Estate Strategy

Coventry and Warwickshire
Integrated Care System

N.B. This document is designed to be iterative to reflect the continued development of place-based models of care, subsequent funding requirements and the priorities of a dynamic estate which looks to support the move of care closer to where it is needed and most suitably delivered.

Contents

Section 1

Foreword and Purpose

Foreword

Coventry and Warwickshire has a diverse and growing population and we have been working together, across health and care, to understand how best to continue to deliver excellent patient care and improve the health and wellbeing of our population.

In doing so, there has been a collaborative commitment from health and care leaders across the Coventry and Warwickshire Integrated Care System (ICS), individual providers and commissioners to determine the direction of travel and priorities as we transition towards Integrated Care System (ICS) designation. These focus on three main aims:

- To deliver better health and care outcomes through transformation of health and social care delivery.
- To integrate and enable local services to deliver the right care in the right setting at the right time.
- To maintain financial stability and ensure sustainability through robust planning and commissioning of value-for-money services.

Our vision for care services looks to improve the health and wellbeing of our population through reducing health inequalities, addressing the wider determinants of health and supporting care closer to home through a neighbourhood-based, place-based approach to service provision and delivery, whilst ensuring that when hospital care is needed, it takes place in high quality buildings, that are fit for the delivery of modern healthcare.

Our estate is a core enabler for the delivery of this vision. We are working toward the provision of a high quality, flexible, sustainable and accessible estate, which is appropriately utilised. We know that if we get this right, our estate can have a truly positive impact on the physical and mental health and wellbeing of our communities, patients and staff.

We recognise the task ahead will be challenging, with considerable work still to do to continue to develop our strategy and implementation plan, including working with our communities and residents to further develop our existing place-based plans. The development of these plans will allow us to optimise our future estate to support these new ways of working.

This document sets out a clear direction of travel, alongside an immediate set of priorities that will form the building blocks to develop innovative estates projects as clinical plans continue to mature.

Delivering this vision for care and the estate, will need to happen against the backdrop of the significant financial challenges facing public sector organisations in Coventry and Warwickshire. This challenging scenario will require us to work together as partners in new and innovative ways.

As we move towards ICS status, we remain committed to working with all our partners and the wider system to strengthen our partnerships to ensure we deliver on our Estate Strategy.

Haq Khan
Director of Finance

Purpose of this Document

This document outlines our Estate Strategy, charting how we can enable our vision for care through the estate and how this links with wider cross-system ICS planning.

Through this document we aim to present how our estate can be used to:

Develop a place-based approach to our community estate.

Respond to care requirements and changes in demand.

Maintain high quality inpatient facilities.

Increase the operational efficiency.

Enhance delivery capability.

Enable delivery of a portfolio of transformation projects.

This document is not intended to replace or replicate the existing strategies or plans of organisations, rather to present the collective work undertaken at provider, commissioner and local authority level both individually and in partnership with one another to improve the quality and outcomes derived from the estate.

This strategy presents the common themes across the ICS to support estate improvement and transformation as well as an overview of the current priority estate-related schemes across our system. It has been brought to the ICS Estate Strategy Group for consideration and sign off, where representatives from providers, commissioners and local authorities have been engaged.

It is important to note that this document is designed to be iterative to reflect subsequent funding requirements and priorities of an ever-evolving estate which looks to shift care closer to where it is needed and most suitably delivered.

Moving forward we are keen build on the work and commitment given to Estate Strategies to date by:

- Bringing together all priority and aspirational projects into one detailed delivery plan, with defined outputs, clear leadership and governance, whilst managing interdependencies.
- Delivering a detailed resource plan and schedule, identifying existing capacity and capability in the system, resource gaps and appropriate roles and responsibilities in the structure.
- Presenting a capital investment plan which can deliver the above, building on the prioritisation process contained within this document and setting out a system wide capital plan that can inform future funding requirements.

Section 2

Executive Summary

Executive Summary (1/3)

Current Estate: Overview and Challenges

- Within our Trusts, there is currently a total **backlog maintenance cost of £43,271,749** and although there are many modern, state of the art facilities, nearly **14% of the Trust estate pre-dates the formation of the NHS in 1948**.
- Within the primary care estate there is **variability in condition of the estate**. There is also fragmented ownership of the primary care estate across individual GPs, GP partnerships, private sector, NHS Property Services (NHSPS), and Community Health Partnerships (CHP).
- **Improving utilisation** of space to reduce running costs and potentially free up surplus land is a key priority with the aim of **pushing capital back into the system**.

ICS Estate Priorities

- **Continue to develop a place-based approach to** support service delivery and optimise use of assets, drawing on the principles of One Public Estate.
- **Respond to care requirements and changes in demand** by putting in place a quality estate enabling us to tackle health inequalities.
- **Increase the operational efficiency of the estate** by improving productivity, tackling backlog maintenance, and optimising running costs.
- **Enhance delivery capability** by supporting wider changes in health care delivery, alongside workforce and digital enablers.
- **Enable the delivery of a portfolio of estate transformation projects** that support the implementation of our vision.
- Establish a workstream group to **manage space utilisation** and/or requests with a focus on the potential to release space, save revenue, and **push capital back into the system**.
- Increase our efforts to ensure our **data collection and management processes are improved** and built upon.
- **Establish a workplan** for the ICS with a **revised and streamlined governance** structure.
- Recruit for the position of an **ICS Estate Programme Director**.
- Make progress against NHS **Net-Zero Carbon** requirements aligned to our ICS sustainability strategy

Executive Summary (2/3)

What are we already doing to deliver our Estate Strategy

- Delivery of our strategy relies on partners –including Local Authorities, CCGs, Trusts, and the property companies. At an ICS level, our focus is on collaboration and common prioritisation, whilst not superseding individual organisational autonomy.
- Currently, planned and underway, there are multiple schemes designed to **support population growth, deliver primary care at scale and bring care closer to home** alongside large-scale estates **transformation and refurbishment projects** in the acute sector.
- We are optimising operational efficiency through **better utilisation** of the estate, by reconfiguration of services in underutilised space.
- By working more effectively **across local public sector partnerships** we are taking a system-wide strategic approach to asset management.

Priority Programmes and Projects

- An ICS prioritisation process for major capital schemes outside of delegated limits took place between September and November 2021 to determine our priority projects across the ICS. Further detail is contained within the remainder of this document (see section 8).
- The prioritised list of 42 projects includes several primary and community schemes which will help in delivering our key objectives of providing care closer to home, focusing on prevention and optimising care in the community.
- The prioritised list also contains several large-scale capital schemes which will aim to transform care across our system and address issues of service fragmentation, significant backlog maintenance and reduce pressures on our acute providers whilst supporting national, regional and Place-based priority action areas.

Executive Summary (3/3)

Capital Investment Requirements

Capital Investment requirements Capital investment requirements based on our current list of 42 prioritised schemes are outlined below. Naturally, the contents of our system capital investment programme will change as schemes mature, capital requirements are refined and our process for prioritising and including projects are developed.

Provider	Capital Requirement As at XXXXX (£million)
Primary Care	£37.9
Acute and Community Care	£283.3
Mental Health, Learning Disabilities and Autism	£422.5
Total System Capital Requirement	**£743.8**

Key Next Steps

This strategy is designed to be **iterative, reflecting the evolving healthcare needs, future schemes, and funding**.

- Our pipeline of projects will be developed, building on collaborative working between primary and secondary care to further drive care into the communities, developing the level of maturity needed to be eligible for future funding.
- As part of this process, within the ICS, we need to focus on **locality planning**, identifying strategic locations (considering ease of access and public transport) for community hubs whilst ensuring digital infrastructure is embedded.
- To deliver system-wide change, we need closer collaboration and earlier engagement between stakeholders.
- Ensure our estates objectives continue to align to both national and regional priorities.

Priority Projects (1/2)

The tables in the slides that follow outlines the top 20 schemes across our Integrated Care System following the completion of our prioritisation exercise. As outlined in this document, this is a live and evolving list that will continue to be updated. Further information on these projects is provided in case studies throughout the strategy and in the appendix.

Rank	Organisation	Scheme	Overall Prioritised Score	Anticipated Capital Required	Strategic Priorities Score	Estates Score	Clinical Score	Workforce Score	Digital Score	Finance Score	Sustainability	Readiness to Deliver Score
1	Primary Care	Leamington North PCN - Cubbington Road Surgery	716	£6,000,000	124	83	122	77	68	123	56	62
2	Primary Care	Hartshill	700	£1,000,000	124	80	130	77	68	98	56	66
3	Primary Care	Dene & Stour Valley - Shipston Medical Centre	686	£13,500,000	124	80	122	77	68	92	56	66
4	SWFT	Phase 2 of Stratford Hospital - Reprovision of services and Community Diagnostics Hub - Demolition of Building 2	678	£10,660,000	124	87	95	81	68	84	85	56
5	CWPT	Single Site Mental Health Inpatient Facility	674	£250,000,000	124	100	141	76	41	91	80	22
6	CWPT	Brooklands Site Redevelopment	669	£135,000,000	124	100	126	73	41	92	75	38
7	SWFT	Community Estate (Rugby and North Warwickshire)	668	£2,500,000	116	90	113	85	68	53	80	63
8	SWFT	Warwick Hospital Development Programme Phase 1	667	£40,000,000	116	90	114	85	68	59	85	51
9	SWFT	Warwick Hospital Development Programme Phase 2	667	£25,000,000	116	90	114	85	68	59	85	51
10	GEH	Community Diagnostic Hub - Phase 2	661	£7,000,000	124	93	135	58	54	77	56	63

Priority Projects (2/2)

Rank	Organisation	Scheme	Overall Prioritised Score	Anticipated Capital Required	Strategic Priorities Score	Estates Score	Clinical Score	Workforce Score	Digital Score	Finance Score	Sustainability	Readiness to Deliver Score
11	Primary Care	Rugby PCN - Houlton/CRS - Relocation	**647**	**£4,000,000**	116	80	126	77	68	79	56	44
12	Primary Care	Leamington Town Centre	**643**	**£6,000,000**	116	80	126	77	68	86	56	34
13	GEH	Reconfiguration of Office Space/Agile Working	**641**	**£4,000,000**	116	93	100	75	54	78	75	50
14	Primary Care	PCN Estates Planning	**641**	**TBC**	124	73	145	77	54	72	47	48
15	GEH	Green Elective Centre - Ward & Theatre	**638**	**£7,000,000**	124	47	145	66	54	92	56	54
16	UHCW	Hospital of St Cross. Redevelopment of the north of the site - Phase 1	**627**	**£48,300,000**	124	100	137	56	14	79	85	32
17	UHCW	Hospital of St Cross. Redevelopment of the north of the site - Phase 2	**627**	**£49,100,000**	124	100	137	56	14	79	85	32
18	Primary Care	Weddington	**621**	**£3,500,000**	124	40	105	77	68	92	56	59
19	GEH	Urgent and Emergency Care and CAU Extension	**613**	**£6,000,000**	124	73	133	66	54	52	56	54
20	GEH	Reconfiguration of Clinical Space in Maternity Building	**610**	**£26,000,000**	116	87	102	66	54	78	56	50

Section 3

Context and Rationale

Service Provision Overview

Coventry and Warwickshire is a diverse area covering two Local Authorities, three Trusts, one Foundation Trust, one Clinical Commissioning Group (CCG), four Trusts, and 21 Primary Care Networks (PCN) covering 152 GP Practices and Branch Practices, as demonstrated in the diagram below. Healthcare services are provided from twelve main locations across the locality.

Our Providers
Coventry and Warwickshire Partnerships NHS Trust
George Eliot Hospital NHS Trust
South Warwickshire NHS Foundation Trust
University Hospitals Coventry and Warwickshire NHS Trust

Our Local Authorities
Coventry City Council
Warwickshire County Council

Our Member Practices by Place	
Coventry	**8 PCNs** 65 GP Practices
Rugby	**1 PCN** 14 Practices
South Warwickshire	**7 PCNs** 40 Practices
Warwickshire North	**5 PCNs** 33 Practices

Coventry and Warwickshire CCG
1,048,561 Registered Patients

Our Main Locations
University Hospital Coventry
George Eliot Hospital, Nuneaton
Warwick Hospital
Brooklands, Solihull
Caludon Centre, Coventry
Ellen Badget Hospital, Shipston-on-Stour
Hospital of St Cross, Rugby
Leamington Spa Hospital
Manor Court, Nuneaton
St Michael's Hospital, Warwick
Stratford Hospital
Woodloes House, Warwick

Clinical Service Strategic Priorities

The Coventry and Warwickshire Integrated Care System brings together health and social care services, local authorities, voluntary and community sector organisations and other partners. Our aim is to deliver life-long health and wellbeing benefits for the people of Coventry and Warwickshire.

Out of Hospital Care

Enabling improved integration of services and increasing service capacity and responsiveness, in recognition of the role that community services will increasingly need to play in an integrated health system. Wrap our place-based teams around GP practices, utilising the primary care system to maximise the benefits of system integration.

Planned Elective Care

A system-wide theatre capacity and demand exercise has been undertaken to compare future requirement (based on agreed assumptions regarding population growth, demand management and intervention rates) with proposed new capacity.

Emergency and Urgent Care

Development of the Emergency Care Infrastructure to support the delivery of the Long Term Plan and local models for delivery of emergency and urgent care. The development of a patient-centred care model, an improved patient experience with a reduction in unnecessary admissions. Delivery of compliance with standards for children and young people in emergency care, 7-day service standards, and an improved working environment.

Mental Health

The NHS Long Term Plan recognises a need to invest in mental health services for both adults and children in order to significantly improve access and early intervention, to bring parity of esteem with physical health services and to address the significant inequalities experienced by people with mental health problems.

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Maternity and Paediatrics

Implementation of agile and mobile working alongside wider system consolidation of non-clinical services.

Learning Disabilities and Autism

'Transforming Care' agenda sets out a series of ambitions to develop community services for people with Learning Disabilities and reduce reliance on in-patient facilities. Whilst many people with a learning disability and/or autism can be safely supported in the community, there will always be a need for some specialist in-patient facilities to provide treatment.

Naylor Implications

Land vacated by the NHS should be prioritised for the development of affordable and key worker housing, where there is a need.

Ways of Working and Community Consolidation

Implementation of agile, modern, and flexible mobile working practices and facilities alongside a system-wide consolidation of community bases (mix of clinical and non-clinical accommodation).

The Scale of the Challenge

The Coventry and Warwickshire Context

- The role of health and social care services have changed significantly since the inception of the NHS and recently the government has set out new responsibilities and a clear agenda for change.
- Coventry and Warwickshire is an area of diversity and complexity with examples of exceptionally high-quality care. However, there is still disparity in patient outcomes across the ICS.
- We are facing significant financial pressures on both the NHS and Local Authorities with increasing demand due to demographic growth and growing public expectation. Projected population growth is expected to increase 14% by 2040, reaching nearly 2,242,536.
- The NHS Long Term Plan (LTP) sets out key priorities for NHS Organisations to deliver against in the coming years. Our focus areas in developing our care models this respect are as follows:
    - Prevention
    - Population Health
    - Primary Care Networks
    - Urgent and Emergency Care
    - Mental Health
    - Cancer
    - Stroke
    - Maternity and Children
    - Service Improvement
- In order to deliver on these commitments, we will have to work as a whole system, integrating health and social care to facilitate care closer to home allowing people to remain independent and manage their own health and wellbeing. We will ~~need to~~ utilise population health analytics to develop and deliver schemes of work designed to be tailored around communities and their specific needs. From this we will not only provide better patient-centred care and outcomes but derive financial and operational improvements to feed system-wide sustainability.
- At present our primary and provider estate is mixed in terms of age, quality and fitness for purpose**,** impacting patient experience and our ability to deliver the objectives we have set out. Going forward harnessing our estate alongside other enablers such as digitally empowered estate and workforce will be key to our success.

National Estate Priorities and Expected Outcomes

In order to make system-wide change fit for purpose and sustainable, it is important to ensure that the impact of any estates change supports the functionality of clinical services. To that end we have engaged our key stakeholders across the ICS to address their key priorities for their sector which are detailed below.

1 Wider Environment

- More appropriate affordable and key worker housing.
- Impact of environments on wider determinates of health: public estate, private housing, and built environments.

2 Primary and Social Care

Modernisation of premises:

- Right place, right premises, right size.
- Increased provision of care homes / hospices for end-of-life care.
- Increased need for supported living options.
- Co-location of providers.

