Coventry and Warwickshire Integrated Board (Shadow)

Papers for the Meeting

18 May 2022, held via MS Teams

14.00 – 16.00

Coventry and Warwickshire
Health and Care Partnership

COVENTRY AND WARWICKSHIRE INTEGRATED CARE BOARD (SHADOW)

Meeting Held on Wednesday 18th May 2022
14:00 – 16:00 via Microsoft Teams

A G E N D A

No	Time	Item	Presenter	Enclosure	Pack No	Purpose
1. Standing Items						
1.1	14:00	Welcome and Apologies	Chair	Verbal		
1.2	14:00	Confirmation of Quoracy	Chair	Verbal		
1.3	14:05	Declaration of Interest	Chair	Enclosure A	Pack 1	Information
1.4	14:05	Minutes of the meeting held on 16th March 2022	Chair	Enclosure B	Pack 1	Endorsement
1.5	14:05	Matters Arising/Action Schedule	Chair	Enclosure C	Pack 1	Information
1.6	14:10	ICS Chair Designate Report	Chair	Enclosure D	Pack 1	Information
1.7	14:20	ICS Chief Executive Designate Report	Phil Johns	Enclosure E	Pack 1	Information
1.8	14:30	Risk Register	Rachael Danter	Enclosure F	Pack 1	Endorsement
Aim One: Improving outcomes in population health and healthcare						
2.1	14:40	Ockenden – One Year On	Jo Galloway	Enclosure G	Pack 1 Pack 2	Information
Aim Two: Tackling unequal outcomes, experience and access						
3.1	14:55	Health Inequalities Strategic Plan	Rachel Chapman	Enclosure H	Pack 1 Pack 2	Endorsement

3.2	15:05	Cancer Performance Report	Ali Cartwright	Enclosure I	Pack 1 Pack 2	Endorsement
3.3	15:15	Performance Report	Ali Cartwright	Enclosure J	Pack 1 Pack 2	Information
Aim Three: Enhancing productivity and value for money						
4.1	15:20	System Financial Update	Adrian Stokes	Enclosure K	Pack 1	Information
Aim Four: Supporting the broader social and economic development of Coventry and Warwickshire						
5.1	15:30	Transition update including System Development Plan and Due Diligence	Rachael Danter	Enclosure L	Pack 1 Pack 2	Information
5.2	15:45	Integrated Care Board Community Involvement Strategy	Nigel Minns	Enclosure M	Pack 1	Endorsement
Transition to ICS						
6.1	15:55	Constitution and Governance Handbook (including Decisions and Functions Map)	Phil Johns	Enclosure N	Pack 1 Pack 2	Endorsement
Information						
7.1	16:00	Schedule of Business for the Board of the ICB	Anita Wilson	Enclosure O	Pack 1	Information
8.1	16:00	Any Other Business	Chair	Verbal		

Dates of Future meetings:

Date	Time	Venue
Wednesday 22nd June 2022 Development session	1.00 - 4.00pm	Face to Face: Committee Room 3, Council House, Earl Street, Coventry, CV1 5RR
Friday 1st July 2022 ICB Meeting (Public)	10.00-12.00am	Virtual by Microsoft Teams
Wednesday 20th July 2022 ICB Meeting (Public)	2.00 - 4.00pm	Virtual by Microsoft Teams
Wednesday 17th August 2022 Development session	1.00 - 4.00pm	Face to Face. Venue TBC
Wednesday 21st September ICB Meeting (Public)	2.00 - 4.00pm	Virtual by Microsoft Teams

Wednesday 19th October 2022 Development session	1.00 - 4.00pm	Face to Face. Venue TBC
Wednesday 16th November 2022 ICB Meeting (Public)	2.00 – 4.00pm	Virtual by Microsoft Teams
Wednesday 21st December 2022 Development session	1.00 - 4.00pm	Face to Face. Venue TBC
Wednesday 18th January 2023 ICB Meeting (Public)	2.00 - 4.00pm	Virtual by Microsoft Teams
Wednesday 15th February 2023 Development session	1.00 – 4.00pm	Face to Face. Venue TBC
Wednesday 15th March 2023 ICB Meeting (Public)	2.00 – 4.00pm	Virtual by Microsoft Teams

Declarations of Interest

Under the Health and Social Care Act 2012, there is a legal obligation to manage conflicts of interest appropriately. ***Where possible, any conflict of interest should be declared to the Chair of the meeting as soon as it is identified in advance of the meeting.*** *Where this is not possible, it is essential that at the beginning of the meeting a declaration is made if anyone has any conflict of interest to declare in relation to the business to be transacted at the meeting. An interest relevant to the business of the meeting should be declared whether or not the interest has previously been declared.*

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (of more than 5% of the issued shares), partner or owner of a private or not for profit company, business or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A consultant for a provider; • In secondary employment; • In receipt of a grant from a provider; • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for CQC or NICE; • A medical researcher.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • A member of a political party; • Suffering from a particular condition requiring individually funded treatment; • A financial advisor.

Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). This should include: • Spouse / partner; • Close relative e.g., parent, [grandparent], child, [grandchild] or sibling; • Close friend; • Business partner.

Coventry and Warwickshire Integrated Care Board (Shadow) - Register of Interests **ENCLOSURE A**

All actions in response to declared conflicts of interests at ICS Shadow Body Meetings are at the discretion of the Chair

Current	First Name	Surname	Current position held	Declared Interest (name of the organisation and nature of business)	Type of Interest					Date of Interest	
					Financial Interest	Non-Financial Professional Interest	Non-Financial	Non-Financial Personal Interest	Indirect	Declared	To
Y	Pamela	Bradbury	Non-Executive Member	Daughter works for Adult Community Services, Out of Hospital Collaborative South Warwickshire NHS FT					✓	Apr-22	Current
Y	Glen	Burley	Chief Executive of South Warwickshire NHS FT and George Eliot Hospital	Spouse is employed as Practice Nurse at Rother House Medical Centre					✓		Current
Y	Melanie	Coombes	Chief Executive, Coventry and Warwickshire Partnership Trust	Nil							Current
Y	Rachael	Danter	System Tranformation Director	Nil							Current
Y	Kevin	Davis	Non-Executive Member	Director of Ladder Apprenticeship Foundation		✓				Apr-22	Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	1. Director of CCAB (Consultative Committee of Accountacy Bodies)				✓		07-Jul-20	Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	2. Non Executive Board Member, Global Health Data at Work (registered in Holland)				✓		01-Jul-20	Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	3. Director/Trustee, Albany Theatre Trust			✓			01-Apr-15	Current

Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	4. Non Executive Board Member/Trustee			✓			Nov-21	Current
Y	Harry	Hayer	Non-Executive Member	Nil							Current
Y	Philip	Johns	Accountable Officer, Coventry and Warwickshire CCG	1. Member of Chartered Institute of Public Finance Accountants (CIPFA)		✓				Dec-20	Current
Y	Philip	Johns	Accountable Officer, Coventry and Warwickshire CCG	2. Member of Healthcare and Financial Management Association (HFMA)		✓				Dec-20	Current
Y	Philip	Johns	Accountable Officer, Coventry and Warwickshire CCG	3. Wife is employed as an Occupational Therapist at South Warwickshire General Hospital Foundation Trust					✓	Dec-20	Current
Y	Philip	Johns	Accountable Officer, Coventry and Warwickshire CCG	4. Wife is Director of Seren Melyn - providing OT services					✓	Dec-20	Current
Y	Nigel	Minns	Strategic Director, Warwickshire City Council	Employee of Warwickshire County Council		✓				May-22	Current
Y	Susan	Noyes	Non-Executive Member	1. Director and owner of Sue Noyes Coaching Ltd. A company providing coaching and mentoring to individual and corporate clients	✓					Apr-22	Current
Y	Susan	Noyes	Non-Executive Member	2. Non-Executive Director of Finance and Resources Committee at Birmingham Women's and Children's NHS Foundation Trust	✓					Apr-22	Current
Y	Susan	Noyes	Non-Executive Member	3. Trustee and Treasurer for Smart Works Birmingham, a charity providing clothing and coaching for women returning to the workplace		✓				Apr-22	Current
Y	Susan	Noyes	Non-Executive Member	4. Associate Coach for Healthy You Ltd, a collaborative of coaches and psychologists providing developmental support	✓					Apr-22	Current
Y	Danielle	Oum	Chair of Coventry and Warwickshire ICS	1. Chair of Birmingham and Solihull Mental Health FT	✓					Oct-21	Current
Y	Danielle	Oum	Chair of Coventry and Warwickshire ICS	Member of Healthwatch England Committee	✓					Oct-21	Current

Unconfirmed Minutes of the Coventry and Warwickshire Integrated Care Board (Shadow) Held on Wednesday 16th March 2022 at 14:00 – 16:00 held by Microsoft Teams

Present		
Danielle Oum	Chair Designate, Coventry and Warwickshire ICS (Chair)	DO
Philip Johns	Accountable Officer, Coventry and Warwickshire Clinical Commissioning Group, CEO Designate Coventry and Warwickshire ICS	PJ
Dr Sarah Raistrick	Chair, Coventry, and Warwickshire Clinical Commissioning Group	SR
Adrian Stokes	Interim Chief Finance Officer, Coventry and Warwickshire Clinical Commissioning Group	AS
Richard Percival	Lay Member - Governance and Audit, Coventry and Warwickshire Clinical Commissioning Group	RP
Rachael Danter	System Transformation Director, Coventry and Warwickshire Health and Care Partnership	RD
Dame Stella Manzie DBE	Chair, University Hospitals Coventry and Warwickshire NHS Trust	SM
Dianne Whitfield	Non-Executive Director, Coventry and Warwickshire NHS Partnership Trust	DW
Kirston Nelson	Chief Partnership Officer, Coventry City Council	KN
Melanie Coombes	Chief Executive, Coventry and Warwickshire NHS Partnership Trust	MC
Glen Burley	Chief Executive, George Eliot Hospital NHS Trust and South Warwickshire NHS Foundation Trust	GB
Jagtar Singh	Chair, Coventry and Warwickshire NHS Partnership Trust	JS
Russell Hardy	Chair, George Eliot Hospital NHS Trust and South Warwickshire NHS Foundation Trust	RH
Councillor Margaret Bell	Warwickshire County Council	MB
Jeremy Gould	Non-Executive Director and Chair of the Trust's Audit Committee, University Hospitals Coventry and Warwickshire NHS Trust	JG
In Attendance:		
Cheryl Brand	Executive Assistant, Coventry and Warwickshire Clinical Commissioning Group (Minutes)	CB
Susan Noyes	Non-Executive Member - Observing	SN
Harry Hayer	Non-Executive Member - Observing	HH
Pamela Bradbury	Non-Executive Member - Observing	PB
Kevin Davis	Non-Executive Member - Observing	KD
Ali Cartwright	Chief Planning and Performance Officer, Coventry and Warwickshire Clinical Commissioning Group	AC
Anita Wilson	Director of Corporate Affairs, Coventry and Warwickshire Clinical Commissioning Group	AW
Jamie Soden	Director of Nursing and Clinical Transformation, Coventry and Warwickshire Clinical Commissioning Group	JS
Susan Rollason	Chief Finance Officer, University Hospitals Coventry and Warwickshire NHS Trust	SR
Simon Page	Vice Chair of South Warwickshire NHS Foundation Trust	SP
Julie Grant	Director of Strategic Transformation, NHSE/I	JG

Theresa Nelson	HR Director, Coventry and Warwickshire Health and Care Partnership	TN
Simon Jones	Acting Chief Digital Information Officer, Coventry and Warwickshire CCG	SJ
Nigel Minns	Strategic Director for People, Warwickshire County Council	NM
Apologies:		
Andy Hardy	Chief Executive Officer, University Hospitals Coventry and Warwickshire NHS Trust	AH
Julie Houlder	Non-Executive Director, George Eliot Hospital NHS Trust	JH
Councillor Kamran Caan	Coventry City Council	KC

Item No:		Action
1.	**Standing Items:**	
1.1	**Welcome, Introductions, Apologies** As above	
1.2	**Confirmation of Quoracy** While the meeting is in shadow form, providing there is one Chief Executive, Chair or Council member (for local authorities) from each organisation in attendance the meeting will be quorate.	
1.3	**Declarations of Interest** None.	
1.4	**Minutes of the meeting held on 26th January 2022** The members were happy to approve and agree the accuracy of the minutes. Mr Stokes asked if the finance update in 3.1 could be updated to note the best-case scenario of eight million surplus and a likely break even. **Action: CB**	**CB**
1.5	**Matters Arising/Action Schedule** The action log was updated.	
1.6	**ICS Chair Designate Report** Ms Oum welcomed all attendees and introduced Harry Hayer, Susan Noyes, Pamela Bradbury and Kevin Davis who are the new Non-Executive members of the ICB, who will join this meeting today to observe. Ms Oum~~s~~ noted that since the last board meeting, she has continued to meet with stakeholders including a recent visit to Warwick Hospital. Key areas of reflection from the Chair are as follows: • The tensions around driving a transformational agenda for the ICS alongside managing the immediate operational challenges • Ms Oum and Mr Johns attended a meeting at Warwick University where they met with the Chancellor who outlined the university's commitment to working with the ICS. A similar meeting is planned with Coventry University to maximize the role of the Higher Education sector. • Ms Oum and Mr Johns and other ICS Chairs met with Andy Street, the Mayor from the West Midlands Combined Authority (WMCA) and the Secretary of State, Sajid Javid. This was a good opportunity to showcase the work of Coventry and Warwickshire around the priorities of prevention, personalisation and performance. • There is a further meeting with the Combined authority to discuss the potential for joint working. There is a potential for trail blazer status for data, health and social care records and digital inclusion. • Preparations are taking place for the transition from health and care partnerships to the Integrated Care Board. The ICB will operate formally in shadow form from the 1st April 2022, and the first meeting of the ICB as a statutory organisation will be held on 1st July 2022. • Ms Oum noted that this meeting would be the last for some attendees in this format and formally thanked Mr R Hardy, Ms Manzie, Ms Raistrick, Ms Whitfield and Mr Singh for their contributions and development of the ICS.	

Item No:		Action
1.7	**ICS Executive Report** Mr Johns gave an update and noted the following as key items of information: • A White Paper about health and social care integration has been issued which is closely aligned to the place based working care collaboratives. There is a meeting on 5th April to discuss further. • Interviews for a number of ICB board positions take place over the coming weeks • The COVID situation was improving; however, numbers are starting to increase again. This has had an impact on the provider admissions and beds which have had to close due to outbreaks • The CQC are developing a methodology for how they will change the way they regulate to improve care for everyone with two core ambitions – to tackle health inequalities in health and care and to assess local systems. A meeting will take place on 7th April to start developing their system of oversight. Mr R Hardy noted that it would be of benefit to have more accurate information about the back log of packages in domiciliary care and care home placements. Information showing a breakdown of the whole flow would give more visibility about what the backlog is. Ms Danter noted that this information could be added to the next paper. Ms Coombes further noted that it is not only domiciliary care that needs more accurate information, but mental health also needs measuring. Ms Oum agreed and stated that there is a need to balance the priority and focus so we are clear on what we are going to be measuring ourselves on. CQC will be measuring against the four priorities and the local population will be holding us to account so papers and discussions need to be more system focused.	
1.8	**Risk Register** Ms Danter presented the risk register paper and explained that it articulates the work the team have been doing on creating a system risk register. The register brings the CCGs corporate risk register, and the existing system risk register together. Since the last paper in January, further work has taken place to look at re-aligning risk leads and risk owners. The CCG Corporate team have been working with other partners in other organisations to look at developing the risk management policy for the system so that it aligns with organisations to ensure consistency of reporting and scoring. Ms Manzie agreed that the risks do reflect the risks across the system and noted that it will be important to think about how to demonstrate that there is enough in-depth activity taking place to show progress and measuring reductions. Mr Singh asked how CWPT's risks would be collected in the wider risk of the ICB in the future and would the board be reflecting on the mental health risks about growing demand and waiting times and suggested holding a risk appetite session. Mr Singh asked how the health inequality risk, the workforce risk and the financial risk would be managed and questioned, what mitigations are in place and what will outcomes be. Ms Grant referred to the Ockendon risk which has been moved to the CCG risk register and suggested that this is kept on the system risk register as it is going to be a very significant priority when the next stage of the report is published. Ms Oums agreed and asked that this risk is on the system register. **Action: RD** Ms Nelson noted that children's mental health and adult issues have different issues and asked that educations responsibility and autism is fed in. Ms Danter noted that further work could be done on this. **Action: RD**	**RD** **RD**

Item No:		Action
	Ms Bell said that it would be useful to include information about the "*Fair Costs of Care"* which will increase the costs of care and as the implications of this are currently unknown this should be added as a risk. **Action: RD** Ms Oum asked that for the financial risk and the NHS having a system deficit, can it be clear that this refers to the system. It would also be useful to have the mitigations organised into where they are taking place (system at Place level) or within an organisation so that there is focus.	**RD**
2.1	**Quality Update** Mr Soden gave an update about the key areas of work within Quality. The quality programme of work supports the delivery of the four aims of the ICS to ensure the population experiences safe, effective, value for money along with a positive experience. Key areas to note are as follows: <u>Children in Crisis</u> The situation is much improved; the numbers and length of time children and young spend on the wards has decreased. Work that has taken place has been identified as best practice and links have been established with Leicester, Nottingham and Northampton. There have been ongoing challenges since the end of November when Omicron began and this has had impacts on staff availability, and the lack of specialist beds which were closed. Resources have been diverted and issues discussed at the Children Integrated Health and Care Board, chaired by John Gregg. In terms of assurance about the quality of providers, work is taking place across both local authorities and the CCG to pull together an integrated model to benchmark where we are with all the providers. The aim is to increase assurance with a prioritisation system in place to work with those providers where there are more concerns. <u>Continuing Healthcare and Court of protection applications</u> There was a backlog of applications, but this has now been completed. <u>Trauma Recovery Vanguard</u> Mr Soden confirmed that the system has been successful in the Trauma Recovery Vanguard Application and secured £2.8m for a fantastic opportunity to change the culture and develop organisational change to work with a group of people who have experienced trauma and to support them. Mr Singh thanked Mr Soden for a very positive report and noted the work that is taking place. Ms Coombes noted that there is still a big demand and there is still a need for a medium to long-term solution for children and young people in Coventry and Warwickshire. Waiting lists are growing as staff are being diverted; and the root problem needs to be addressed. Mr Soden agreed and noted that there has been a 70% increase of children and young people with severe mental health issues requiring access to services. The Integrated Children's Board was put on hold whilst the response to Omicron was being worked through, however moving forward, the work of this board will be key. Ms Oum thanked Mr Soden for the information about improvements and stated that the Trauma Recovery for Vanguard is a very important piece of work. Ms Oum would like to understand what learning can be applied across the whole system and asked that this item	

Item No:		Action
	comes back to a future ICB meeting. Ms Brand will add to ICB action schedule and forward schedule of items. **Action: CB**	**CB**
3.1	**People Workstream Update** Ms T Nelson joined the meeting to give an update on the workforce priorities. • Additional work has been commissioned to support the development of the ICB and its people function. Stakeholder engagements have taken place and noted that there are gaps in collecting timely information about social care and workforce data • NHSE/I have introduced a national programme to support the recruitment of reservists who will be a temporary workforce call when extreme pressures arise • Challenges remain about retaining the workforce. There are a number of things in place to try and keep staff such as the employee assistance programme and the Carer's Passport. • There are 800-1000 registered nursing vacancies. There is an ambitious project called Project 1000 which works with the Chief Nurses and HR Directors across the system to find more creative ways of training nurses such as blended learning, masters programmes and apprenticeship programmes • There are 300 Healthcare Support Worker vacancies – the problem is trying to retain them, so their future career options need to be carefully considered • There is a system wide Equality, Diversity and Inclusion subgroup which is working on three key priorities which were agreed at the Partnership Executive Group. Ms Manzie commended the work undertaken by colleagues on a number of joint initiatives and there are a many positive 'green shoots' where the system can work collaboratively. Mr Johns noted that the workforce should be triangulated at a system level and not see people as something separate to quality, finance, and performance. Ms Raistrick stated that in terms of health inequalities, if staff are happy and healthy, this helps us on our journey of reducing health inequalities. Ms Oum noted that it is about the initiatives and approaches and understanding the scale of the challenge and the system embracing the opportunities to work together. Ms T Nelson explained that the timeliness of data is important to understand the size of the risk to see where the challenges are. Mr R Hardy said that the issue of social care recruitment is disproportionately important for the ICS to understand going forwards. Ms T Nelson agreed and noted that the NHS should consider its branding offer to attract and keep the workforce. Ms Oum said there were models that do work to address retention issues; for example working with partners in the voluntary, community sector and Further Education sector and working together as a system to look at those. Ms Oum thanked Ms T Nelson for the update and asked for the next update to include information about the role of the system in scaling up some of these initiatives and drawing on wider partnerships.	
3.2	**Medically Fit for Discharge**	

Item No:		Action
	Ms Danter explained that guidance was received with an overall aim of reducing the number of medically fit for discharge patients and encourage the system to get patients home as quickly as possible by a home first approach or into supported community services. Progress has been made on the benchmarks set, although it is slower than hoped and there have been some challenges. There were COVID 19 outbreaks in care homes and issues remain in domiciliary care. There are internal issues within organisations, so they are looking at where the blockages are. The paper describes the actions being taken to address the issues and the next steps of planned work. The aim is to get back to the target by the end of June; and it is not impossible to achieve this. The paper describes the risks in achieving that target; for example, COVID and the removal of the hospital discharge grant. The Better Care Fund will be reviewed to see if this could be utilised. There is an opportunity to do a piece of work on the consideration of risk across the whole pathway. For example, could more be done to discharge patients' home with a package of care that the family are comfortable with until the full package can be put in place. Mr Burley stated that a wider range of indicators is required as there are a group of patients who should not be in an acute setting in the first place and other patients which show the internal processes should have been quicker. It is important that we continue moving forwards with the good practice that is in place. Mr Burley explained that the review taking place of Ellen Badger does highlight some of the inflexibilities of having community hospital beds. The discharge to assess capacity across the whole system needs to be reviewed every six months. Ms Danter confirmed that the review would be concluded by the end of April, after which there will be time to understand the implications of how to address issues and look at options and opportunities to continue some services and the cost of that to the system. The discharge to assess capacity should regularly be reviewed to see whether the capacity meets the current demand. Mr Minns noted that parallel workstreams are required. There are three different discharge to assess systems and there should be one system that works well for everyone. Ms Oum thanked Ms Danter and confirmed there are several issues to think about – commissioning of services and the approach to collaboration and how information is presented so there is a system everyone understands. Members **NOTED** the update.	
3.3	**Finance Update** Mr Stokes provided an update on the risk assessed forecast outturn. This year's outturn is consistent with last year and that is break even for the end of the year. The likely scenario is that there will be a small deficit of about £3m. The system is anticipating achieving its capital forecast and is working actively to manage the spend for year-end. In terms of looking forward into next year, efficiency remains a key challenge that will require scrutiny. This is due to COVID allocation for 2022/23 being reduced and convergency adjustments to both reduce overall resource consumption to spending review 2021 funded levels and ICBs moving towards a fair share funding distribution. There is also a significant amount of the 2021/22 efficiencies only being achieved non-recurrently and this will add to the challenge of planning a break-even position for 2022/23. Inflation has changed significantly over previous months, so there will be inflationary pressures in the system to manage too. In terms of the Elective Recovery Fund, the system will receive less than last year so the forecast will need adjusting and this will be a challenge.	

Item No:		Action
	For COVID, we need to look carefully at the COVID costs coming in and out to get a better understanding of what the financial position will be for next year. The initial allocation for capital is being worked through and some of the commitments made over the last 12 months has put us in a challenging position and now it is time to be creative about the funding of that over the coming months. Ms Oum thanked Mr Stokes for the update and asked about the purpose of the ICS and the four priorities and how is this reflected in an approach to financial planning. Mr Stokes noted that this is shown in a number of ways including keeping some money back so we can target different things, there is inequalities money which has been allocated. The budget setting has been a challenge to try and ring-fence some money and set it aside. We are now working as a system rather than four or five separate organisations and this helps to free up money to do things. Members **NOTED** the update.	
3.4	**Digital Update** Mr Stokes explained that the Digital Update gives information about progress on the development of the Coventry and Warwickshire ICS Digital Transformation Strategy. It details how we can use digital and data to reimagine how care is delivered to make health and care services tailored to individual care needs. Mr Burley is the Executive sponsor for the strategy and there is a working group of clinical and digital leads who are responsible for developing and socialising the strategy with the partner organisations for buy-in and alignment. There are challenges around the finances as the amount of money allocated differed to what was bid for. Mr Simon Jones has been coordinating across the system the development of the digital strategy. Engagement has taken place across partners and with clinical staff. A series of interviews were held to gather as many voices as possible. A digital strategy of patient journeys will be used to focus on where investments need to be and what can help to reimagine health and care delivery. It is not just computers on desk but a total innovation of how we do things to help inform how we redirect money in different ways. A number of principles of vision have been developed along with a series of digital and data capabilities which is underpinned by data. To do this, we need to make sure we have the right capacity in place to be able to plan and put in place governance structures Mr Burley stated that the strategy requires resources to be committed to glue it all together, ensure it is coordinated and prioritise what we so as a system. Ms Oum stated that this strategy would enable the system to be more flexible about how we use resources so that we can target initiatives that are of benefit. Members **ENDROSED** the ambition and direction of travel.	
4.1	**Transition to ICB Update** Members **NOTED** the update.	
5.1	**Constitution and Scheme of Reservation and Delegation** This item will be taken outside of this meeting. Ms Wilson will email members to request if they have any feedback. **Action: AW**	**AW**
6.	**<u>Any Other Business</u>** There were no items raised.	

