enabling change to happen

Although we've set our priorities, there are other things that we know that we need to get right in order to be able to achieve the things that we want to.

These are what we call our "enablers" and through addressing these key areas we will create the conditions for change to happen.

We also need to transform our system so we can make decisions based on local community needs, work more closely together to improve things address inequality and deliver joined-up services which are value for money.

Areas which enable change to happen



What will be different by 2028

By 2024, **75% of the adult population** of Coventry and Warwickshire will have **downloaded the NHS App**.

We will **reduce the energy consumption of our NHS Trust estates** by 4-5% every year through to 2028.

By September 2023 we will have a jointly agreed **3 year financial recovery plan**, showing a route to recurrent balance. By March 2024, we will have agreed a **framework and roadmap** for delegated financial responsibility and allocations to Place. This will include an approach to increasing the proportion of our system spend on preventative and out of hospital care.

By 2024, we will develop a **comprehensive assurance and performance framework for the Integrated Care System**, available at varying geographic levels with mutual accountability by organisation, underpinned by a single dashboard that will map and monitor all the different plans and strategies.

We will develop a **comprehensive quality framework for our Integrated Care System** by 2025, that demonstrates a shared system ambition and commitment to quality. Grounded on the principle of subsidiarity, this will be population focused, embracing co-production and collaboration, with a focus on equality, diversity, inclusion and shared decision making.

Our Transformation Programme will enable implementation of the ICS's six-point Financial Strategy, through **demonstrable improvement in the effective use of resources** that is informed by clinical and care professionals.

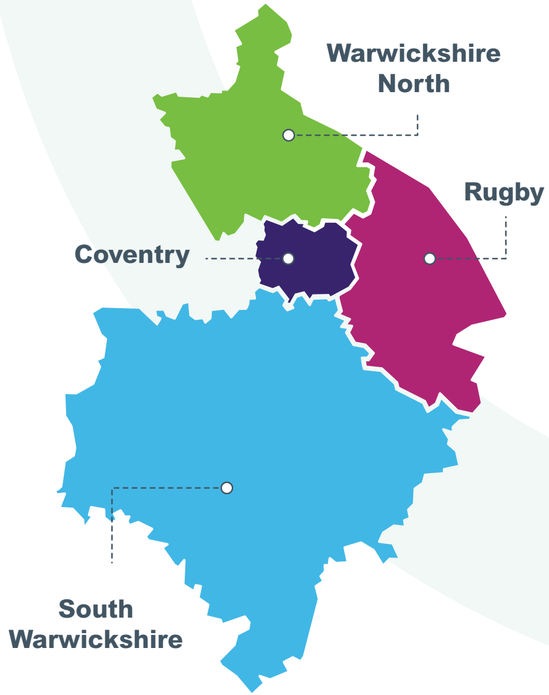
Delivery through Place

Much of the activity to integrate and improve health and care services, and to improve population health and wellbeing, will be driven by organisations working in partnership with each other and with local people and communities through our four Places – Coventry, Warwickshire North, Rugby and South Warwickshire.

We know that the four Places have an identity that local people and communities can relate to and will be where the transformation of our Integrated Care System over the coming five years will be most visible to them. The Places bring together health, care and wider partners, including District and Borough Councils and Voluntary, Community, Faith and Social Enterprise Sector leaders and organisations, alongside local people and communities. The breadth of each Place Partnership acknowledges not only the range of factors that impact the health and wellbeing of local people and communities, but also the wide range of resources that different partners, and communities themselves, can offer.

Each of our Places has a different starting point and unique circumstances in terms of the people they serve, range of health and care providers in the local area, assets and causes of inequalities to name just a few. Although there are common features and many priorities that are consistent across the Places, there is also local difference, with each Place taking a different approach to planning, leadership, delivery, oversight and governance.

Place Plans and priorities within them respond to the priorities in the Integrated Care Strategy and our two local Health and Wellbeing Strategies, as well as the unique strengths of and challenges facing each individual Place.



Place projects in action

Our Places are delivering a wide range of projects on behalf of their local populations You can read about a small selection of them here or visit our website to find out much more about what our four Places are working on.

Delivering through our four Places - Happy Healthy Lives

Lillington Respiratory Project

Through this project…

We will take a population health approach to boost respiratory health in Lillington East, which is in the 20% most deprived neighbourhoods in England. This will involve a new Community Connector role based in Warwick District Council supported by a project team from health, local authorities and the voluntary and community sector.

The impact will be…

Improved awareness of respiratory conditions and prevention and greater personalised support from services and the local community. As a result we aim to see and increase in uptake of support, improved health and wellbeing and a reduction in unplanned and emergency presentations for respiratory conditions.

Musculoskeletal (MSK) project in Coventry

Through this project…

This is a low back pain project in UHCW which includes piloting the development of a new multi disciplinary team (MDT) triage approach and a patient involvement project.

The impact will be…

Training a team of advanced physiotherapists to support evaluation and the implementation of Population Health Management in Coventry Place.

The development and implementation of a new MDT triage and a new clinical pathway for chronic pain and fibromyalgia.

Wider Determinants of Health in Warwickshire North

Through this project…

Reduce number of people smoking in deprived areas in line with rates in more affluent areas of the Place.

Reduce the number of obese children in year 6 in line with rates in more affluent rates.

Reduce social isolation for people who are disadvantaged by deprivation, unemployment, race, ill-health and old age.

Four focus areas are: smoking cessation, obesity, mental health and learning disabilities.

The impact will be…

Key projects include Models of Care – End of Life, Homeless Support, Smoking Cessation, Obesity & Learning Disability.

Reduce the number of people smoking in more deprived areas of the Place to match the lower rates of those smoking in more affluent areas.

Reduce the number of children in year 6 who are overweight/obese to match those with lower rates in more affluent areas.

Reduce the social isolation of people who are disadvantaged by deprivation, unemployment, race, ill-health, and old age in the area.

Find out more

Our Integrated Care Strategy and Delivery Plan are all available in full on our website, click the links below for more information..

The Coventry and Warwickshire Integrated Care Strategy
www.happyhealthylives.uk/Strategy

The Coventry and Warwickshire Integrated Health and Care Delivery Plan
www.happyhealthylives.uk/DeliveryPlan

Our priorities and how we are working together to deliver them
www.happyhealthylives.uk/workingtogether

How we are creating the conditions for change to happen
www.happyhealthylives.uk/enablingchange

The transformation of the Coventry and Warwickshire health system
www.happyhealthylives.uk/systemtransformation

Delivering through our four Places
www.happyhealthylives.uk/placedelivery

Coventry and Warwickshire
Integrated Care System