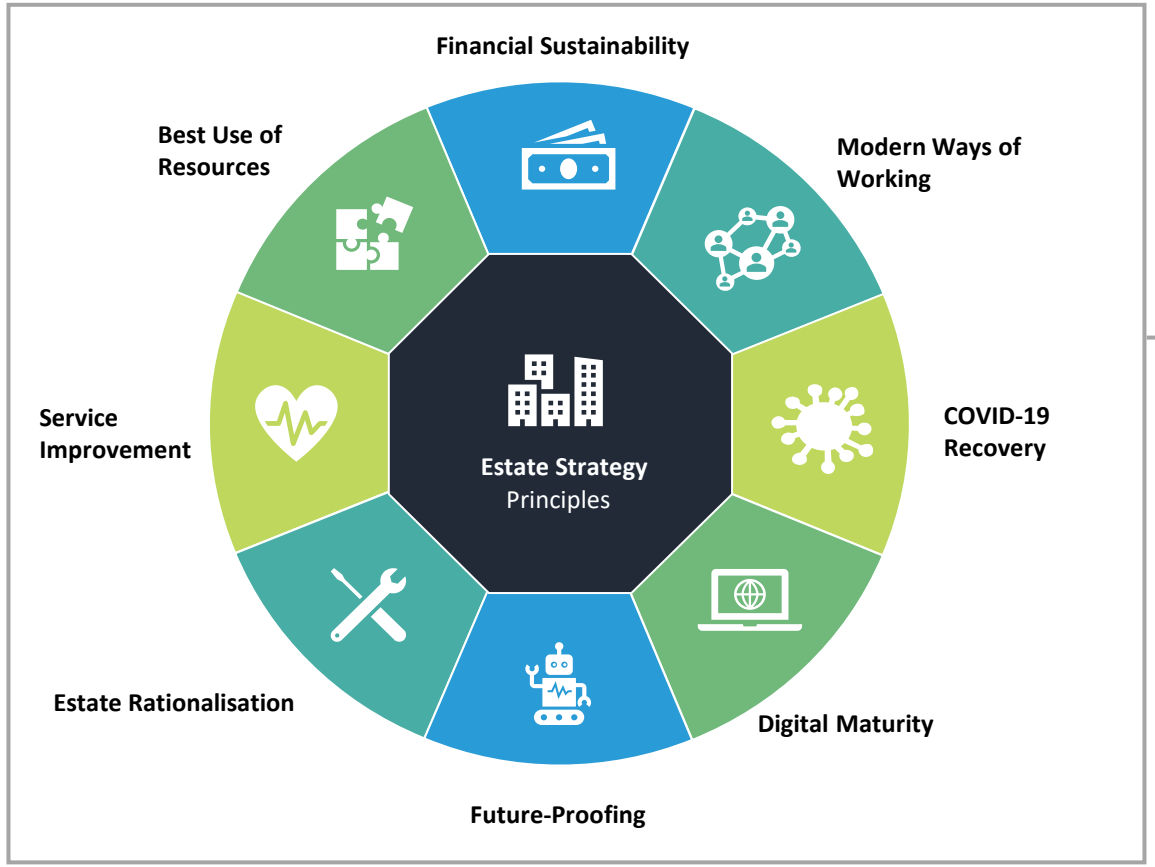
3 Mental Health, Learning Disabilities and Autism

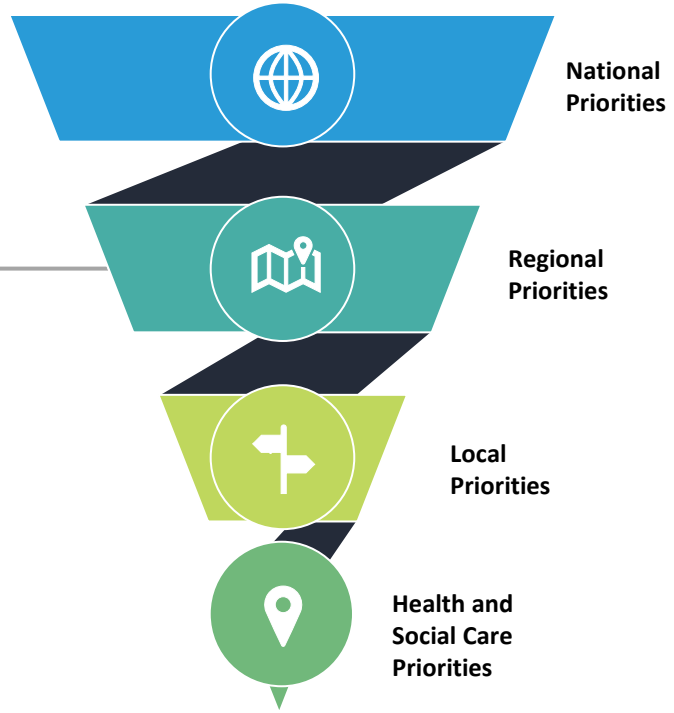
- Local expansion of facilities to reduce the reliance on Out of Area placements.
- Modernise the inpatient environment, addressing ligature risks and facilitating therapeutic interventions
- Accommodate the significant planned expansion of community services
- Greater integration with Primary Care and Social Care services.

4 Acute and Community Care

- Non-acute services moved into a community setting.
- Merging and modernisation of the estate to be compliant with modern standards of care.
- Ability to absorb increases in acute demand on current footprint.
- More demand in community hubs / multi-functional sites.
- Co-location of services.
- Efficiency and effective use of community sites.

Estate Strategy Principles and Strategic Hierarchy





The National Direction

Our Estate Strategy sits within the wider context of national priorities and benchmarks.

Carter Report

The Carter Report identified the need to create a set of metrics that could serve as a barometer for hospitals to compare themselves with their peers and provide a baseline for improvement. NHS Improvement developed the Model Hospital and the underlying metrics to identify what good looks like, giving Trusts information on key performance indicators.

NHS Long Term Plan

The NHS Long Term Plan 2019 outlines how healthcare provision can be fit-for-purpose into the future. To ensure that the NHS can achieve improvements for patients over the next ten years, the NHS Long Term Plan sets out how to overcome the challenges that the NHS faces, such as staff shortages and growing demand for services.

Net-Zero NHS

The NHS embarked on a process to identify the most credible, ambitious date that the health service could reach net zero emissions. Delivering a 'Net Zero' National Health Service provides a detailed account of the NHS's modelling and analytics underpinning the latest NHS carbon footprint, trajectories to net zero and the interventions required to achieve that ambition. It lays out the direction, scale, and pace of change. It describes an iterative and adaptive approach, which will periodically review progress and aims to increase the level of ambition over time.

Place-Based Systems of Care

The NHS in England is facing growing financial and service pressures at a time of rising demand. 'Placed-Based Systems of Care: a way forward for the NHS in England' proposes an approach to tackling these challenges. It argues that NHS organisations need to move away from a 'fortress mentality' whereby they act to secure their own individual interests and future, and instead establish place-based 'systems of care' in which they collaborate with other NHS organisations and services to address the challenges and improve the health of the populations they serve.

One Public Estate

The One Public Estate (OPE) programme is a collaboration between the Local Government Association (LGA) and the Cabinet Office's Government Property Unit, set up in 2013, OPE has set a new goal - to encourage partnerships between NHS organisations and councils. The initiative is two-pronged; to progress with the need for housebuilding and allow for the NHS to sell land, putting some money back into fast-emptying purses. Councils are seen by OPE as important public sector partners for this work because they can concentrate on the housebuilding side of things while the NHS can offer the spare land.

Naylor Review

The Naylor Review 2017 was a landmark report, highlighting the challenge of making sure the NHS has the buildings and equipment it needs and the scale of the opportunity that the NHS estate offers to generate money to reinvest in patient care. After the NHS staff, the healthcare estate is the NHS's largest asset; it is also one of its largest drivers of cost. The NHS must use its land and property efficiently and productively so that it can continue to provide high quality patient care and maximise value for the taxpayer.

Our Care Commitments

Our aim is to deliver life-long health and wellbeing benefits for the people of Coventry and Warwickshire. There will be times when we need to make difficult decisions, but when we do, we will listen to the views of local people and our staff, and we will have transparent processes for making those decisions. In order to make this happen we are making the following commitments:

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

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

We all need to do more to look after our own health and wellbeing so that we depend less on our local health and social care services, while knowing they are there when we need them. Voluntary organisations and community groups play an enormous role in keeping people healthy and independent and we will change how we work with communities to enable community leadership and build capacity. We will do more to support carers too, not only to improve the health of family members they care for, but also their own health and wellbeing.

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

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

Strategic Ambitions for Care

We are proposing three strategic ambitions for the health and wellbeing of our residents which together encompass our long-term vision for change for health and wellbeing in Coventry. The outcomes we hope to achieve are:

People are healthier and independent for longer

By this we mean promoting healthy lifestyles and behaviours to help people stay healthy and well and prevent limiting long-term health conditions. This also means, where people have existing health problems, preventing these from escalating to the point where they require significant, complex and specialist health and care interventions. It means helping people to age well, with health and social care working together to prevent long term health conditions and slow the development of older people's frailty. The focus is on empowering people to take action to improve health and wellbeing for themselves and others (our Year of Wellbeing vision) and providing effective, timely and appropriate support where it is needed.

We will monitor our direction of travel against this ambition through key performance indicators, for example:

- Healthy life expectancy
- Physically active adults
- Screening and immunisations take-up
- Emergency readmissions
- Dementia diagnosis
- Premature mortality / morbidity (years lived with disease)

Children and young people fulfil their potential

By this we mean we want to work together as partners to make sure that every child in the city has the same opportunity to thrive. We want to make sure that every child has the best possible start in life because we know that getting this right is key to tackling health and social inequalities and preventing poor outcomes. This also means that all children are supported to reach their potential in school, further education and employment, and that families are supported to make healthy lifestyle choices. Improving opportunities for children and young people will help address concerns in the city around violence and exploitation and young people's mental health and wellbeing.

With a younger than average population in the city, we know that a specific focus on children and young people in Coventry is important. We will monitor our direction of travel against this ambition through key performance indicators, for example:

- Good level of development (five-year-olds)
- Healthy weight Year 6 (childhood obesity)
- Young people feeling safe
- Proportion of young people progressing into sustainable education, employment or training
- Child and Adolescent Mental Health Services – demand / performance
- Children living in poverty

People live in connected, safe, and sustainable communities

By this we mean working together to create communities that have a healthy environment, economic prosperity and where the social needs of people are met. This includes action to address climate change and improve air quality, for example through promoting active travel. It is also about working together in local places to build community resilience and promote community cohesion. It means building communities where everyone in our diverse population has a stake and can thrive – where people have access to jobs, secure housing, feel safe and connected with people around them.

We will monitor our direction of travel against this ambition through key performance indicators, for example:

- Families in temporary accommodation
- Fuel poverty
- Self-reported wellbeing
- Gross Disposable Household Income
- Air quality (NO2)
- Residents' self-reported ability to influence / improve local area

Our Response to the NHS Long Term Plan

To support the creation of five-year strategic plans covering the period 2019/20 – 2023/24, setting out how systems will deliver the commitments in the NHS Long Term Plan, our priorities are as follows:

Prevention

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

Population Health

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

Primary Care Networks

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

Urgent and Emergency Care

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

Mental Health

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

Cancer

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

Maternity and Children

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

Stroke

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

Service Improvement

Implement several system-wide schemes to remove waste and avoid duplication.

Engaging with our Local Communities

Our Estate Strategy will support the public sector in Coventry and Warwickshire to be sustainable and effective for our local communities in future, addressing increased demand and health inequalities.

In order to successfully deliver care that is coordinated and centred around the needs of patients and users, we need to understand what communities want and need and how we can work with our partners in local government to achieve this. To that end we need robust local engagement plans as part of the ICS transformational process.

To ensure meaningful conversation with residents and communities we will be taking this forward in two main ways:

1. **Working to engage with our residents on the care models and themes from across the ICS that drive the Estate Strategy.**

a) We want to focus on supporting our communities to live healthy, happy lives and are developing a programme wide engagement strategy which will help us to do this.
b) Working with patients, carers, local people, voluntary and community groups and other agencies to build relationships and improve our plans.

2. **Once proposals reach an appropriate level of maturity, engage in deeper, more specific consultation on individual Trust schemes.**

a) We want to look closely at the individual schemes in this strategy as they develop to understand how they will impact residents and staff and develop specific engagement plans.
b) Considering them on a case-by-case basis we will ensure that our engagement is meaningful and the feedback we receive will be incorporated into how we deliver changes.

Through this process we will ensure that our local population and system partners in local government are sighted on capital developments, increasing their chances of positive reception and supporting sustainable delivery of associated care models.

Section 4

Population Profile

Drivers and Opportunities for Change

In addressing health and wellbeing, care and quality, and financial sustainability, we face both significant challenges and opportunities around our estate. These are summarised below and described in more detail on later pages. Our approach to addressing these recognises the interdependencies between them, e.g., taking a place-based approach to support delivery of care closer to home can optimise use of assets, reduce running costs and release surplus space for development.

Population and Demand

- We are facing significant financial pressures on both the NHS and Local Authorities with increasing demand due to demographic growth and growing public expectation. Projected population growth is expected to increase 14% by 2040, reaching nearly 2,242,536. We have a diverse population. In Coventry 33% of the population identified as people from Black and Minority Ethnic (BaME) backgrounds in the 2011 census. The proportion of BaME groups in Warwickshire in 2011 was 12%.
- Coventry and Warwickshire has a unique mix of providers serving local and national populations due to recognised specialist centres of expertise and links to academic research and require a fit for purpose estate to retain their status.

Vision for Care

- Future vision for care is focused on both radical service transformation and incremental improvements to address demand changes.
- Move towards a 'population health' approach to deliver services differently with a greater focus on prevention, moving care closer to home (place-based care) and reducing demand in hospitals.
- Aim to reduce variation, improve quality of care and drive productivity across the ICS.
- Future care model and vision (described in section 5) outlines the opportunity for delivery of 'holistic' health and social care services utilising the estate in different ways.

Estate

- General condition of the primary and provider estate is mixed in terms of age, quality and fitness for purpose with rising backlog maintenance impacting on running costs and patient experience.
- Whilst central capital funding is focused on transformational projects, improving the overall condition of the estate remains a key priority and enabler for wider transformational objectives.
- Better utilisation of the estate (including through wider local government and public sector collaboration) is needed.
- Plans to modernise and utilise the estate are being explored to drive service improvement, reduce voids and improve productivity (in line with national guidance e.g., Carter).

Financial

- Estate running costs impact overall affordability and financial sustainability
- Substantial efficiencies will need to made over the next five years to both remove the underlying deficit and manage future pressures.
- Potential for capital receipts to support estate transformation. However, in some cases, release of land is reliant on investment in other areas.

Enablers

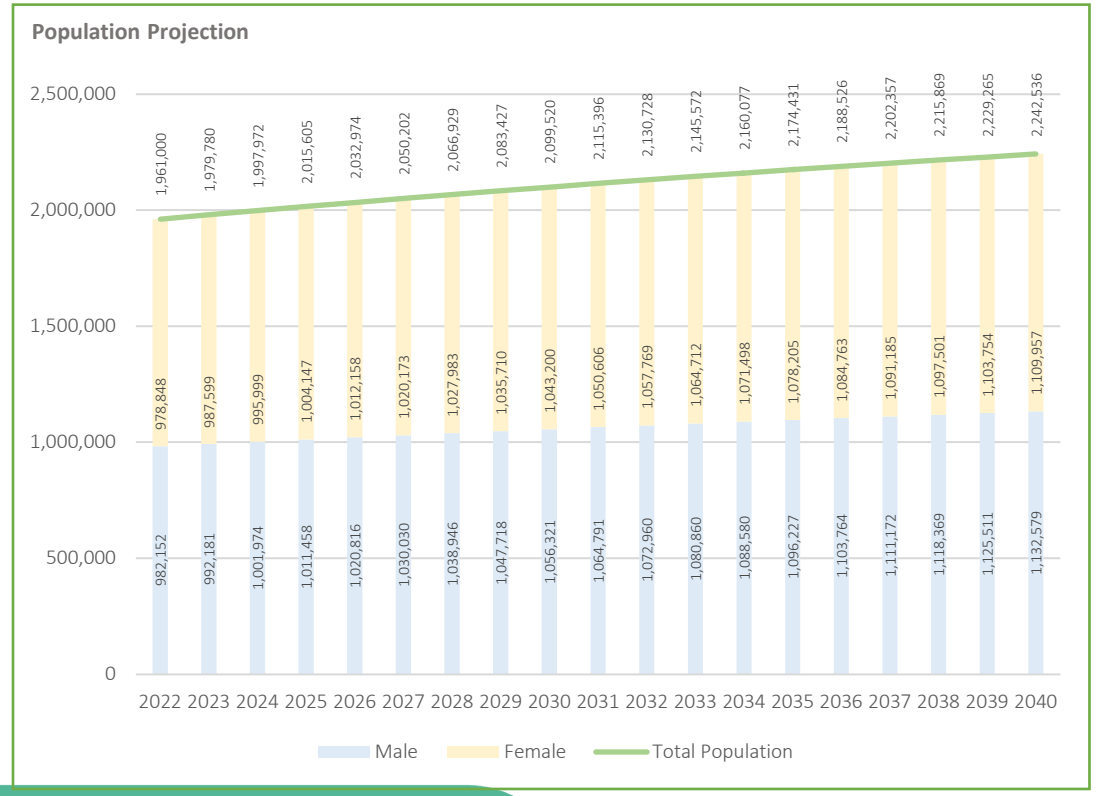
- Ageing workforce along with limited recruitment and retention of staff, will impact future service sustainability. Access to affordable and key worker homes and improved condition of workplace environments is a contributing factor for future recruitment challenges.
- Digital interventions and associated security measures to support service ambitions and delivery (e.g., self care, staff ability to work in an agile and integrated way) are currently hindered by poor existing infrastructure. Opportunities to address this alongside estate changes are being explored.