Item No:		Action
	Date of the Next Meeting: **Date:** Wednesday 20th April 2022 (Development session) 13.00-16.00 **Date:** Wednesday 18th May 2022 (ICB Meeting) 14.00-16.00	

ACTION SCHEDULE - COVENTRY AND WARWICKSHIRE INTEGRATED CARE BOARD (SHADOW)

ACTION REF	MEETING DATE	AGENDA ITEM	ACTION	RESPONSIBLE OFFICER	COMPLETION DATE	CURRENT STATUS	UPDATE
19	13/10/2021	2.3	VCSE Delivery plan to be presented at a future meeting	Nigel Minns	Jul-22	In progress	CB emailed Nigel Minns on 2nd and 28th Feb to ask when he could present this item
24	8/12/2021	1.5	Philosophy of care development	Phil Johns	Ongoing	In progress	PJ confirmed that there is a Clinical Forum meeting on 17th March and he will then provide feedback. Update: 8/5/2022 - SR confirmed that the Clinical Executive Group agreed that in advance of the CNO/CMO being in post, will work together for our population prioritising care over individuals organisations
24	8/12/2021	1.5	Development of Health Inequalities Strategy	Rachel Chapman	May-22	In progress	This was presented at the 26th January 2022 ICB Board and it was agreed that this would be bought back to the 18th May ICB Meeting
27	26/01/2021	2.4	Draft Community Engagement Strategy	Phil Johns	May-22	In progress	On the agenda at the 18th May ICB meeting
29	26/01/2022	3.1	Left shifting to lower cost health care settings in order to get assurance about the local term trajectory of the system.	Phil Johns/Rachel Danter	May-22	In progress	Discussions have been held about what acute hospital capacity configuration is needed going forward. Further discussions required to understand the scale of the benefit to be gained. There is a point prevalence survey which will link to the medically fit for discharge work
32	26/01/2022	5	ICB meetings - should they be public and with published minutes and how we may in future consider public attendance. Ms Oum asked AW to look at the guidance and best practice	Anita Wilson	May-22	In progress	ICB meetings to be public from 1st July. Papers and MST links to be published on the Coventry & Warwickshire ICS website which is https://www.happyhealthylives.uk/our-story/icb-shadow-board/
34	16/03/2022	1.8	Risk Register - RD to ensure Ockendon is kept on system risk register.	Rachael Danter	May-22	In progress	
35	16/03/2022	1.8	Risk Register - Children and adults mental health and educations responsibilitiey's needs further work.	Rachael Danter	May-22	In progress	
36	16/03/2022	1.8	Fair costs of care to be added to the risk register	Rachael Danter	May-22	In progress	
37	16/03/2022	1.8	Risk Register - the financial risk - ensure this is clear that it is a system deficit and ensure the mitigations are organised into where they are taking place	Rachael Danter	May-22	In progress	
38	16/03/2022	2.1	Trauma Recovery Vanguard - Item to be discussed at a future ICB meeting to understand learning	Chief Nursing Officer	Sep-22	In progress	ICB given update at 16th March 2022 board. At a future ICB meeting, a further update to be given outlinging the learning

1. ICS Chair's Designate Report

1.1 I start my report to the Board by celebrating the news that the Health and Social Care Bill has received Royal Assent, paving the way for us to become a statutory Integrated Care Board on July 1st 2022. The upcoming transition will undoubtedly present challenges for us as a system as we establish new ways of working, but it will also present opportunities. Similarly, the Covid pandemic stress tested our resilience and capacity like never before, but it also showed us what can be achieved when local organisations and communities work together. Much of society will never return to how it was pre-pandemic – and our health system is no different.

1.2 We now have an opportunity to build upon the collaborative approach that has been developed and improve healthcare outcomes for everyone in Coventry and Warwickshire. Regardless of the pressures of delivery, we must not lose our focus on how we can make health and care more accessible, inclusive and reflective of the diverse communities across our region.

1.3 The new ICS will have the following 4 core purposes:

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

1.4 Our ICS will bring partners together to deliver on these aims and address challenges across our system. Through working more closely together we have a better opportunity than ever to address health inequalities in our population, including the wider determinants of health such as housing or socio-economic exclusion, and to improve the health and wellbeing of everyone in Coventry and Warwickshire.

1.5 As Chair, a key part of my role is to ensure that we never lose sight of these aims and continue to strive to deliver against them. With that in mind, within this report I intend to highlight the work happening across all partners where we are making progress on delivering our aims so we can empower and support people in Coventry and Warwickshire to start well, live well and age well.

2.0 Summary of key meetings

Improve outcomes in population health and healthcare	**17th March 2022 - Warwickshire Health and Wellbeing Board** I presented on the developing ICS, as well as hearing about other key areas for improving outcomes, inequalities and involving local communities.
	24th March 2022 – South Warwickshire Patient Engagement. A group of local Patient Participation Group members and third sector representatives coming together to improve health and wellbeing in South Warwickshire. They received presentations on SWFT's developing engagement strategy as well as an update on the development of the ICS.
	1st April 2022 – HSJ Provider Summit Unlock the potential of integration and collaboration, a real opportunity to network and learn from our partners in other areas

	4th April 2022 – Coventry Health and Wellbeing Board Received the UHCW *"More than a hospital"* strategy outlining their ambition for moving forward and improving outcomes.
	7th April 2022 – Coventry and Warwickshire ICS Walkthrough with CQC There was fantastic representation across Coventry and Warwickshire stakeholders, providing practical feedback in the development of their system assurance framework.
Tackle inequalities in outcomes, experience and access	**20th March 2022 – NHS Health and Wellbeing Event in collaboration with Coventry Muslim Forum** Attended by a wide range of innovative, committed and community focused teams , the event demonstrated that different approaches to engagement are needed if underserved communities are to supported to start well, live well and age well.
	22nd March 2022 – Shaping WMCA's Devolution Deal on Health Exploring the opportunities for improving health in the West Midlands presented by the Levelling Up White Paper and shaping the ask for a potential trailblazing devolution deal for WMCA – building on work already being done at a local level, and learning lessons from elsewhere
	7th April 2022- West Midlands Mental Health Commission Exploring how we can contribute to the pursuit of a region which is both mentally healthier and has fewer mental health inequalities.
Enhance productivity and value for money	**13th April 2022 – A lunch meeting with LMC colleagues across the ICS** Through discussion we set out clearly the scale and range of challenges within primary care and the vital work happening within General Practice.
	19th April 2022 – Hospital tour with UHCW Chief Executive, Andy Hardy and Chair, Stella Manzie I was impressed by the facilities but even more so by the positivity and imagination of the colleagues I met throughout the afternoon.
Help the NHS support broader social and economic development.	**29th March 2022 – A conversation with the voluntary sector** Discussed the role of the voluntary and community sector within the ICS with Sue Ogle, Chief Executive Officer - Voluntary Action Coventry and Kate Morrison, Chief Executive - Warwickshire Community & Voluntary Action

	29th April 2022 – Visit to Coventry University underlined the vital role the universities play as strategic partners and demonstrated ways of widening access to socio-economic inclusion through education and employment.

1. ICS Chief Executive Designate Report

1.0 Ockendon

1.1 Progress on the initial Ockenden report's 7 Immediate and Essential Actions were submitted on behalf of the three provider Trusts to NHS England/improvement (NHSEI) on 14th April following an insight visit at South Warwickshire NHS Foundation Trust (SWFT) on the 5th April where NHSEI and the LMNS team reviewed evidence of progress on the recommendations. Further insight visits for George Eliot Hospital NHS Trust (GEH) and University Hospital Coventry and Warwickshire (UHCW) will take place in August. The focus of work during May will be completing the Equity and Equality Strategy for submission to NHSE by the end of May, as well as Continuity of Carer plans and Capacity and Capability self-assessments, both of which need to be submitted by 15th June.

1.2 The Ockenden Final report published on 30th March 2022 was circulated to the Local Maternity Neonatal Services (LMNS) Board on the 11th April and will be discussed in detail at the June meeting. Work has commenced on reviewing the additional 15 Immediate and Essential Actions.

1.3 Key issues remain around workforce and for units at GEH and SWFT non-compliance with recommendations has resulted in implementing mitigating actions with patients being referred to pathways at UHCW. The LMNS Board reviews the actions regularly and most recently at the 9 May meeting. In addition, there is an emerging issue around digital capability with lack of interfacing between differing maternity systems and planned introduction of a new IT system in the system, the impact of which is being discussed and closely managed as part of the implementation of the ICS Digital Strategy.

2.0 Urgent Care Pressures

2.1 Urgent and emergency care pressures continue to be a challenge across the system. Emergency Department (ED) attendances are significantly above those compared to the same month in 2021. ED attendances March 2022 were 8,206 compared to March 2021 6,499. This combined with 'flow' issues have caused pressure with ambulance hand over delays. A number of measures have been agreed to manage the risk across the system and a plan is in final development for actions when under severe pressure. Robust plans have been in place for bank holidays to include a Multi-Agency Discharge Event (MADE) before the weekend that brings together the local health system to, support improved patient flow across the system unblock delays.

3.0 Formal Establishment of Integrated Care Systems

3.1 The Health and Care Bill has received Royal Assent by Her Majesty the Queen, enacting the most significant health legislation in a decade into law. The Act introduces measures to tackle COVID-19 backlogs and rebuild health and care services, backed by £36 billion over the next three years through the Health and Care Levy, it will also contain measures to tackle health disparities and create safer, more joined-up services that will put the health and care system on a more

sustainable footing. This is an important step on the journey towards establishing Integrated Care Systems on a statutory footing, which will take place on 1 July 2022.

4.0 New ICB Appointments

4.1 We are delighted to announce that three new Executives and four new Non-Executive Members have been appointed to the Coventry and Warwickshire ICB. The successful candidates bring a wealth of knowledge, skills and experience to their new roles. We are continuing to bring together an executive team which is committed to working together to ensure our services are high quality and meeting the priorities of our communities. Our new appointments to our Integrated Care Board are Madi Parmar as Chief Finance Officer, Dr Angela Brady as Chief Medical Officer and Tracy Pilcher as Chief Nursing Officer.

4.2 Non-Executive Members also form a vital part of our Board, providing an independent and objective view on our policy and decision while making sure that we remain accountable to the population we serve. The new Non-Executive Members for the Integrated Care Board are Susan Noyes for Audit, Pamela Bradbury for Quality, Harry Hayer for Remuneration and People and Kevin Davis for Inequalities.

5.0 Fuller Stocktake

5.1 On 11 November 2021, NHSEI announced a new national stocktake led by Dr Claire Fuller, Senior Responsible Officer of Surrey Heartlands Integrated Care System ('ICS') and Chief Executive Designate of Surrey Heartlands Integrated Care Board. The overarching aim of the "Fuller Stocktake" is to provide specific and practical advice to all ICSs, as they assume new statutory form, as to how, in their own geographies, they can accelerate implementation of the primary care, out of hospital care and prevention ambitions in the NHS Long Term Plan. The framework for the stocktake was developed around the six "challenge questions" set out below and nine workstreams, one of which (Life course: live and work well) is being Chaired by Glen Burley, Chief Executive of SWFT.

- How can primary care and system partners work together to best meet the health needs of people in their local areas?
- **How can the primary care workforce be recognised, supported and developed as part of 'one workforce' so that it contributes to delivering more integrated models that improve population health?**
- How do we best facilitate timely access to primary care, taking account of different needs and preferences?
- What could strengthen the relationship between primary care, the communities and people it serves, and the wider health and social care system?
- How do we ensure effective primary care voice and representation within systems? What barriers do we need to overcome and how do we do that?
- **How can primary care use data to better understand the needs of patients and focus care where it is needed most - and how can systems help make this happen to improve the health of the population?**

Following a period of broad engagement across the spring, Dr Fuller is expected to formally publish her initial report imminently. The recommended actions that flow from the report will undoubtedly have implications for the further iteration of the local Primary Care Strategy but also for the development of the Integrated Care Partnership's Integrated Care Strategy and the Integrated Care Board's five-year plan.

6.0 Thank You

6.1 I would like to extend my sincere thanks and gratitude to members of the Coventry & Warwickshire CCG Governing Body at their last public meeting. Whilst their tenure may have been only 15 months and for some less, they have consistently and enthusiastically brought their knowledge and expertise in guiding the CCG through a transitional period.

Recommendation

Members are requested to **NOTE** the contents of the report.

End of Report

Report Title:	Corporate Risk Register
Report From:	Rachael Danter, Chief Transformation Officer
Author:	Andrew Wilkins, Deputy Director of Corporate Affairs, Coventry and Warwickshire CCG
Previous Considerations and Engagement:	The Corporate Risk Register is currently being presented to every Shadow Board meeting of the Integrated Care Board. It was last presented to March's Integrated Care Board
Purpose:	For information

Contribution to meeting the aims of the ICS:

Effective risk management arrangements enable the identification and management of risks that could impact our ability to achieve the objectives of the Integrated Care Board and System. This management in turn supports the achievement of the four aims of the Integrated Care System (ICS).

As reported to 13 October 2021, 26 January and 16 March 2022 Shadow Integrated Care Board, new risk management arrangements are being developed as we transition to an Integrated Care Board and greater system working. Whilst these arrangements are being developed, the Corporate Risk Register is being reported to provide ongoing assurance regarding the identification and management of system risks during the transition period.

Extreme or high risks to the delivery of the system priorities set out in the System Development Plan are recorded on the risk register. Low to medium risks are managed on local risk registers.

As a developmental and responsive process, the Corporate Risk Register will continue to be developed with a clear focus on the achievement of the four aims of the ICS.

Contribution to meeting the priorities of the ICB:

Effective risk management arrangements enable the identification and management of risks to the delivery of the priorities of the ICB. The priorities are included within the risk register documentation and risks are identified against each of the ICB priorities.

As the risk register is further developed, careful consideration will be given to the balance of risks across the different ICB priorities. It is important that risks are not considered in isolation and that a holistic view is taken to the combined risk profile of each ICB priority.

Further developments to the system risk management arrangements outlined in the report will promote and support collaborative system wide working in the identification and management of system wide risks that threaten the achievement of the system priorities.

Recommendation:

Members are requested to:

- NOTE the risks affecting the achievement of the agreed ICB Priorities and the arrangements in place to manage those risks;
- NOTE the progress being made in the development of the system risk management arrangements.

Implications							
Conflicts of Interest:	None identified.						
Financial and Workforce:	Please see the finance related risks identified in the Risk Register.						
Performance:	Please see the performance related risks identified in the Risk Register.						
Quality and Safety:	Please see the quality and safety related risks identified in the Risk Register.						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	Risks are identified from a range of information and sources, a key source being the insights, feedback, and outputs of engagement activities with our patients and communities.						
Clinical and Professional Engagement:	The Corporate Risk Register receives considerable input and ongoing scrutiny from our clinical colleagues.						
Risk and Assurance:	Effective risk management arrangements will be essential to the ICB's ability to deliver its statutory functions and achieve its priorities for the patients of Coventry and Warwickshire.						

1. Executive Summary

1.1 This paper provides an update on the corporate level system risks and the arrangements in place to mitigate those risks. It also provides and update on the work underway to further develop the system risk management arrangements to enable readiness to operate from 1 July 2022.

2. Risks relating to ICB Agenda Items

2.1 To support ICB consideration of risks during the business of this meeting, the following risks are highlighted as being associated to items on today's agenda. The Board are encouraged to give consideration as to whether the key risks associated with these items are correctly captured on the corporate risk register and whether the reports received provide assurance in respect of the management of the risks related to those items.

Item: Ockendon – One Year On

Associated risk: The system needs to achieve the expectations of the Ockenden 1 (7 Essential and Immediate Actions) and Ockenden 2 (15 Essential and Immediate Actions) reports via robust and forensic oversight of provider achievements. If these aren't achieved there is a risk that the system will not be able to provide robust assurance that the local population are receiving the level of care they require in a safe environment, resulting in the potential for women, babies and their families experiencing unmet needs, poor care and negative media coverage for the organisations.

Item: Performance Report – Cancer Waiting Times

Associated risk: If we do not utilise our capacity and manage our cancer referrals effectively there is a risk that patients will continue to wait longer for both diagnosis and treatment. This may potentially result in failure of key cancer standards and sub-optimal pathways for our patients with variation across our ICS for both access and inequality.

Item: Finance Update

Associated risk: Due to the system-wide deficit of c£80m pre-COVID, £149m underlying deficit post COVID, coupled with additional revenue costs made recurrent through COVID, there is a risk that this could lead to an undeliverable level of transformational and efficiency requirements resulting in failure to achieve medium term financial balance.

Item: People Workstream Update

Associated risk: If the ICB is unable to recruit and retain the required workforce, there is a risk that the vacancy level will impact on service delivery, in addition to pressure on its current workforce, resulting in increased sickness and higher turnover, therefore impacting service delivery.

3. Changes to the Corporate Risk Register since March's ICB meeting

3.1 Since March's ICB, the CCGs corporate governance team have continued to meet with Risk Owners and Risk Leads to refine and update the risks recorded on the register.

3.2 The current position of the ICB Corporate Risk Register is as follows:

Total Open Risks	**16**
Total open extreme risks ≥15	3
Total open high risks = 12	13
Number of new risks	1
Number of increased risks during the period	0
Number of risks decreased	1
Number of risks closed/deescalated during the period	1

3.1 The following risks have been added to the risk register since the register was last presented to the ICB:

- Q.025 - Coventry and Warwickshire system delivery of Ockenden

Members will note that at their 16 March meeting it was reported that this risk was removed from the CRR (*to be managed locally on the CCG nursing risk register as after review it was agreed that the risk sits with and is being regularly monitored by the provider organisations delivering care*). Since that decision, there has been the publication of the Ockenden Report 2 and it has been acknowledged that a system level risk remains.

3.2 The following risks have decreasing risks scores since the register was last presented to the ICB:

- PC/001 Elective Recovery – Risk decreased to 12. Whilst the waiting list continues to grow, the activity throughout is also increasing. There has been improvement in RTT position demonstrated across the System with significant reduction reported in our longest waiting patients.

3.3 The following risks have been resolved or de-escalated to local CCG risk registers since the ICB Corporate Risk Register was last presented to the ICB:

- Q/003 - Deprivation of Liberty Safeguards and Court of Protection Applications was closed from the Corporate Risk Register due to the backlogs being cleared and therefore all ongoing work becoming business as usual.

4. Draft Integrated Care Board Risk Management Policy

4.1 The ICB Risk Management Policy has continues to be developed to ensure that the ICB has effective risk management practices in place to support delivery of system objectives.

4.2 The System Quality Group have had the opportunity to contribute to the policy and the 13 April 2022 CCG Audit Committee endorsed the policy subject to some minor amendments. The engagement and development of the policy will continue through to its presentation to 1 July ICB Meeting for its adoption. It will then be presented to the ICB Audit Committee for their endorsement.

5. Conclusion

5.1 The developments to the system risk management arrangements are progressing and are on track for achieving readiness to operate by 1 July 2022. The development of the Shadow Integrated Care Board Corporate Risk Register is a positive demonstration of the beginnings of shared ownership and collaboration in the management of system risks.

6. Recommendation

Members are requested to:

- NOTE the risks affecting the achievement of the ICB Priorities and the arrangements in place to manage those risks;
- NOTE the progress being made in the development of the system risk management arrangements.

End of Report

Corporate Risk Register

NHS Coventry and Warwickshire Integrated Care Board

Helping Coventry and Warwickshire to start well, live well and age well

The four aims of the ICS:

Improving outcomes in population health and healthcare

Tackling unequal outcomes, experience and access

Enhancing productivity and value for money

Supporting the broader social and economic development of Coventry and Warwickshire

						Unmitigated Risk Score				Residual (Current) risk Score				Target Risk Score						
Date added	Reference	Risk description	System priority	Risk Lead	Risk Owner	Initial Impact Score	Initial Likelihood Score	Unmitigated Risk Score	Measures in place to Manage the Risk Preventative - stops the problem occurring Detective - detects the problem when occurs Directive - written/verbal instructions/ policies, etc. Monitoring - reporting and oversight arrangements	Residual Impact Score	Residual Likelihood Score	Residual risk Score	Further Actions Planned including Timescales	Target Impact Score	Target Likelihood Score	Target risk Score	Status (Change from previous residual risk score)		Assurances	Update (current statement on effectiveness of actions in place, justification for current risk score or change in score)	Last Reviewed (Date and by whom)
Apr-21	F/002	**System deficit** Due to the system-wide deficit of c£80m pre-COVID, £149m underlying deficit post COVID, coupled with additional revenue costs made recurrent through COVID, **there is a risk that** this could lead to a undeliverable level of transformational and efficiency requirements **resulting in** failure to achieve medium term financial balance.	Live within our means	Adrian Stokes, Chief Finance Officer	Chris Lonsdale, Director of Finance - Place; Liz Flavell-Smith, Director of Finance - Strategy Alistar Flemming, Head of System Financial Planning	5	5	25	**Preventative:** - Investment Panel meeting (CCG) in place to sign off all proposed investments - National Covid-19 and budget guidance being applied (CCG and Trusts) - Continued assessment of national guidance (CCG and Trusts) **Detective:** - Finance position to be reported monthly (currently CCG and providers send monthly reports, this will be one report from both in July) - Monthly review and financial reporting mechanisms for main budgets (although planning position suspended) - CCG and Trusts - Process of confirmation with NHSE/I via System review meeting **Directive:** - Budget setting national guidance followed and implemented for CCG and Trusts - National guidance position is continuously assessed and implemented with Assurance given to F&P Committee (both CCG and Trusts) **Monitoring:** - Monthly Finance and Performance meetings. - Bi-monthly Governing Body meetings.	4	3	12	Following submission of system plan 28 April 22 a review of the underlying position will be undertaken. This will go through assurance at FAB and come to F&P Commitee for Q1.	3	3	9	No change	↔	**Operational** Financial reporting mechanisms System technical finance group which assesses financial risk and mitigations **Oversight** Reports to Finance and Performance Committee, Audit Committee, FAB, Governing Body **External** External Audit, NHSE/I review process	**April 2022:** System plan was submitted on 28 April 22 and will go through the assurance process at FAB and will go Finance and Performance Committee for Q1.	April 22 Liz Flavell-Smith/Chris Lonsdale/Alistair Flemming
Apr-21	P/001	**Urgent and Emergency Care** **If** there is a demand and capacity deficit across urgent and emergency care services, **there is a risk that** patients will not be seen in the right care setting within the right timeframes, leading to increased ambulance handover delays, **resulting in** patients receiving sub-optimal care, a poorer patient experience, the system incurring more costs for these services and capacity being compromised for new presenting patients.	Successfully Manage Urgent and Emergency Care	Rachael Danter, Chief Transformation Officer	Helen Lancaster, Head of Transformation	5	5	25	**Preventative Actions in Place:** - Local Urgent Care Boards at Place to plan demand and capacity required. - System wide virtual ward group to be established to maximise Virtual ward capacity across the system. - Community urgent response workstream implemented and further recruitment to maximise capacity on going. - 7 day week service for UHCW/GEH for pathway 3 and EOL discharges, working with LA's in commissioning of different discharge pathways 2, 3 and EOL provision. - System wide work programme to address care home and domiciliary care provision shortage including expansion of Mockely Manor, and review of system delivered service based at Ellen Badger (or alternative location). - Methodical review of pathway 0-1 patients to establish care needs and identify alternative solution. **Detective Actions in Place** - Daily Medically Fit for Discharge meetings with providers and LA to identify solutions and ensure actions. **Directive Actions in Place** - Contracting teams set baseline activity levels within contracts across providers. - Pre hospital pathway workstream developed to provide alternatives to ED conveyancing. - Plans in place for surge capacity. - Reduction in category 3 ambulance conveyancing programme in place. **MonitoringActions in Place** - System operational discharge and delivery group (weekly meeting). - Contract team monitor delivery through mandated contracting meetings, and issue query notices, and requests for Remedial Action Plans, where necessary. - Domiciliary care resilience action plan developed and monitored through discharge task and finish group. - System approach to Urgent Treatment Centres to be established. - Operational end of life group in place.	5	3	15	Plan to implement Single Health Resilience Early Warning Database (SHREWD) across all providers. Actions in extremis plan to be developed further. Working group to be established to monitor system pressure.	3	4	12	No change	↔	**Operational assurance:** - Contract team monitor delivery against process tracking performance measures through mandated meetings. - Business Intelligence, Planning and Performance Team collate performance across all providers. **Oversight:** - Clinical Quality and Governance Committee - Finance and Performance Committee - CCG Governing Body **External:** - Regional assurance processes, Health Oversight Committee (HOSC), NHS I/E reviews of the system through system review meetings (SRM). - Performance is also reported across Coventry and Warwickshire as a whole, through the STP urgent Care Board , reporting to PEG, and also reporting against key targets through to the Regional NHS I/E urgent care forum and system leads.	**April 2022:** Clinical Assessment and Placement team are working closely at place and across the system to ensure that we support effective discharges. There remains challenges due to CQC restrictions and the limited availability of insurance for care homes receiving Covid+ admissions and the team are working with NHSE/I and the LA's to resolve this. Additional bridging service has started for Local Authorities to unblock delays for out of hospital services.	April 2022 Helen Lancaster
Apr-21	P/002	**Elective Care - Recovery** **If** the system is not able to align its elective recovery programme to the national recovery proposals, **there is a risk that** patients will not be seen in the right care setting within the right timeframes, **resulting in** patients receiving sub-optimal care, a poorer patient experience, the system incurring more costs for these services and capacity being compromised for new presenting patients.	Restore Elective Care	Rachael Danter, Chief Transformation Officer	Laura Nelson, Director of Operational and Financial Recovery	5	5	25	**Preventative Actions in Place:** - A clinical review of all inpatient waiters has been undertaken through a system called E-Review, allowing the system to be clear around the clinical priority of patients. - Successful application and delivery of both accelerator and first phase of Targetted Investment Funding (TIF) allocation to aid delivery - Bid for TIF phase 2 funding. - Monthly system Elective Care Board in place including all partners across the system to support elective recovery. - Use of capacity across the system based on highest risk speciality areas including transfer of whole orthopaedic pathways. - Get it Right First Time (GIRFT) focus on pathway opportunities linked to Midlands Elective Delivery Programme focus on Gynae, Ophthalmology and Urology. **Detective Actions in Place:** - Business Intelligence, Planning and Performance Team request updates on issues, risk and mitigation actions being taken by lead commissioner/contract lead - System wide theatre productivity group in place to share best practice and learning ensuring we utilise all capacity effectively. - Review Day Surgery Units across system complete and share best practice and ensure correct/all procedures being carried out as day surgery **Directive Actions in Place:** - Contract Documentation, activity schedules, quality schedules, SDIPs - Query Notices, Remedial Action Plans (RAPs). - Contracting teams set baseline activity levels within contracts across providers. - Effective use of digital and AI platforms system wide to focus on 'digital first' opportunities. - Outpatient Transformation targets for advice and guidance and virtual appointments. **Monitoring Actions in Place:** - Contract team monitor delivery against these through mandated contracting meetings, issue query notices/requests for Remedial Action Plans. - Weekly COO escalation meetings with overall system review of waiting lists and mutual aid/transfer of priority patients as needed to support equitable delivery of priority patients and reduction of 104 weeks waits across the system. - System theatre oversight group with KPIs to improve theatre utilisation and delivery of the first system wide 'perfect week' focused on day case utilisation.	3	4	12	Consistent review of position and any opportunities to share best practice. System led GIRFT engagement with clear focus on HVLC procedures and productivity opportunities.	3	4	12	Risk Decreased	↓	**Operational** - Contract team monitor delivery against process tracking performance measures through mandated contracting meetings. - Business Intelligence, Planning and Performance Team collate performance across all providers. - Elective Care Delivery Board **Oversight** - Finance and Performance Committee. **External** - Restoration plans submitted to NHSE/I.	**April 2022:** Whilst the waiting list continues to grow, the activity throughput is also increasing. There has been improvement in RTT position demonstrated across the System with significant reduction reported in our longest waiting patients (104 weeks and 52 week position), although it is recognised that it will take a considerable amount of time to reduce the waiting list back to pre-covid levels the teams are committed to recovering the position as quickly as possible through effective transformation.	April 2022 Laura Nelson