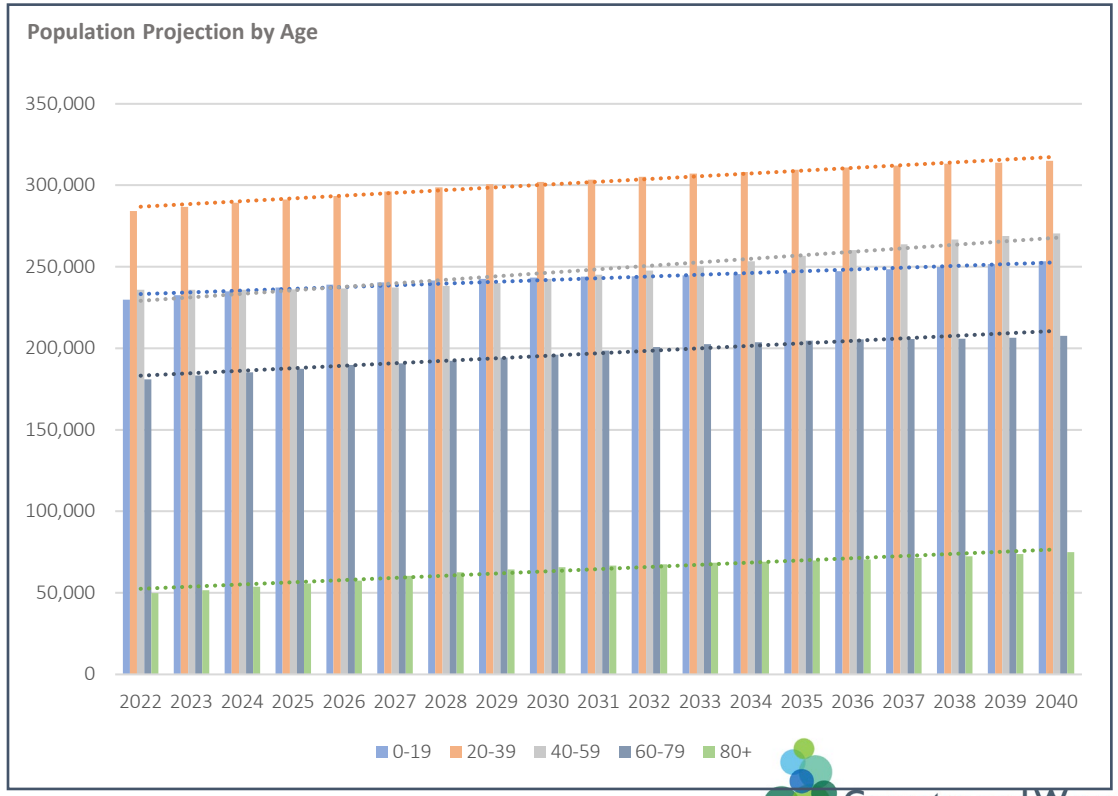
Housing

- Partners' land disposal pipelines create a significant opportunity for development of new housing including affordable and key worker housing.
- Shortage of affordable and key worker homes and accommodation needs to be addressed to support recruitment and retention.
- Opportunities to address this being pursued through site disposals for affordable and key worker housing.
- More widely housing and the environment are key drivers of health and addressing those wider environmental factors is critical to the prevention of ill health.

Population Projections

In the past ten years, Coventry's population has grown by a fifth, making it the second-fastest growing local authority outside of London. Based on 2018 ONS projections, the current population across Coventry and Warwickshire is 1,961,000. This is expected to increase 14% by 2040, reaching nearly 2,242,536. That largest age group within Coventry and Warwickshire are people between the ages of 20 and 39 with the fastest growing age group being the 40–59-year-olds.





Population Profile (1/2)

Life Expectancy

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

Preliminary analysis about what drives the life expectancy gap between Coventry and England and within Coventry & Warwickshire suggest the top three conditions are: Circulation, Respiratory and Cancer.

Employment

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

General Health

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

Diversity

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

Fuel Poverty

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

Chronic Diseases

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

Population Profile (2/2)

Children and Young People

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

Almost one in three Warwickshire children (31.7%) and 37.8% Coventry children aged 10-11 are classified as being either overweight or very overweight. The rate of children being admitted to 13 hospital for injuries in Warwickshire is rising and is significantly higher than the national rate. There are also significantly more hospital admissions for alcohol specific conditions for under 18s in Warwickshire than the national average (49.6 per 100,000 – the highest in the West Midlands).

Coventry is 32.7 (4th highest in West Midlands). The rate of under 18 conceptions has reduced across our area but remains higher than national average in Coventry and higher than other authorities of similar deprivation in Warwickshire. The proportion of children in care in Coventry is above the national average. There are also higher levels of children on protection plans or being looked after in care in Warwickshire North and pockets of South Warwickshire.

Mental Health

One in four adults will experience a mental health problem in any given year. Estimated prevalence of common mental health disorders amongst 16+ is 14.8% in Warwickshire, and 19.1% (c. 55,300 residents) in Coventry. Depression prevalence and incidence rates are increasing across Coventry and Warwickshire.

Suicide

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

Older People

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

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

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

Dementia

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

Public Health Outcomes

The table below compares public health outcomes from across the West Midlands to the national average (England only).

Indicator	Period	England	West Midlands	Birmingham	Coventry	Derby	Herefordshire	Sandwell	Shropshire	Solihull	Staffordshire	Stoke-on-Trent	Telford and Wrekin	Walsall	Warwickshire	Wolverhampton	Worcestershire
Healthy Life Expectancy at Birth (Male)	2017 – 2019	**63.2**	61.5	58.5	61.9	61.6	64.1	59.2	64.6	66.6	61.5	56.7	58.2	57.9	64.6	58.6	65.1
Healthy Life Expectancy at Birth (Female)	2017 – 2019	**63.5**	62.6	59.3	64.2	62.6	66.5	59.5	64.9	65.7	63.8	56.7	62.6	58.7	64.1	58.6	65.8
Life Expectancy at Birth (Male)	2018 – 2020	**79.4**	78.5	77.1	78.0	78.8	79.9	76.1	80.2	80.4	79.3	75.9	78.2	77.5	79.7	76.6	80.0
Life Expectancy at Birth (Female)	2018 – 2020	**83.1**	82.5	81.8	82.0	82.2	83.8	80.7	83.7	84.0	83.1	79.7	81.9	81.7	83.4	81.3	83.5
Disability-Free Life Expectancy at Birth (Male)	2017 – 2019	**62.7**	61.6	59.9	62.0	59.4	62.2	59.5	66.3	63.7	62.4	56.4	60.3	59.3	62.7	59.2	64.1
Disability-Free Life Expectancy at Birth (Female)	2017 – 2019	**61.2**	60.6	58.5	61.9	59.2	62.8	57.4	64.0	61.4	61.1	54.3	62.8	57.8	62.5	56.8	63.4

Deprivation

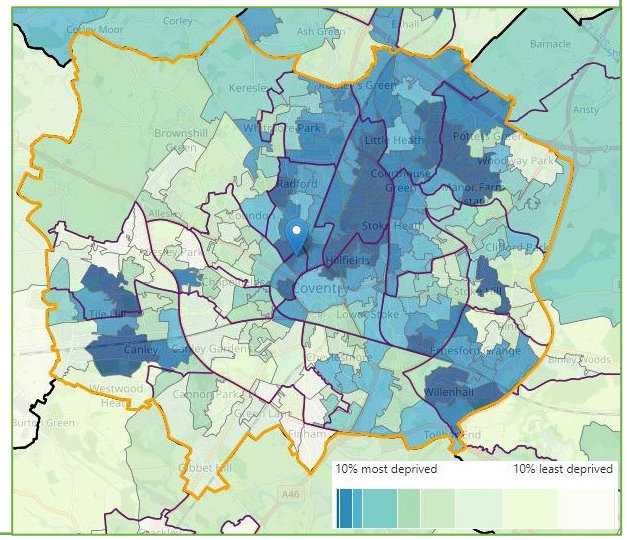
Whilst Coventry is the 46th most deprived local authority area out of 326 across England (English Indices of Deprivation 2015), Warwickshire is one of the 20% least deprived counties in England. Nevertheless, there are significant variations and inequalities across our area, with deprivation and poor health outcomes experienced in both local authority areas. There are 44 Lower-layer Super Output Areas (LSOAs) in the 10% most deprived nationally in Coventry and Warwickshire; 36 of these are in Coventry, 6 are in Warwickshire North and 2 in Rugby.

Coventry

Based on information from the 2019 Joint Strategic Needs Assessment (JSNA) for Coventry, 14.4% of Coventry's Lower-layer Super Output Areas (LSOA) were amongst the 10% most deprived in England and 26.7% of LSOAs were amongst the 30% most deprived in England. Many areas with high deprivation are in the central northeast and northeast of the city with pockets in the southwest and southeast. Nearly 19% of Coventry neighbourhoods are amongst the 10% most deprived neighbourhoods in England.

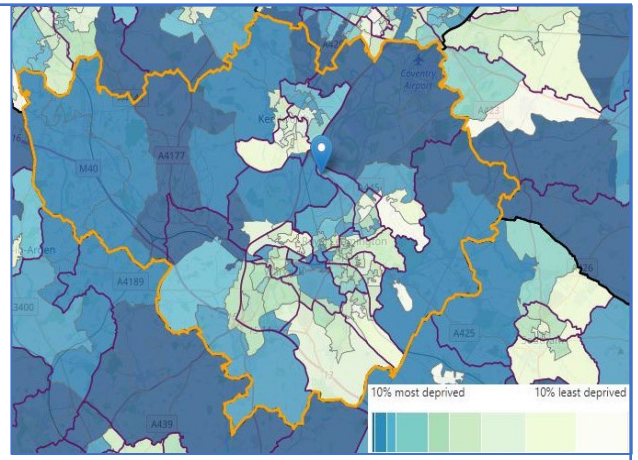
Looking at all its neighbourhoods, Coventry's overall position in the IMD 2019 has improved notably compared to the IMD 2015. The city has become relatively less deprived overall, when compared to other local authority areas. All the different measures of summarising multiple deprivation at local authority level show a notable improvement in ranking for Coventry.

Coventry performs the most poorly in the deprivation domain 'Living Environment' which measures the quality of housing, air quality and road traffic accidents. The adjacent map shows the IMD domain for Coventry in 2019.



Warwickshire

Compared to other higher tier local authorities reviewed in the 2019 Index of Multiple Deprivation, Warwickshire ranked 121 out of 151 – slightly lower than in the previous publication in 2015 when it ranked 124 out of 154.



In 2019, Warwickshire had two fewer LSOAs in the 10% most deprived nationally than in 2015. Overall, in 2019 there were six more LSOAs in the 30% most deprived nationally than in 2015.

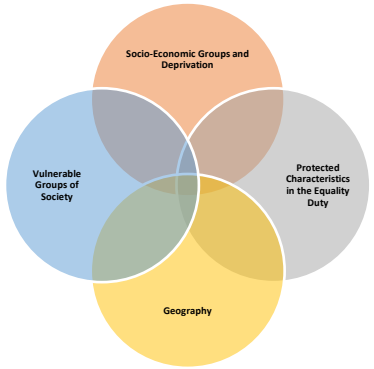
In Warwickshire, the deprivation domains of 'Barriers to Housing and Services' and 'Education Skills and Training' have the highest number of LSOAs in the 30% most deprived nationally, as shown on the map below.

Place-Based Approaches for Reducing Health Inequalities

We have held workshops throughout 2021/22 to focus on place-based principles of care. The design principles for each place are detailed below. For further information on the detail that sits behind the strategies please refer to the full documents in Appendix B.

Definition of Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. Health inequalities have been documented between population groups across at least four dimensions. It is important to note that these are overlapping dimensions with people often falling into various combinations of these categories.



Economic Case for Acting on Health Inequalities

- There are many reasons to come together to find solutions at a national and local level to break the cycle of entrenched health inequalities in England. As many of these inequalities are avoidable, the moral case cannot be overstated.
- There are also economic reasons for action. The high burden of disease in deprived areas generates higher use of health and social care services, higher unemployment, and lower productivity.
- The Marmot Review estimated that health inequalities cost society £31 billion in lost production, in 2010 prices. Whilst this is a national figure, it is in local jobs and economies where this impact is borne out.
- The higher burden of disease experienced by women living in the most deprived neighbourhoods costs the NHS 22% more per person than women living in the least deprived neighbourhoods, despite having shorter life expectancy (or £400 per person per year in secondary care costs).
- For men, this figure is 16% per person (or an additional £300 per person per year in secondary care costs). This results in an additional spend of £4.8 billion per year, almost 20% of the total hospital budget [footnote 17], without considering additional costs, including social care provision.

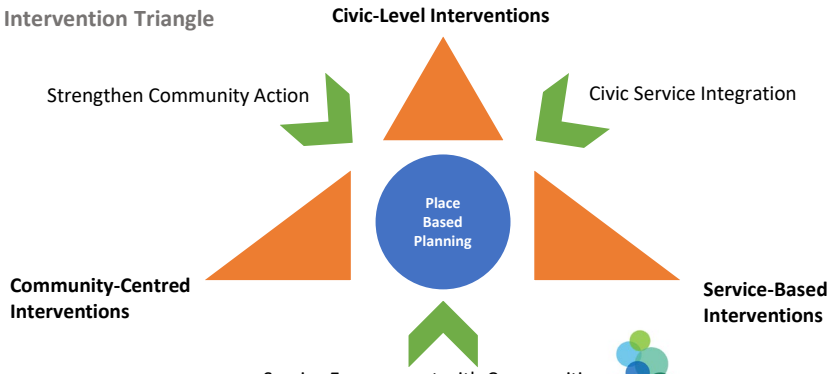
Why Place Matters

Important lessons from the Labonte Model are that:

- People do not have the same opportunities to be healthy.
- Given the range of causes, a joined-up, place-based approach is necessary.
- Interventions that solely rely on individual behaviour change are likely to widen inequalities. These need to be addressed within the context of their root causes in the wider determinants of health.
- Resources should be allocated proportionately to address the levels of need for specific communities or populations to achieve equitable outcomes for all.

There is, therefore, a critical role for local areas to play in reducing health inequalities across the life course, by taking a joined-up place-based approach - and utilising the leadership, expertise and levers that are available to them to affect this environment.

Population Intervention Triangle



Section 5

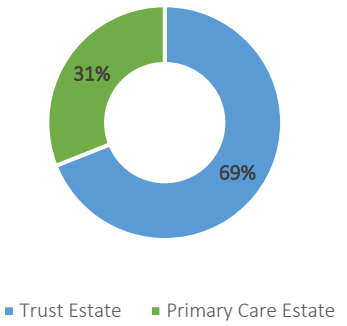
Estate Overview

Overview of the Health Estate*

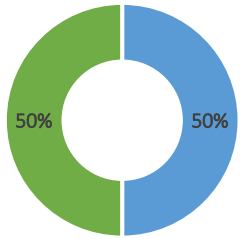
Our health and care estate is variable. It is a mix of age, quality and fitness for purpose. It ranges from recently built state of the art facilities to facilities (including within the primary and community estates) which are not fit for purpose or falling behind in terms of quality, impacting service provision.

Health Estate	Trust	Primary Care	Total
Floor Area	412,291	Data available June 2022	
Backlog Maintenance	£43,271,749	Data available June 2022	
No. of Properties	342	154	496
NHSPS	40 (as per ERIC)	15	55
CHP	5 (as per SHAPE)	10	15
Total Running Costs	c.£16.5m (as per ERIC)		
Net Book Value			
Void Space			

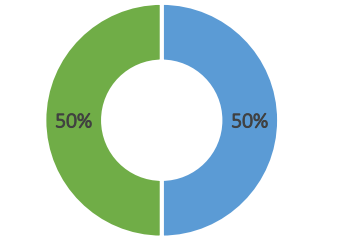
No. of Properties



Percentage of Backlog Maintenance
*TBC



Percentage of Footprint
*TBC



Our Vision for Primary Care

The make-up of the primary care estate across the Coventry and Warwickshire footprint is complex. The CCG is not directly responsible for owning and managing health estate but has a strategic role in commissioning primary care services across the area. We are developing the interface between primary care and community services to understand how we can effectively and efficiently deliver services and manage demand both now and in the future.

Our Vision for Primary Care

General Practice is at the heart of our local health and social care system, providing essential general medical services to a registered patient list, acting as the first point of contact for referral to wider health, and increasingly to social care and third sector / community assets.

To achieve this vision, we will need a shared commitment to:

- Further develop a high quality, responsive, proactive, and sustainable primary care offer for our population.
- Expand the workforce so that care is delivered by a competent integrated multi-disciplinary workforce.
- Ensure services are operating from fit for purpose estate located in the right place.
- Optimise digital technology to maximise efficiency, productivity and innovations in patient care.
- Evidence based, value driven care that delivers improved outcomes for patients and system benefits to our local integrated care system.
- Work in partnership with a range of providers and partners to deliver joined up personalised care that meets the needs of our diverse communities.

If we are to transform our ways of working, we need to ensure that our estate and infrastructure is appropriate and in the right place.

Our Strategic Themes for Primary Care

Location

Meet predicted population growth and new housing developments.

Standards

Meet new regulations and requirements.

Flexibility of Use

Offer wider range of service and provide multiple functional use.

Digital Infrastructure

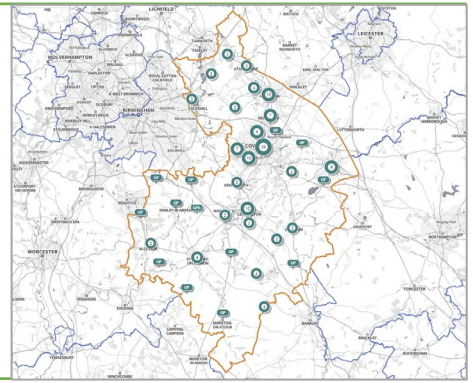
Increase use of digital innovation and technology to maximise efficiency and access.

State of the Estate: Primary Care

Primary care infrastructure is critical to support our ambition for care closer to home. The current primary care estate is characterised by many small properties, in fragmented ownership which impacts the ability to enact change at pace, given the various interests and complex arrangements which need to be managed. Transformation in the primary care estates is critical as it acts as a key enabler to delivering the overall vision for care. There are a total of 154 GP practices – 30 of them being 'branch' practices whose data is included alongside their 'parent' practices – there are 124 'parent practices'.

GP Practice Breakdown by Place

Our Member Practices by Place	
Coventry	**8 PCNs** 65 Practices
Rugby	**1 PCN** 14 Practices
South Warwickshire	**7 PCNs** 40 Practices
Warwickshire North	**5 PCNs** 33 Practices



CQC Assessment Rating

Across Coventry and Warwickshire as a whole, the latest CQC ratings for our practices is as follows:

CQC Assessment Rating	
Outstanding	7 Practices
Good	111 Practices
Required Improvement	1 Practice
No Data	4 Practices

GP Business Types and Ownership

Business Types	Parent Practices	Branch Practices	Total
CHP	9	1	**10**
NHSPS	10	5	**15**
GP / Private Ownership	76	19	**95**
Third Party	13	3	**16**
Not Known	16	2	**18**
Total	**124**	**30**	**154**

GP Patient Survey

The average score across Coventry and Warwickshire for the GP Patient Survey is 84.2 from a total of 123 practices (branch practices are not scored separately).

Analysis

A consistent and complete approach needs to be developed around data collection and management for all practices within Coventry and Warwickshire to fill the gaps in information.

Demand and capacity analysis needs to be refreshed for each PCN.

State of the Estate: Trusts (1/4)

There are 342 sites across the Trust estate. The table below provides a breakdown of the number of different Trust sites across the region:

Trust Name	Trust Type	Number of Sites												
		General Acute Hospitals	Specialist Hospitals (Acute Only)	Mixed Service Hospitals	Mental Health (including Specialist services)	Learning Disabilities	Mental Health and Learning Disabilities	Community Hospitals (with inpatient beds)	Other inpatient	Non-inpatient	Support Facilities	Sites that are unreported	Sites leased from NHS Property Services	Sites occupied without charges
South Warwickshire NHS FT	Acute – Small	2	0	0	0	0	0	2	0	79	40	50	19	3
University Hospitals Coventry and Warwickshire NHS Trust	Acute – Teaching	2	0	0	0	0	0	0	0	5	2	1	0	0
George Eliot Hospital NHS Trust	Acute – Small	1	0	0	0	0	0	0	0	25	1	23	11	0
Coventry and Warwickshire Partnership NHS Trust	Mental Health and Learning Disability	0	0	1	9	10	5	0	0	12	10	2	10	37
Totals		**5**	**0**	**1**	**9**	**10**	**5**	**2**	**0**	**121**	**53**	**76**	**40**	**20**

The State of the Estate: Trusts (2/4)

Our entire Trust estate stands at just over 400,000 sqm. The largest site within the ICS is the University Hospital Coventry which at 148,851 sqm forms over 36% of the entire Trust estate. Across the entire Trust estate 94.5% of the floor area is NHS occupied. Just under 15% of our occupied floor area is not functionally suitable with just under 12% of our clinical space not being functionally suitable. Just under 4% of our floor area is empty with 3% of our floor area being under-used.

Top 3 Largest Sites by GIA

No.	Trust Name	Site Name	Site Type	Tenure	GIA	GIA Percentage of the Entire Estate
1	University Hospitals Coventry and Warwickshire NHS Trust	University Hospital Coventry	General Acute Hospital	Whole Site - Private Finance Initiative (PFI)	148,851	36.10%
2	George Eliot Hospital NHS Trust	George Eliot Hospital	General Acute Hospital	Freehold	51,996	12.61%
3	South Warwickshire NHS Foundation Trust	Warwick Hospital	General Acute Hospital	Freehold	50,035	12.14%

Entire Estate

Element	Size
GIA (sqm)	412,291
Land Area Owned (ha)	74.72
Land Area not delivering Services (ha)	0.44

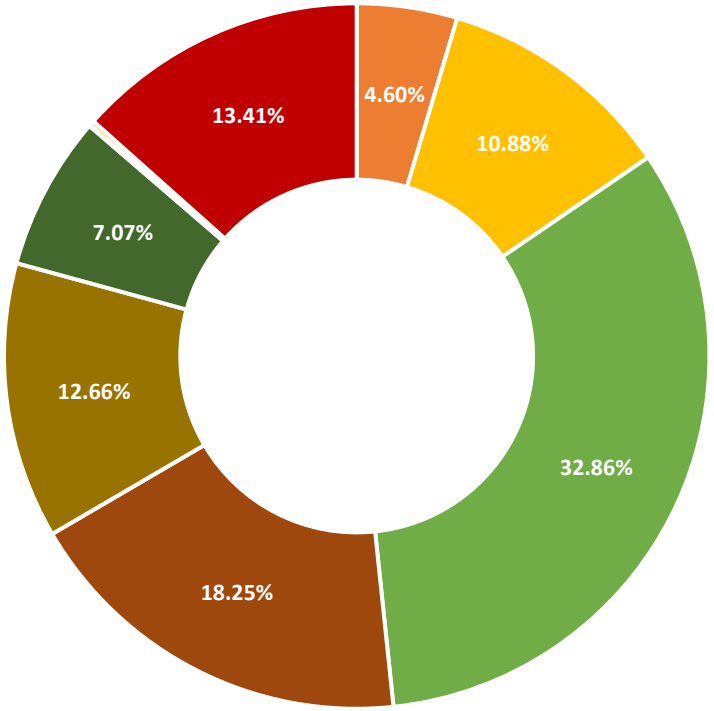
Entire Estate

Element	Percentage
NHS Estate Occupied Floor Area	94.55
Not Functionally Suitable – Occupied Floor Area	14.71
Not Functionally Suitable – Clinical Space	11.54
Floor Area – Empty	3.95
Floor Area – Under Used	3.05

State of the Estate: Trusts (3/4)

As can be seen in the diagram below, 13% of our Trust estate was built before the formation of the NHS in 1948. In addition, around 33% of our Trust estate is being 50+ years old, nearly 15% being almost 70+ years old, with only 15% being less than 17 years old.

Age Profile



Age Bracket	Percentage of the Estate
Pre-1948	13.41%
1948 – 1954	0.22%
1955 – 1964	0.06%
1965 – 1974	7.07%
1975 – 1984	12.66%
1985 – 1994	18.25%
1995 – 2004	32.86%
2005 – 2014	10.88%
2015 – 2024	4.60%

Breakdown

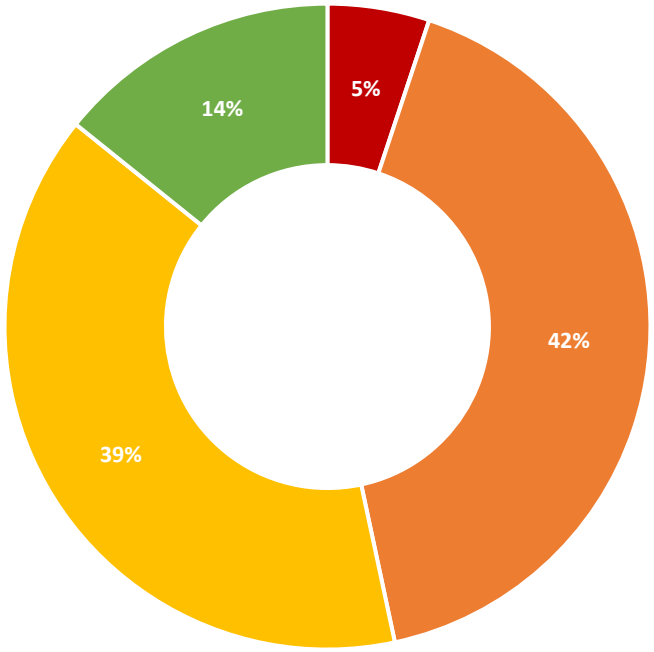
Sites with the largest amount of estate per time period:

- **Pre-1948:** 69% of Ellen Badger Hospital
- **1948 – 1954:** 3% of Ellen Badger Hospital
- **1955 – 1964:** 1% of sites within Coventry and Warwickshire NHS Trust (other reportable sites)
- **1965 – 1974:** 13.46% of George Eliot Hospital
- **1975 – 1984:** 44.81% of Brooklands Hospital
- **1985 – 1994:** 52% of Warwick Hospital
- **1995 – 2004:** 100% of Hawkesbury Lodge, The Caludon Centre, St Michael's Hospital, Woodloes House, and Aspen Unit
- **2005 – 2014:** 92% of University Hospital Coventry
- **2015 – 2024:** 70% of Stratford Hospital

State of the Estate: Trusts (4/4)

As can be seen in the diagram below, 5% of the total backlog maintenance is apportioned as high risk, with 42% being apportioned as significant risk, 39% as moderate risk, and 14% as low risk. The total value of backlog maintenance across the Trust estate is estimated as £42,271,749.

Backlog Maintenance by Risk



Backlog Risk	Cost	Percentage
High Risk	£2,208,895	5%
Significant Risk	£17,977,361	42%
Moderate Risk	£16,930,987	39%
Low Risk	£6,154,506	14%
Total Risk	**£43,271,749**	**100%**

Breakdown

Sites with the largest amount of:

High Risk Backlog:
- Hospital of St Cross
- £2,059,900

Moderate Risk Backlog:
- Hospital of St Cross
- £5,704,802

Significant Risk Backlog:
- Warwick Hospital
- £6,672,920

Low Risk Backlog:
- Brooklands Hospital
- £1,683,500

Top 3 Sites for Total Backlog Maintenance		
1	Hospital of St Cross	£10,944,454
2	Warwick Hospital	£8,067,673
3	George Eliot Hospital	£7,045,121

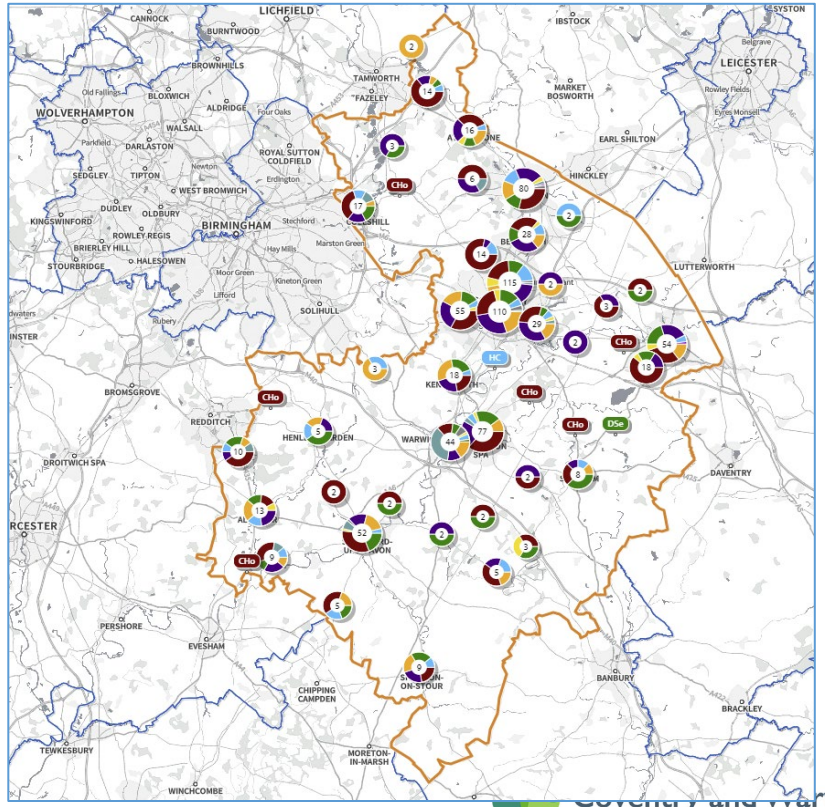
State of the Estate: Mental Health, Community, and Social Care

We have plans to work more closely across health and social care, in line with the FYFV. Sufficient, high quality and sustainable social care delivered directly by local authorities or commissioned through external providers (e.g., in the residential, nursing and home care markets) can deliver excellent outcomes for our residents and reduce the burden on health and care services.

Overview

Mental Health, Community and Social Care	
Health Centres, Clinics, Walk-in Centres	69
Pharmacies	199
Care Homes	254
Children's' Centres	31
Dental Services	126
Genito-Urinary Medicine	2
Independent Hospital / Treatment Centres	34
Mental Health Facilities	1
Non-Clinical Administration and Support	12
Opticians	123

CQC Assessment Rating	
Outstanding	4
Good	170
Required Improvement	57
Inadequate	5
No Assessment	8



State of the Estate: NHSPS and CHP

We continue to engage with both NHS Property Services and Community Health Partnerships to maximise the utilisation, occupancy and efficiency of our estate. We will look to strengthen these ties through collaborative working, targeted pilots and continued engagement as we continue to transition towards ICS status.

Overview

NHSPS and CHP continue to provide support as our trusted estates partner across our emerging ICS. NHSPS have been supporting stakeholders on an individual basis and as part of collective discussions to provide and review benchmarked estates costs across their respective estates and on a comparative basis for our local Trusts.

NHSPS attend and actively participate in local estates forums and have produced a vacant space presentation outlining what space is available within its estate, the costs to system for the space and length of term this space has been held vacant, allowing us to review on a regular basis.

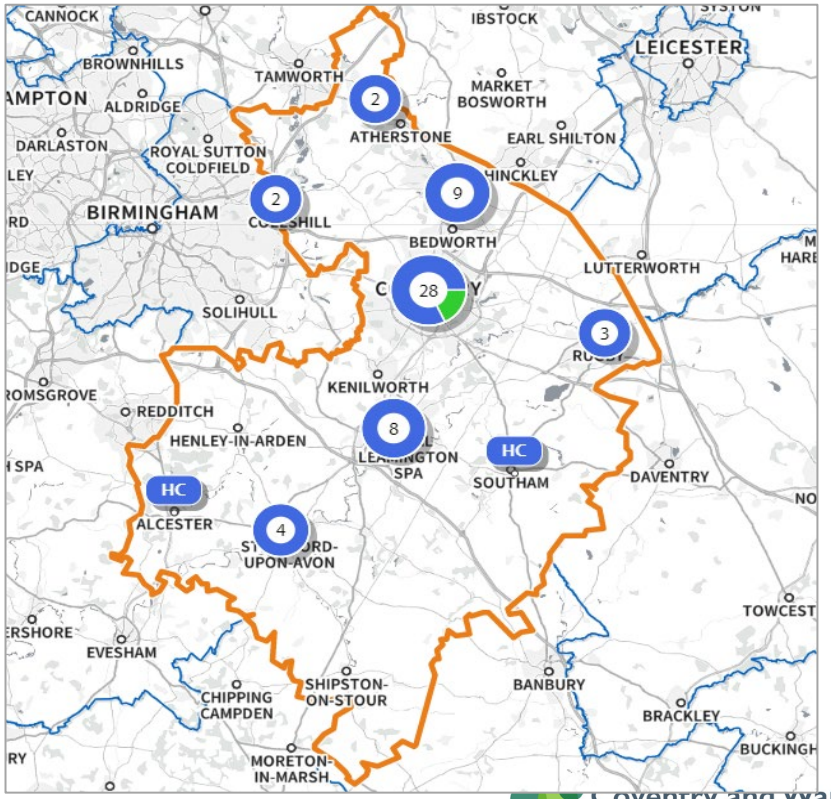
NHS PS continue to work alongside CHP on various projects across our ICS from review of space (optimisation, utilisation and vacancy) to producing collective information for comparison by systems.

Ongoing Projects

- NHSPS is currently working on delivery of a new GP surgery
- CHP and NHSPS are working together on a review of the utilisation and optimisation of Coventry City properties to reduce space across the region and optimise use of this accessible health care destination.
- Working alongside our Trust's to support in the delivery of Community Diagnostic Hubs and Out of Hospital services across the region, some of which we hope will facilitate disposals for reinvestment within our ICS.
- Support in response to Covid-19 in terms of provision of space, testing sites, hot hubs and vaccination space.

Committed Collaboration

We will continue to build on our existing ties with the property companies across our system in order to reap the benefits that can be gained through working as complimentary teams, we will look to work together to review how NHSPS and CHP can support in terms of lease advisory, planning support and strategic office reviews across our system.



Section 6

How our Estate can **S**upport our Vision for Care

Our Key Estate Priorities

In order to deliver the best care for our people, we are aiming to make the best use of NHS and local authority owned estate resources. By using our collective estate, we can ensure our buildings are fit for purpose and used efficiently, whilst improving the condition and quality of our estate alongside reducing costs. As the service strategies across all partnership organisations are maturing, they will have to be enabled by estate change. The estate priorities focus on how the partnership organisations can enable delivery of the vision for care across the ICS. To achieve this, our key priorities are:

Develop a place-based approach to support service delivery and optimise use of assets, drawing on the principles of One Public Estate.

Respond to care requirements and changes in demand by putting in place a quality estate enabling us to tackle health inequalities.

Increase the operational efficiency of the estate by improving utilisation, tackling backlog maintenance, and optimising running costs. Make progress against NHS **Net-Zero Carbon** requirements.

Enhance delivery capability by supporting wider changes in health care delivery, alongside workforce and digital enablers. Increase our efforts to ensure our **data collection and management processes are improved** and built upon.

Enable the delivery of a portfolio of estate transformation projects that support the implementation of our vision. **Establish a workplan** for the ICS with a **revised and streamlined governance** structure. Recruit for the position of an **Estate Director**.

Establish a workstream group to **manage space utilisation** and/or requests with a focus on the potential to release space, save revenue, and **push capital back into the system**.

Empowering our Workforce 1/2

To deliver high quality services and support and develop a strong workforce to enable cross-sector, integrated teams to deliver person-centred care, we have identified some key priorities for our workforce. In addition, supporting delivery against these priorities, we have identified four key enablers.

People Strategy

We will provide clarity on recognising that workforce transformation takes place at:

- Within Place: South Warwickshire, North Warwickshire, Coventry and Rugby.
- Primary Care Networks.
- Clinical pathways e.g., cancer.
- Individual organisations including Trust, Local Authority, Primary Care providers.

The work of the People Board, underpinned by the Coventry and Warwickshire People Plan, sets out a plan to provide strategic leadership to the development and implementation of the people priorities of the:

- ICS strategic plan
- ICS People function
- ICS People Strategy.
- NHS Long Term Plan.
- NHS People Plan.

The People Board has six sub-groups focused on key areas of delivery:

- Equality, Diversity and Inclusion
- Health and Wellbeing
- Education
- Leadership and Organisational Development
- Recruitment and Attraction
- People Planning

How will the estate support the workforce?

- **Affordable and Key Work Housing:** Land disposal and service reconfiguration provides us with an opportunity to develop affordable and key worker housing. This will enable retention of staff in area.
- **Transportation:** In order to ask our workforce to work more robustly in the community both in and out-of-hours, we need to ensure that they have a reliable and safe methods of transport.
- **Work environments:** Workplaces should provide staff, as well as patients, with an environment that provides quality and safe care alongside the health and wellbeing of personnel. Additionally, building our resources in research and education can enable 'pull' of quality workforce into the area.