						Unmitigated Risk Score				Residual (Current) risk Score				Target Risk Score						
Date added	Reference	Risk description	System priority	Risk Lead	Risk Owner	Initial Impact Score	Initial Likelihood Score	Unmitigated Risk Score	Measures in place to Manage the Risk Preventative - stops the problem occurring Detective - detects the problem when occurs Directive - written/verbal instructions/ policies, etc. Monitoring - reporting and oversight arrangements	Residual Impact Score	Residual Likelihood Score	Residual risk Score	Further Actions Planned including Timescales	Target Impact Score	Target Likelihood Score	Target risk Score	Status (Change from previous residual risk score)		Assurances	Update (current statement on effectiveness of actions in place, justification for current risk score or change in score)	Last Reviewed (Date and by whom)
Apr-21	P/004	**Autism/ ADHD** Due to capacity outstripping demand alongside sustained and increasing demands for adult and children neurodevelopmental (autism/ADHD) diagnostic assessments, **there is a risk that** waiting times will remain long and are increasing, **resulting in** poor quality of service and poorer outcomes for patients as well as increased costs and reputational risk to the ICB.	Accelerate Preventative Programmes	Ali Cartwright, Chief Planning and Performance Officer	Matt Gilks, Director of Commissioning	5	4	20	**Preventative:** As part of the business case all patients are being contacted to ensure an appointment is still necessary All patients joining the waiting list are triaged to ensure patients are treated according to need. Additional capacity is being brought on line with CWPT via additional private providers to reduce the waiting times. **Detective:** Measurement of average and longest waiting times. Measurement of referral levels Additional costs to the ICB **Directive** Neurodevelopmental business case **Monitoring:** Monthly reports are produced which monitor progress against the agreed trajectory, number of assessments completed and waiting times.	3	4	12	Delivery of the Autism Waiting Times Business Case (on track with the agreed trajectory) will continue over the period of the next two years in order to reduce the risk in line with the delivery of the trajectory.	3	2	6	No change	↔	**Operational:** Two weekly trajectory monitoring meetings with CWPT (Chaired by Matt Gilks) **Oversight:** Learning Disability and Autism Board/Finance and Performance Committee/Governing Body (as part of the Performance Report). Clinical Quality and Governance (when appropriate). **External:** Warks SEND Steering Committee/NHSEI	**April 2022:** The business case has been finalised and signed off by the CCG and Warks SEND Inspection Statement of Action has been approved by NHSEI. Now moving to implementation stage, however the deliverables will take time and we expect this position to continue in the medium term for the next two years. The ICB has agreed to reduce waiting times to a maximum of 13 weeks by June 2024. This is being monitored on a weekly basis.	April 2022 Matt Gilks
Apr-21	Q/001	**Transforming Care** **If** the ICB is unable to provide the necessary support to those with a Learning Disability and/or Autism in the community, **then** there is a risk that more people with a Learning Disability and/or Autism will be admitted to hospital or the that number of people in hospital will not reduce, **resulting** in significantly adverse impacts on the quality of life for these people and their families.	Accelerate preventative programmes Protect the most vulnerable Restore Elective Care	Phil Jones, Accountable Officer	Jamie Soden, Director of Nursing and Clinical Transformation	4	5	20	**Preventative:** - Increased operational capacity for delivery of effective discharge and admission avoidance alongside increased rigour - Swift action to ensure admissions avoidance offer is commissioned - Intensive Support Team & Community Forensic Service being established on recurrent basis to support all-age people with learning disabilities and/or autism **Detective:** - Local Government Association peer review in early 2021, discharge assurance process under review, weekly system discharge planning and admission avoidance meeting, Root Cause Analyses for all admissions; Review of 12 point discharge plan in operation; Review of system Dynamic Support Register in operation **Directive:** - 21/22 Operational plan and 3 year road map, system wide governance arrangements, National guidance, Building the right support (2015), Long Term Plan Objectives **Monitoring:** - LD and Autism Board, strategic steering group and LD/A finance meeting every month . Operational Steering Group every 2 weeks. Weekly Discharge Assurance and Admission Avoidance meeting - Escalation meetings with NHSE/I, Monthly regional SRO meetings. - Monthly performance reports regarding key metrics to Finance and Performance Committee. Bi-monthly Clinical Quality and Governance Committee reports.	4	4	16	Detailed review of all inpatients undertaken to set out pathways to discharge up to end of March 2024. Continued focus on Safe and Wellbeing Reviews and their associated Oversight and Scrutiny Panels, with themes and findings going to Clinical Quality and Governance Committee in May 2022.	3	3	9	No change	↔	**Operational** - 21/22 Operational Plan, and 3 year LDA roadmap - Plan overseen by Operational and Strategic Steering Groups in place with regular review - Operational and Strategic Steering Groups overseeing working groups: Admission Avoidance and Discharge Assurance Groups, LDA Finance Group, Autism Risk of Admission Workstream, Keyworker Pilot, Accommodation and Support Workstream. **Oversight** - Reports to CQG Committee, Arden LDA Board, Finance and Performance Committee, CW HCP and Collaborative Commissioning Boards. **External** - LDA Executive Board (System-wide group) - Coventry and Warwickshire Partnership Executive Group - CWPT LDA Transformation Board - NHSE Regional Oversight Panels, Deep Dives and Escalation Meetings.	**April 2022** No change in overall risk score. Reduction in the adult cohort in March with 4 discharges, and no admissions at the time of report, putting the number at 44 adult inpatients. 1 CYP admission from the community, putting the current number at 6 CYP inpatients, although 2 are on section 17 leave in the community. System-wide escalation process for admission avoidance and discharge assurance in place and working well.	April 22 Jamie Soden
Jul-21	Q/012	**Children in Crisis** **If** the system is unable to mobilise a robust service to support children experiencing a mental health and/or an emotional crisis **there is a risk that** community services, A&E's and paediatric wards will be overwhelmed by the number of children requiring support, **resulting in** children and young people with extreme emotional challenges not receiving the timely care they need in an appropriate environment.	Accelerate preventative programmes Protect the most vulnerable Restore Elective Care	Nigel Minns, Strategic Director for People, Warwickshire County Council	John Gregg, Director of Children's Services Jamie Soden, Director of Nursing and Clinical Transformation	4	5	20	**Preventative:** -Daily Multiagency calls to manage those in A&E/paediatric wards -Additional youth workers deployed to acute hospitals where needed -Additional resources diverted from core CAMHS service to support crisis intervention -Deployment of the Director of Nursing and Clinical Transformation to lead Bronze and the operational response across the system -Additional governance has been established through Bronze, Silver and Gold to provide additional leadership, oversight and rapid decision making. **Monitoring** -Bronze, Silver and Gold system escalation calls in place -Daily monitoring of the number of children in crisis in community settings, A&E and on Paediatric wards **Detective:** -Paediatric Wards reviewed against a recent CQC visit to another hospital and actions talked to ensure appropriate support is in place -Independent review of mental health services for Children In Crisis **-Directive** -Weekend plans for all sites and organisations collated and shared at the Thursday Silver call	4	3	12	Satisfied that the correct measures are in place and will take time to take effect.	3	2	6	No change	↔	**Operational** Multiagency daily calls Bronze **Oversight** Silver and Gold Reports to CQG Committee **External** CAMHS Transformation Board	**April 2022:** The national guidance has now been released and the CCG leads are reviewing it to understand the implications. At this time it appears the time frame for completion is significantly shorter than the CCG has been working to for CoP. The time frame for implementation is anticipated to be 12 months	April 22 Jamie Soden
Aug-21	Q/018	**Increased Quality Concerns Post COVID in Community Care Providers across Coventry and Warwickshire** **If** the ICS is unable to meet the capacity currently required to both proactively and reactively deliver a robust integrated assurance monitoring programme across Coventry and Warwickshire, **there is a risk** that the ICS is unable to provide robust assurance that the local population are receiving the level of care they require in a safe environment, **resulting in** the potential for patients experiencing unmet needs and poor care and negative media coverage for the ICB.	Protect the most vulnerable	Jo Galloway, Chief Nursing Officer	Jamie Soden, Director of Nursing and Clinical Transformation	4	5	20	**Preventative:** CCG Clinical Care Home Team staff and LA QMO have prioritised (by known risk) providers for planned joint QM visits. However, due to increased resource required to manage existing providers with quality concerns follow up visits conducted to monitor the quality provision and provider progress against their SIP are being delayed. Therefore the following detective action is in progress: **Detective:** The number and level of risk of providers on escalation Assessment of other quality assurance activity demands and the resources currently available noting gaps An assessment of our teams ability to meet these demands and the level of risk this presents Recommendations that will be agreed via AQS and presented to Care EAG. **Monitoring:** A SEP/PEP meeting monthly providing CCG/LA/CQC oversight monthly (and virtually if required) to share intelligence and coordinate reactive quality monitoring and assurance.	4	3	12	The team will update the workplan to reflect the new starters and their increasing confidence and productivity as they progress through their induction. The development of the system Care EAG and subgroups has led to the formation of a new multi agency, system wide Quality and Workforce group for community providers. This group will be refocused with less emphasis on responding to Covid and more on the development of sustainable, high quality providers across Coventry and Warwickshire. The CCG are jointly leading the development of this group with Coventry and Warwickshire Social Care	3	3	9	No change	↔	**Operational assurance:** oversight via operational SEP Multiagency daily presence **Oversight** Service Escalation Panel Provider Escalation Panel Reports to CQG Committee **External** WCC/CQC	**April 2022:** New staff are progressing through their induction and increasingly contributing to the assurance process. Escalation panels in both Coventry and Warwickshire are seeing a more stabilised picture across care homes. Staffing remains an ongoing Challenge	April 22 Jamie Soden
Dec-21	Q/023	**Care Home Provision and Domiciliary Care availability/capacity** **If** there is a continued shortage in the provision of bedded placements and domiciliary care in Coventry and Warwickshire, **there is a risk that** vulnerable service users will be placed out of area and/or at an increased cost, **resulting in** delays that could impact on discharges, including EoL and the general welfare of patients.	Protect the most vulnerable Restore Elective Care	Nigel Minns, Strategic Director for People, Warwickshire County Council Kirsten Nelson Director of Education/Chief Partnerships Officer, Coventry City Council	Becky Hale, People, Strategy & Commissioning, Warwickshire City Council Jon Reading, Head of Commissioning and Quality, Coventry City Council	4	4	16	**Preventive:** Continues to be a focus within LAs and silver command discussions. Work continues to increase capacity including use of SPOT contracted providers. Workforce plans in development. Implementation of discharge to assess review recommendations in Warwickshire. **Detective:** Coventry and Warwickshire dashboards in operation. Care EAG being reconstituted to become long term Joint Commissioning Forum. **Directive**: Work underway to deliver fair cost of care exercise across Coventry and Warwickshire. **Monitoring:** Monitoring of sourcing activity. Continued risk based approach to quality assurance activity within the care market.	4	3	12	Focus of discharge task and finish group. Care at home review underway to inform future commissioning model (Warwickshire only).	2	3	6	No change	↔	**Operational Assurance:** Daily joint local and health meetings **Oversight:** System, bronze and gold **External:** NHSEI	**April 2022:** Provider capacity due to COVID and staffing remain a significant problem. Discussions continue on a commissioners wide basis and individual patient packages are reviewed daily to identify individual solutions where possible.	April 22 Becky Hale
	Q/025	**Coventry and Warwickshire system delivery of Ockenden** **If** the system does not achieve the expectations of the Ockenden 1 (7 Essential and Immediate Actions) and Ockenden 2 (15 Essential and Immediate Actions) via robust and forensic oversight of provider achievements and appropriate funding, **there is a risk that** the system will not be able to provide robust assurance that the local population are receiving the level of care they require in a safe environment, **resulting in** the potential for women, babies and their families experiencing unmet needs, poor care and negative media coverage for the organisations.	Protect the most vulnerable (ensuring equality and access to maternity and neonatal services)	Jo Galloway, Chief Nursing Officer	Mary Mansfield, Deputy Director of Nursing and Quality	4	4	16	**Preventative Actions in place** The LMS will monitor the providers to ensure that they achieve the recommendations of Ockenden 1 and 2. **Detective Actions** Active themed insight review visits of providers and reviewing their returns **Monitoring Arrangements in place** Implementation of robust and forensic systems, processes and provider reviews to ensure oversight of any delays or barriers to implementation of the recommendations. **Directive Actions in place** Ockenden 1 and 2 expectations Working with NHSE/I and providers in a supportive, collaborative and collegiate manner to embed and implement recommendations.	4	3	12	Rolling programme of insight visits to all providers. Monitoring of returns, reviewing systems and processes, particularly in relation to continuity of care.	3	3	9	New Risk		**Operational** Quality team contact with providers on a regular basis. **Oversight** LMNS (Local maternity and neonatal system) Clinical Quality and Governance Committee Governing Body **External** NHSE oversight.	**April 2022** New risk added as assurance is required in relation to system meeting the recommendations of Ockenden and Kirkup recommendations (awaiting publication).	April 2022 Natasha Lloyd-Lucas/Mary Mansfield
	STP2	**Workforce shortages** **If** the ICB is unable to recruit and retain the required workforce, **there is a risk that** the vacancy level will impact on service delivery, in addition to pressure on its current workforce, **resulting** in increased sickness and higher turnover, therefore impacting service delivery.	Care for and develop our workforce	Theresa Nelson, HR Director, Coventry and Warwickshire Health and Care Partnership	Chief Nurse, People Board and Chief Nursing Officers	4	4	16	**Preventative:** Health and wellbeing support, staff in mind, leadership development, safe cultures including speak up. **Detective:** Analysis of staff survey, WRES, inclusive cultures, health needs assessment to understand what is being offered staff to help keep them well and healthy, student experience survey. **Directive:** Piece of work being commissioned (One People Strategy) **Preventative:** Development of Carer's passport, EDI networks being developed. **Monitoring:** Existing People Board structure - Training Hub, Skills for Health and other partners which reports to People Committee.	4	3	12	Satisfied that the correct measures are in place and it is a case of allowing them time to take effect. Piece of work being commissioned (One People Strategy).	3	3	9	No change	↔	**Operational Assurance:** Sub groups of People Board; HR & OD group **Oversight:** People Board, People Committee and ICB Board **External:** People Plan monitored by Regional People Board, NHSEI, Health Education England	**April 2022:** Deep dive being undertaken into system wide vacancies. Health and wellbeing remains a priority and promotion of supporting services. Staff survey action plans being developed.	April 22 Theresa Nelson

						Unmitigated Risk Score						Residual (Current) risk Score				Target Risk Score							
Date added	Reference	Risk description	System priority	Risk Lead	Risk Owner	Initial Impact Score	Initial Likelihood Score	Unmitigated Risk Score	Measures in place to Manage the Risk Preventative - stops the problem occurring Detective - detects the problem when occurs Directive - written/verbal instructions/ policies, etc. Monitoring - reporting and oversight arrangements	Residual Impact Score	Residual Likelihood Score	Residual risk Score	Further Actions Planned including Timescales	Target Impact Score	Target Likelihood Score	Target risk Score	Status (Change from previous residual risk score)		Assurances	Update (current statement on effectiveness of actions in place, justification for current risk score or change in score)	Last Reviewed (Date and by whom)
	STP15	**Mental Health - Inpatient capacity** **If** the system is unable to provide alternatives to admission and facilitate timely discharge for those with Acute mental Health problems, **then** this could **result in** delivering poor quality services and a need for patients to receive their care in suboptimal out of area placements.	Protect the most vulnerable	Sharon Binyon - Medical Director	Richard Onyon - Associate Medical Director	5	4	20	**Preventative:** Additional Crisis House support (admission avoidance) Plan and mobilise additional bed capacity within Coventry and Warwickshire bed base and right sizing MH bed based offer Strengthening the flow team to deliver an enhanced wrap around discharge across Coventry and Warwickshire. - A dedicated complex Discharge Case Manager - Social Worker (2.00 wte) and Neurodiversity MDT support - Joint brokerage - Liaising with housing colleagues to strengthen input and outcomes - Scoping bespoke provider offer for Neuro diversity **Detective** Identified the themes for the list of long waiters to progress delays **Directive** A refreshed and revised local Out of Area trajectory is in place for Coventry and Warwickshire. **Monitoring** A bronze, gold and silver system escalation process has been established.	3	4	12	There was a national expectation to reach a zero Acute Out of Area ambition by 30.09.2021, which has not been achieved. Current operating conditions are leading to bed pressures in local acute MH services including suboptimal bed flow, delayed discharges and longer than average length of stay; impact of NHS Infection Prevention Control on available bed numbers and staffing pressures.	2	3	6	No change	↔	**Operational Assurance:** Bronze, gold and silver system escalation process **Oversight:** System, bronze and gold **External:** NHSEI	**March 2022:** There was a national expectation to reach a zero Acute OOA ambition by 30.09.2021, which has not been achieved. Current operating conditions are leading to bed pressures in local acute MH services including suboptimal bed flow, delayed discharges and longer than average length of stay; impact of NHS Infection Prevention Control on available bed numbers and staffing pressures.	Sonya Gardiner March 2022
	STP19	**General Practice Estate** **If** we fail to address estate constraints recognised in the General Practice Estate Programme **there is a risk that** Primary Care Networks will be unable to fully deploy funding available to them via the national Additional Roles Reimbursement Scheme; and/or the strategic direction of travel established in Coventry and Warwickshire Five Year Plan in terms of 'left shift'/boosting of out of hospital care may be impeded **resulting in** the local health and care system being unable to deliver the anticipated benefits set out in the NHS Long Term Plan.	Maximise all enablers	Ali Cartwright, Chief Planning and Performance Officer	Hannah Willetts, Director of Primary Care	4	4	16	**Preventative:** General Practice Estate Programme established. Programme incorporates; (1) A number of priority projects at individual GP practice level - some in development, some in delivery; and (2) Options development and appraisal work in a number of prioritised localities to identify future estate solutions. CCG staff resource aligned to estate agenda via the CCG Primary Care Team. In relation to securing funding for project development and delivery, the CCG has a systematic and well-developed approach to responding to planning applications and has demonstrated success in securing developer contributions via both Section 106 Planning Obligations and the Community Infrastructure Levy. The CCG works with partners in relation to estate planning and infrastructure delivery via both the system-level Coventry and Warwickshire Health and Care Partnership Estates Strategy Group and Place-level Estates Groups. **Monitoring:** Via the Primary Care Commissioning Committee - reporting at both Programme and project levels. **Directive:** The CCG is working with PCN Clinical Directors to progress local implementation of two national programmes flowing from the 2019 General Practice Premises Policy Review; the Primary Care Data Gathering Programme and the PCN Strategy Support Programme.	4	3	12	Key area of focus locally is the implementation of the Primary Care Data Gathering and the PCN Strategy Support Programmes across the upcoming financial year (2022/23). CCG approach to resourcing estate agenda under review.	3	3	9	No change	↔	**Operational Assurance:** General Practice Estates Programme **Oversight:** NHS Coventry and Warwickshire CCG Primary Care Committee	**April 2022:** Planning in progress for local implementation of PCN Strategy Support Programme - likely to commence June 22. Communication issued to all practices regarding primary care data gathering programme.	Hannah Willetts April 2022
	STP20	**General Practice Workforce** **If** we fail to recruit and retain the general practice workforce **there is a risk that** we will be unable to deliver both business as usual, restoration of services and the transformation that is required, **resulting in** increased pressure on other areas of the system such as urgent and elective care and poor patient outcomes and increase the risk of more of the workforce leaving general practice.	Focus our delivery on Place based care.	Ali Cartwright, Chief Planning and Performance Officer	Sue Phillips, Head of Primary Care	4	4	16	**Preventative** Comprehensive health and wellbeing programme in place for the primary care workforce in readiness for full primary care integration in 2023 Local recruitment and retention schemes under way. 2022/23 additional funding secured **Detective** Review the impact of all local schemes and use of budget. **Directive** Primary Care Workforce Strategy and General Practice Nurse Strategy. PCN Directed Enhanced Service. **Monitoring** Review and communicate workforce data with the whole workforce governance structure, with the general practice leadership groups, the Clinical Executive Group. Also shared with Primary Care Commissioning Committee	4	3	12	Continuation of local schemes to promote maximum update of local schemes, regular and ongoing engagement with the general practice workforce to ensure the support offer is appropriate. Continued escalation to senior leaders to ensure they are aware of the challenges.	3	3	9	No change	↔	**Operational:** Primary Care Operational Group Training Hub Board **Oversight:** Primary Care Commissioning Committee People Board **External:** NHSE Regional Team Health Education England	**April 2022:** Three training nurses associates have been recruitment and are being trained and a late career GP programme has been launched. The Primary Care Workforce submission as part of the Operating Plan has been approved.	April 22 Sue Phillips
	STP21	**General Practice Workload** **If** the demand on general practice continues/and or increases, **there is a risk that** general practice will be unable to meet the demand and patient expectations **which will result in** poor patient outcomes, reputational risk, increased scrutiny and pressure on other parts of the system, as well as impacting morale and performance of general practice.	Focus our delivery on Place based care.	Ali Cartwright, Chief Planning and Performance Officer	Sue Phillips, Head of Primary Care	4	4	16	**Preventative** Launch of communication strategy to support patient decision making to use the most appropriate services, and what patients can expect when they attend their general practice (in consultation with Healthwatch) and promotes extended access. National winter funding to deliver system PCN and practice support. **Detective** Review data regularly and discussion with individual practices what has been impacting on access, HoSC review is underway (Warks County Council). **Directive** NHSE directions, GMS Contract and PCN DES **Monitoring** Review GP Appointment data regularly, NHS 111, A&E activity data, resilience schemes in place.	4	3	12	Large and comprehensive workforce programme under way. Significant investment in GP ICT. PCN Estates process in place to identify any capacity pressures. Work to begin to pick up transformational work required to support increased efficiency and resilience in general practice (for example piloting an administrative hub)	3	3	9	No change	↔	**Operational Assurance** GP IT Groups (SW/Coventry, Rugby and WN) Training Hub Board Local Estate Forum Primary Care Delivery Group **Oversight Assurance** Primary Care Clinical Advisory Group Primary Care Commissioning Committee Digital Transformation Board People Board **External Assurance** NHSEI Health Education England	**April 2022:** Work ongoing to support primary care in all areas. Primary Care away day is being organised to agree priorities for 2022/23.	April 22 Sue Philips
	STP22	**General Practice Information and Communications Technology (ICT)** **If** the digital transformation ambitions set out in local GP ICT plans/programmes (including in relation to infrastructure) are not delivered in full, **there is a risk that** efficiency opportunities will not be realised impacting transformation activity, **resulting in** potential reduction in performance, patient experience and access. Ultimately, there is a potential impact on patient outcomes through reduction of ability to capture, access, share and report on real time patient data at point of care through resilient and fit of purpose infrastructure including provision of clinical systems (GPFutures framework), population health management and Integrated Care Record.	Maximise all enablers	Adrian Stokes, Interim Chief Finance Officer	Simon Jones, Interim Chief Information Officer	4	4	16	**Preventative:** Investment synergised across places in line with strategic priorities (GPFutures, DFPC and GP Capital) **Detective:** SLA reports from IT providers **Directive:** GPIT Strategy arising from ICS Digital Transformation Strategy **Monitoring:** Staff resource aligned to GP ICT agenda within CCG Primary Care Team. GP ICT plans/programmes established and governance in place. National Primary Care (GP) Digital Services Operating Model in place.	4	3	12	Awaiting the 2022 GP IT Operating Model. Further funding has been secured for business continuity and Voice over Internet Protocol (VoIP) Telephony.	4	2	8	No change	↔	**Operational Assurance** GP IT Groups **Oversight Assurance** Primary Care Commissioning Committee Digital Transformation Board **External Assurance** NHSE/IDX	**April 2022**: Implementation of second HSCN lines underway planning for VoIP implementation active.	April 22 Simon Jones
Feb-22	STP23	**Cancer** **If** we do not utilise our capacity and manage our cancer referrals effectively **there is a risk that** patients will continue to wait longer for both diagnosis and treatment. **Resulting in** failure of key cancer standards and sub-optimal pathways for our patients with variation across our ICS for both access and inequalities potentially.	Restore Elective Care	Rachael Danter, Chief Transformation Officer	Laura Nelson, Director of Operational and Financial Recovery	5	5	25	**Preventative:** Ensuring screening programmes are effective and delivering within timescales. Engaging with public health and target key populations across our ICS **Detective:** Shared learning across our ICS through Cancer Managers group Regular oversight of 62 day PTL backlog Deep Dive into reasons for deterioration and areas of opportunity specifically linked to Urology which makes up circa 30% of backlog. **Directive:** Review of pathways and alignmnt to best practice eg: Lower Gi straight to test, one-stop clinics and admin process variation and management. Effective use of IS to support clearance of diagnostic tests linked to cancer pathways eg; cystocopies Enhanced use of A&G Systemwide Urology workshop Initial conversation with Macmillan; focusing on potential funding opportunities associated with Inequalities agenda Cancer Patient Collaborative Forum - A refresh of TOR, membership and focus; linking with WMCA and ICS Inequalities workstream. **Monitoring:** Cancer Managers and teams continue to review 62day & 104+ day Systemwide oversight included as standing agenda item at C&W Cancer Board. A range of initiatives currently under review to support improved position. ICS/providers establish access to weekly COO group (escalation)Activity monitored via governance boards. Linking GIRFT recommendations across specialities	4	4	16	Satisfied that the correct measures are in place. Bi-Weekly operational meetings now in place to share learning, track patients and identify key risk specialties.	3	3	9	No change	↔	**Operational Assurance** Local Cancer Manager and operation teams performance reviews. Regular oversight of 62 day PTL backlog Cancer Patient Collaborative Forum **Oversight Assurance** ICS/providers establish access to weekly COO group (escalation) Activity monitored via governance boards **External Assurance** NHS Coventry and Warwickshire Finance and Performance Committee NHSE	**April 2022:** Whilst our performance remains a challenge we have started to see reduction in the number of patients waiting over 62 days and continue to focus on these and our 104 day patients on a weekly basis.	April 22 Laura Nelson

Risk Appetite (as per Risk Management Policy)

The Governing Body will, where necessary, tolerate overall levels of risk that are classified as **12** or lower where action is not cost effective or reasonably practicable. The CCG will not normally accept levels of risk scored 15 or more and will therefore ensure that plans are put into place to lower the level of risk whenever an extreme risk has been identified.