Empowering Our Workforce 2/2

Supporting Affordable Housing and Homes for Key Workers Programme

Recognising the role of housing in reducing health inequalities and the economic benefits that new housing creates we are eager to work more closely with LA's and other system partners to maximise opportunities to develop affordable housing and homes for Key Workers. Through identification and disposal of surplus land, we will look to develop land for housing. In support of the workforce vision on attracting and retaining staff in the area, the opportunity to develop more homes for NHS staff is being pursued.

Our Housing Context

The table below outlines the required annual growth in housing need for both affordable housing and economic led housing. As we look to manage this growth we will adopt a place-based planning approach, improving access to appropriate housing for our population and developing greater ties to our OPE partners to explore how our surplus NHS estate can be redeveloped for housing.

Housing Need per Annum 2011-31	Annual Affordable Housing Need	Economic Led Need	Affordable as % of Economic Led Need
Coventry	600	1,350	44%
North Warwickshire	92	210	44%
Nuneaton & Bedworth	85	496	17%
Rugby	171	425	40%
Stratford-on-Avon	233	650	36%
Warwick	280	600	47%
Coventry / Warwickshire Total	**1,462**	**3,731**	**39%**

Progress, Opportunities, and Actions

We are already working with our OPE partners at the George Elliot Hospital and we will look to further these ties.

We have also implemented a Town Planning, Section 106 & CIL Task & Finish group as part of our revised governance structure, this forum will be used in part to take account of how health can support affordable housing growth.

We will continue to review our surplus land and disposal pipeline and how this can support required growth in affordable housing and homes for NHS staff.

Explore opportunities around affordable and key worker homes.

Digital Enablers to Optimise Care

Use technology and information to enable smarter, safer working

- More flexible and efficient use of space through digital solutions and re-purposing of physical space to meet these modern ways of working and service delivery.
- Patients will find moving between services a more seamless and less fragmented experience.
- A more mobile workforce who can access information from anywhere and accelerate how quickly they can deliver solutions through moving towards cloud services.
- Maintain an infrastructure that is reliable, modern, secure, sustainable, and resilient in order to support digital transformation and business continuity.
- We will expand and unify platforms for communication and collaboration to enable staff to work as effectively and efficiently as possible.

Digitise health and care records so that information can be shared quickly, appropriately, securely, to improve health outcomes

- Improve data and access to relevant information through improved functionality of electronic patient records delivering patient flow and bed management functionality, monitoring of physical health observations using handheld devices and electronic requesting and viewing of results for diagnostics.
- Clinician time will be saved and risks around medication errors will be reduced by completing implementation of electronic prescribing and medicine administration systems.
- Digital solutions that allow clinicians to identify effective and timely interventions.
- Support the Greener NHS Programme through reducing the use of paper and improve on our records management
- Use of shared care records with system partners at an ICS level and regionally where appropriate to support whole system demand and capacity intelligence.

To provide public facing digital services

- Patients will have more choice in how they interact with clinical services.
- Patients will have increased access to their health records and be able to contribute updates to their details and clinically relevant content.
- Introduce patient facing applications, authenticated through the NHS App, to allow patients and service users access to their care plan, progress and outcome measures.
- We will introduce assistive technology that can be used in patients' homes that supports better outcomes for patients and better uses clinician time.

To understand data and its context to be able to make informed decisions to improve patient care and population health

- Assess and where necessary improve the quality of clinical data content.
- We will ensure that we have the right data, for example capturing data about protected characteristics will enable us to address health inequalities
- We will structure and code our data so that it can be used appropriately and effectively.
- We will develop the information required to deliver care, manage and develop services, for example, we will be able to identify at-risk populations.
- We will aim to personalise care and manage population health, evaluate clinical pathways and answer the question “What works for whom and why?”.

Green Priorities and Objectives

Our aims in terms of our green and sustainability initiatives are to provide:

Energy

Transition to low/zero carbon solutions for the provision of energy services.

Water

Reduce unnecessary water usage and use water efficiently.

Waste

Lean and efficient services where waste is managed to minimise environmental harm, prioritising prevention.

Estate

A multi-purpose, biodiverse estate with greenspaces utilised staff, patients, and visitors.

Travel

Improved local air quality and reduced carbon emissions from travelling sustainably.

Supply Chain

Partnership working to improve efficiency and eliminate carbon.

Food and Nutrition

Sourcing healthier, locally produced food to improve wellbeing and reduce carbon.

Care

Patient focused, low carbon care.

People

Informed and engaged staff, patients, volunteers, and carers, who are empowered to deliver and receive sustainable healthcare.

Climate

A resilient and robust service provision which responds to a changing climate.

Our Place-Based Strategies

We have held workshops throughout 2021/22 to focus on place-based principles of care. The design principles for place-based systems of care are detailed below. For further information on the detail that sits behind our four place-based strategies (Coventry, Rugby, Warwickshire North, and South Warwickshire) please refer to the full documents in Appendix B.

Place-Based System of Care: 10 Design Principles

Define the population group and the system's boundaries
In some cases, this will be relatively straightforward, but in others it will be more complex, particularly in large urban areas where people move across administrative boundaries to access care and support. Whatever geographical boundaries are chosen; place-based systems of care should take responsibility for all people living within a given area.

Identify the right partners and services
While place-based systems of care will have a strong focus in the NHS, they will also involve local authorities, the third sector and other partners. This is particularly the case where the aim is to focus on population health and not just health and care services. Providers will take the lead in establishing place-based systems of care because it is providers who need to collaborate in developing new models of care that are clinically and financially sustainable.

Develop a shared vision and objectives
This will build on work done by commissioners and health and wellbeing boards in understanding the needs of the local population, as well as providers' knowledge of local services. Over time, systems of care must develop more meaningful and systematic ways of gathering and disseminating information about the patients' preferences.

Develop an appropriate governance structure
To do this successfully, the structure must be inclusive enough to ensure that those involved in delivering and receiving services are meaningfully involved in decision-making. Partners are likely to need to cede some of their own sovereignty and agree how decisions will be made collectively – including whether there are some issues over which organisations should retain the right to approve decisions.

Identify the right leaders and develop a new form of leadership
This requires the development of a new kind of system leadership based on negotiation and influence rather than direction. Leadership needs to extend right through the organisations involved in place-based systems of care and we would emphasise the role of clinical leaders in developing new care models that span organisational and service boundaries. System leadership that is not underpinned by clinical leadership and the engagement of frontline clinical teams will not deliver the changes needed.

Agree how conflicts will be resolved
Agreeing how conflicts will be resolved within the system of care is essential. There will be an emphasis on informal mechanisms such as mediation rather than resorting to legal action. Wherever possible, conflict should be viewed as a healthy reflection of the state of collaborative working and the ability of the organisations involved to disagree and move on. At the same time, partners should be clear about the consequences for organisations that fail to play by the agreed rules and behaviours of the system.

Develop a sustainable financing model
First, local partners need to agree the collective resources available to meet the objectives of the system. Second, commissioners must develop new ways of contracting with providers to align incentives behind the system's objectives. Third, providers of care within the system will need to agree how they allocate resources and share costs, risks and rewards.

Create a dedicated team
A dedicated team to be established to support the work of the system and act on behalf of leaders in implementing decisions. In the absence of such support, there is the ever-present risk that plans will not be executed, resulting in frustration and loss of commitment. Of course, new ideas and ways of doing things will only make a difference if they can be successfully implemented across the organisations involved, which means that the dedicated team should not work independently of others.

Develop systems within systems
In working to meet common objectives it is likely that different partnerships will emerge within and across place-based systems to tackle issues of concern. This means that systems of care must develop 'systems within systems' to focus on different aspects of their objectives, drawing on skills and services from across the community. The important task is to ensure that activities of different groups form part of a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives.

Develop a single set of measures
This will involve agreeing a small set of metrics to assess the overall performance of the system, as well as how these metrics will be collected and reported – including to the public. A larger set of metrics will also be collected to allow partners to understand how they are contributing to the overall goals of the system and identify areas for improvement. This should include measures to test whether the system is behaving in a way that aligns with its agreed values and behaviours.

Vision for Care: Out of Hospital Care Estate Impact

Underpinned by a systematic focus on prevention, supported self care and optimising our community offering, we will further develop a 'place based' population health system of care which draws together social, community, primary and specialist services with the goal of investing in our out of hospital capabilities, enabling improved integration of services and increasing service capacity and responsiveness.

Through the further development of our Primary Care Networks, our Out of Hospital services will enable our citizens to stay healthy and independent and wherever possible prevent the need for hospital admission. When services are required we will ensure patients are seen in the right place, at the right time by the right person.

Pipeline Value: £11-17m

Our Commitment	Capital Plans and Current Projects	Our Pipeline
Reduce Medical Emergency Admissions by 5% Target 80% of patient discharges to usual place of residence within 7 days of admission Wrap our place based teams around GP Practices, utilising our Primary Care System to maximise the benefits of system integration	**Coventry and Warwickshire Out of Hospital Care Collaborative – Digital revolution STP Capital Bid.** Wave 2 scheme SWFT leading with FBC approved for £9.42m, completion due March 2022 The scheme is to implement a population health intelligence system to support the proactive and preventative delivery of out of hospital care at the locality level; turning data into intelligence it will focus resources in the place they will have the greatest impact. The community electronic patient record (EPR) together with the locality hubs and integrated Single Point of Access (i-SPA) in Warwickshire will support estate rationalisation across Warwickshire. All partners in the STP will benefit from this scheme.	1. **UHCW Community Diagnostic Hub – TBD £2-8,000,000 -** Development of a new and dedicated Community Diagnostic Centre in the city centre in partnership with Coventry University 2. **SWFT – Community Estate** - **£2,500,000 –** Transfer of NHS PS Ownership to support Out Oh Hospital Care and address known backlog and compliance issues at Atherstone Clinic (North Warwickshire) and the Orchard Centre (Rugby) 3. **GEH – Community Diagnostic Hub Phase 2 - £7,000,000** – Expansion to radiology capacity to enable the complete separation of urgent and routine diagnostics

Vision for Care: Planned Care Estate Impact

We will optimise the efficiency of our planned care across providers, delivering better value, delivering efficiency savings and reducing unwarranted variation in our planned care provision. Our primary objectives is to deliver shorter waits for planned care and provide patients with a wide choice of options for quick elective care.

Our estate will continue to support the Planned Care workstream in further refining and developing our action plan which will focus on supportive systems and processes, trained teams, commissioned services and prepared public.

Pipeline Value: £104.1m

Our Commitment	Capital Plans and Current Projects	Our Pipeline
Deliver Shorter Waits for Planned Care – Rolling out the use of Musculoskeletal First Contact Practitioners by 2023/24, extend access to online support for MSK Patients Reduce Face to Face outpatient attendances by 30% by 2023/24 Delivering productivity improvements to generate £26.3m of efficiency through transforming planned care by 2023/24	**Replacement of Elective Theatres block at Rugby St Cross Hospital (StX) (£23,033m) Phase 1 (£5.634m) –** Replacement of two Modular Theatres as the first phase in developing a new six theatre block. Theatres do not meet current HTM standards, with issues around age and condition. The new Modular units will underpin the Phase 2 scheme of the potential replacement of up to six theatres at StX. This development could consist of six theatres, anaesthetic rooms, post-operative recovery beds, store rooms and dirty utility. The new unit will support transfer of activity to StX to release capacity at UH in order to manage trauma demand, cancer targets, reduce bed pressure, theatre capacity and parking. Should these theatres fail their annual validation through lack of compliance, the affected theatres would be taken out of use. This would result in a significant loss of system MSK theatre activity. The system theatre demand and capacity modelling shows the system would be unable to absorb this activity elsewhere, resulting in patients waiting longer than 18 weeks for surgery	1. **UHCW – Hospital of St. Cross Theatres – Redevelopment of the North Site – Phase 1 - £48,000,000 –** Demolish and clear the north Rugby site to make like-for-like replacement to enable phase 2. 2. **UHCW – Hospital of St. Cross Redevelopment of the North Site – Phase 2 - £49,100,000 -** Development of an elective care hub for Rugby, including acute, primary, community and third sector services. 3. **GEH – Green Elective Centre – Ward & Theatre - £7,000,000 –** Addition of a 30 bedded modular ward and additional modular theatre to create a self contained elective centre that can function all year round.

Vision for Care: Urgent and Emergency Care (1/2)

As demand for Urgent and Emergency Care continues to rise, our focus is on improving access to appropriate care and delivering early interventions. We will look to simplify our UEC offer through delivering a fully integrated, networked response so that the most appropriate care can be given as quickly as possible.

We will continue to build on the good progress that has been made in improving our performance against the 4 hour wait, same day discharge and average length of stay by further developing our Emergency Care infrastructure through a patient centred care model, improving patient experience and focusing on reducing emergency admissions.

Pipeline Value: £7m

Our Commitment	Capital Plans and Current Projects	Our Pipeline
Increase the same day discharge through a comprehensive Same Day Emergency Care (SDEC) model Providing acute frailty service for 70 hours a week with assessment within 30 minutes of arrival Develop our admission avoidance programme with our PCNs Ensure no patients wait more than 15 minutes for ambulance off load	**Development of Hybrid Theatres at UHCW (£10,045m) – Future Project** This will support the following services: Major Trauma Centre Status; Vascular Surgery Specialty Centre Status and Obstetrics specialist centre status. The facility will support the treatment of major trauma, vascular emergencies, obstetrics emergencies, emergencies requiring IR, TAVI and elective endo vascular surgery providing the ability to undertake multiple surgical interventions within one hybrid theatre for patients who previously would have had to be transferred between theatres and services. Failure to deliver this capital development will undermine the Trust's specialist centre status and mean they will not be compliant with national standards and other specialty guidelines. The absence of this facility has a negative impact on morbidity and mortality.. **Emergency Department Development at UHCW.** **Stage 1 - 2 Resus Bays (£500k) -** The ED stage 1 scheme proposes the development of two additional Resus Bays to provide resilience in the Department for treatment of life-threatening major trauma and emergency patients and forms part of the need to right-size the capacity of the ED at total capital costs of £31,488m. Stage 2 ED scheme proposes further development of the Emergency Department Footprint to meet current and future demands for emergency care.	1. **GEH – Urgent and Emergency Care – CAU Extension - £6,000,000 –** Scheme will enable CAU to relocate creating space on the ground floor to extend A&E, addressing existing issues of capacity and demand 2. **SWFT – Intensive Care Unit - £1,000,000 –** Provision of additional capacity to enable the Trust to respond to increasing demand arising from the ongoing impact of Covid-19

Vision for Care: Urgent and Emergency Care (2/2)

As demand for Urgent and Emergency Care continues to rise, our focus is on improving access to appropriate care and delivering early interventions. We will look to simplify our UEC offer through delivering a fully integrated, networked response so that the most appropriate care can be given as quickly as possible.

We will continue to build on the good progress that has been made in improving our performance against the 4 hour wait, same day discharge and average length of stay by further developing our Emergency Care infrastructure through a patient centred care model, improving patient experience and focusing on reducing emergency admissions.

Pipeline Value: £7m

Our Commitment	Capital Plans and Current Projects	Our Pipeline
Increase the same day discharge through a comprehensive Same Day Emergency Care (SDEC) model Providing acute frailty service for 70 hours a week with assessment within 30 minutes of arrival Develop our admission avoidance programme with our PCNs Ensure no patients wait more than 15 minutes for ambulance off load	**Emergency Care Department George Elliot (£7.75m)** **Phase 1 (£2.765m)** The development of a more appropriately sized Ambulatory Care facility that will result in an increase in throughput of Ambulatory Emergency care cases. Create a dedicated facility to enable frailty assessment ensuring that frail elderly patients are seen in a timely manner and immediately sign posted for the right care. Development of a Medical Day Case Procedure area. Creation of a discharge lounge to enable the safe transfer of stretcher patients awaiting discharge on the day. **Phase 2 (£5m)** Develop/implement additional inpatient capacity of at least 28 beds to provide flex capacity in surge periods, e.g., winter and to provide a decant facility in the summer to allow for the decontamination programme to be undertaken.	1. **UHCW – Hospital of St. Cross Theatres 2023/24 - £7,500,000 –** Complete replacement of theatres. 2. **UHCW – Hospital of St. Cross Theatres 2025/26 - £7,500,000 –** ED Footprint Stage 2&3 – New build modular theatres and critical care 3. **CWPT – Hybrid Theatre – £14,900,000** required to maintain Major Trauma status for trust, new build traditional operating theatre with advanced imaging intensifiers.

Vision for Care: Mental Health Estate Impact

To support the delivery of the Long Term Plan and the 5 Year Forward View for Mental Health we will focus our investment in delivering a step change for mental health services, focusing on prevention and early intervention to support people to actively participate in their own self-care, wellbeing and recovery. By doing this we aim to reduce the length of stay for our patients when admission is needed and to reduce the number of Out of Area Placements we make as a system with a commitment to ultimately remove the need for patients to be treated Out of Area. We will look to deliver mental health services as locally as possible.