Grading Matrix

Risk Level Indicator

Risk factor	Risk descriptor
1-3 Green	Low Risk
4-6 Yellow	Moderate Risk
8-12 Amber	High risk
15-25 Red	Extreme risk

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

Likelihood x Consequence = Level of Risk

Matrix Terminology Descriptions - Likelihood (Guide only)

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain

Frequency (general) **How often might it/ does it happen**	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency (timeframe)	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability **Will it happen or not**	<1%	1-5%	6-20%	21-50%	>50%

Matrix Terminology Descriptions - Impact (Guide only)

	1	2	3	4	5
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Patient Experience	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience – readily resolvable	Mismanagement of patient care	Serious mismanagement of patient care	Totally unsatisfactory patient outcome or experience
Complaint/ Claim Potential	Locally resolved potentially	Justified complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim
Objectives / Projects	Insignificant cost increase/ schedule slippage. Barely noticeable reduction in scope or quality	<5% over budget schedule slippage. Minor reduction quality / scope	5-10% over budget / schedule slippage. Reduction in scope or quality requiring client approval	10-25% over budget / schedule slippage. Doesn't meet secondary objectives	>25% over budget / schedule slippage. Doesn't meet primary objectives
Service/ Business Interruption/Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Financial including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Statutory Duties/ Inspection/Audit	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse Publicity/ Reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Information Governance/ Records	Damage to an individual's reputation. Possible media interest.	Damage to a team's reputation. Some local media interest.	Damage to a services reputation/ local media coverage. Serious breach of confidentiality e.g. up to 100 people affected	Damage to an organisation's reputation/ Local and politically sensitive media coverage.	Damage to NHS reputation/ National media coverage.

Management	Potentially serious breach. Less than 5 people affected or risk assessed as low, e.g. files were encrypted	Serious potential breach & risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected		Serious breach with either particular sensitivity e.g. sexual health details, or up to 1000 people affected	Serious breach with potential for ID theft or over 1000 people affected

The four aims of the ICS:

Improving outcomes in population health and healthcare
Tackling unequal outcomes, experience and access
Enhancing productivity and value for money
Supporting the broader social and economic development of Coventry and Warwickshire

System Priorities - System Development Plan

State how the content of the paper and the recommendation meets one or more of the following:

Accelerate preventative programmes *and activities that target those at greatest risk, eg.pre-rehabilitation, mental health programmes*

Work together *, as partners, at system and Place to identify and address health inequalities and variations in health and care provision*

Protect the most vulnerable *, ensuring inclusivity runs through everything we do*

Focus our delivery on Place-based care *, supported by strong, well developed PCNs*

Successfully manage urgent emergency care (UEC) *, particularly winter pressures (including Flu) alongside managing any further Covid-19 surges (continuing Covid-19 vaccination and mass testing)*

Restore elective care *to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics*

Care for and develop our workforce *ensuring they continue to have the resilience and support to deliver the best care to our patients and communities particularly our BAME employees*

Maximise all enablers *that support us deliver our Five-Year Plan commitments eg. digitally enabled care, our estate and flexible working*

'Live within our means' *and become financially sustainable*

Report Title:	Health Inequalities Strategic Plan
Report From:	C&W Inequalities task group reporting to Population Health, Inequalities and Prevention Enabling Delivery Group
Author:	Rachel Chapman, Consultant in Public Health UHCW/Coventry City Council Liz Gaulton Chief Officer Population Health Management and Inequalities
Previous Considerations and Engagement:	Health inequalities strategic principles agreed by shadow ICB in January 2022. Draft strategy considered at shadow ICB development day in April 2022. Significant system engagement has taken place during development of the strategy (detailed in the strategy document)
Purpose:	Endorsement

Contribution to meeting the aims of the ICS:

The Health Inequalities Strategic Plan explicitly contributes to the ICS four key aims:

- Tackling unequal outcomes, experience and access:
- Improving outcomes in population health and healthcare:
- Enhancing Productivity and value for money:
- Supporting the broader social and economic development of C&W:

Contribution to meeting the priorities of the ICB:

This paper and the recommendations meets the following priorities:

Work together, as partners, at system and Place to identify and address health inequalities and variations in health and care provision

Reducing health inequalities also contributes to the following priorities:
Protect the most vulnerable, ensuring inclusivity runs through everything we do

Focus our delivery on Place-based care, supported by strong, well developed PCNs
Restore elective care to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics

'Live within our means' and become financially sustainable

Recommendation:

Members are requested to ENDORSE the Health Inequalities Strategic Plan for submission and adoption to the Board of the Integrated Care board post 1 July 2022.

Implications							
Conflicts of Interest:	None						
Financial and Workforce:	Future financial decisions should take account of and prioritise reducing health inequalities Workforce engagement and training will be needed to enhance understanding of health inequalities, and needs of different communities. This links with the wider equality, diversity and inclusion work in the People Strategy						
Performance:	The ICS will be performance monitored for progress on reducing health inequalities. A local monitoring framework is being developed.						
Quality and Safety:	Reducing health inequalities will contribute to improving quality and safety of services, and will improve patient experience particularly for groups who have previously experienced poorer access and experience						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	Community co-production and engagement will be key to delivery of the plan						
Clinical and Professional Engagement:	Significant system-wide engagement, including with clinicians, has been undertaken in development of the strategic plan. This is detailed in the strategic plan document						
Risk and Assurance:	Risks will be identified through each of the delivery plans						

1. Executive Summary – Health Inequalities Strategic Plan

1.1 Key points and purpose:

ICSs have been asked by NHSE/I to develop Health Inequalities Strategic Plans. These should be place-based and developed in partnership with key local stakeholders, co-ordinated by the DPH for that place. The C&W plan has being developed by the Inequalities task group, which is a subgroup of the system Population Health, Inequalities and Prevention (PHIP) group.

A set of principles for the strategy was agreed by shadow ICB in January 2022 and used to develop the strategic plan:

1: Addressing health inequalities is core to and not peripheral to the work of the C&W ICS

2: C&W plan will be based on the King's Fund model of Population Health, recognising the importance of all quadrants in reducing inequalities while focusing on the health and care quadrant in terms of delivery

3: C&W plan will be built around the Core20+5 health inequalities framework

4: Take an evidence-based approach

5: Innovation will be encouraged

6: Community co-production needs to be central to delivery of the plan

7: Need to embed reducing health inequalities across all ICS work

8: Reducing inequalities will be key to decisions on the prioritisation and allocation of resources

The draft plan was submitted to NHSE/I at the end of March, no specific feedback has been received. The draft plan was discussed at the shadow ICB development day in April. Since then there has been further work on the delivery plans and the approach to performance monitoring which are included in the final document.

1.2 How does the paper support the achievement of the Integrated Care Strategy/ Aims of the ICS and support the achievement of the ICB Priorities

Reducing health inequalities is core to the purpose of the ICS and its aim to tackle unequal outcomes, experience and access.

As well as being an explicit aim addressing health inequalities is a legal duty; it is morally the right thing to do and is driven by the business imperative of building financial sustainability through effectively targeting our resources. It therefore underpins the other three aims of the ICS:

- Improving outcomes in population health and healthcare:
- Enhancing Productivity and value for money:
- Supporting the broader social and economic development of C&W:

The health inequalities strategic plan will support the ICS to deliver its priority:
Work together, as partners, at system and Place to identify and address health inequalities and variations in health and care provision.

In addition, it will contribute to the following priorities:

- Protect the most vulnerable, ensuring inclusivity runs through everything we do
- Focus our delivery on Place-based care, supported by strong, well developed PCNs
- Restore elective care to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics
- 'Live within our means' and become financially sustainable

2. Engagement

2.1 There has been significant system-wide engagement while developing the strategy which is detailed in the attached document.

2.2 Engagement and co-production with the local population will be crucial in developing and implementing the delivery plans. As an example, a significant piece of public engagement work has just been completed with IPSOS-MORI on the work looking at prioritising waiting lists to reduce health inequalities. The ICS People and Communities strategy will provide the framework for engagement and co-production.

2.3 Local Authorities will be key in engaging with local communities, linking in with and strengthening existing mechanisms. Two examples are given here – the Warwickshire Health Equity Group and the Coventry Community Messengers.

2.4 In Warwickshire, a pilot Health Equity Group programme has launched with the purpose of exploring ways in which community perspectives on reducing inequalities in health and wellbeing can be heard and acted upon. 22 Warwickshire residents (representing all 3 Places) have signed up to the initial training programme, which focuses on setting the scene for current health inequalities in Warwickshire, and starting a conversation about what is needed to make a meaningful impact on health and wellbeing improvements. The pilot training module concludes imminently, with the group taking a pivotal role in reviewing the model and designing its next steps. The Group has identified mental health as its first priority, and is keen to look at ways of getting information about services and support out to population groups that are under-represented as users of the services.

2.5 Coventry has a very diverse and active voluntary and community sector with many small and well-connected groups, as well as community leaders and "go-to" people in local neighbourhoods. During the Covid pandemic a network of over 300 Community Messengers were recruited from existing faith, voluntary and community networks in the city. The messengers perform two main functions: they help to disseminate healthy messages into their community and they collect and feedback community intelligence which is then used to influence a number of areas of work. This programme was extremely successful in reaching communities during the pandemic and is being continued and expanded as part of a wider approach to engaging with local communities on their health.

3. Next steps - delivery

3.1 Outline delivery plans for Core20+5 and the major NHS transformation programmes have been included in the strategic plan. The existing inequalities task group which reports to PHIP is being refreshed to become an Inequalities Delivery Group. This will be chaired initially by Liz Gaulton (ICB), and jointly by Public Health Consultants going forwards. The terms of reference for the group are being refreshed to support delivery of the strategy and links with wider system work on health inequalities.

Conclusion

Reducing health inequalities is an explicit core aim of the ICS and underpins all four of its aims. The Health Inequalities Strategic Plan has been developed through extensive engagement with the wider system. It sets out specific deliverables for the NHS, focused on the Core20+5 groups, which will contribute to the whole system approach to reducing inequalities.

Recommendation

Members are requested to ENDORSE the Health Inequalities Strategic Plan.

End of Report

Report Title:	Cancer Deep Dive Performance Report
Report From:	Alison Cartwright, Chief Officer Performance and Delivery
Author:	Michelle Park, System Lead for Cancer Zoe Slade, System Transformation Manager
Previous Considerations and Engagement:	CCG Finance and Performance Committee (April 2022)
Purpose:	For discussion: To update the ICB on the most recent performance relating to the national cancer targets and its recent decline with an outline of the associated actions to improve performance and provide assurance.

Contribution to meeting the aims of the ICS:

This report provides a deep dive review into cancer performance across Coventry and Warwickshire, and sets out the system-wide actions being implemented to deliver the ICS aims for the following:

- Improving outcomes in population health and healthcare
- Tackling unequal outcomes, experience and access

Contribution to meeting the priorities of the ICB:

This programme of work supports the ICB priority to:

Restore elective care to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics

Recommendation:

Members are requested to:

- Note the contents of the report and actions to improve performance.

Implications	
Conflicts of Interest:	Not applicable
Financial and Workforce:	Not applicable

Performance:	Cancer performance is subject to the NHS constitutional targets measuring various stages of the pathway including two week waits, 28 day faster diagnostics and 62 day standards. The detail included within this report outlines current performance against each of these standards. Due to the number of long waiters currently in the System, a further deterioration in performance is likely to be seen in the coming months as these patients are treated, with an improvement to the performance standard recovering during Quarter 3 following the implementation of the actions outlined in the report.						
Quality and Safety:	The Trust cancer teams continue to scrutinise the 104 day waits, reviewing on a patient-by-patient basis. All >104-day waiters are subject to clinical harm reviews which are undertaken by the Lead Nurse and Cancer Medical Lead in each Trust.						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	Not applicable						
Clinical and Professional Engagement:	Clinical and Professional engagement is provided via the Cancer Transformation Board who have responsibility for overseeing the Cancer Improvement action plan.						
Risk and Assurance:	Given the level of performance, Cancer is a key system performance risk and consequently reported on the ICS Corporate Risk Register, which includes further detail on risk mitigation. One of the considerations for the system is how the risk is balance to ensure effective use our total elective capacity to support cancer recovery across the system whilst supporting regional elective recovery, particularly in the high throughput specialities that have large patient 62 day backlogs which include Urology (179), lower GI (90), Gynaecology (59) and Head and Neck (54). This makes up 77% of our cancer backlog and we need to ensure for these specialties specifically we monitor pan system mutual aid effectively.						

Cancer Performance

1.0 Executive Summary

1.1 Cancer performance has been consistently challenged in Coventry and Warwickshire, however during Quarter 3, 2021/22, the 62 day cancer metric fell to its lowest level with performance significantly below the national average.

1.2 Two week wait referrals continue to increase and are now higher than pre-Covid levels and the impact and pressure of the pandemic has continued throughout the year.

1.3 Providers are reporting several key pressures associated with performance, including workforce and sickness, patient compliance, referral surges/quality of referrals and timely diagnostics.

1.4 Within this context, meeting the requirements of the 62 days target along with the reduction of the 62 day waiting list backlog has been challenging across the system. Whilst the backlog reduced by over 30% during Quarter 4, over recent weeks unvalidated data shows that it's starting to increase again. There are currently 497 patients waiting for treatment that have breached the 62 day standard a variation of 239 against our March 2022 plan.

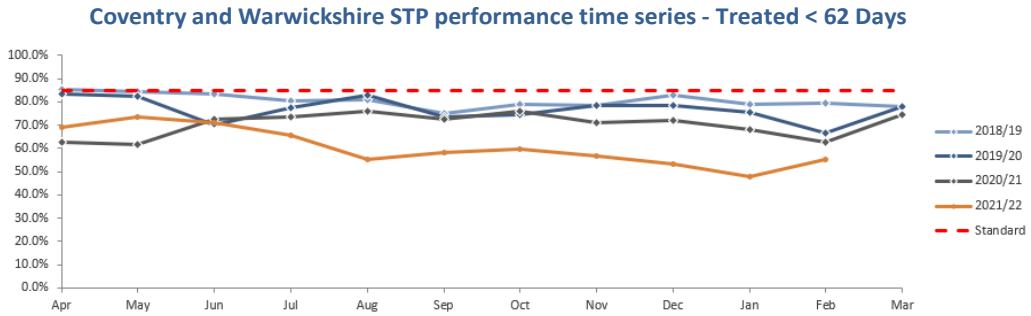
1.5 As at 24th April 2022, 109 patients have been waiting in excess of 104 days. The majority of these patients relate to Urological, Gynaecology and Head and Neck pathways. The Trust cancer teams continue to scrutinise the 104 day waits, reviewing on a patient-by-patient basis. All >104-day waiters are subject to clinical harm reviews which are undertaken by the Lead Nurse and Cancer Medical Lead in each Trust.

1.6 The 28-day faster diagnosis target of 75% is a priority for the System. For Q3, achievement against this target was 68.8% and while some tumour sites are performing well, others are more challenged. Particular areas of concern are Urology, Lower GI and Gynaecology. A System Steering Group for Urology/Lower GI is being implemented imminently.

1.7 System wide initiatives across all pathways, short term and medium/long term action plans are in place for all tumour sites to support continued improvement and timescales and expected outcomes are detailed within this report. Engagement with both primary and secondary care colleagues along with closer collaboration with diagnostics and pathology aims to ensure delivery of these improvements.

2.0 Background

2.1 Cancer performance has been consistently challenged in Coventry and Warwickshire, with the impact of Covid causing a further deterioration with an increasing number of patients experiencing long waits for treatments. The graph below provides a trend analysis of the 62 day over the last full 3 years and 2021/22 to date showing the year on year deterioration:



2.2 Throughout the pandemic there was a national and system focus to ensure cancer procedures were prioritised and patients treated and local Trusts transferred patients to the Independent Sector. For the majority of cancer services, the use of the Independent Sector ceased towards the end of Q3 2020/21 with Trusts repatriating activity back to Acute sites.

2.3 The impact of reduced capacity coupled with a limited access to theatres due to covid, challenged performance delivery and resulted in a considerable 62-day backlog. The backlog position has been the main area of increased focus, and whilst the backlog has reduced, this position has fluctuated throughout the year with high numbers seen again in Q3 2021/22 and into Q4, resulting in a decline in performance.

2.4 Some arrangements which existed before covid, such as a one-stop Breast clinics and Endoscopy services, were unable to resume to historical capacity levels owing to social distancing constraints of covid and lack of physical space.

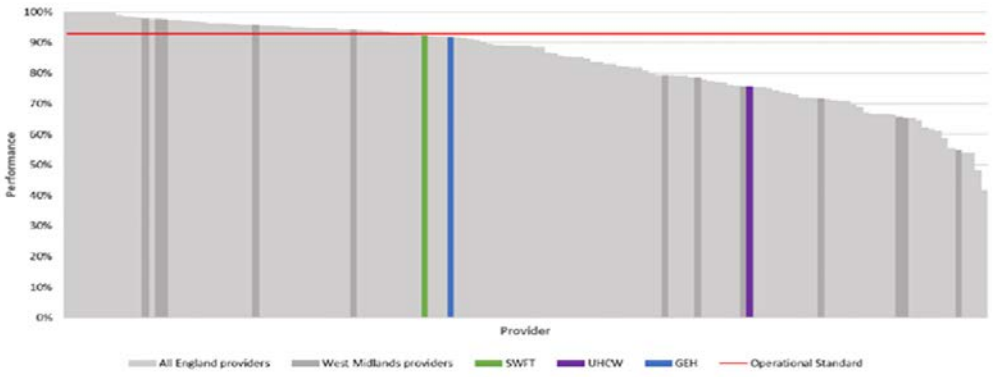
2.5 While focus has been on recovering cancer services and treating long waiting patients which has impacted on performance, we continue to see increasing referrals and an increase in the patient backlog.

2.6 This report details the current performance of the four main cancer access targets, actions to improve performance and the associated risks and mitigations.

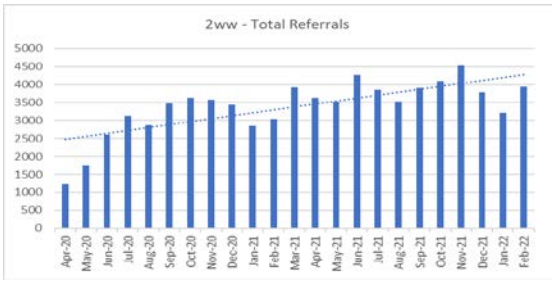
Current Performance

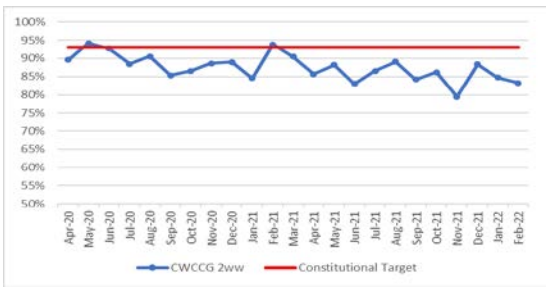
3.0 Two week wait referrals

3.1 The chart below shows the system providers 2 week wait performance against England and Regional Trusts in February.



3.2 Across the system, two week wait referrals have surpassed pre-covid levels, with the full year outturn for 2021/22 expected to exceed 2019/20 by approximately 5.1%. This increase has impacted on performance and the graphs below show the number of referrals and performance.



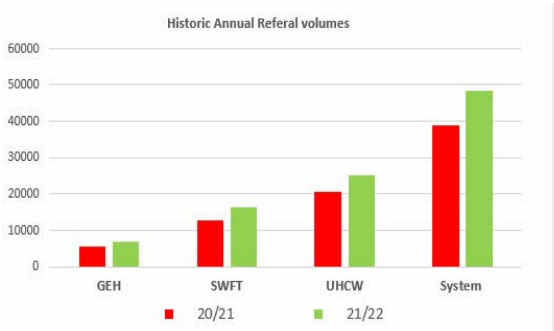


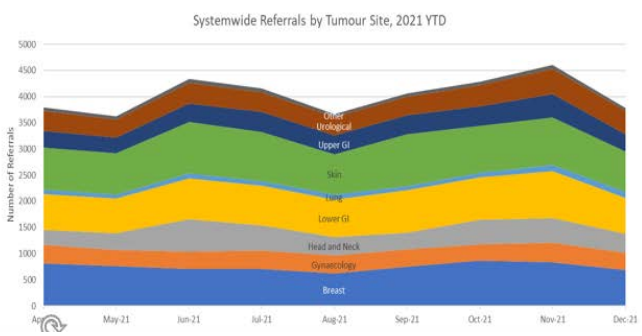
3.3 This increase in referrals is being seen nationally with the national cancer lead suggestion that it is expected that this level of referrals will continue and should be incorporated into demand planning.

3.4 This increase is most significant in high-volume pathways, especially Breast, Head & Neck, Lower GI, Upper GI and Lung, which have all seen rolling average referral rates increase by over 10% during the course of the year.

3.5 Throughout the year all three Trusts have witnessed referral surges as the pandemic has impacted on referral flow. Recent audits in Breast and Head & Neck suggest the reduction in capacity for examinations in primary care prior to referral may be adding further pressure to secondary care services.

3.6 The current year breakdown by pathway and the historic data for overall referrals is shown as below:

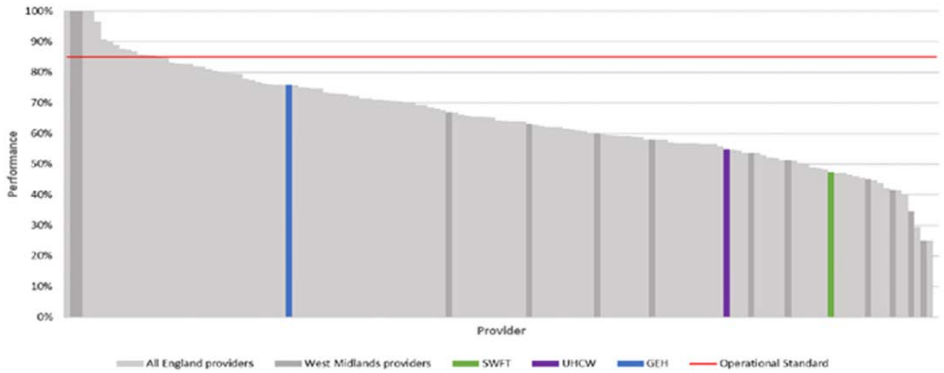




3.7 Following the increase in referrals and referral guidance changes during the last few years, there is a need to investigate the pre-referral pathway, including uptake of screening to support the whole pathway analysis. Practice level data is being reviewed to understand the variation of referrals and screening across the Coventry and Warwickshire footprint.