Pipeline Value: £294.5m

Our Commitment	Capital Plans and Current Projects	Our Pipeline
To ensure NHS 111 is the single universal point of access for people experiencing mental health crisis by 2023/24 To develop new and integrated models of primary and community mental health care to give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care by 2023/24. By 2023/24 we will introduce menta health transport vehicles, introduce mental nurses in ambulance control rooms. By 2023/24 mental health liaison services will be available in all acute hospital A&E departments and 70% will be at "core 24" standards, expanding to 100% thereafter	**Caludon Centre (Acute Mental Health Inpatient Unit) £9,000,000 -** investment required to address a range of known anti ligature, compliance and qualitative works at the Caludon Centre in line with CQC and NHSI guidance.	1. **CWPT – Single Site Mental Health Inpatient Facility - £250,000,000** - To replace the three Mental Health in-patient units, all of which fall short of current standards and have significant backlog requirements, with a purpose-built facility ideally on a single site in order to secure workforce resilience and economies of scale. 2. **CWPT – Anti Ligature Works PFI - £6,000,000 – Non PFI - £4,500,000 -** Neither of CWPT's mental health in-patient facilities, The Caludon Centre in Coventry and St Michaels Hospital in Warwick, achieve expected environmental standards in relation to anti-ligature risk. In addition, anti-ligature works are also needed at the Trust's two inpatient sites the Manor Hospital and Brooklands. Programme of internal modifications and change of fixtures and fittings in order to minimise ligature risks and achieve compliance with expected national standards**.**

Vision for Care: Learning Disabilities & Autism Estate Impact

To support the delivery of the Transforming Care agenda we will further develop on our existing community services for people with Learning Disabilities and reduce our reliance on in-patient facilities. We are committed to investing in our CWPT infrastructure to ensure that the Trust, recognised as the West Midlands specialist provider for people with learning disabilities and autism continues to operate as a centre of excellence. Our focus is on ensuring joined-up, better coordinated care, delivered by primary care, social care, community teams and the voluntary sector working together in multidisciplinary teams and hub to reduce reliance on hospital admission wherever possible.

Pipeline Value: £138m

Our Commitment	Capital Plans and Current Projects	Our Pipeline
To ensure NHS 111 is the single universal point of access for people experiencing mental health crisis by 2023/24 To develop new and integrated models of primary and community mental health care to give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care by 2023/24. By 2023/24 we will introduce mental health transport vehicles, introduce mental nurses in ambulance control rooms. By 2023/24 mental health liaison services will be available in all acute hospital A&E departments and 70% will be at “core 24” standards, expanding to 100% thereafter	**CWPT –Lyndon House re-provision -** The proposal is to enable the rebuild and re-provision of Lyndon House respite service and broadening of the service offer to allow for admission avoidance and extended assessment (step-up / step-down) placements for children and young people with a learning disability and or/autism for whom a specialist longer term solution will need to be commissioned. The Trust owns a suitable site and has submitted a planning application. Subject to securing capital funding, works could start on site in September 2021 and the new facility could be operational before the end of 2022.	1. **CWPT – Brooklands Site Redevelopment - £135,000,000 -** To replace the current not fit for purpose accommodation on the Brooklands site with a new purpose-built facility. Brooklands provides low and medium secure in-patient secure care for people with LD and Autism and services the whole of the West Midlands and beyond. 2. **CWPT –Lyndon House - £3,000,000 –** Replacement of Children’s respite facility with an extended 8 bed new purpose-built facility. The additional capacity would support the extended assessment of young people with very complex emotional and behavioral difficulties who would otherwise be admitted to hospital or a very expensive independent sector placement, supporting both the Children in Crisis and Transforming Care agendas.

Vision for Care: Primary Care Estate Impact

To support our key priority of providing care closer to home, we will continue to invest in our Primary Care infrastructure, focusing on opportunities to consolidate non-clinical and clinical staff, deliver primary care at scale and integrate our general practice with community services.

We will give people more control over their own health, encouraging collaboration between GPs, their teams and community services as PCNs to increase the services they can provide jointly. We will continue to develop digital-first primary care agenda and continue our commitment to ensuring that care is delivered in the Right Place, at the Right Time and by the Right Person.

Please note this is indicative only and schemes may vary in scope/delivery/timeline depending on a range of external factors

Pipeline Value: £37.9m

Our Commitment	Capital Plans and Current Projects	Our Pipeline
We aim to reduce face-to-face outpatients through GP referral support, referral avoidance and triage and treatment services Ensure faster access to GPs and other primary care staff Continue to prioritise development of our PCNs and our integrated community/neighbourhood teams	**Priory Medical Centre (£6.7-7m):** Due to pressures in capacity two Warwick Town Centre practices (Priory Medical Centre and Cape Road Surgery) merged to become a single practice. The practice currently operates from two sites however an OBC was approved by PCC to relocate onto one central site in Warwick. Build in progress due for completion summer '21 **Whitestone Surgery (£3.68m):** Current pressures in capacity (room utilisation is currently 90%) and housing growth in the area requires additional space. Locality project with key partners and connected with the Transforming Nuneaton/Healthy Towns project. Initial locality review completed with SH, and long list of locality solutions developed. **Foleshill (3.68M)**: A new build development on a site purchased by MIND, which will deliver primary care, pharmacy, community and other services. A key site serving an area of high deprivation targeting improved access. In delivery, completion due early summer '21 **Transforming Nuneaton –** key scheme in early planning, opportunity as part of Healthy Towns Fund	1. **Leamington North PCN – Cubbington Road Surgery - £6,000,000 -** Feasibility study for a new practice location. Part funded through CIL. 2. **Hartshill - £1,000,0000 –** New build GP Practice, part funded through ETTF. 3. **Weddington - £3,500,000 –** New build facility 4. **GP Connect Woodway - £2,400,000 -** To increase clinical rooms capacity and waiting area etc. 5. **Dene & Stour Valley – Shipston Medical Centre - £13,500,000 –** New build project with SWFT on Ellen Badger Hospital site 6. **Arden – Pool Medical Centre - £500,000 –** Increasing capacity 7. **Leamington Town Centre - £6,000,000 –** co-location of Clarendon Lodge and Sherborne Medical Centre to single new build 8. **PCN Estates Planning – TBC –** PCN planning to understand estates requirement to deliver ARRS roles 9. **Rugby PCN – Houlton/CRS Relocation - £4,000,000 –** Response to housing development, locality solution including relocation of Whitehall and CIlifton Road Surgery 10. **Navigation 1 – CoCHC - £1,000,000 –** Addressing capacity issues at Meridian Practice, place project with CHP to improve utilisation.

Section 7

Future Programmes

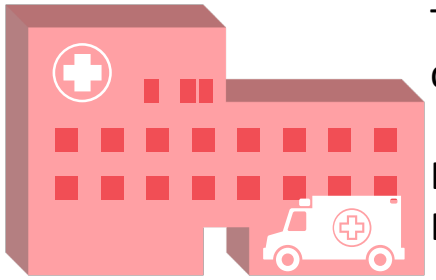
Key Estates programmes: Workstream areas

Pilots & Case Studies

2022 10 booths | **2027** 12 booths | **2032** 13 booths | **2037** 15 booths

Audiology Pilot

Capital Plans and Projects



Theatres developments

Emergency Departments

Other Workstreams

- Land Disposal
- Infrastructure Levy
- Delivery Models
- One Public Estate

Interdependencies

- Workforce
- Operations (Elective and UEC)
- Digital
- Place Based Transformation
- Sustainability
- **Mental Health and CAMHS**
- Data sharing, BI and Analytics
- **Health Inequalities**

GEH – Back Office functions & Maternity clinical space review

Digital Care revolution – Virtual wards

Mental Health Units

Asset Management

NHS Supply Chain

Model Health System model.nhs.uk

SHAPE Strategic Health Asset Planning and Evaluation

and Warwickshire

First Draft v1

Future Capital Priorities (1/2)

Our strategy sets out the emerging priorities for estates as a core enabler to the delivery of the vision for care in Coventry and Warwickshire. There remains a substantial amount of work and key deliverables to develop the strategy and implement the objectives contained within. This document sets out an immediate set of priorities that will continue to develop over time. In developing our process for prioritisation of capital schemes, we have been challenged to consider how proposed schemes support the delivery of the vision of care for the ICS. As projects and the process for prioritising them changes and evolves over time so too will the matrix to ensure that that it continues to support key objectives of delivering care closer to home, reducing pressures on acute provision and how the estate can enable the transformation of care across our ICS. This slide outlines the context, process and criteria for prioritisation as well as some of the key next steps in insuring that the strategic management of capital continues to be a key priority for the ICS.

Prioritisation Process

Context : As mandated by NHSE/I, all capital bids produced by NHS organisations are required to be supported and prioritised by the ICS and included in the ICS Estates Strategy. Whilst that is not to say that the priority rank 1 scheme will always be the first to access capital, it does demonstrate that schemes and capital are being managed at system level therefore optimising the chances that we have as a system to access future rounds of central capital funding.

Process : The development of our prioritisation process and matrix took place through three sessions, with representation from all of our NHS Providers, the CCG and Primary Care.

Workshop 1 was used to reach agreement to the categories and criteria used to assess major schemes as well as reaching agreement on the management of the threshold for schemes to be included in the matrix.
Workshop 2 was used to review the final metrics, categories and format as well as running a demo scoring to enable further challenge and review of the outputs of Workshop 1.

Following this, and in advance of the final workshop, all partner organisations were asked to review their schemes for inclusion and assign weightings against each of the agreed criteria/metrics and metric categories. This information was collated and presented back to the ICS at **Workshop 3** where the final list of prioritised schemes was reviewed and signed off.

Prioritisation Criteria

Eight categories were used in order to assess schemes, each with constituent metrics covering priority areas relevant to the category. The list of categories agreed is as follows and further detail is found in the slides that follow:

The categories above were supported by; a breakdown of constituent metrics; weighted scores for category and individual metric based on consensus priority; narrative description of schemes included and anticipated required capital. Schemes were subsequently scored on a scale of 1-5 against their ability to satisfy each of the metrics which enabled the demonstration of the agreed priority list.

Future Capital Priorities (2/2)

Whilst we have developed a first iteration of our capital prioritisation matrix, we will continue to develop this tool and our methodology to ensure that capital management remains at the forefront of our work. This slide outlines the next steps and our commitment to the ongoing management of the tool, as well as our key drivers for capital investment.

Next Steps and Lessons Learned

Ongoing Maintenance and Management

The development of the prioritisation matrix represents an important first for our system as we transition to ICS status. Not only has it enabled us to gain a better understanding of proposed schemes across our localities but we now have a clear methodology for prioritising our capital expenditure.

However, the priority rankings that we have developed will change as we evolve our process for prioritisation, this forms a key next step in terms of the ongoing maintenance of this tool. Our commitment to evolving this process is as follows:

- We will monitor and update our process through a dedicated Capital Prioritisation workstream which will review scores quarterly and the process more generally on a monthly basis to identify any proposed adjustments to weightings, additions to categories or metrics and in order to reflect changing national and regional NHS priorities.
- Further, and learning from the process we have undertaken so far, we will look to appoint a single arbiter of the scoring process, to allow for greater transparency in the scoring and to ensure that narrative justification is provided against all of our schemes scores.
- We will develop more specific scales for each of the existing metrics and thresholds for the award of the 1-5 scale.
- We will standardise our approach to monitoring and scoring.
- We will develop an approach to the presentation of capital across our schemes, factoring in cashflow, indexation, inflation etc.

Key Drivers for Capital Investment

Building the Required Capacity for System Planned Activity and Facilitating Operational and Corporate Productivity Improvements

Enhancing our Digital Capabilities and Supporting Digitally Enabled Pathway Redesign

Developing Infrastructure in a Sustainable Way

Delivering high quality clinical services and addressing our known clinical risks

Supporting the Health and Wellbeing of our Workforce - Considering the entire estate workforce with a view to sharing resource and working more flexibly

Rationalising, Consolidating and Optimising Our Estate

Expanding Primary Care Capacity to improve access, local health outcomes and address health inequalities

Translating our Drivers into Prioritisation Criteria (1/4)

As part of Workshop 1 in our Capital Prioritisation Process we identified the key criteria against which our schemes would be prioritised, the process here was to translate our key priority areas and drivers as a system into quantifiable metrics and categories that could be used to differentiate our schemes. The challenge was to create meaningful metrics and categories that represented our priorities at system level but importantly did not preclude certain schemes or result in a prioritised list where schemes with significant CapEx attached to them scored highest. Acknowledging that we still have work to do to refine our process for prioritisation the next slides demonstrate our current position and the constituent parts to each of our drivers for capital investment.

Strategic Priorities – 3 Metrics – Weighted Total – 124/800 Marks - 16%

Our first category covers Strategic Priorities. Each of our organisations were required to justify how their scheme was able to satisfy relevant policies at national, system/ICS and Place level. We have worded the metrics in a generic way, the reason for this being that our schemes cover the care spectrum, therefore are guided by policy documents that may differ substantially. Trying to apply a one-size-fits-all policy therefore would discriminate against more specialist schemes. For each answer, our organisations are required to justify their score with associated narrative and the relevant policy.

Strategic Priorities			
Scheme ability to meet relevant National Policies/Priorities	Scheme ability to meet relevant ICS Policies/Priorities	Scheme ability to meet relevant Place Policies/Priorities	**Strategic Priorities Total**
41	41	41	**124**

Estates – 4 Metrics – Weighted Total – 100/800 Marks - 10%

Our Estates prioritisation category covers the key metrics relating to improving our system infrastructure through capital developments. Schemes were assessed against their ability to address existing backlog maintenance liabilities and ranked based on the quantum addressed. The second category assesses ability for schemes to improve organisations compliance, the third addresses Carter Metrics and the final Estates metric is scored against the schemes ability to reduce our system void cost.

Estates				
Scheme reduces organisations Backlog maintenance liabilities	Scheme proposes to address space that does not currently meet NHS standards from statutory/mandatory compliance perspective	Scheme improves organisations performance against Carter Metrics: % Clinical vs non-clinical floor space, Occupied vs Unoccupied & corporate/ administrative functions	Scheme proposes to reduce system void space	**Estates Total**
33	17	33	17	**100**

Translating our Drivers into Prioritisation Criteria (2/4)

Clinical – 5 Metrics – Weighted Total – 134/800 Marks - 17%

Our Clinical metrics category translates our clinical priorities into assessment criteria. Following the weighting process for our categories and metrics, this emerged as our highest scoring category. The metrics here include ability for the scheme to address our known clinical risks as well as exploring deprivation in the locality of the proposed scheme and the number of our patients that stand to benefit from the scheme. We also aligned the metric to our Right Place, Right Care, Right Time commitment with this metric and addressing a known clinical risk awarded a higher weight than other clinical categories with a potential 29 points.

Clinical						
Scheme proposes to address a known clinical risk	Number of patients that will benefit from the scheme	Scheme proposes to reduce waiting times or improve access to care thereby allowing patients to move more quickly through the system	Scheme proposes to support right place, right care, right time by either; improving community provision, improving availability of step-down facilities or reducing pressure on acute hospital beds	Scheme identifies opportunities to improve collaboration/ coordination of clinical service provision between partner organizations or reduces variation in clinical services	Proposed locality of scheme addresses an area of high deprivation IMD Metric 5 = Decile 1-2 4 = Decile 3-4 3 = Decile 5-6 2 = Decile 7-8 1 = Decile 9-10	Clinical Total
29	19	19	29	19	19	**134**

Workforce – 5 Metrics – Weighted Total – 85/800 Marks – 11%

Our Workforce metrics award marks based on the ability of our schemes to respond to our system wide workforce priorities and alignment to the NHS People Plan. Marks are awarded for ability to improve workforce efficiencies through better availability of training facilities, for better enabling agile working and for general improvements to staff environment. The highest weighted metrics in this category are awarded to schemes able to demonstrate improvements in workforce productivity and for addressing known system workforce risks.

Workforce					
Scheme will identify opportunities to improve flexibility of workforce through adoption of agile working	Scheme identifies opportunities to improve workforce productivity	Scheme proposes to improve staff environment	Scheme identifies opportunity to support areas where services are vulnerable because of workforce challenges/risks	Scheme identifies opportunities for increased provision of training to staff and upskilling of staff	Workforce Total
17	21	13	21	13	**85**

Translating our Drivers into Prioritisation Criteria (3/4)

Digital – 2 Metrics – Weighted Total – 68/800 Marks - 9%

Our Digital category explores how closely our schemes align to the What Good Looks Like (WGGL) Framework and to ICS Digital Strategy Objectives. As with our Strategic Priorities category the wording of this category is left intentionally generic so as to allow for narrative justification regarding how the schemes align to the frameworks in question. The Digital agenda was the subject of discussion throughout our capital prioritisation process and will require further iterations to properly define this category moving forward. With enhancing our digital capabilities being a key priority for our health system in improving population health outcomes, this is a key factor in prioritising schemes but there is work to do to explore how to assess this category. We are undertaking a Digital prioritisation process in January/February 2022 after which we will we will better understand whether to include this in our existing capital prioritisation process or sit adjacent to it, particularly in view of the generally separate allocations for digital funding.

Digital		
Scheme aligns to What Good Looks Like (WGGL) National Framework	Scheme aligns to ICS Digital Strategy Objectives	**Digital Total Score**
34	34	**68**

Sustainability -4 Metrics – Weighted Total – 94/800 Marks – 12%

The Sustainability category for our capital prioritisation matrix assesses how well our schemes support our priority of achieving a Net Zero Carbon NHS. We prioritised our schemes based on their improved use of renewable energies, reducing our system residual waste, ensuring construction Net Zero Carbon and in reducing unnecessary patient/staff travel.

Sustainability				
Scheme proposes to improve Organisation performance in terms of clean renewable energy usage	Scheme proposes to reduce volumes of residual waste	Scheme proposes to ensure construction spend is targeted at net zero carbon	Scheme identifies opportunities to improve staff/patient travel sustainability, offering lower carbon travel choices or reducing the need for unnecessary travel	**Sustainability Total**
24	24	24	24	**94**

Translating our Drivers into Prioritisation Criteria (4/4)

Finance – 3 Metrics – Weighted Total – 129/800 Marks - 16%

After our weighting and scoring process, Finance emerged as our second highest value metric category in terms of overall weighting. Here, our schemes were assessed against improving our bottom-line position at organisational level, with a view to addressing our system deficit. This scored 67 points, our highest overall weighted score across all categories and metrics. Next, our schemes were assessed against ability to generate capital receipts for reinvestment into the system and whether the schemes were supported in part by earmarked funding.

Finance			Finance Total Score
Scheme proposes to improve organisations bottom line/revenue affordability position	Scheme provides opportunity to generate transitional/one-off capital receipt	Scheme is supported in part by earmarked funding	
67	31	31	**129**

Readiness to Deliver – 4 Metrics – Weighted total – 66/800 – 8%

Our Readiness to Deliver category provides us with an alternative way of prioritising our schemes. Here, we assessed how 'primed' our schemes were to be delivered should capital funding be made available. We assessed against timescales for delivery, requirements for public consultation, availability of Business Cases and planning documentation. Whilst this metric category received the lowest overall weighting across our 8 categories, it nonetheless allows us to quickly demonstrate which schemes can be delivered in-year and within defined timescales.

Readiness to Deliver				Readiness To Deliver Total Score
Scheme is realistically deliverable within years; 1-2 (score 5) 2-4 (score 4) 4-6 (score 3) 6-8 (score 2) 8+ (score 1)	Scheme is likely to be subject to the requirement for public consultation; yes (score 1), potentially (score 3), no (score 5)	Scheme is supported by the availability of underway business cases (score 1 if no) (score 3 SOC) (score 4 OBC) (score 5 FBC or No Business Case Required)	Scheme is supported by approved/outline planning documentation (score 5 yes, 1 no)	
21	15	15	15	**66**

Our Capital Roadmap

The tables below set out the indicative list of our prioritized major capital schemes capable of being delivered should capital funding be made available to deliver them, it also sets out the required capital total by Trust and at system level.

2022 – 2024

Trust	Scheme	Capital Requirements
CWPT	1. Anti-Ligature Works 2. Hawkesbury Lodge Refurb 3. Lyndon House 4. Brooklands RIO/ASD – Phase 3	£15,800,000
SWFT	1. Warwick Hospital Development – Phase 1 2. Intensive Care Unit National Directive	£41,000,000
GEH	1. Car Park 2. Community Diagnostic Hub – Phase 2 3. Green Elective Centre – Ward & Theatre 4. Urgent and Emergency Care and CAU Extension 5. Mortuary Extension	£32,500,000
UHCW	1. Linear Accelerators 2. CEF Rugby – Net Zero Carbon 3. Hospital of St.Cross Theatres Phase 1	£13,600,000
PC	1. PCN Estates Planning 2. Hartshill 3. Navigation 1 – CoCHC 4. Dene & Stour Valley – Shipston Medical Centre 5. Arden – Pool Medical Centre	£16,000,000
	System Requirements	£118,900,000

2024 – 2026

Trust	Scheme	Capital Requirements
CWPT	1. Brooklands Site Redevelopment 2. Coventry City Centre Reconfiguration	£139,250,000
SWFT	1. Stratford Hospital – Reprovision & Community Diagnostic Hub	£10,600,000
GEH	1. Reconfiguration of Clinical Space in Maternity Building 2. Reconfiguration of Office Space/Agile Working	£30,000,000
UHCW	1. Hybrid Theatres 2. Community Diagnostic Hub 3. Hospital of St.Cross: Gastro/Endoscopy Expansion 4. Hospital of St.Cross – Redevelopment of North of site – Phase 1 5. Hospital of St.Cross – Redevelopment of North of site – Phase 2	£116,600,000
PC	1. Rugby PCN – Houlton/CRS – Relocation 2. Leamington North PCN – Cubbington Road 3. GP Connect – Woodway	£12,400,000
	System Requirements	£308,850,000

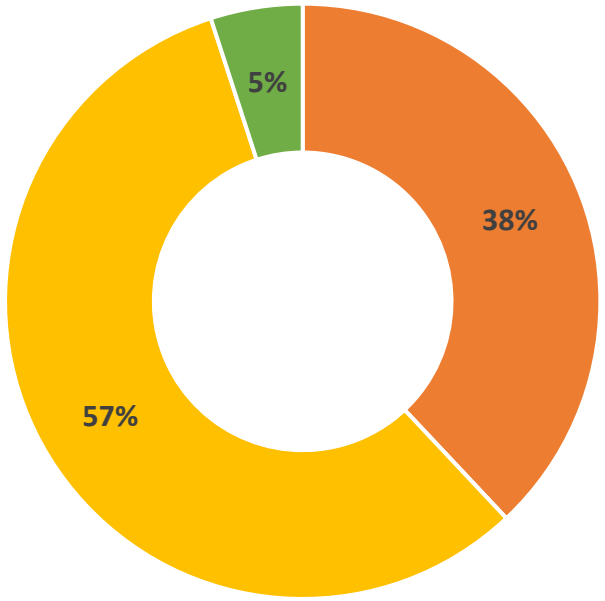
2026 Onwards

Trust	Scheme	Capital Requirements
CWPT	1. Single Site Mental Health Inpatient Facility 2. St. Michaels Older Adults/Physical Complexities Centre of Excellence 3. Stanley & Pembleton Dementia Centre of Excellence	£267,500,000
UHCW	1. Hospital of St. Cross Theatres	£7,500,000
PC	1. Leamington Town Centre	£6,000,000
	System Requirement	£281,000,000

Investment by Service Line – Capital Requirements Breakdown

The breakdown of our capital requirements provides an insight into our priority investment areas as well as highlighting risks that exist within our system estate. This slide outlines the division of our investment required by service area across Mental Health, Primary Care and Acute and Community provision.

Breakdown of Requirements



Breakdown	Percentage
Primary Care	5%
Mental Health, Learning Disabilities, and Autism	57%
Acute and Community	38%

Analysis

Mental Health, Learning Disabilities and Autism:
Much of our proposed investment is focused on transforming our mental health inpatient care by addressing inappropriate, not fit for purpose estate at Brooklands (£135m) and the creation of a single site inpatient mental health facility (£250m). Nonetheless, Mental Health investment remains a key priority area for us in demonstrating our commitment to the 5 Year Forward View for Mental Health and the NHS Long Term Plan.

Primary Care:
Whilst Primary Care only accounts for 5% of the total capital investment requirement across our system, this is due to the nature of primary care investment which is generally lower in CapEx value. Our commitment to Primary Care investment is demonstrated by our priority list, with 7 of our top 20 schemes focusing on investment into our primary care infrastructure.

Acute and Community:
Our commitment to investment in our acute and community care is demonstrated again in our prioritised list of capital projects, with 5 of the top 10 schemes targeting improvements to our acute and community care provision.

Disposal Plan

There are significant opportunities for disposals of surplus land in the Coventry and Warwickshire area through reconfiguring our existing asset base, improving our utilisation and rationalizing our estate, by doing so we can generate capital receipts for reinvestment into our health economy and unlocking surplus sites for development, including for housing. The plan below includes estimated disposal values. We are in the progress of formulating plans to identify the timescales for the disposal of our "remaining years" pipeline as outlined below and will explore further disposal opportunities through our Disposals and Void workstream as part of our revised governance structure

The tables below set out the indicative list of our prioritized major capital schemes capable of being delivered should capital funding be made available to deliver them. It also sets out the required capital total by Trust and at system level. **Please note this is indicative only and schemes may vary in scope/delivery/timeline depending on a range of external factors**."

Disposal – Headline Financial Impacts: Surplus Land & Housing Summary by Financial Year (estimate year of disposal completion)

Deliverable / Financial Year	2017 – 19	2019 – 20	2020 – 21	2021 – 22	Remaining Years	Totals
Land Area (Ha)	0.122	0.1	0.21	1.6	7.41	**9.442**
Estimated disposal value £m	1.05	0.39	0.5	1.6	10.4	**13.94**
Estimated Housing Units	9	10	4	65	262	**350**
Gross Running Cost reduction £m	0.07	0.02	0.05	0.14	0.32	**Tbc**

Disposal Status – Headline Impact	No. of Sites	Land Area (Ha)	Estimated disposal value £m	Total # Estimated Housing Units	# Housing Units for NHS Staff	Gross Running Cost reduction £m	Cost to Achieve Vacant Possession £m
Vacant and Declared Surplus and disposal transaction in progress	0	0	0	0	0	0	0
Vacant and Declared Surplus/ disposal subject to marketing	2	0.122	1.05	9	0	0.07	0.02
Vacant but not yet Declared surplus	1	0.208	0.5	4	0	0.05	0
Occupied - OBC approved to achieve vacant possession	0	0	0	0	0	0	0
Future opportunity subject to strategy/ feasibility	13	9.292	21.28	436	0	1.482	21
Other Sites	0	0	0	0	0	0	0
Totals	16	**13.662**	**22.83**	**449**	0	1.602	21.02

Financial Drivers, Challenges and Opportunities

Prior to 01 April 2021 we had three CCG organisations in Coventry and Warwickshire. These were Coventry and Rugby CCG, Warwickshire North CCG and South Warwickshire CCG. These organisations have now merged to form the NHS Coventry and Warwickshire CCG. The merger of the three CCGs provides a clear opportunity to generate financial efficiencies as well as streamlining our governance.

We have identified seven key action areas to reduce the financial pressures faced by our system. These are; Creating a financially sustainable future; ensuring people keep well and out of hospital whilst ensuring best possible value from service provision; Becoming more efficient; focusing on recurrent efficiency and productivity improvement; Ensuring best possible value from assets; maximising the value gained from the estate and rationalising wherever possible; Capital; managing capital collectively to minimise risk and generate the greatest system return on investment; Workforce; creating a sustainable system wide workforce and the elimination of high cost temporary staff; Mental Health Investment; meeting the Mental Health Investment Standard for each of the 5 years of the plan; Risk; demonstrating commitment to the level of transformation required for sustainability
The system are exploring opportunities to work together better across estates, finance, governance, HT, IT, Payroll and procurement, with a view to optimising and standardising processes as much as possible across provider organisations. The objective behind this and the priorities for coming years are to; Reduce the cost of back-office functions across Coventry and Warwickshire by standardising functions and sharing best practice; Reduce duplication and variation in clinical support services; Help front line clinical staff shape the most efficient ways of working.

Whilst the NHS organisations are committed to delivery, the transformation of the estate to support the emerging ICS priorities will require a combination of flexibility in the use of existing cash resources across the ICS footprint, access to sources of borrowing and innovative finance and availability of national PDC funding. A summary of the NHS provider 5-year capital plans inside and outside the system capital envelope is provided below.

Inside System Capital Envelope

Provider	2021-22 F/Y Plan £000s	2022-23 F/Y Plan £000s	2023-24 F/Y Plan £000s	2024-25 F/Y Plan £000s	2025-26 F/Y Plan £000s	System 5/Y Plan £000s
CWPT	6,734	23,414	45,365	35,750	10,800	**122,063**
GEH	6,600	6,617	6,800	5,642	5,837	**31,496**
SWFT	11,929	17,149	8,374	8,062	8,035	**53,383**
UHCW	21,881	55,467	39,887	15,138	17,490	**149,378**
Total	**47,144**	**102,647**	**100,426**	**64,592**	**42,162**	**356,320**

Outside System Capital Envelope

Provider	2021-22 F/Y Plan £000s	2022-23 F/Y Plan £000s	2023-24 F/Y Plan £000s	2024-25 F/Y Plan £000s	2025-26 F/Y Plan £000s	System 5/Y Plan £000s
CWPT	4,535	2,362	400	410	410	**8,117**
GEH	-	-	-	-	-	**-**
SWFT	10,157	-	-	-	-	**10,157**
UHCW	29,519	23,085	10,408	10,060	5,511	**78,583**
Total	**44,211**	**25,447**	**10,808**	**10,470**	**5,921**	**96,857**

Alternative Funding Sources

Given the constraints on capital, we have been considering the ways in which the vision for the estate change can be funded. This strategy sets out the need for both transformational projects and improvements to the condition of the existing estate. Although the business case for tackling poor estate condition can be strong (though ongoing savings in running and maintenance costs), the funding opportunities are more limited. The options for public and private capital are illustrated below as well as some alternative routes of funding currently being explored across the system.

Land Disposal

- Across our ICS we will look to land disposal as a source of capital investment.
- Show example from Disposals from Previous Estate Strategy.
- We will also look to explore release of land through long leases, sharing revenue and through adoption of agile working (see Lewes House Pilot).

S106 and Community Infrastructure Levy

- Section 106 and CIL provides us with an opportunity to seek contributions towards the cost of infrastructure including health for new developments through the town planning system. We have developed a specific Task and Finish workstream dedicated to exploring these opportunities.

Alternative Delivery Models

- We are also exploring how alternative delivery models can unlock value in our NHS estate for example.
- Pilot utilisation studies of back office functions at Lewes House, exploring the possibility to adopt open-plan offices to free-up space in the maternity building.

Charities / Third Sector

- We will look to explore the opportunities presented by working together with charities and the third sector across our system to secure investment to improve our estate environment.

One Public Estate

- We are looking to strengthen our ties with One Public Estate in the coming years, we have a nominated attendee who represents our system at the One Public Estate board and we will look to build on the ongoing OPE project at GEH with a view to exploring the opportunities presented by One Public Estate Funding.

Private Finance

- Our partners have experience in operating and managing estates through PFI contracts.
- We will continue to explore the opportunities presented by PFI as we develop our capital project pipeline.

Asset Management Workstream

The Asset Management workstream will aspire towards continuous review and improvement of asset management across our ICS. The following priority areas and our commitment to them are found below:

Objective	Description
Ongoing Asset Management	Working in conjunction with the Disposal and Void workstream to drive the reduction of ICS Void Space
Pan ICS Procurement	Moving towards shared procurement across our ICS and greater collaboration with our NHS Supply Chain in order to realise cost efficiencies and economies of scale
ERIC Data	Developing an ICS approach to ERIC data recording, analysis, metrification and reporting
Model Hospital	Developing an ICS approach to the use of the Model Hospital and its application for Benchmarking
Backlog Maintenance	Generating a better understanding of the quantum of ICS backlog maintenance liabilities and ongoing management/reduction
SHAPE	We will commit to developing our SHAPE atlas in order to create a single repository for our estates data
Operational Management of Estate – Clinical and Non-Clinical Space & unoccupied space	To work towards all Trusts operating with a maximum of 35% non-clinical space and 2.5% unoccupied space
Premises Assurance Model	To work towards an ICS approach to the production and ongoing revisions of Trust Premises Assurance Models

Disposals and Void Workstream

The Disposals and Void workstream will aspire to work collaboratively across our localities and our partner organisations to reduce our system void space and to identify opportunities to release surplus land for disposal. The following priority areas and our commitment to them are found below:

Objective	Description
Surplus Land & Disposal Tracker	Develop, monitor and keep under review our Strategic Disposals Tracker
Void Space	Review our system void space to identify potential projects that could support better utilisation of space
Capital Schemes	Work in conjunction with the Capital workstream to monitor schemes, project and programmes where opportunity exists to release surplus land
Local Authorities	Develop greater partnership and collaborative working with our local authorities to explore opportunities to identify projects to reduce void.
Digital	To explore alternative ways of delivering our clinical services, including the use of digitisation to reduce reliance on bricks and mortar solutions and free up or better use our existing asset base
Disposals Strategy	The group will look to develop our ICS Disposals Strategy, identifying key priority areas and a system solution to generating capital receipt
Void Strategy	The group will look to develop our ICS Void Strategy, exploring pilot utilisation studies targeted at reducing void space and developing an agreed approach to improving the management of our estate.
Agile Working - Corporate and Administrative Functions	Explore opportunities to develop agile working across our system. To work towards shared service consolidation or outsourcing of corporate and administrative functions

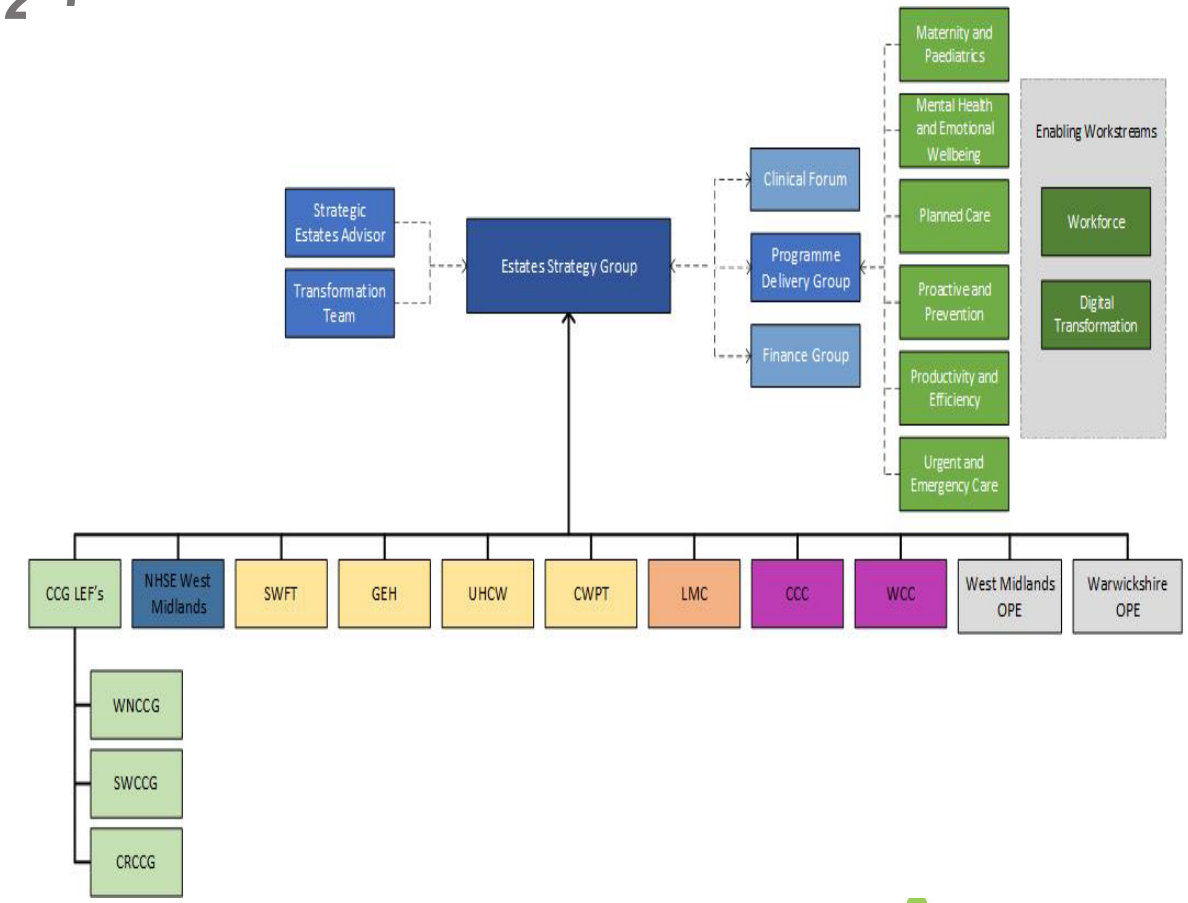
Section 8

Governance and Delivery Plan

Governance Overview (1/2)

This section describes our governance and delivery arrangements for the estate. As part of the development of our ICS Estate Strategy we have reviewed and streamlined our governance structure. The former governance structure is found on this slide with several Local Estates Forums feeding into the Estates Strategy Group which in turn reported into the Clinical Forum, Programme Delivery Group and Finance Group with attendance from all our NHS partner organisations, our three former CCGs now merged into one CCG organization as well as NHSE/I, OPE and Primary Care. Whilst effective in delivering our objectives as a Integrated Care System in recent years, the previous governance structure was limited by extensive reporting lines, lack of clear and specific objectives and outputs to guide each Local Estates Forum and limited alignment to our One Public Estates partners.