4.0 Patients waiting more than 62 days (backlog) and 62 day performance

4.1 The chart below shows the system providers 62 Day performance against England and Regional Trusts in February. Whilst nationally, performance for many providers is below the 85% standard, GEH performs well when comparing against national and regional providers. UHCW and SWFT are in the lower quartile, with SWFT in particular showing a deteriorating position.

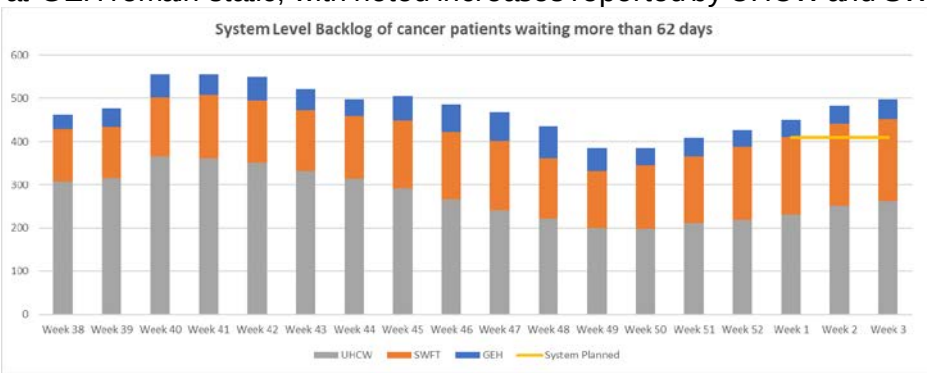


4.2 In the 2021/22 operational plan, there was a requirement to reduce the 62 day backlog with the aim to return to pre-pandemic (February 20) values by March 2022. This aspiration and key priority have been rolled forwards to the 2022/23 plan. A summary of the position against the agreed monthly plan (as at 24/04/22), is set out below:

	Backlog (>62 day) position	**Plan (April)**	**Variance against April plan over/(under)**
GEH	46	47	(1)
SWFT	190	165	25
UHCW	261	198	63
All Providers	**497**	**410**	**87**

4.3 The chart below provides an overview of the weekly position as at 24/04/22 (this is taken from the latest weekly cancer patient tracking list, PTL, which is unvalidated). The following is noted:

- Despite a reduction towards the close of 2021/22, PTL volumes have started to increase.
- Current system wide backlog exceeds the April plan by 87.
- Volumes at GEH remain static, with noted increases reported by UHCW and SWFT



4.4 The proportion of patients waiting over 62 days by tumour site across the system is detailed below:

Tumour site	Number of patients on waiting list >62 Days	Percentage of total list	(Reduction)/Increase in patient numbers on previous week
Urology	179	36%	-12
Lower GI	90	18%	4
Gynaecology	59	12%	4
Head and Neck	54	11%	10
Lung	39	8%	7
Breast	26	5%	-3
Skin	25	5%	1
Other	15	3%	3
Total	**497**		**14**

4.5 Appendix 1 shows the breakdown of >62 day breach reasons for February 2022. Highlights detailed below:

- 46.7% owing to diagnostic delay
- 15.2% reported as capacity issue
- 22.8% other reason (not listed)
- 7.6% patient choice/DNA
- 5.4% medical
- 2.2% admin delay

4.6 Trust leads have reported on a range of factors, attributing to overall increase in the number of patients waiting and being treated over 62 days, particularly during the end of 2021 and the early part of 2022 including:

- **Workforce sickness**, Appendix 2 demonstrates staff absence (excluding annual leave) indicating absence as a result of COVID at Trust level.
  - In UHCW there has been a considerable increase throughout the year noting a doubling of the rate comparing April 2021 to the latter end of the year, continuing into January 2022.
  - Although the information is not available specifically for those staff working across cancer pathways, it does provide an indication of the pressure faced within the cancer team.
  - Data is not available for periods of annual leave, performance declined during the summer of 2021 and is likely to be impacted by staff who are on leave before the end of the financial year e.g. February and March 2022.
- **On the day cancellations** owing to staffing/bed capacity shortfalls due to urgent care pressure;
- **Surge in 2ww referrals** and the direct impact of:
  - Reduced capacity for face to face examinations in primary care during the pandemic;
  - National screening and cancer campaigns e.g. Breast towards the end of 2021
  - Diagnostic waiting lists for specified tumour sites, for example Head and Neck
- **Patient choice/compliance** variable across specialities, in particular Lower GI;
- **Lack of Theatre capacity**;
- **Complexity of patients**
- **Late referrals** into UHCW as specialist treatment centre
- **Diagnostic delays**;
- **Impact of out of area referrals** for example patient flow from Birmingham and Solihull into SWFT;
- **Impact to capacity and lack of flexibility** due to covid swabbing and self-isolating prior to appointments.

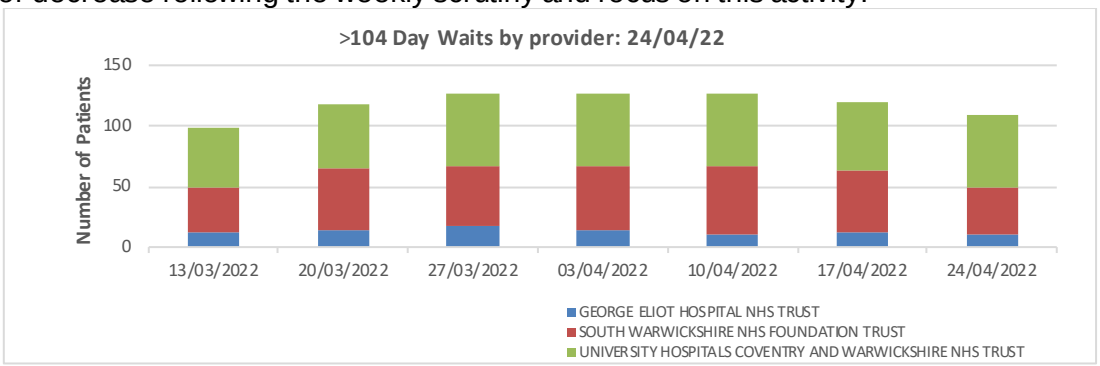
4.7 The System team are currently developing a systemwide trajectory of impact interventions on cancer waiting time standards and will also undertake further analysis on patients presenting as an emergency case within secondary due to the delay in waiting times.

4.0 104 day waiters

4.1 As at 24th April 2022, 109 patients have been waiting for more than 104 days (60 at UHCW, 38 at SWFT and 11 at GEH). The majority of these patients relate to Urological (66%), Gynaecology (9%) and Head and Neck (8%) pathways; Trust cancer teams scrutinise the 104 days waits, in line with the 104 week elective pathway process reviewing on a patient-by-patient basis to determine if there are any alternative treatment plans and to ensure patients are allocated a TCI date.

4.2 All 104 day waiters are subject to clinical harm reviews monthly which are undertaken by the Lead Nurse and Cancer Medical Lead.

4.3 The chart below shows the rising volumes of >104 day waits during March, with the stabilisation and start of decrease following the weekly scrutiny and focus on this activity.



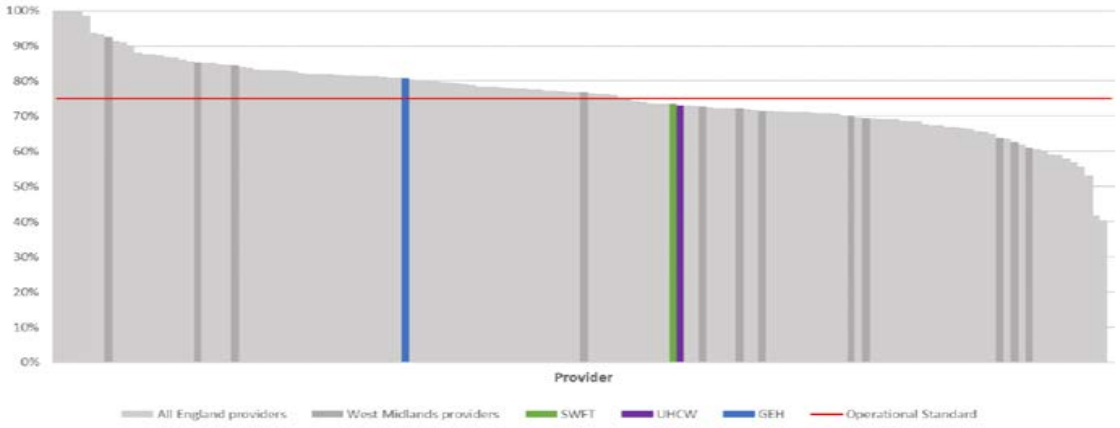
5.0 28 Day Faster Diagnosis Target

5.1 The Faster Diagnosis Standard (FDS) is a new performance standard, introduced in October 2021 to ensure patients who are referred for suspected cancer have a timely diagnosis. Currently best practice pathways have been published for colorectal, lung, prostate, oesophageal and Head and Neck cancers.

5.2 The ICS System 28 Day Faster Diagnosis Delivery Group provides leadership and oversight of the delivery of changes to support the successful move towards the 28-day standard. The programme will bring together several existing groups to work collaboratively to move towards the goal of 28-day diagnosis.

5.3 The Delivery Group was established towards the end of 2021. The ICS Cancer Team meets fortnightly with the Cancer Managers of each Trust to review the 62-day waiting list backlog and the 28 Day Faster Diagnosis position. The group has agreed to prioritise Urology and Lower GI on the basis that 57% of patients recorded are within the current >62 day backlog.

5.4 For all pathways, during February 2021/22 the system performed at 74.2% of patients receiving an outcome within 28 days from referral, versus a target of 75%. The provider position is detailed below compared to all and regional providers:



5.5 The Operational Plan for 2022/23 expects all Systems to meet the 75% target by March 23.

5.6 Whilst strong performance can be seen in some pathways, such as Breast, Skin and Upper Gastrointestinal, other pathways, often with more complex diagnostic approaches and high volumes currently do not meet the 75% target, including Urology, Lung and Gynaecology. Quarterly (2021/22) System 28 Day Faster Diagnosis performance is shown below:

	Q1	Q2	Q3
Suspected brain/central nervous system tumours	50.00%	88.89%	70.00%
Suspected breast cancer (urgent and symptomatic)	91.80%	94.69%	92.46%
Suspected children's cancer	88.89%	87.76%	93.22%
Suspected gynaecological cancer	52.13%	56.93%	51.10%
Suspected haematological malignancies (excluding acute leukaemia)	50.67%	42.00%	32.26%
Suspected head & neck cancer	35.26%	57.09%	66.58%
Suspected lower gastrointestinal cancer	40.36%	47.33%	42.78%
Suspected lung cancer	51.69%	48.98%	50.38%
Suspected sarcoma	85.71%	64.71%	59.09%
Suspected skin cancer	80.17%	77.45%	77.08%
Suspected upper gastrointestinal cancer	70.07%	77.05%	83.29%
Suspected urological malignancies (excluding testicular)	53.41%	61.47%	49.20%
Total	**66.00%**	**69.69%**	**68.78%**

5.7 System-level action plans are in place for all pathways, detailed in Appendix 4&5, to work towards delivering the CWT targets and continued improvement.

6.0 System Approach to Cancer and Recovery Plans

6.2 A number of systemwide actions have been initiated to address the performance against cancer waiting time standards. This includes:

- Weekly PTL walk throughs with providers;
- review of local access policy;
- actions to balance risk of mutual aid for routine vs cancer.

6.3 The information within Appendix 4&5 outlines a range of System and Provider immediate and medium to long actions to:

- Minimise further increases/decline against the 62-day waiting list position;
- reduce the number of 104 day waiters;
- improve performance against the 28-day Faster Diagnosis Target.

Additionally, several system wide initiatives are in place/in development with a focus on:

6.4 **Primary Care Engagement**

- Development and launch of system wide 2ww referral forms in line with tumour site plans;
- PCN level audits undertaken to inform a) pathway transformation b) quality of referrals;
- Training and Education including cancer focused Protected Learning Time events and targeted support to PCNs;
- Regular communication and engagement with primary care, for example system wide 2ww referral forms, results of audits;
- Supporting implementation of national guidance associated with GP contracts for both Quality Outcome Framework (QOF) and the PCN Direct Enhanced Service (DES).

6.3 **Patient Compliance**

The ICS Cancer Patient Experience and Engagement Group has recently agreed a set of priorities to further understand and support improved patient compliance. The focus of the group is detailed below:

- Working in partnership with Trust leads to review the data definitions and identify where there is genuine lack of patient compliance across tumour sites;
- Patient consultation focusing on a review of appointment letters across secondary care; ensuring that the wording is in line with local health literacy levels and stressing the urgency of the appointment;
- A general communication, supported through the use of communication channels and a range of social media platforms to the general public regarding the importance of attending appointments;
- Ongoing primary care education sessions and messaging, ensuring patients are provided with a verbal explanation and resources, acknowledging that they will be referred on a 2ww suspected cancer pathway.

6.4 **Secondary Care Engagement**

- 2ww referral audits undertaken, for example Head and Neck at UHCW/SWFT;
- Deep dive pathway mapping undertaken across national best practice timed pathways: Urology/Lung;
- Deep dive pathway mapping commenced early 2022: Gynaecology and Skin;
- Working individually with providers where there are pressured areas and linking in with the System Gateway published reviews for Gynaecology, Urology and General Surgery (Bowel and Breast). The area of focus is Productivity, Theatre Utilisation, and Improved outcomes;
- System wide workshops for 2022; Urology and Lower GI scheduled for Q1 2022/23;
- Systemwide Breast Group established and monthly meetings in place;
- Trust internal discussion/huddles with pressured tumour sites and recovery plans in place to support improved position;

6.5 **Building broader understanding of Diagnostics**

- Collaborative working/improved dialogue with Pathology colleagues. It is proposed this is further supported by a proposed Pathology Operational Delivery Group.
- Histopathology Review; additional BI support to understand pathway delays/impact on patient waiting times
- Development of proposal to change how GPs request FIT to support Lower GI pathway

6.6 The ICS Cancer team continue to develop action plans and link with programmes of work where there are interdependencies, for example Clinical Diagnostic Board. In addition, working with other parties, including the voluntary sector to support continued improvement, share best practice and consider potential funding opportunities.

7.0 Risks

7.1 Cancer is identified as a key risk in the ICS Corporate Risk Register and the cancer team hold a more detailed risk and issues log for all the key system risks detailing mitigating actions, however a key risk is effectively using our capacity effectively to support cancer recovery alongside pan system working and supporting regional elective recovery, particularly in the high throughput specialities that have large patient 62 day backlogs which include Urology (179), lower GI (90), Gynaecology (59) and Head and Neck (54). This makes up 77% of our cancer backlog and we need to ensure for these specialties specifically we monitor pan system mutual aid effectively.

7.2 To note, due to the number of long waiters currently in the System, a further deterioration in performance is likely to be seen during the next months as these patients are treated, with an improvement to the performance standard recovering during Quarter 3 following the implementation of the actions outlined in the report.

8.0 Recommendations

8.1 The Board are asked to note the contents of this report and note that an update will be provided during Quarter 3, 2022/23. The report will provide an overview of the actions implemented and provide further assurance and updates on progress in delivering the key requirements of the Operational Plan.

Report Title:	Performance Report
Report From:	Alison Cartwright, Chief Officer Performance and Delivery
Author:	Kerry Doughty, Head of Performance and Delivery
Previous Considerations and Engagement:	Finance and Performance Committee 4 May 2022
Purpose:	For information - To update the Integrated Care System (ICS) on the February 2022 position regarding headline activity information and performance against national targets and priority indicators for NHS Coventry and Warwickshire CCG (the CCG)

Contribution to meeting the aims of the ICS:

This report provides a review of activity and performance against the national performance standards and local priority indicators. The report identifies the key risks and challenges across the key performance areas and provides detail on the actions being undertaken to address the issues and improve performance in order to deliver the following ICS aims:

- Improving outcomes in population health and healthcare
- Tackling unequal outcomes, experience and access

Contribution to meeting the priorities of the ICB:

This report seeks to provide assurance against the following ICB priorities:

- **Accelerate preventative programmes** and activities that target those at greatest risk, eg.pre-rehabilitation, mental health programmes
- **Work together**, as partners, at system and Place to identify and address health inequalities and variations in health and care provision
- **Successfully manage urgent emergency care (UEC)**, particularly winter pressures (including Flu) alongside managing any further Covid-19 surges (continuing Covid-19 vaccination and mass testing)
- **Restore elective care** to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics

Recommendation:

Members are requested to note the contents of the report for assurance as to actions to improve performance as required.

Implications	
Conflicts of Interest:	Not applicable

Financial and Workforce:	Not applicable						
Performance:	See detail within the report						
Quality and Safety:	See detail within the report						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	Patient and Public engagement is part of any service redesign or new service developed to address performance concerns. Patient communications on the current expectations around waiting list and access to other support services including local voluntary sector organisations continue.						
Clinical and Professional Engagement:	Clinical and professional colleagues are represented in relevant performance monitoring and assurance meetings across the system. The relevant clinical teams are also included in the development, agreement and implementation of Performance recovery actions and mitigations.						
Risk and Assurance:	High risk areas given current level of performance challenges due to multi-factorial issues and impacted further by Covid-19 pandemic. Full details have been included in the Corporate Risk Register and any mitigations and actions in place to manage this risk are outlined in the report.						

1.0 Performance Report

1.1 General Practice remain under pressure and activity remains above pre-pandemic levels; total face to face appointments have increased from 2021 levels. Following three months of small decreases, February 2022 has shown an increase. The percentage of patients seen on the same day or next day is still increasing and comparing favourably to February 2020. Primary Care has also delivered over 1,377,184 Covid vaccinations since December 2020, 12,223 of which were in February 2022 which increases primary care activity levels to 109% of February 2020 levels.

1.2 Schemes funded as part of the Winter Access Fund, such as Primary Care Surge (a virtual GP triage support offer from the collaboration of Federations) and Respiratory Monitoring at Home continued into Q4 and are being closely monitored to ensure effectiveness.

1.3 In total, 2,088,960 Covid vaccinations have currently been administered in Coventry and Warwickshire, of which 757,070 are first dose vaccinations. 93.3% of those vaccinated have also received a second dose and 81.3% of the eligible population have now received a booster following the huge upscaling of the booster programme in December. The uptake rate across JCVI cohort 1-12 (those aged 18 and over) is 82.9%.

1.4 A&E attendances on a CCG basis are 14% below the activity levels as at the same month in 2020, and now 8% under year to date, due to significantly lower attendances through the Winter period in comparison to 2020/21.

1.5 Delivery of the national constitution and local performance priorities continues to be impacted by Covid. In February 2022, Coventry and Warwickshire system achieved 2 out of the 17 Constitutional and Acute priority indicators. Benchmarking is contained within the report where available to provide context and exception reports with recovery actions for the areas not achieving the required standard are detailed within the report. Areas of particular concern are detailed below:

1.5.1 Elective Waiting Lists:

The total waiting list size for February was 93,903 with 4,677 of those patients waiting over 52 weeks, compared with 4,781 in January. There were 158 patients who had been waiting over 104 weeks, compared with 199 in January. 10,273 patients were waiting over 40 weeks, compared with 10,095 in January. There has been an increase of 13,921 patients on the waiting list comparing February 2022 to February 2021.

Coventry and Warwickshire achieved zero 104 week waits by 31 March 2022, and were the only system in the West Midlands to achieve this. As anticipated through modelling of the waiting list, there will be some patients tipping over into 104 weeks during Q1. There is a plan in place for at risk patients tipping over by end of Q1 to be treated, with no more 104 week waits for the rest of 2022/23. Focus is now on reducing to 78 weeks, in line with national plans.

1.5.2 Two Week Cancer Waits

UHCW, GEH and SWFT failed to achieve the 93% target for 2 week waits for cancer referrals in February. 660 CWCCG patients were seen after 2 weeks, out of 3,948. Of these, the longest waiting time was a patient who waited 52 days at SWFT. The delay

has been attributed to patient choice. There has been an improvement for Head and Neck patients at UHCW of whom 49.8% were seen in 2 weeks.

1.5.3 62 Day Cancer Standard

In February there were 92 breaches out of 223 patients treated. Of these patients, 38 waited more than 104 days.. A system wide Performance Improvement Plan has been developed and focusses on Head and Neck, Breast, Lower GI, Urology and Gynaecology tumour pathways and also increasing diagnostic capacity to improve performance, which will be supported by the Community Diagnostic Hub plans. It is also hoped that with the introduction of the 28 day faster diagnosis target will help drive improvements earlier in the cancer pathway.

1.6 Delivery of the Mental Health targets is also challenging with 11 of the 17 national/local targets not meeting the required standard. Areas of particular concern are:

1.6.1 Out of Area Placements:

The target for number of patients placed out of area inappropriately has been revised to end of March 2022, following discussions with NHSE/I, however as of 28 March 2022, there were 32 patients placed out of area. Out of area admissions continue to be reviewed at weekly multi-agency review meetings to progress discharge and repatriation opportunities where possible and appropriate. There has recently been an increase to the number of admissions, due to increased numbers of wards impacted by Covid outbreaks, wards closed or restricted for new admissions, and a specific need for female PICU beds

1.6.2 Autism Assessments

The Neurodevelopmental service remains challenged, with additional funding being provided to support additional capacity. This should increase the number of assessments undertaken each month and support the reduction of the longest waiting patients in the system.

The focus of redesign is focussed on building capability and capacity across wider health, care and education services locally to diagnose and support people with autism. Aligned to the local and national Autism Strategies, a system wide neurodevelopmental diagnostic transformation programme has been established with representations from the partner organisations to address key areas for improvement.

1.7 Children in Crisis (CIC) – systems and processes, which are now embedded, continue to effectively support and manage the flow of children and young people through the Paediatric wards at both UHCW and Warwick Hospitals. The number of children on our Paediatric wards has stabilised and however, a shortage of social care residential placements have caused delays in both Coventry and Warwickshire. Planning for the system workshop continues and opportunities to expand the programme to more preventative activities is being actively pursued.

2.0 Activity

Primary Care Activity

2.1 The table below shows that for February 2022, primary care consultations are above 2019/20 levels for the same period. The proportion of face to face appointments increased during February, and while this did not achieve the peak of October 2021, this is a positive indication that the increasing trend of 2021/22 will be maintained into 2022/23.

	Pre-Covid baseline	COVID period		
Category	**Feb-20**	**Dec-21**	**Jan-22**	**Feb-22**
Total appointments	392,268	405,047	416,226	413,658
Face to face appointments	288,693	225,389	227,472	230,003
% face to face	**73.6%**	**55.6%**	**54.7%**	**55.6%**

Month	Same Day	1 Day	2 to 7 Days	8 to 14 Days	15 to 21 Days	22 to 28 Days	More than 28 Days
Feb-22	218,664	36,778	84,793	41,129	16,811	8,721	6,355
	52.9%	8.7%	18.4%	10.5%	4.5%	2.6%	2.2%
Feb-20	184,510	27,119	80,832	51,169	23,067	14,514	10,717
	49.7%	6.7%	19.4%	11.8%	5.8%	3.6%	3.0%

2.2 In addition to the above, Primary Care has also delivered over 1,377,184 Covid vaccinations since December 2020, 12,223 of which were in February 2022 which increases primary care activity levels to 109% of February 2020 levels.

2.3 The Winter Access Fund (WAF) programme has continued through Q4.

- Primary Care Surge have generated 10k appointments in the 3 months it has been operating (Jan to March 2022) which supported practices through periods of challenge and improve resilience;
- Respiratory Monitoring (Nov to Feb 2022) has seen 590 admissions onto the virtual ward, 552 patient discharges, 1,410 virtual GP appointments and over 6k contacts .197 patents are currently on the virtual ward, all of which have contributed to admission avoidance and ensuring patients are treated in the more appropriate setting for their clinical condition.
- The workforce bank now has 80 practices and 393 GPs registered, with over 9011 hours having been advertised and filled, which has also supported primary care resilience.

2.4 An Administrative Hub pilot is still underway, whereby VoiP telephony calls are diverted to a 'mini call centre'. The leaning from this pilot will be shared across all Places and will be used to support general practice transformation going forwards.

2.5 Assurance reporting has been provided to NHSE and adjustments to appointment activity and budget have been made in agreement with NHSE Regional team. Of the £4.4m original allocation £1.685m has been released back to NHSE. This underspend is directly related to the short mobilisation time of the WAF and workforce pressures.

Acute Activity

2.6 The overall Coventry and Warwickshire (C&W) CCG acute activity for each Point of Delivery for the year to date and Month 11 is detailed below:

		Apr - February				February				Compared with Feb 20
	POD / Service Area	2019/20	2021/22	Diff	% Diff	2019/20	2021/22	Diff	% Diff	
Emergency	A&E Attendances	378,499	347,128	-31,371	-8% ↓	32,438	28,032	-4,406	-14% ↓	86%
	Non Elective 0 LoS Admissions	28,267	24,803	-3,464	-12% ↓	2,260	1,939	-321	-14% ↓	86%
	Non Elective 1+ LoS Admissions	63,023	46,581	-16,442	-26% ↓	5,356	3,860	-1,496	-28% ↓	72%
	Non-Elective Average LoS	7.04	7.07	0.03	0% →	7.14	7.73	0.59	8% ↑	
	Non-Electice Non-Emergency Admissions	2,450	2,356	-94	-4% ↓	161	201	40	25% ↑	125%
Elective	Outpatient First appointments	323,403	261,499	-61,904	-19% ↓	27,823	23,586	-4,237	-15% ↓	85%
	Outpatient Follow-up appointments	518,494	377,378	-141,116	-27% ↓	44,107	32,731	-11,376	-26% ↓	74%
	Outpatient Procedures	308,068	291,562	-16,506	-5% ↓	25,707	26,698	991	4% ↑	104%
	Outpatient NF2F	40,550	250,544	209,994	518% ↑	3,678	19,438	15,760	428% ↑	428%
	Daycase admissions	111,551	102,674	-8,877	-8% ↓	9,785	9,098	-687	-7% ↓	93%
	Ordinary Elective admissions	14,885	12,672	-2,213	-15% ↓	1,301	1,112	-189	-15% ↓	85%
	Elective Average LoS	2.67	2.59	-0.07	-3% ↓	2.85	2.53	-0.32	-11% ↓	

**Data Source Secondary Uses Service (SUS) on a CCG basis at all providers*

2.7 A&E attendances on a CCG basis are 14% below the activity levels as at the same month in 2020, and now 8% under year to date, due to significantly lower attendances through the Winter period in comparison to 2020/21. Emergency admissions remain well below 2020 levels.

2.8 Both daycase activity and inpatient electives have seen a reduction, compared to pre-Covid levels. Daycases are at 93% of 2020 levels, and inpatients are at 85%, with work continuing to restore services and clear the backlog.

2.9 Non face-to-face outpatient activity has also significantly increased as required by the Operational Plan with a corresponding decrease in face-to-face first and follow-up appointments. Further work is required to fully understand patient experience and outcomes by health inequalities group in this area, which the Elective Care Board is exploring.

3.0 Conclusion

3.1 The system remains under pressure in relation to general practice and urgent care pressures but continues to maintain good elective recovery rates with reductions in waiting lists and times continuing. Although the system is currently only achieving 2 of the 17 constitution indicators a number of performance areas are improving but concern remains around urgent care, particularly ambulance handovers, cancer services and autism diagnosis rates.

4.0 Recommendation

4.1 ICB Board are requested to note the contents of the report for assurance and to note the actions to improve performance as required.

End of Report

Report Title:	System Financial Update to NHS ICS Board
Report From:	Adrian Stokes, Acting CFO, C&W CCG
Author:	Chris Lonsdale, Director of Finance Place, C&W CCG; Alistair Fleming, Head of System Financial Planning, UHCW
Previous Considerations and Engagement:	Builds on concepts discussed at FAB and PEG.
Purpose:	For discussion, For information

Contribution to meeting the aims of the ICS:

- Improving outcomes in population health and healthcare: The financial plan underpins system planning and operational guidance in delivering national planning priorities and in improvements on Elective Recovery.
- Tackling unequal outcomes, experience and access: Planning includes additional funding to support the programme of work on inequality.
- Enhancing Productivity and value for money: providing update and assurance regarding financial performance and planning
- Supporting the broader social and economic development of C&W: Plans include work programmes with wider partners, particularly the Better Care Fund.

Contribution to meeting the priorities of the ICB:

This paper relates to the ICB priority of to *'Live within our means' and become financially sustainable'.* It also picks up on outcomes alongside partner organisations as follows:-

- Improvements on both the 2022/23 Capital and Revenue planned position with a remaining revenue deficit for the current financial year.
- The financial plan supports joint working with the councils through the Better Care fund and through that support for UEC.
- Allocations for the Elective Recovery fund have been allocated as part of the financial planning position.
- Review of outstanding issues such as inflationary funding above the allocation received, unavoidable and technical pressures are within the boundaries of acceptability.
- In-year capital position is within the allocation.
- Further review / analysis needs to be undertaken on the following two financial years as they are not currently compliant with the System Operational Capital allocation.

Recommendation:

The majority of the paper is to note for information. However, there are the following specific discussion points:-

- Continued focus on recurrent financial positions of organisations within the system
- How far the Board is willing to move the financial position
- Maintaining focus on outcomes and inequalities in a financially challenged system

Implications							
Conflicts of Interest:	N/A						
Financial and Workforce:	2022/23 financial performance						
Performance:	The financial plan underpins system planning						
Quality and Safety:	The financial plan underpins system planning						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	N/A						
Clinical and Professional Engagement:	N/A						
Risk and Assurance:	System Financial Risk						

System Finance Update to NHS ICS Board

1. Executive Summary

1.1 This paper covers the current system financial planning round, follows on from the financial updates from previous months and also picks up a number of current pertinent issues. Specifically the paper will cover:

- 2022/23 System Planning Updates for revenue
- 2022/23 System Planning Updates for capital

2. 2022/23 System Financial Planning - Revenue

2.1 Having agreed allocative principles the Finance Advisory Board (FAB) has instigated a number of confirm and challenge meetings to address the remaining challenge for the system where this would not be accepted nationally or regionally. The review process has had the following impact:

Description	£m
Deficit March Submission	54
Inflation Deep Dives	-8
Covid Reductions	-6
Workforce/Balance Sheet	-4
Efficiency Stretch	-2
CCG Underspend	4
28th April Submission	38

2.2 March submission resulted in £54m deficit drivers (2.9% of T/O). This demonstrates that the System had addressed a significant amount of the starting deficit: £110.8m (as presented to the System Review Meeting – see Appendix 1)

2.3 Following a series of Confirm and Challenge meetings the system is at £38m deficit.

- Removal of £8m inflationary pressures where the expectation is that they are BAU funded.
- Further work on efficiencies and making Covid BAU.
- CCG underspend removed to reflect Care Home Pressures

2.4 Outstanding issues are:

- Inflationary pressures above funding
- Unavoidable operational cost pressures of medically compliant rotas
- Technical cost pressures
- Ongoing discussions with NHSEI around what an acceptable plan would be for 22/23.

- Continued mobilisation of the transformation programme as discussed in last ICD development session (GIRFT, left shift, Right Care, Estates review etc.).
- The changes to funding agreed do not impact on the agreed budgets for Elective recover, the Better Care Fund or the Inequalities budget allocation already within the system financial plans.
- Inequalities funding will enable the system to support additional focus on the programme which will not fully deliver until it becomes core business for the ICB.

3. 2022/23 System Financial Planning - Capital

3.1 Having received its multi-year capital allocations the system has also been through confirm and challenge process around its overall capital programme. Following this the System has submitted a 22/23 capital plan within the allowable 5% tolerance, having previously been 61% over commitment and Regionally red flagged. However, the current plan is currently not compliant for 23/24 and 24/25.

Inside Capital Envelope Funding - excludes other funding sources such as Digital			
Provider	**22/23 £m**	**23/24 £m**	**24/25 £m**
CWPT Total	8.6	4.1	5.5
GEH Total	4.8	8.2	8.2
SWFT Total	12.3	17.6	12.9
UHCW Total	15.1	20.9	17.7
Grand Total	40.8	50.8	44.3
Allocations:	**39.4**	**34.7**	**34.7**
Variance:	**-1.3**	**-16.1**	**-11.5**
5% allowable overshoot	**41.4**	**36.5**	**34.4**
Revised Variance	**0.6**	**-14.4**	**-9.9**

3.2 Further detailed prioritisation work is to be completed over the next few weeks. There are a number of issues and caveats within the submission outlined below:-

- System is clear these plans are reliant upon access to funding still to be confirmed (e.g. Technology).
- The System has previously raised concerns regarding the national formula that other Systems have questioned regarding its treatment of large PFI builds.
- As the key element of the formula is depreciation led, this unfairly penalises the C&W System and also does not account for accommodating the A&E builds, Autism Secure Units or Pathology Systems described to the Regional Capital Team.
- In 2020/21, the System did not receive the CDEL cover agreed for the GEH Theatres. As a result, the System had to hold back capital schemes to the

value of c. £4.3m, which has caused a knock on effect to the System capital programmes going forward.

- Additionally, the System did not receive the COVID related capital guaranteed and again had to fund this from within our System 'business as usual' envelope.
- With 2021/22 Capital spend extremely tight, there was a national request that if organisations had options to contribute to improve this position that would be appreciated. The System responded that CWPT would report a capital undershoot of £0.85m and requested this to be recycled to support the 2022/23 Capital Programme. While the Regional Team recognised the support from the System, they could not commit to this request currently, with the current capital pressures.

3.3 Finally, the impact of IFRS 16 has not been considered to date due to a lack of guidance. However, it is anticipated that this will cause a further capital pressure.

4. Recommendation

4.1 The majority of the paper is to update the ICS Board on the key System finance issues. However, there are the following specific discussion points:-

- There is an expectation of further movement of the position from this point and the Board needs to consider how far it is reasonable to move.
- Recognition of the need to focus on our recurrent position ahead of challenging efficiency next year.
- In-year focus on delivery of the financial position whilst focus remains on Improving Outcomes and tackling inequalities.
- The extremely challenging capital funding allocations, intensified by the current / future System capital requirements and the impact of prior year CDEL constraints to achieve balance.

End of Report

Enc K

Coventry and Warwickshire
Health and Care Partnership

System 2022/23 Financial Planning Update

11th May

Adrian Stokes

C&W System 2022/23 Planning Update (i)

Classification	Description	Total Pressures £m	Pre Submission £m	March Submission £m	Final submission £m	Target £m	Notes
Allocation reduction	Convergence	-8.2					
	Covid Q1 unavoidable	-44.2		-4.1	-4.0		
	Hospital Discharge Team	-3.9					
	Tariff Productivity 1.1%	-13.5					
	Spec Comm	-11.0					
	ERF / TIF reduction	-28.6					
Allocation reduction Total		-109.4	-24.4	-4.1	-4.0		1
Inflation	Non-pay inflation	-22.7			-23.1		
	Pay inflation	-6.9					
Inflation Total		-29.6	-29.6	-29.6	-23.1		2
National request - unfunded	Global Digital Exemplar	-0.7					
	Quality specification	-1.0					
National request - unfunded Total		-1.7	-1.7	-1.7	-1.8		
Operational Cost Pressure	Hospital Discharge Team	-0.7					
	Medical Rotas	-4.8			-2.4		
	Stroke	-0.3					
	Autism Waits letter of action	-3.0			-3.0		
	ICR	-0.1					
Operational Cost Pressure Total		-8.9	-8.9	-3.4	-5.4		3
Technical Cost Pressure	Capital IFRS	-0.5					
	Depn	-7.2					
	MFF change	-2.0					
	PDC Loan	-5.4					
	Population Health	-0.3					
Technical Cost Pressure Total		-15.4	-15.4	-15.4	-3.6		
Grand Total		-165.0	-80.0	-54.2	-37.9	-34.0	
Efficiency %		-	0.0%	5.9%	6.8%	7.0%	
Deficit as % of T/O		8.9%	4.3%	2.9%	2.0%	1.8%	

Notes:

1) The system has challenged itself to ensure that this is absorbed through increased productivity and efficiency.
2) As part of the challenge process inflation assumptions have been tested and revised.
3) As per 1

C&W System 2022/23 Planning Update (ii)

- The System had a starting 2022/23 position of a £165m deficit to address (8.9% of Turnover). The key drivers were:
  - £109.4m allocation reductions (compared to H2 x 2);
  - £55.6m unfunded cost pressures
- To meet this challenge the system implemented its own review process:
  - Improvement to £80m pre-submission
  - March submission details the £54.2m deficit drivers (2.9% of T/O) left residually in the System Draft Plan submission. This demonstrates that the System has addressed a significant amount of the starting deficit: £110.8m
  - Following a series of Confirm and Challenges the system submitted a revised final plan of £37.9m deficit (2.0% of T/O)
  - The System has set an indicative target of reducing the deficit to £34m (1.8% of Turnover – Which would increase efficiency improvement to 7%)
  - Outstanding issues are:
    - Inflationary pressures above funding
    - Unavoidable operational cost pressures of medically compliant rotas
    - Technical cost pressures

C&W System 2022/23 Next Steps

Action	Lead	Week				
		28/03/2022	04/04/2022	11/04/2022	18/04/2022	25/04/2022
a. Regional deep dive into drivers at UHCW	UHCW			√	√	√
b. Regional benchmarking of Mental Health Providers	CWPT			√	√	√
c. Regional Confirm and Challenge into CWPT	CWPT			√	√	√
d. Other operating income reconciliation	All			√	√	√
e. Assess new cleaning standards impact	All			√	√	√
f. COVID assessment — conditions needed to reduce further	All	√	√	√	√	√
g. Inflation deep dives/benchmarking	All	√	√	√	√	√
h. Review of depreciation drivers	All	√	√	√	√	√
i. Spec Comm discussions	All	√	√	√	√	√
j. Continued organisational deep dives	All	√	√	√	√	√
k. Balance Sheet assessments	All	√	√	√	√	√
l. Regional response to WTE challenge	All			√	√	√

Post April submission – Law of diminishing returns but one final push across whole system

Coventry and Warwickshire
Health and Care Partnership

C&W System 2022/23 Capital Planning Update

Inside Capital Envelope Funding - excludes other funding sources such as Digital			
Provider	**22/23 £m**	**23/24 £m**	**24/25 £m**
CWPT Total	8.6	4.1	5.5
GEH Total	4.8	8.2	8.2
SWFT Total	12.3	17.6	12.9
UHCW Total	15.1	20.9	17.7
Grand Total	**40.8**	**50.8**	**44.3**
Allocations:	**39.4**	**34.7**	**34.7**
Variance:	**-1.3**	**-16.1**	**-11.5**
5% allowable overshoot	**41.4**	**36.5**	**34.4**
Revised Variance	**0.6**	**-14.4**	**-9.9**

- The System has submitted a compliant capital plan for 22/23, having previously been 61% over commitment and Regionally red flagged.
- The process agreed through FAB has enabled the System to submit a compliant capital plan for 22/23, i.e. within 5% tolerance of the allocation.
- The current plan is currently not compliant for 23/24 and 24/25.
- Further detailed prioritisation work is to be completed over the next few weeks.
- There are a number of issues and caveats within the submission that have been outlined below:
    - A key element of the formula is depreciation led, this unfairly penalises the system and also doesn't account for accommodating the A&E builds, Autism Secure Units or Pathology Systems.
    - In 2020/21, the System did not receive the CDEL cover agreed for the GEH Theatres. This has resulted in us holding back capital schemes to the value of c. £4.3m, which has caused a knock-on effect on capital programmes going forward.
    - Additionally, C&W did not receive the COVID related capital guaranteed and again had to fund this from within the System 'business as usual' envelope.
    - There remain concerns regarding the national formula that other Systems have also questioned regarding its treatment of large PFI builds.

Coventry and Warwickshire
Health and Care Partnership

Report Title:	Transition update including System Development Plan and Due Diligence – Progress Update May 2022
Report From:	Rachael Danter, Chief Transformation Officer
Author:	Hayley Allison, Head of Transition Dan Davis, Transition Programme Management Lead
Previous Considerations and Engagement:	Transition Leads Forum, May 3 CCG Governing Body, May 18
Purpose:	For Information

Contribution to meeting the aims of the ICS:

This programme of work enables the system partners to work together and support delivery of a safe and efficient transition into an ICS which will then deliver the overall ICS aims:

- Improving outcomes in population health and healthcare:
- Tackling unequal outcomes, experience and access:
- Enhancing Productivity and value for money:
- Supporting the broader social and economic development of C&W:

Contribution to meeting the priorities of the ICB:

This programme of work supports all of the ICB priorities:

Accelerate preventative programmes and activities that target those at greatest risk, eg. pre-rehabilitation, mental health programmes

Work together, as partners, at system and Place to identify and address health inequalities and variations in health and care provision

Protect the most vulnerable, ensuring inclusivity runs through everything we do

Focus our delivery on Place-based care, supported by strong, well developed PCNs

Successfully manage urgent emergency care (UEC), particularly winter pressures (including Flu) alongside managing any further Covid-19 surges (continuing Covid-19 vaccination and mass testing)

Restore elective care to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics

Care for and develop our workforce ensuring they continue to have the resilience and support to deliver the best care to our patients and communities particularly our BAME employees

Maximise all enablers that support us deliver our Five-Year Plan commitments eg. digitally enabled care, our estate and flexible working

'Live within our means' and become financially sustainable

Recommendation:

Members are requested to note the contents of the paper for information

Implications							
Conflicts of Interest:	Not applicable						
Financial and Workforce:	All financial and workforce implications are overseen by the financial and workforce workstreams, including the TUPE of CCG and system staff into the new organisation. Progress to date is detailed in the supporting information						
Performance:	Not applicable						
Quality and Safety:	The Quality and Safety workstream is developing the Quality Framework and supporting system governance structure in preparation for the formal ISC Board. Progress to date is detailed in the supporting information						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	Not applicable						
Clinical and Professional Engagement:	The Clinical and Professional Leadership (CPL) workstream are overseeing the work to develop a framework for future CPL development and ongoing deliverables. Progress to date is detailed in the supporting information.						
Risk and Assurance:	The Transition Programme holds its own Risk Register. There are currently no red risks identified.						

Transition update including System Development Plan and Due Diligence – Progress Update May 2022

1. Introduction

1.1. The purpose of this report is to update the NHS Integrated Care System (ICS) Body regarding the positive progress being undertaken through the system-wide Transition Forum. As the Board will be aware, the transition into a full ICS is a statutory requirement that needs to be completed by the **30th of June 2022** ready for go live on the **1st of July 2022**. The Health and Care Act 2022 has now finished its passage through Parliament with notification of Royal Assent so the ICB establishment is confirmed for July 2022

2. Transition Plan

2.1. A refreshed Readiness to Operate Statement (RoS) assessment and System Development Plan (SDP) were submitted to NHSEI on the 31st March. In addition to this, a comprehensive suite of evidence documents was uploaded for each workstream to be reviewed against the RoS and SDP.

2.2. Our current and projected (for 30th June) RoS scorings are shown below:

Current:

Not on target, significant concerns	Progress made, minor concerns	On target, no concerns	Not applicable	Completed
0	3	31	1	2

Projected:

Delivery by June 2022 is not achievable	Delivery by June 2022 is at risk but mitigation plan in place	On target for delivery by June 2022	Not applicable	Completed
0	1	33	1	2

2.3. NHSEI provided feedback on our submission stating that:

2.3.1. Overall good progress is being made against the ROS, the system is working closely with NHSEI on ICS establishment and is sharing evidence to support ongoing assurance of the ROS elements which is much appreciated.

2.3.2. The SDP showed good development from previous submission, with the exception of the financial section which requires further detail re. finance strategy, medium term position, underlying position, system efficiency and capital prioritisation.

2.4. The two areas that require additional information for the next submission are the Clinical and Professional Leadership (CPL) and Financial Planning, and our feedback was as follows:

2.4.1. **ICB Leadership model** – we recognised the progress in last 2-3 months in the development of Clinical Executive Group and Forum and reporting lines. However more detail is requested on all 5 principles, we understand this is in development outside of the summary but feel greater evidence is required to increase assurance.

2.4.2. **Financial planning** – we are asking that all systems address the requirement to deliver the operational plan and associated expenditure within system allocation, through the planning process completing by 28 April 2022. We know you are in discussion with our finance colleagues with regard to your latest position.

This feedback has been returned to the ICS Transition Workstream Leads and will be addressed in advance of our final submission.

2.5. Pre-transition key Workstream activities continue to be monitored on a fortnightly basis, the final list of activities are summarised at Appendix 1.

2.6. The Transition programme has an associated risk register. Currently there are no red risks identified as all actions are on track to deliver.

3. Due Diligence (DD)

In respect of the due diligence activities NHSE requires CCGs to undertake in order to close their existing organisation(s) and to establish the ICB, Workstream Leads from across the relevant CCG departments submitted statements on 22 April 2022 confirming the work undertaken to complete each activity or, where the activity is in progress, what actions will be required to complete. The work undertaken and the actions outstanding have been 'signed off' by the relevant CCG Director.

The statements have been shared with the Scrutiny Panel for the DD programme, which comprises the CCG's Accountable Officer and two external legal and audit representatives (Gerard Hanratty, the Head of Health at Browne Jacobson LLP and Paul Capener, Consortium Director at CW Audit). On 9 May 2022 the Panel will convene and invite Workstream Directors and Leads to talk through the processes undertaken in respect of their activities and ask any questions they may have. Following this, the representatives from Browne Jacobson and CW Audit will produce Assurance Reports which will include any recommendations in respect of any DD activity, be they 'complete' or 'in progress'. Any recommendations will be tracked to completion as part of the programme.

On 1 June 2022 the CCG's Accountable Officer is required to submit a letter of assurance to NHSE in respect of the DD programme. On 8 June 2022 this letter, the aforementioned Assurance Reports and a DD programme closure report will be presented to the CCG's Audit Committee, which oversees the programme. The Audit Committee will be asked to recommend to the CCG's Governing Body that the DD programme is signed off. On 15 June 2022 the DD Programme Closure Report will be presented to GB asking for sign-off the DD programme and on 22 June the same report will be presented to shadow ICB for information. The ICB's Board will be formally presented with the report at its inaugural meeting on 1 July 2022.

Any issues or risks which would prevent the DD programme progressing as planned would be promptly escalated to the ICS Transition Workstream Leads Forum, led by the Head of Transition, and the CCG's Executive Team. As of 3rd May 2022, there are currently no issues or risks of this severity identified.

4. Next Steps

The next system ROS assessment is due to be completed for **20th May** to enable review by NHSEI regional colleagues ahead of the submission of the final RoS on 10th June. The upcoming key milestones for within this period are shown below:

4.1.1. **13th May:** Share a copy of due diligence checklist, plans and staff & property lists (for those systems with boundary changes) with regional NHSEI

4.1.2. **20th May:** Submit final proposed ICB constitution (including standing orders) for final review by the regional team prior to Regional Director approval

4.1.3. **20th May:** Submission of Readiness to Operate checklist and supporting evidence to NHSEI regional team

4.1.4. **25th May:** Check point meeting with NHSE/I on Readiness to Operate

5. Recommendation

1) to NOTE the progress made to date and the next steps process
2) to NOTE that there are no red or amber risks identified at this stage

End of Report

Report Title:	Integrated Care Board Community Involvement Strategy
Report From:	Nigel Minns, Strategic Director of People, Warwickshire County Council Rose Uwins, Senior Communications and Engagement Lead – Coventry and Warwickshire Clinical Commissioning Group and Integrated Care System
Author:	Rose Uwins, Senior Communications and Engagement Lead – Coventry and Warwickshire Clinical Commissioning Group and Integrated Care System
Previous Considerations and Engagement:	The conclusions of the report are grounded in patient insight gathered from across the partner organisations of the ICS and developed in conjunction with the involvement leads from across the ICS and representatives from Healthwatch The objectives of the strategy have previously been considered at Place Forum, Clinical Quality and Governance, System Strategy and other committees
Purpose:	For Endorsement

Contribution to meeting the aims of the ICS:

The paper outlines how the partner organisations of the Integrated Care System will work together with our local communities to develop an approach to involvement, building on the mechanisms already in place. Good involvement and ensuring that local people are at the heart of everything that we do will contribute to the successful delivery of all of the aims of the ICS.

- Improving outcomes in population health and healthcare:
- Tackling unequal outcomes, experience and access:
- Enhancing Productivity and value for money:
- Supporting the broader social and economic development of C&W:

Contribution to meeting the priorities of the ICB:

Accelerate preventative programmes and activities that target those at greatest risk, eg.pre-rehabilitation, mental health programmes

Work together, as partners, at system and Place to identify and address health inequalities and variations in health and care provision

Protect the most vulnerable, ensuring inclusivity runs through everything we do

Focus our delivery on Place-based care, supported by strong, well developed PCNs

Successfully manage urgent emergency care (UEC), particularly winter pressures (including Flu) alongside managing any further Covid-19 surges (continuing Covid-19 vaccination and mass testing)

Restore elective care to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics

Care for and develop our workforce ensuring they continue to have the resilience and support to deliver the best care to our patients and communities particularly our BAME employees

Maximise all enablers that support us deliver our Five-Year Plan commitments eg. digitally enabled care, our estate and flexible working

'Live within our means' and become financially sustainable

As outlined above, involvement is key to all activities as health and care services and new ways of working will not be inclusive or successful without the involvement of individuals and communities.

Recommendation:

Members are requested to ENDORSE the strategy for submission and adoption by the Integrated Care Board post 1 July.

Implications							
Conflicts of Interest:	None						
Financial and Workforce:	This report links to the OD/Workforce strategy in supporting our workforce to deliver new ways of working through public involvement						
Performance:	Good involvement will support all of our performance targets making services more inclusive and in line with community priorities						
Quality and Safety:	This document outlines how involvement will contribute to supporting the work of the quality teams across the ICS						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	The conclusions reached in the document are based on insight from across the ICS partner organisations as well as local Healthwatch The document outlines the need for patient involvement the development of our approach to engagement and involvement.						
Clinical and Professional Engagement:	Clinical engagement will form part of the development of our approach						
Risk and Assurance:	Low risk: This document forms part of the Readiness to Operate suite of documentations necessary to become an Integrated Care Board in July 2022. If NHS England are not satisfied that the document is fit for purpose this could mean we are not fully assured going forward into the ICB. To mitigate against this, the document has been informally assessed by NHSE and the requested changes made. In addition it follows the suggested template issued and provides detailed response throughout as to our mechanisms for involvement.						

Enc M

Version Control

Document: ICB Communities Strategy

Author: Rose Uwins, CWCCG

Version: 3.0

ICB Communities Strategy

Contents

Introduction and current position

Introduction

Everyone working in health and social care in Coventry and Warwickshire has a common purpose. We want every person in Coventry and Warwickshire to start well, live well, and age well. This means enabling people to take action themselves to prevent becoming ill in the first place, to recover well, or to manage long term health needs as independently as possible.

Working together in an Integrated Care System (ICS) means listening to local people and, where needed, change the way health and care partners work together, removing the barriers between services and joining up care around people and populations. Providing equal access to good health care and advice is one way to improve people's health and wellbeing. The whole ICS working together also enables us to address the other factors that might affect people's health such as housing, education and access to jobs.

Better, joined up, statutory and voluntary services should result in a system that works better for local people, reducing the complexity that currently exists which people often tell us they find difficult to navigate. Improved, more easily accessible services for communities lead to better outcomes for everyone.