The Estates Strategy Group oversees the estates delivery plan for our ICS, providing oversight and coordination to organisations regarding the definition of scope for any estate work activity; coordination of business cases; risk management and monitoring progress of estate projects that impact on other workstream programmes. The group is ultimately accountable to the Coventry and Warwickshire Integrated Care System Board, reporting up through the Programme Delivery Group and the Partnership Executive Group. Whilst we have updated our overall estates governance structure as per the next slide, the Estate Strategy Group will continue to act as the decision-making body in guiding strategic estates decisions. The Terms of Reference for this group are summarized in the following slides.



Governance Overview (2/2)

As part of the development of our ICS Estate Strategy we have reviewed and streamlined our governance structure. We will implement new, focused workstream groups to enable a more cohesive, integrated approach to the management of our void space, disposals, efficiencies and capital plans and prioritisation across our system.

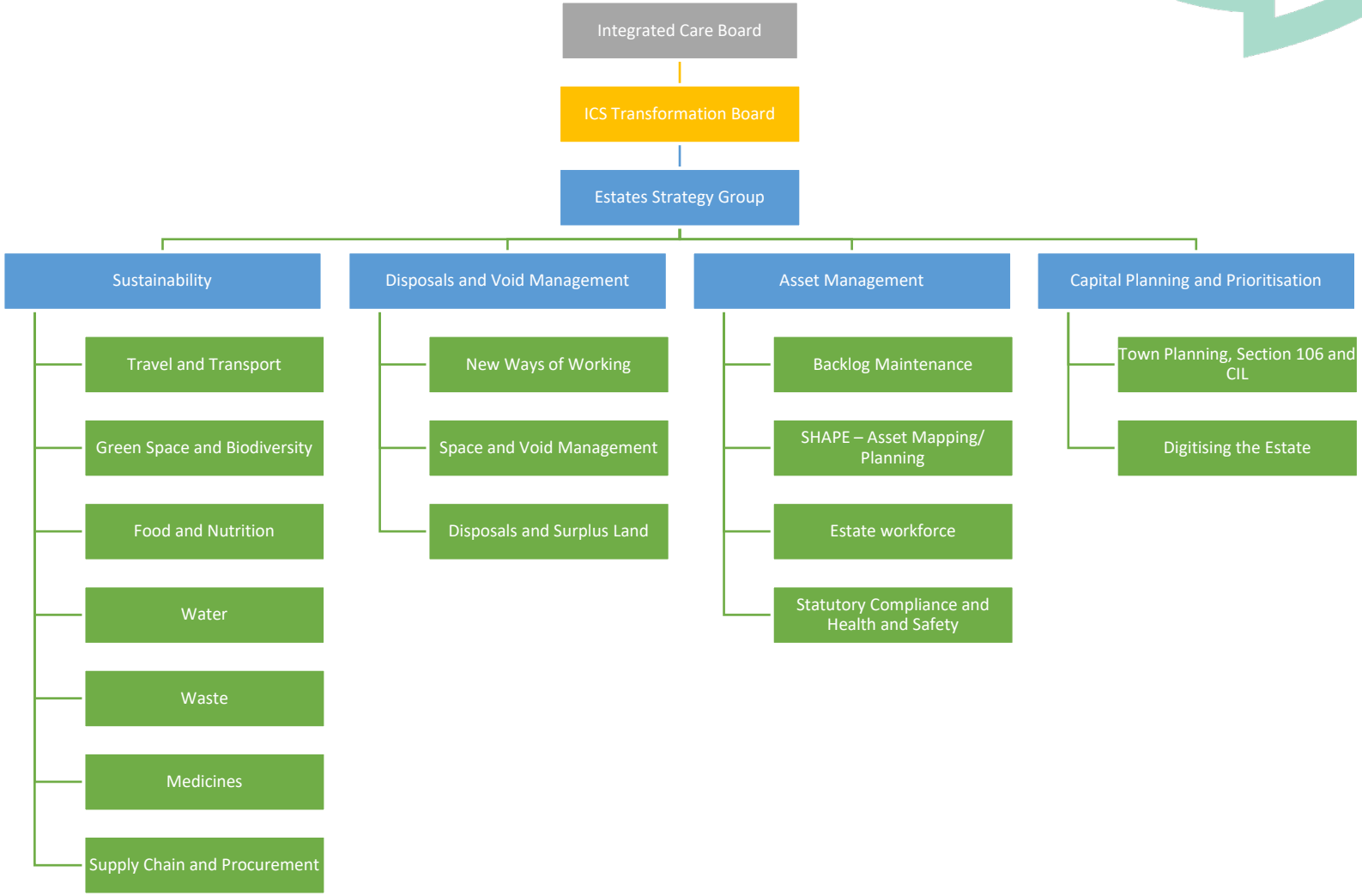
Our revised governance and operating model shown here, will empower our senior decision makers across the ICS to set the strategic direction for the estate across our localities and will enable closer strategic alignment between our clinical priorities and estate developments.

The revised governance will simplify reporting and output delivery, with a single Estates Strategy Group with agreed membership from our CCG, NHS providers, Local Authorities, Property Companies, OPE and NHSE/I. Workstream groups will feed into the ESG and cover Disposals and Void Management, Asset Management and Capital Planning and Prioritisation.

Task & Finish Groups will feed into each of these workstream groups with clear terms of reference and agreed time constrained outputs with each Task and Finish Group responsible for addressing our estates priorities. Within the Disposals and Void Workstream, the groups will cover; New Ways of Working; Space and Void Management; Disposals and Surplus Land.

Our Asset Management Task & Finish Groups will focus on; Backlog Maintenance; SHAPE: Estates Strategy and Statutory Compliance and Health and Safety.

Our Capital Group will focus on reviewing and updating our revised Capital Prioritisation Matrix as well as beginning to generate a strategic system approach to the management of Town Planning, Section 106 and CIL as well as interfacing with the digitizing the estate Task & Finish Group.



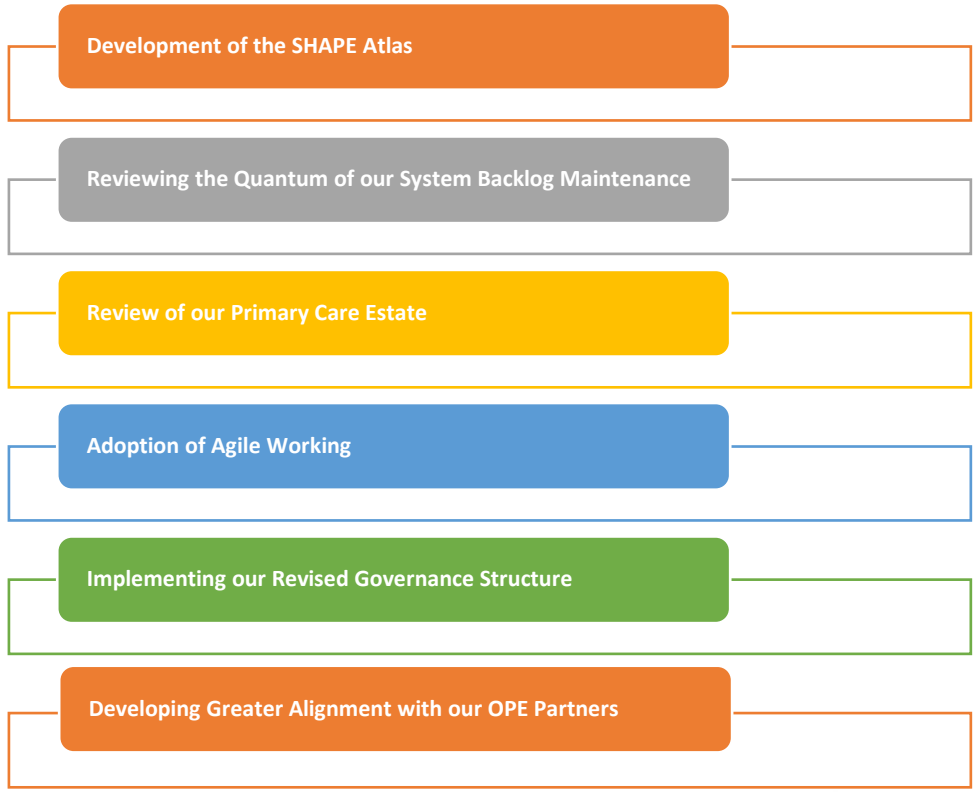
Section 9

Delivering our Strategy

Delivering the Future: Our Partnership Commitments (1/2)

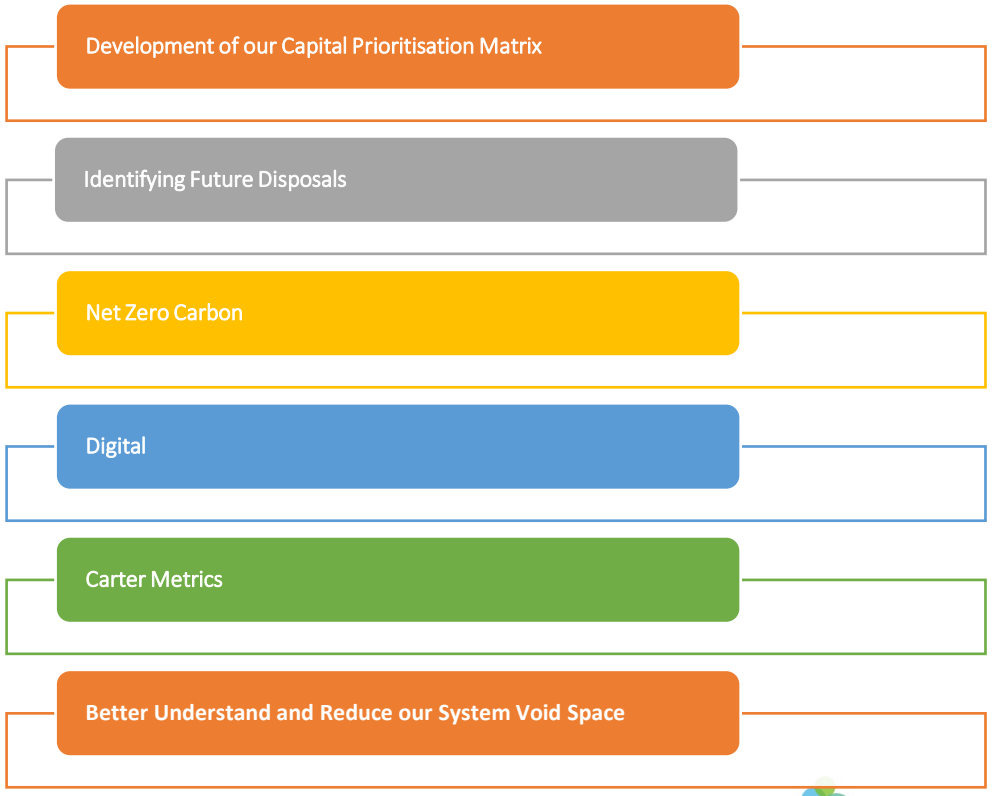
We have developed 13 Partnership Commitments that will enable us to continue to drive forward our clinical model of care with estates acting as a key enabler, allowing us to optimise the care we provide to our citizens and driving better use of our existing asset base. Our 13 Commitments are:

1. **Development of the SHAPE Atlas:** We will adopt the management and use of SHAPE across our geography to better manage and map out our estate with a view to identifying opportunities to better co-locate and coordinate our service provision
2. **Reviewing the Quantum of our System Backlog Maintenance Liabilities**: We will review our existing backlog maintenance liabilities to understand where the significant risk lies and address this
3. **Review of our Primary Care Estate in terms of tenure, GIA etc.:** We will review our Primary Care estate to better understand our tenancy agreements, the quality of our space and how we can better deliver primary care to our citizens
4. **Adoption of Agile Working:** We will build on the pilot studies we completed as part of this estate strategy with a view to the scaling up our adoption of Agile Working practices
5. **Implementing our Revised Governance Structure:** We will implement our revised governance structure and ensure outputs are delivered in line with agreed timescales
6. **Developing Greater Alignment with our OPE Partners:** We will look to strengthen ties with our OPE Partners to



Delivering the Future: Our Partnership Commitments (2/2)

7. **Development of our Capital Prioritisation Matrix:** We will ensure that our Capital matrix is developed and reviewed continuously through our dedicated Capital Pipeline and Planning Workstream
8. **Identifying Future Disposals:** We will review the entirety of our estate to identify future disposal opportunities, generating capital receipt that we can reinvest into our health economy
9. **Net Zero Carbon:** We will continue to work towards delivering a Net Zero Carbon NHS, focusing on adoption of the NHS Green Plan across our organisations
10. **Digital:** We will continue to adopt a Digital first approach when considering estates developments, and continue to work collaboratively with our Digital Workstream
11. **Carter Metrics:** We will prioritise alignment to the Carter Metrics with the focus of optimizing the utilisation of our estates
12. **Better Understand and Reduce our System Void Space:** We will explore the void we currently hold across our system and develop plans to reduce this with a view to operating a zero-void estate



Programme Risks and Mitigations

This section describes the key risks and mitigations at a programme level. Individual workstreams, Task & Finish groups, projects and activity will have their own specific risks and issues which will be reflected within the individual business cases and materials underpinning those schemes/projects/workstreams. The below outlines the key system risks in delivering the objectives of this Estate Strategy.

Programme Risk	Description	RAG Status	Mitigating Action
Insufficient Resource	Risk of inability to deliver estate strategy visions at programme and project level due to lack of dedicated resource provision.		We commit to the appointment of a dedicated Programme Director for our ICS Estates Programme to manage and oversee progress against our key priority areas.
Required Capital Investment to deliver our objectives exceeds funds available to the system	As part of the development of this Estate Strategy we have developed an extensive programme of major capital works to transform the delivery our healthcare. The total value of these works is significant and presents a risk in terms of limited availability of capital funding.		Prioritisation to be monitored on an ongoing basis at system and organisation level. Alternative funding routes to be explored through the dedicated Capital Workstream and priority projects to be identified exploring better ways of utilising our existing estate.
Insufficient capability and capacity to deliver on estate strategy	There is a risk that delivering this estate strategy will be hampered by the significant burden of managing Covid-19 recovery and the substantial change coming tied to our transition to ICS.		We will continue to review resource across our system and the appointment of our estates Programme Director will ensure that priorities outlined in this document are delivered.
True cost of our estate -Lack of consistency and reporting across the ICS	Limits the ability to benchmark our services from a cost perspective and limits our ability to collate estates data.		We will look to adopt the use of the SHAPE atlas, as part of this process we will complete a large-scale review of our asset base.

Glossary

Acronym	Definition
ICS	Integrated Care System
ICS	Integrated Care System
PCN	Primary Care Network
CCG	Clinical Commissioning Group
CWICS	Coventry and Warwickshire Integrated Care System Trust
SWFT	South Warwickshire Foundation Trust
UHCW	University Hospitals Coventry and Warwickshire Trust
CWPT	Coventry and Warwickshire Partnership Trust
GEH	George Elliot Hospitals Trust
GP	General Practitioner
NHS PS	NHS Property Services
CHP	Community Health Partnerships
LA	Local Authority
OPE	One Public Estate
CCC	Coventry City Council
SHAPE	Strategic Health Asset Planning and Evaluation

Acronym	Definition
LTP	Long Term Plan
5YFV	5 Year Forward View
LGA	Local Government Association
OOH	Out of Hospital
OOA	Out of Area
BaME	Black and Minority Ethnic
PFI	Private Finance Initiative
ONS	Office of National Statistics
JSNA	Joint Strategic Needs Assessment
EICS	Education Health Care Plan
QOL	Quality of Life
LSOA	Lower-layer Super Output Areas
WCC	Warwickshire County Council
EPR	Electronic Patient Records
i-SPA	Integrated Single Point of Access
CDH	Community Diagnostic Hub
WMCA	West Midlands Combined Authority
PAM	Premises Assurance Model

Acronym	Definition
IMD	Index of Multiple Deprivation
CQC	Care Quality Commission
STP	Sustainability and Transformation Plans
StX	Hospital of St. Cross
MSK	Musculoskeletal
CAU	Clinical Assessment Unit
A&E	Accident & Emergency
SDEC	Same Day Emergency Care
UEC	Urgent and Emergency Care
LD	Learning Disabilities
PCC	Primary Care Committee
ETTF	Estates and Technology Transformation Fund
CIL	Community Infrastructure Levy
HBN	Health Building Note
GIA	Gross Internal Area
NHSE/I	NHSE England and Improvement