But truly integrated care does not just involve organisations coming together to decide what is best for the communities we serve. A strong and effective ICS will have residents and communities at its heart, enabling people to be part of the identifying the issues and helping to find solutions in a way that works for them and meets the real priorities of local communities. The insights and diverse thinking of local people will enable us to tackle health inequalities and the other challenges faced by health and care systems.

To involve individuals and communities in a way which is both meaningful and representative will take everyone working together and a cultural shift in how ICS organisations operate. The ICS design framework sets the expectation that all partners across the system should agree how to listen consistently to, hear what is being said by and collectively act on the experience and aspirations of local people and communities. Across Coventry and Warwickshire, all partner organisations, particularly the two Local Authorities, voluntary sector and Healthwatch, have developed many examples of excellent best practice in working with communities, understanding experiences and championing co-production, and we will build on and learn from their experiences in shaping the ICS approach.

Despite that rich understanding held by all partners, we have not always historically worked together as a system to engage local people, instead relying on individual organisational networks. COVID-19 changed this and showed what we could do without organisational barriers, working together with one another, local Healthwatch organisations, partners in the Voluntary, Community and Social Enterprise sector and the population of Coventry and Warwickshire. Developing our learning from this and from the excellent work already being undertaken by all ICS partners in involvement will allow us to build on existing relationships, networks and activities and develop a strategy with and for individuals and communities. This strategy will lay the groundwork for how we work

together as a system and how we share and develop new ways to develop two-way communication with the diverse communities that make up Coventry and Warwickshire, engaging and involving local people on their terms and in a way that works for them.

This strategy covers how the partner organisations of the Coventry and Warwickshire Integrated Care System will create a framework for working together and how we will decide what engagement should happen at Place, Primary Care Network Level and System, sharing insights to enable a broader and better understanding of what is important and makes the biggest difference to individual communities. It also covers how involvement will support the priorities of the ICB and the ICP as they become established. Finally, it outlines the involvement mechanisms currently in place and how we will embed involvement throughout the ICB, developing the cultural competency to understand what people tell us and use that insight to reduce health inequalities and improve health and wellbeing.

This document is only the preliminary draft of our Strategy. Throughout 2022/23 we will engage with the people who live and work in Coventry and Warwickshire, stakeholders and our workforce to develop the strategy further and ensure that our objectives, methodology and goals are the right ones for everyone and delivered in the right way, with and for local communities.

How we use language in this document

Part of Cultural Competency is how we use language in our own documents to refer to people and diverse communities. The NHS Race and Health Observatory have developed a set of five principles to follow when writing and talking about race and ethnicity. We will adopt these principles, not only within this document but through all our involvement work.

Be specific - We will always be as specific as possible about who we're talking about. Collective terminology should never be used for convenience or to save time. We will be clear in our conclusions and our recommendations about who we are really talking about, and we will require all organisations we commission to disaggregate findings by ethnic group.

No acronyms or initialisms - We will never use acronyms, initialisms or other contractions to refer to groups of human beings. Contractions like 'BME' and 'BAME' create a further level of needless abstraction from the communities and individuals we are talking and writing about.

Context - We will only use collective terminology where we absolutely must. And even where collective terminology is required, we will always be guided by context and will not adopt a single blanket term. We will always challenge ourselves to think specifically about what we are trying to say. In practice, this means that you will see the terms 'Black and Asian', 'Black and minority ethnic', 'ethnic minority', 'Black, Asian and ethnic minority' and 'people who experience ethnic health inequalities' depending on the context and the content of the work reported on. Where the context is not decisive, we will use the above collective terms interchangeably. This is to reflect the fact that no one term suits everyone and to pursue our objective of respecting individual and community dignity. As above, even where we do use these terms, we will not use acronyms or initialisms.

Transparency - We will always be up front and open about the approach we have taken to language. We will link to the NHS Race and Health Observatory report and display these principles on our website, and we will include explanatory text in all our documents and reports to explain our approach to language.

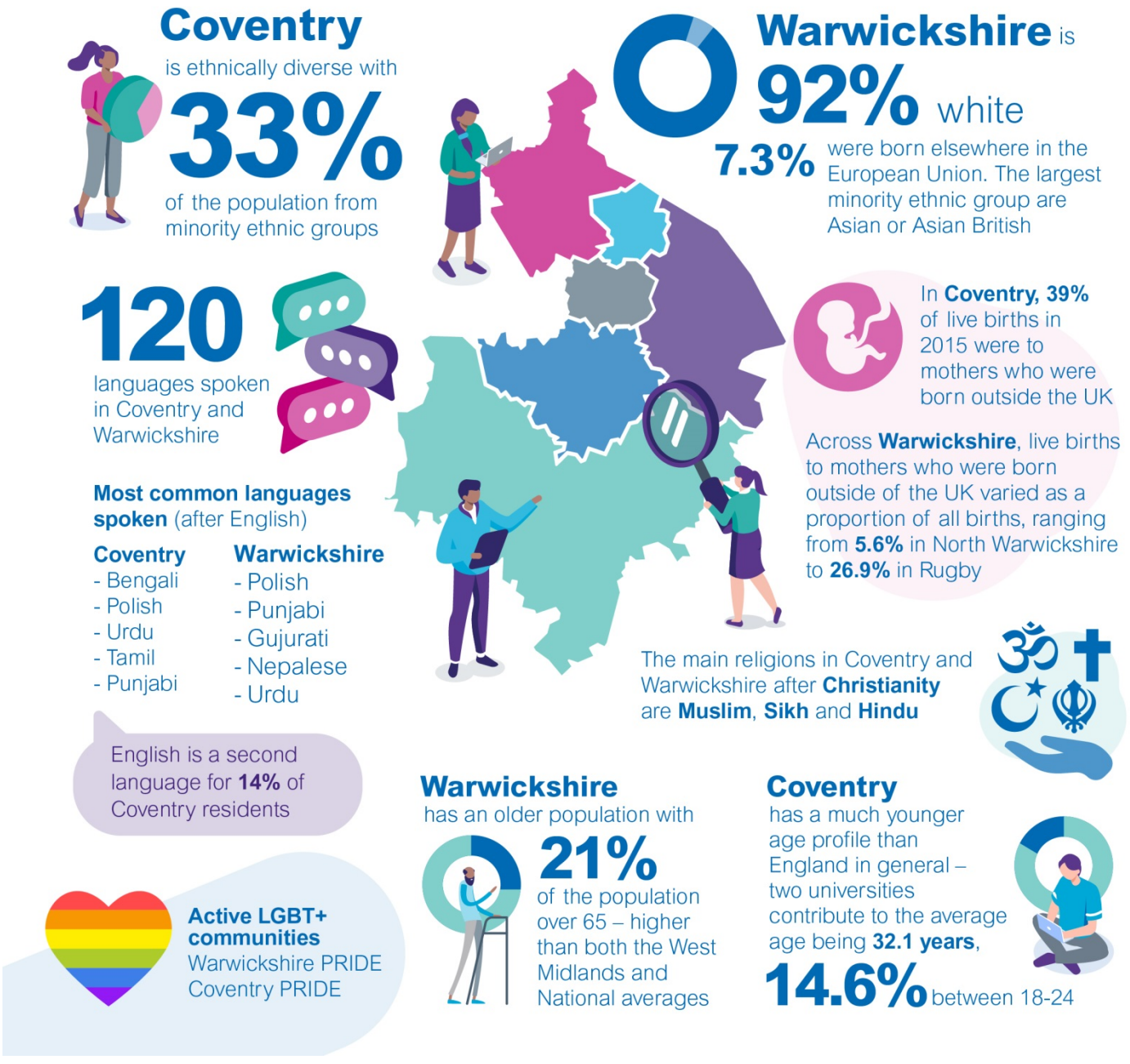
Adaptability - We accept that language develops and that a term that is acceptable today may not be in a few months' time. We will not draw a line under these considerations, and we will always welcome productive challenge around our approach to language and the rest of the work we do. We will change and adapt our language over time to ensure that our work remains relevant to our stakeholders.

You can find out more about the NHS Race and Health Observatory and the research that led to the development of these principles here - NHS Race & Health Observatory Terminology Consultation Report

The local population

Our new Integrated Care System will cover the footprint of our Coventry and Warwickshire Sustainability and Transformation Partnership. This footprint is home to a population of approximately 1.02m and covers two Local Authorities (Coventry and Warwickshire), and five Districts and Boroughs. It is served by three acute hospitals, two community service providers and one mental health trust, as well as 19 Primary Care Networks and 119 General Practices. There is also a thriving third sector and a diverse range of community organisations reflecting our population, as well as independent providers which make up the provider landscape.

This area is hugely diverse area, with many different communities. The below infographic demonstrates a small part of that diversity and the related need for services to be designed in a way which is culturally competent and cannot ever be "one size fits all"



The partner organisations of the ICS

- Coventry and Warwickshire Integrated Care Board
- Coventry City Council
- Warwickshire City Council
- Coventry and Warwickshire Partnership NHS Trust
- George Eliot Hospital NHS Trust
- South Warwickshire NHS Foundation Trust
- University Hospitals of Coventry and Warwickshire NHS Trust

The role of involvement and cultural competency in reducing health inequalities

Throughout this document you will see reference to "cultural competency", the ability to understand and interact effectively with people from diverse cultures. Improving our cultural competency is at the heart of our drive to reduce inequalities, and to develop services based on respect and appreciation of the cultural context of an individual's life.

We are fortunate that Coventry and Warwickshire is home to multicultural and diverse communities that can help us shape the future of the health and care system. We know a person's culture influences how they may want to access health and social care services and the kind of treatment options they are comfortable with. We must develop a greater understanding around managing language barriers, values and beliefs and/or basic dietary requirements within certain communities and gain a level of understanding in relation to health literacy within the local population. Without the cultural competency to understand the values and aspirations of our local communities, we are unable to ensure that the services we design and deliver meet individual social, cultural and linguistic needs. Furthermore, without the cultural competence to engage and collaborate with diverse communities in a way that is appropriate to them, we cannot build a true picture of how they feel about their local services and the experiences they have. Developing cultural competence is vital if we are to reduce health inequalities and ensure that health and care provision is high quality, safe and effective.

Collectively, we need to better understand and respond to communities when they tell us about their culture. We must put aside any assumptions and stereotypes which may influence how we perceive them and be aware of our own biases, even when they are unconscious, and actively work to eliminate them from our design and delivery of care. From rural villages to towns and suburbs to vibrant inner-city districts, from different faiths to diverse ethnicities, every part of Coventry and Warwickshire has their own cultures and communities which we need to learn from.

We must also recognise that within communities there may well be differences in how individual members of that community respond to engagement on health care, for example due to generational or gender differences, and so our engagement work must reflect this. There are countless opportunities for community engagement and collaboration, but we need a commitment from everyone who works in the system to actively seek and respond to ideas and feedback so we can constantly strive to improve.

The role of involvement is vital in building the mutual links with local communities that are needed to enable us to listen and understand when people tell us their priorities and to collaborate with people on solutions. Inclusivity will impact the kind of communications

methods we deliver and how, as system partners, we can support communities to be in control of their own health and health outcomes, prioritising prevention in the way that works for individuals and making sure we are clear in communicating what services and support is available. Ultimately, working together as an Integrated Care System, alongside the people we are here to serve, will help to reduce health inequalities and improve the health and wellbeing of the population.

Our current position and areas for development

Our approach in responding to the pandemic and delivering the vaccination programme has shown us that when we work together, without barriers between local authorities, NHS providers and commissioners and communities, we can better support and respond to the needs of local residents and communities and extend our reach much wider and deeper into local communities, particularly those who may have been excluded in the past.

Throughout the strategy you can see case studies from across the partners of the ICS which demonstrate the breadth and depth of activity which already takes place. These activities give us a strong foundation to build upon when designing how we work together as a system and better collaborate and engage with both individuals and communities.

However, there remains barriers to delivering engagement, both as a system and at local Place and Neighbourhood level, which this strategy aims to eradicate as we begin to work as one whole system.

Addressing the areas for development

Working together as ICS partners to deliver involvement and engagement

As demonstrated above, each organisation within the ICS retains its own strong community links and relationships. There is considerable innovation across the system as well as successful models for involvement in place. We need to build on these areas of good practice to establish a consistent and meaningful approach to involvement and engagement across the ICS.

Historically, although organisations have collaborated successfully on individual service transformation and design projects, there is no overall system approach to involvement and engagement, and no mechanism for sharing insight between organisations outside of on an individual project basis. There is also no formal co-ordination between organisations of engagement schedules, leading to some communities being approached multiple times to share their views on similar issues and consequent engagement fatigue and lack of interest in working with statutory organisations.

Often, as organisations we engage when we need-input rather than doing this routinely and creating a culture of always listening. We must also acknowledge that we aren't always the right people to do the engagement. Sometimes, the best engagement takes place through those already in direct contact with residents/communities as part of daily interaction and any approach must build on this knowledge.

Involving local people and communities

COVID-19 has brought about rapid change in how we deliver our engagement and involvement. Avenues which were previously open to us in engaging local communities, such as outreach at face-to-face community events or holding drop-in sessions in local community venues, were paused and are, at time of writing, only tentatively beginning to start again. Engagement has moved primarily online and those unable to use digital services have become more isolated from our work and are at risk of being left behind.

In some cases, this has led to positive questioning of the efficacy of generic one-size-fits-all engagement in truly connecting with priority groups. Through thinking differently about engagement avenues, we have been able to use different tools to engage with people to reflect the move away from more scattergun approaches and traditional town hall events.

However, the pandemic has also thrown into sharp relief the issues and barriers felt across our ICS when trying to involve communities. Although there are positive connections with many diverse groups and excellent work taking place we still have further to go. As part of the work to develop this strategy, individual partner organisations, as well as the two local Healthwatch organisations, compiled the following list of themes from recent insight work which address the main four areas for development:

Changing how we do things

- Lack of priority for engagement and involvement given in organisations
- Poor communication and connectivity between the NHS and Local Authorities and service users/communities leads to fragmentation of engagement activity and lack of clarity of purpose
- Top-down approach adopted by the NHS and Mainstream Institutions is unwelcomed by the community

Trust

- Uneven responses from local people, for example men often underrepresented or hear from the same groups of people means that groups can feel marginalised
- Lack of trust in the NHS/social care and partner organisations
- Desire to see more targeted engagement with key population groups across the ICS.
- Duplication between organisations with some groups being “over-engaged” and others feeling ignored

Improving our methodology

- Perceived lack of skills and tools available to communicate and connect with the communities in diverse settings
- Lack of awareness of best practice methodologies for effective engagement with seldom heard and faith communities
- Lack of awareness or recognition within our organisations around the value of community assets to help shape local priorities and solutions, leading to a deficit- or needs-based approach

Maintaining our relationships

- Past poor involvement of communities in service planning, monitoring and management, leading to a cynicism around the point of being involved and lack of belief in it making a difference
- Desire for more community discussion groups and forums
- Requests for the recruitment of more health champions/ambassadors

This feedback is an excellent starting point. These issues will be best tackled through co-ordination at a system level, rather than through individual organisations as the issues highlighted are likely to cross all service providers.

Involving the Voluntary, Community and Social Enterprise Sector

A key aspect of involving communities which are most impacted by health inequalities will be working through, and with, the local voluntary, community and social enterprise sector, particularly the community or "grass roots" organisations, defined as those with a turnover of less that £10,000 per annum. These groups are at the heart of their communities, often supporting people who are unable to access health and care services through current routes.

Local communities will benefit greatly from the inclusion of these groups on both strategic and local planning, as they will often be better placed to understand these issues at a local and hyper-local level and share their own experiences of tackling them that can be used across the system, shaping services to fit the priorities of diverse communities and contributing to improved outcomes and access. There is increasing awareness of the value and influence of social action versus more traditional volunteering, the former being more informal and unstructured but also flexible and dynamic, and it was of huge benefit during the Pandemic allowing for an almost instant response to changing local priorities.

Historically, statutory organisations have asked a lot from local community groups, without always considering what we might offer in return. To develop meaningful relationships this can no longer be seen as a one-way street for support. Before we ask any more from these groups, we must first understand how we can better support them to deliver their services to their communities and how they can better access funding and resources to participate.

The partner organisations of the ICS are Anchor institutions and as large local institutions they have an opportunity to support training, employment and professional development for the people of Coventry and Warwickshire. Supporting volunteers and wider organisations who support them is a key part of this work and supporting third sector participation will also allow us to assist them to improve their offer to their communities both through opportunities to access training for staff and volunteers, and by supporting with the development of policies and procedures.

To make this engagement meaningful, developing this structure at a Place and Neighbourhood level will be key to success as the priorities of many groups and communities are likely to be linked to individual areas, rather than operating at a system level.

Meeting anticipated ICB legal duties on public involvement

Involving the local population is, as evidenced above, the right thing to do, reducing health inequalities and allowing us to develop and deliver better services. However, as a statutory organisation, the ICB will also be bound by legal duties to involve:

NHS Constitution – places a statutory duty on NHS bodies and explains a number of rights and responsibilities which are a legal entitlement, protected by law. One of these rights is the right to be involved directly or through representatives:

- In the planning of healthcare services
- In the development and consideration of proposals for changes in the way those services are provided
- In the decisions to be made affecting the operation of those services.

Health and Social Care Act 2012 and 2021 – Within Coventry and Warwickshire ICS, all NHS partners have legal duties to involve the public in their decision-making about NHS services. These requirements are deliberately placed upon organisations to reinforce the importance and positive impact of 'public involvement'.

The main duties on NHS bodies to make arrangements to involve the public are set out under sections 14Z44 (for NHS Coventry and Warwickshire ICB) and section 242 (for NHS trusts) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012). Additionally, NHS Coventry and Warwickshire ICB includes, within its constitution, details about the arrangements for public involvement and links to this strategy, which outlines the principles to be followed in implementing them.

These 'public involvement' duties have applied to commissioners and providers for many years and are largely unchanged. However, a significant change proposed in the Health and Care Act 2021 is that the description of people to be involved has been extended from 'individuals to whom the services are being or may be provided' to also include 'their carers and representatives (if any)'. While it is already common practice to involve carers and their representatives, and to do so is in line with previous statutory guidance on the public involvement duties, this change makes it a legal requirement for arrangements for public involvement to secure the involvement of carers and representatives (if any), as well as service users themselves.

The legislation does not include a definition of carers or representatives [revisit with DHSC as legislation proceeds]; however, we consider relevant carers[1] and representatives should be identified by reference to the individuals who use, or may use, the services in question. It is up to local organisations to identify who to involve – depending upon the circumstances, nature of the services and decision-making process

[1] A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid. When we refer to carers in this document, this is inclusive of both adult and young carers.' Reference NHS commissioning » Who is considered a carer? (england.nhs.uk)

in question – but relevant carers and representatives could include individual patients' advocates or family members who help organise their care, as well as councillors and community leaders, VCSE sector organisations, local Healthwatch and other organisations able to represent the interests of the individuals who use, or may use, the services in question. A stakeholder analysis can help determine which groups are relevant representatives depending on the context.

The ICB and local NHS trusts are also subject to the new 'triple aim' duty (sections 14Z43 and 26A respectively). This requires these bodies to have regard to the 'triple aim' of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. Effective working with local people and communities will be essential to understand local populations and deliver this triple aim.

The Public Sector Equality Duty – The Equality Act 2010 – The Equality Act 2010 promotes fair treatment of people regardless of any protected characteristic they may have. All our communications and involvement activities will take this into account, paying due regard to those people with protected characteristics and ensuring equitable opportunity to be involved.

Aims and principles of the strategy

The aims of the ICS

- **Improve outcomes** in population health and healthcare
- **Tackle inequalities** in outcomes, experience and access
- **Enhance productivity** and **value for money**
- Help the NHS **support broader social and economic development.**

Successful involvement of the people of Coventry and Warwickshire and local communities is integral to the success of these aims

- To design and deliver effective services which are value for money, we must have a deep understanding of the priorities of the individuals and communities who use them.
- The insights and diverse thinking of individuals and communities are essential to enabling us to tackle health inequalities and the other challenges faced across the health and care system.
- The creation of statutory ICS arrangements brings fresh opportunities to strengthen our wider work with communities, building on existing relationships, networks and activities and supporting broader social and economic development.

We are not starting from scratch. The two local Health and Wellbeing Boards have developed Health and Wellbeing Strategies which outline how they we to work with communities and this work will form a significant part of the development of our approach.

The ICS has agreed a vision for our system, which explicitly highlights the importance of involvement, seeking and acting on feedback from both local people and staff.

The 10 principles for engagement

In September 2021 NHS England published implementation guidance for ICSs on working with people and communities. This set out 10 principles, developed through work with systems, and designed to be a golden thread running throughout the ICS, whether activity takes place within neighbourhoods, in places or across whole system geographies.

In addition to these principles, our local Healthwatch organisations have worked together to develop a "Good Engagement Charter" which echoes the principles outlined by NHS England above and provides us with a mechanism for assessing our engagement and involvement activities.

Objectives of the strategy

This strategy outlines how we will work together as partner organisations of the Integrated Care System to develop the mechanisms through which we can build trust with local people, how we involve them in the development of the right services for them and giving them confidence to use them, how we enable the services we design and deliver to be culturally competent, and how we reduce health inequalities and improve health and wellbeing across Coventry and Warwickshire.

To do this, we've identified three key objectives which align to the aims of the ICS and the wider vision.

1. To develop our involvement functions and networks across the ICS to support the delivery of the ICS vision and become a system where working collaboratively with each other and the local population is the default.

2. To support the ICB and ICP to deliver on their priorities

3. To continue to develop the current routes of involvement of individuals and communities in our governance and workstreams, based on the 10 principles for involvement and identify the areas for further growth and associated actions

Delivering on our objectives

1. Developing our involvement functions and networks

To support the delivery of the Coventry and Warwickshire ICS vision and deliver involvement against the ten principles we must address the current areas for development for involvement outlined in section one and develop ways of working together as an ICS.

To take this objective forward, a working group has been formed with the involvement leads from local authorities and health organisations, in addition to representatives from both Healthwatch organisations. This group has agreed to drive the work forward collaboratively to ensure that all partners organisations of the ICS (and wider) are represented.

Through the working group, we will establish a framework for how we work together.

To start this process we established what our vision and aims are for involvement as an Integrated Care System. These will then define how we will come together as individual organisations, and work as partners to involve local people and community groups.

Our vision

"To **work together** to make our health and care system **work for everyone**"

Our mission statement

As partner organisations in the Integrated Care System, we believe in working together with the population of Coventry and Warwickshire, and each other, building relationships that are honest, open, realistic, and transparent – but also optimistic, positive, and collaborative.

When health care services are suitable for local diverse communities, we know that inequality will be reduced, but that can't happen without bringing the communities' voices and experiences into the heart of organisational decision-making and design and delivery of services. We must put people at the heart of everything we do because we know that outcomes are better when they are designed in partnership.

Truly putting people at the heart of everything we do is easy to say, but hard to do in practice. It will require innovation, bravery and a cultural shift within all ICS organisations to change how things are done, involving everyone from senior leaders to commissioners and planners to frontline health and social care staff. We must develop a shared understanding of what good involvement looks like for our ICS and equip staff, stakeholders and the local population with the skills needed to participate, lead change, and flourish.

Having the right structures to support involvement is not enough and there is much work to be done to build trust amongst local communities, some of whom have felt ignored or marginalised in the past. To understand what matters most to people and what will have the biggest impact on their lives we must develop an "always listening and learning" environment where people can share their experiences and needs with us at any time, not just when we decide we want to talk to them. When we have gathered insight we must share knowledge between partners so individuals only have to tell their story once and we

reduce the burden of involvement which falls on some communities. When we do improve things, we need to continually demonstrate the difference that community involvement has made, to show the population the value of their contributions and to champion the benefits of involvement to both local communities and the staff who work with them.

When we get it right we will unlock the local expertise of residents in order to redress inequalities and genuinely level-up outcomes for all communities. We will build trust for people to feel they can share their experiences, telling us what is working and where we need to improve. When people feel involved and listened to, not only will they access our improved services but feel empowered to take control of their own health and wellbeing. Ultimately this will help people across Coventry and Warwickshire to start well, live well and age well, regardless of their background or circumstance.

Critical actions to deliver the objective

To deliver against our mission and the aims of the ICS, the following actions must be delivered

1. Develop a framework for how we work together as partner organisations within the ICS
2. Promote cultural change across the ICS to put people at the heart of everything we do
3. Build trust and relationships through always listening and learning
4. Equip everyone with the tools they need
5. Demonstrate the difference that community involvement makes

The first three areas will be our initial focus of delivery, delivering the building blocks to achieve the third and fourth actions.

The ICS Vision	We will enable people across Coventry and Warwickshire to start well, live well and age well, promote independence, and put people at the heart of everything we do			
Our vision for involvement	We will work together to make our health and care system work for everyone			
How we will do this	Promote cultural change across the ICS to put people at the heart of everything we do	Build trust and relationships through always listening and learning	Equip everyone with the tools they need	Demonstrate the difference that community involvement makes

Action – 1. Developing a framework to support how we work together

As outlined above, it is imperative we understand what engagement happens where, and who delivers that engagement in order that we can reduce duplication and build positive relationships with communities through those networks, organisations or individuals who are best placed to support them.

A great benefit of becoming an ICS is that the development of two Care Collaboratives (our local Place-Based Partnerships) and four Places means that decision making will be happening at a more local level, focusing on local community priorities. This means people can input on issues which are directly relevant to them and there will be more opportunity to build trust and for organisations to demonstrate clearly the difference which their involvement makes.

Although at time of writing the legislation is not in yet in place, it is anticipated that the statutory duty for involvement in health care service change and development will transfer from the current Clinical Commissioning Group to the ICB. There will also be no change in the statutory obligations of local authorities to involve people in service change.

This means that, as an ICS, we must agree a framework, set of principles or other mechanism which supports how we work together and allows us to define what good looks like for involvement in Coventry and Warwickshire for the benefit of local communities. It also will reflect that the majority of work will happen at Place and Neighbourhood level and support the statutory organisations to be assured that the legal duties around involvement have been delivered appropriately, while also allowing the individual organisations, Care Collaboratives and Places the freedom to do things in ways that are tailored to the diverse communities they serve and directly address their priorities.

This framework will build on the good practice and knowledge already built through the work of the partner organisations of the ICS. It must be developed in conjunction with local communities and our workforce and support all ICS partner organisations to ensure best practice involvement throughout all their activities. As the framework must address the statutory requirements outlined in the Health and Care Act, its scope will be assuring and supporting Health and Care Involvement, however it will need to recognise that involvement of individuals and communities can often range much more widely than single topics and cover a much wider variety of topics of interest to the community.

Across Coventry and Warwickshire there is already work in place to develop engagement routes and approaches at a Place level which will inform the System framework and what good looks like for communities.

Key deliverables and activities for Year 1

- Engagement programme to develop what good looks like with communities, avoiding duplication with Place based work
- Framework / Set of Principles for Health and Care Public Involvement in Coventry and Warwickshire

Action – 2. Promote cultural change across the ICS to put people at the heart of everything we do

Truly putting people at the heart of everything we do is easy to say, but hard to do in practice. It will require innovation, bravery and a cultural shift within all ICS organisations to change how things are done, involving everyone from senior leaders to commissioners and planners to frontline health and social care staff.

We must develop a shared understanding of what good involvement looks like for our ICS and equip staff, stakeholders and the local population with the skills needed to participate, lead change, and flourish (see action 1). This is closely linked to the development of the ICS Workforce and OD strategy as we aim to support our entire workforce to learn to do things differently. It also means using the development of the ICB functions and committees to "bake in" involvement right from the start and championing the 10 principles for engagement as the foundation of how we do things (see pg. XX - How is the ICB listening to people and communities for further information).

To support the overarching goal of changing how we do things, the working group of involvement leads is proposing the establishment of a wider "Involvement Network" for the ICS. This network will include all partner organisations of the ICS but also VCSE representation, borough, district and parish council and Place-based representation, as well as other organisations and individuals.

The network is designed to bring together those working in involvement and engagement in a single place for discussion, collaboration and co-ordination. It will also help to define our local principles or framework for what good looks like outlined in Action 1.

Individual organisations will retain their involvement functions, and Places/Care Collaboratives will develop their own arrangements to ensure that they involve and engage with the local communities they serve, drawing support from the network and constituent organisations as appropriate.

In conjunction with the ICS Workforce and OD strategy, this group will drive the cultural change, supporting senior leaders to champion the need for involvement to the wider workforce.

Individual patient and service user experience also forms a vital part of our work and it is proposed that we explore a separate Patient Experience group to support Quality Monitoring, either as a distinct entity or a sub-group of the involvement network. This group will have close links to the wider involvement network, but bring together clinicians, patient experience leads from NHS providers, the Integrated Care Board quality function and engagement and involvement leads with a specific focus on individual patient experience and quality monitoring trends. Through further co-ordinating involvement in quality monitoring across the ICS we will be better able to put the patient at the heart of everything we do.

Key deliverables and activities for Year 1

- Development of the involvement network
- Ongoing development of VCSE engagement routes to support participation

- Embedding into quality monitoring, establishing quality experience group
- Build links with the Workforce/OD strategy to ensure that the workforce across the ICS have the opportunity to develop necessary skills and learn the benefits of involvement
- Build on the mechanisms already in place to understand what works and what needs further development, based on the 10 principles of engagement

Action – 3. Build trust and relationships through always listening and learning

To build trust we must demonstrate that we want to not only understand local community priorities but that we will also act on them. We must develop an "always listening and learning" environment where people can share their experiences and needs with us at any time, not just when we decide we want to talk to them.

When we have gathered insight we must share knowledge between partners so individuals only have to tell their story once and we reduce the burden of involvement which falls on some communities.

This work will be developed in conjunction with the establishment of a "Decision Support Unit" as part of our Population Health Management Strategy, exploring how we can better include qualitative data in our planning and decision making, building on what we already know and people have already told us.

Much of the relationship building and work to develop trust will occur at a Place and Neighbourhood level, driven by our Care Collaboratives and Place functions as those with closer links to communities. To support this we need to establish clear governance routes for information from community assets / VCSE organisations into System, Place and Neighbourhood, so that regardless of where insight is gathered, it is able to be channeled to where will it make a difference.

To further reduce duplication we will develop an understanding of engagement and involvement activity and assets across the system, allowing partner organisations to work together and co-ordinate through available channels, rather than all organisations developing independent routes to the same communities. This will also enable us to identify gaps which might exist at an ICS level, cross referenced against the Core 20 plus 5 cohorts.

Trust will ultimately be built through our actions, not our words. This means showing clear outcomes from involvement and demonstrating that we are not only listening but we are acting on the information we hear, and on occasions where we can't address specific community priorities we must be honest and open about our reasons why, so people feel involved and listened to. As outlined in our vision this will not only support better access of our improved services but empower individuals to take control of their own health and wellbeing.

Key deliverables and activities for Year 1

- Map of engagement and involvement activity and assets across the system to reduce duplication and identify gaps

- Explore development of a single or linked repository of all qualitative insight from partners, linked to PHM and the Decision Support Unit
- Establishment of clear routes for all information and experience at system, place and neighbourhood level
- Engagement programme to work with communities to understand what "good" involvement looks and how to develop culturally competent, inclusive feedback mechanisms for the wider communities.

Action – 4. Equip everyone with the tools that they need

It is not enough to just set up new routes for involvement and hope they will be successful. To ensure buy in and achieve the cultural shift required to fully adhere to the principles of engagement, we will need to support individuals, local communities, the organisations which work with them and our staff to understand, buy into and fully participate in the new ways of working.

This goal will be delivered in the longer term as development of the previously detailed actions will define the tools that are needed to promote positive ongoing involvement. This will be developed in conjunction with local communities, the third sector and our workforce and but we anticipate the following areas will be explored:

- Individual Residents and Communities
    - What do we already know? What's already there?
    - Training and development to participate on committees and Boards as "experts by experience", "community champions" and more.
    - Explore financial remuneration for attending meetings as a representative

- Community representatives/ leaders, Community/Grassroots organisations, Voluntary Sector and Social Enterprises
    - Training and development to participate on committees and Boards as community champions or representatives of service users
    - Explore Financial remuneration for attending meetings as a representative
    - Training and development to engage on our behalf
    - Funding for engagement projects

- Workforce across the ICS
    - Training and development at all levels of staff on how (and why) to involve effectively, utilize community champions, co-produce services and other new ways of working
    - Guidance and further training on resources available, how to complete an equality impact assessment and other core parts of addressing inequality.

Key deliverables and activities for Year 1

- Development of engagement programme to work with communities, the third sector and our workforce to co-produce how we develop our involvement

Action – 5. Demonstrate the difference that community involvement makes

When we make improvements, we need to continually demonstrate the difference that community involvement has made, show the local population the value of their contributions and champion the benefits of involvement to those who work in the health and care system.

This will be a core element of developing trust with communities as outlined in Action 3. "You said we did" must form a key and ongoing part of our communications and involvement, building a wider ICS narrative on the benefits and impact of involvement, not just communicating when the whole project is completed. As outlined above, when there are times that we cannot deliver on something a community tells us is a priority for them, we must be honest and clear as to our reasoning why and seek alternative solutions in partnership with the community.

The ICS website will be developed to contain a dedicated section to support the narrative of involvement, linking to all the partner organisations and Place-based work as it develops so a system-wide picture of activity is clearly demonstrated. This work must also be proactively communicated, in a range of on and offline ways, to participating individuals and communities when change occurs. Ultimately this will create the conditions for a virtuous cycle of involvement, the more people see that their contributions make a difference the more inspired they will be to contribute more, leading to further, community-centered change.

To achieve the cultural shift required internally as an ICS to put patients at the heart of everything we do, we must also communicate to our workforce and partners the benefits of involvement using real life examples, patient and service user stories and case studies to enthuse and inspire our workforce to start to move to an involvement by default culture.

Key deliverables and activities for Year 1

- Development of the ICS website
- Ongoing narrative programme to communicate best practice
    - Communities, residents and third sector
    - Workforce

2. Supporting the delivery of ICB and ICP priorities for 2022-23

Priorities of the ICB and ICP

Involvement and engagement will play a key role in improving people's lives, supporting the ICB to deliver its priorities. We know the COVID-19 pandemic has had a significant impact on the population's long-term health and wellbeing, both physical and mental, further increasing health inequalities as some communities are reported to be affected much more seriously than others.

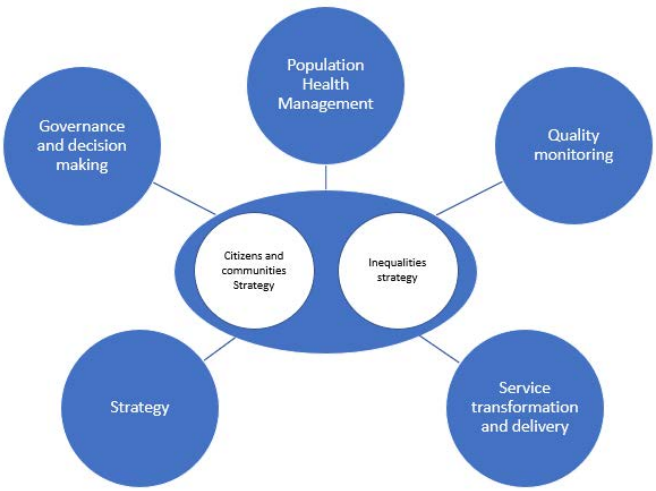
The pausing of other health services while we responded to the initial pandemic, and the process of restarting them again, has had, and continues to have, significant effects on people's health and has been exacerbated by second and third waves of variants. Inequalities, both caused by the pandemic and those which are already entrenched within societies, are rising.

Tackling these growing inequalities across health and care is at the heart of the priorities of the Integrated Care System. Successful involvement with local people is integral to this work, as without understanding the priorities, values and aspirations of individuals and communities we cannot clearly identify the causes of, or solutions to, the inequalities which affect them.

The statutory development of the ICS enables the partner organisations of the ICS to work better and more closely together. By working together, and with our local Healthwatch organisations and other partners, we can build a more complete understanding of the inequalities faced by some groups and individuals across Coventry and Warwickshire and work with local people and communities on joined-up solutions.

This strategy is being developed in conjunction with our Inequalities Strategy which outlines our approach to tackling inequalities in outcomes, experience and access within our system. This Inequalities Strategy identifies the Core 20 Plus Five cohorts within our system who are in greatest need of support. Involvement is an essential part of developing our approach to supporting the priorities of these groups, ensuring any intervention on their behalf is culturally competent and driven by learning from the experiences and perspectives of these cohorts. These cohorts will be our priority when targeting our involvement resources as we develop.

Together with the dedicated inequalities work, involvement will be key to supporting the ICB across all its functions to deliver on their priorities.



Work to develop the ICB priorities is ongoing, however, building on the current work of the shadow ICB there are key roles for involvement in the following priority areas:

- Supporting the delivery of the Inequalities strategy
- Embedding a Population Health Management Approach driven by community involvement
- Development of the Coventry and Warwickshire Strategy by the ICP
- Transformation, restoration and redesign of services
- Ongoing response to the pandemic and vaccination programmes
- Maintaining inclusive, high quality services

The ICB will inherit a strong engagement and involvement ethos from the Clinical Commissioning Group which precedes it, and we will build on that knowledge and the structures already in place, as well as that of all the organisations across the ICS.

These priorities, and the actions that support them, will evolve and develop through the life of the strategy. We will further develop our strategy for delivering against these objectives as we develop as an ICB, and individual involvement plans will be developed to address each priority, building on the work which has been undertaken across the ICS.

Although these are the priorities of the ICB and ICP, it should be noted that much of the involvement is likely to take place within and driven by the Care Collaboratives and not solely through the ICB structures.

Population Health Management	
Priority – Embedding Population Health Management	
The role of involvement Moving to a Population Health Management approach is a key priority of the ICB. As the ICB develops this approach, involvement and the gathering of qualitative data to inform decision making will be an integral part of reducing health inequalities and enabling us to identify and address physical, mental and social wellbeing priorities of the population and reduce the variance in support which has previously contributed to inequality. Population Health Management puts the individuals and communities at the heart of their own care, wrapping services around them and supporting them to take control of their own care. Involvement will be key in delivering this, building relationships with both communities and with the third sector who will be integral to the work.	**Involvement in Action – Healthier Communities Together in Coventry** As we transition to an ICS, working collaboratively across the system will be vital if we are truly improve healthcare outcomes and address the wider determinants of health. However, in order to facilitate more effective partnership working, the infrastructure that allows for collaboration must be redesigned to reflect the closer cross-sector relationships that will be established when the ICS is formed. The Healthy Communities Together programme has created a cross-sector strategic team to create a more collaborative approach to tackling health inequalities consisting of Coventry City Council, Coventry & Warwickshire Partnership Trust, Grapevine and local GPs. By using a hyper local model of collaboration, the aim is to put people with lived experience of mental health needs, community groups, and small voluntary and community sector organisations at the heart of decision making. This new way of working will empower communities to determine the shape of their healthcare services and create new relationships between people, service providers, and the voluntary and community sector.
Delivering on the priority We will continue to build upon this approach through the work to develop a shared insight database to support decision making for Population Health (Pg. xx) and building trust with communities to build understanding of their priorities (Pg. xx). Our work with developing relationship with the third sector, building on initiatives already in place will be integral to delivery.	

Reducing health inequalities	
Priority – Supporting the delivery of the inequality strategy	
The role of involvement Through involvement and understanding of individual communities' priorities and aspirations, we will be able to design and deliver services tailored to meeting those priorities, improving access and ultimately reducing inequalities for the local population. This work will encompass all the partner organisations within the ICS building on best practice to understand priorities	**Involvement in Action – Building community links through local champions** We know that the South Asian Community are at an increased risk of diabetes compared to the white population. Diabetes brings with it the risk of long-term complications such as heart and kidney disease, amputations, and blindness. It is therefore key for us to address these inequalities if we are to achieve equitable health outcomes. The Diabetes Community Champions programme was established to raise awareness of the condition within high-risk communities. These Champions are volunteers from within the communities we are aiming to reach, which means they can effectively engage with their community in a culturally competent way. They form a vital link between the NHS and their local community, and they carry out crucial work to educate and raise awareness of diabetes. There are now 30 Diabetes Community Champions operating in Coventry and Warwickshire and the programme has proved extremely effective at engaging with high-risk communities. The community champions have supported with delivery of culturally competent outreach events, including cookery classes with a focus on authentic South Asian recipes to support healthy living in a sustainable way and delivering other health information.
Delivering on the priority This work is closely tied to that of the Inequalities Strategy and a separate delivery plan will be developed to support this work. In Appendix XX you can find examples of how well delivered, culturally competent involvement will support a reduction in health inequalities and reduce the prevalence of risk factors in our communities - two key priorities of our ICB. Using a logic model, they also show the assumptions which we have made and examples of how we intended to measure our success.	

Strategic development	
Priority – Development of the ICP strategy for Coventry and Warwickshire	
The role of involvement The Integrated Care Partnership (ICP), along with the two Health and Wellbeing Boards for Coventry and Warwickshire, will be responsible for setting the strategic direction of travel for Coventry and Warwickshire, with a focus on how we can reduce health inequality and improve outcomes. Supporting meaningful involvement of communities for the ICP will be essential in ensuring that this strategy identifies and responds to the priorities of all residents of Coventry and Warwickshire.	[Case study to follow – HWBB community involvement)]
Delivering on the priority Building on the community links already in place and the work of the Health and Wellbeing Boards, a full involvement plan will be developed to ensure that this work is developed with the input and support of local communities.	

Service transformation and delivery	
Priority – Restoring services	
The role of involvement To develop culturally competent services which people want to use and create new pathways for care which reduce inequality, we need to understand how they will be received by the varied and diverse communities across our area. This entails establishing more meaningful relationships and seeking joint solutions in partnership with communities, putting communities at the heart of our planning and decision making around the services which they use. Supporting the development of individuals and community representatives to help shape our services, using health and care experience profiles to inform planning and using co-production approaches will all lead to better services and improved access, reducing health inequalities. Restoring services inclusively will require involvement of the local population to ensure that those services continue to meet patient need and we rebuild local service provision to meet the physical, mental and social needs of communities affected by severe economic and social disruption throughout the pandemic.	**Involvement in Action - Shaping services with people who are homeless or vulnerably housed** The Anchor Centre in Coventry is a specialist GP service, designed to meet the needs of the local homeless and vulnerably housed population. When it needed to be reprocured it was imperative that this was done in partnership with those who used the service and we could be assured that the service was fit for its users and delivered by a provider who understood the specific challenges faced by this cohort. The involvement team from the Clinical Commissioning Group undertook an extensive piece of engagement with the local homeless population, attending drop-in centres and other support services to talk directly to people and understand their experiences, what mattered most to them about the healthcare services they receive and how they thought they could be improved. Third sector organisations were also engaged with to learn from their experiences of working with people who are homeless and what worked best. This learning was all fed into the development of the service contract, adding addition outreach requirements which were deemed a necessity for support. This work was also used to craft questions for potential providers which would test their understanding of the needs of this cohort. Third sector representatives who worked with people who are homeless and Healthwatch Warwickshire sat on the evaluation panel, considering the responses and ensuring that the successful provider would be able to deliver a GP service which worked for this group. This approach allowed the voice of this often marginalised cohort to be represented and listened to throughout the process, ensuring the service addressed what they told us mattered most and has been taken forward as a model for local involvement in the redesign of NHS services for the CCG.
Delivering on the priority As restoration of services continues, the work outlined against Objective 1 (Pg. xx) will create the structures to support ongoing involvement of communities to inform this work and put individuals and communities at the heart of our restoration work.	

Service transformation and delivery	
Priority - Supporting delivery of ongoing vaccination campaigns	
The role of involvement Good involvement has been instrumental in ensuring uptake of vaccination across the diverse communities of Coventry and Warwickshire. Working together across ICS organisations we were able to reach into communities we had not previously had strong links to and work with then to understand their priorities and the barriers to vaccination. We developed new groups and links and were able to support local communities to deliver their own messages in their own way	**Involvement in Action – Supporting Vaccination amongst Children and Young People** Widespread vaccine uptake across all age groups was vital to our response to Covid, both to reduce the risk of serious illness and to reduce transmission within the community. However, certain sections of the younger demographics were showing hesitancy in getting vaccinated. The Positive Youth Foundation organised a live vaccination Q&A session where over 50 young people met with staff from the CCG and Public Health in Coventry. The panel were asked a range of questions and addressed concerns or misinformation that were causing vaccine hesitancy amongst the attendees. Whilst only a relatively small group, this type of engagement work is crucial to give the public, particularly those who have doubts over getting vaccinated, a chance to ask direct questions to NHS professionals. The Positive Youth Foundation saw an increase in confidence in vaccines amongst young people following this session. To further increase vaccination uptake, some of the group decided to make a video to spread the word about the importance of vaccination to their peers, leading to a much wider reach.
Delivering on the priority Building on the good links already in place across the ICS, involvement will continue to drive uptake for the vaccination campaigns across 2022/23	

Quality Monitoring	
Priority - Maintaining inclusive, high quality services	
The role of involvement It is not enough to design evidence-based services, we must ensure that the services remain suitable for the diverse communities that they serve. To do this, patient and service user experience must be gathered through involvement with local communities and be heard and acted upon, with learning recorded and embedded. This means creating a culture of always listening and learning, and of sharing our knowledge between organisations so we can identify potential issues quickly at a system level, whilst also feeding information to where it can most make a difference - at Place and Neighbourhood level.	**Involvement in Action – Using Patient Feedback to inform campaigns** Following patient and carer feedback to the Quality team on the lack of education and information on decisions some patients may need to make when unwell, the CCG worked closely with the Quality team, local advocates, charities, Healthwatch and those with lived experience to design a new communications campaign to raise these issues. Having discussions with loved ones about your wishes, should you be suddenly taken ill, injured or at the end of life, are not easy conversations to have. Whether you are having this discussion due to a terminal diagnosis or just because you want your loved ones to be better prepared. The campaign was co-designed to support people to be prepared – how to talk about it, plan for it, and record your wishes with useful resources. This work led to a Coventry and Warwickshire wide bus campaign to empower people to discuss their life choices with supported online information and materials. The bus campaign covers the geographical areas below on 30 bus rears over the summer of 2021, once pandemic restrictions were lifted. Digital content (website and social media) and staff messaging have been created and shared with CCG staff and all health and social care across the system to promote the campaign. All campaign materials have been created in partnership with the complaints team, patients, clinical leads and Compassion in Dying (national charity). The online resources and packs available offer a range of advice and guidance to support discussions and help people plan, all information is hosted and directed to the CCG website. In addition to the above campaign, all printed resources and materials have also been posted to primary care practices, care homes, hospices and secondary care quality and safeguarding leads across the provider trusts to further increase the reach.
Delivering on the priority This work will be supported through development of an Involvement Network and inclusion of our quality functions from across the ICS in that is outlined on Pg. xx. This work will further be supported by the development of a shared insight function, outlined on Pg. xx.	

3. Individuals and communities in ICB governance and workstreams

How is the ICB listening to people and communities

As the statutory organisation leading the integration of NHS services, local authorities and local partners, it is critical that the ICB is able to demonstrate that it is meeting its legal duties and provide assurance that effective involvement is taking place across the system from the day it becomes a statutory organisation.

Our routes for engagement have been mapped to the 10 Principles of Engagement to demonstrate the current mechanisms in place and identify areas to be improved through the life of the strategy.

1. Put the voices of our people and communities at the centre of decision-making and governance

The voice of Coventry and Warwickshire individuals and communities must be built into the governance arrangements of all our key decision-making forums within the ICB and ICP to demonstrate that we are listening to and acting upon what local communities are telling us.

The Board of NHS Coventry and Warwickshire Integrated Care Board

- The ICB will appoint five independent non-executive members to the board to bring independent and respectful challenge to its plans and promote open and transparent decision-making.
- To ensure there is transparency around decision making, all meetings of the ICB will be held in public and will be widely advertised to encourage members of the public to attend. The minutes of the ICB meeting will also be published to allow those who are unable to attend the opportunity to review discussions and decisions that are made
- The board membership will include partner members from both Local Authorities which will help to create connections to local communities via local democratic representatives
- The ICB constitution includes information on how it involves people and communities, and the principles it follows in implementing these arrangements

Coventry and Warwickshire Integrated Care Partnership

- The Partnership will have responsibility for developing the integrated care strategy for the population of Coventry and Warwickshire, covering health and social care and addressing some of the wider determinants of health and wellbeing. The citizen voice will continue to be represented at this board as through the ICB
- The expertise of professional, clinical, political and community leaders will play a key role in the partnership membership, as well as Healthwatch as the statutory body for understanding people's views
- Meetings will take place in public to support transparency and local accountability, and minutes of these meetings will also be published online and made available to the public
- Best practice involvement and engagement of individuals and communities will be employed in the development and monitoring of the strategy to ensure that it is reflective of the priorities of local communities, building on the two Health and Wellbeing strategies for Coventry and Warwickshire.

As further structures are developed to support the ICB, it will be responsible for ensuring that they also apply the 10 principles appropriately. This includes our wider committees which support the activities of the Board and our Care Collaboratives in Coventry and Warwickshire which bring together NHS, local authorities and other system partners within each county to collectively plan and deliver services. The voices of individuals and communities will be achieved through:

- Including representation from people and communities
- Building on existing engagement approaches at place, including health and wellbeing boards and primary care networks, as well as support the development of the ICS framework/principles
- Working closely with the VCSE sector and Healthwatch (See Principle 5)

Actions for development in 2022/23

- Work with the third sector to increase the participation of in our decision-making forums
- Further development of our committee structure to ensure appropriate representation at all levels
- Training and development for our non-executive directors and other representative participants in decision making forums to ensure they have the tools that they need to contribute effectively and hold the ICB to account if the patient/citizen voice has not been considered

2. Start engagement early when developing plans

Involvement and engagement must form an integral part of all stages of our work, ensuring that individual and community input is sought and informs all aspects of developing and delivering our plans, from initial scoping and planning, to delivery, to monitoring and evaluation.

Initial scoping and planning
Embedding engagement into our scoping and planning will be achieved through adoption of our Population Health Management approach, where qualitative data, gathered through involvement, will inform part of our initial scoping and understanding of community priorities and our planning will be based on what local communities have told us they need.

Ensuring best practice engagement and consultation
Once a priority has been identified, we will adhere to the measures outlined in the "Good Engagement Charter" developed by our local Healthwatch organisations in Coventry and Warwickshire, which can be found in Appendix XX – The Good Engagement Charter.

When undertaking formal consultation with the public, the ICB will adhere to the Gunning Principles.

- Consultation must be at a time when proposals are still at a formative stage.
- The proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response;
- Adequate time must be given for consideration and response; and
- The product of consultation must be conscientiously taken into account in finalising any statutory proposals.

These principles are reflected in the Good Engagement Charter and will also be applied to our engagement work, regardless of whether it will entail formal consultation or not, to ensure that involvement is always considered appropriately as part of all our activities and is started early in the process when plans are at a formative stage.

Equality and Quality Impact Assessments
All plans which are considered by the ICB must have an equality and quality impact assessment (EQIA) which outlines both the impact of any changes on the local population, particularly those with a protected characteristic, and what mitigations can be put in place to address any negative outcomes. These assessments must be informed by involvement of individuals and communities who may be affected by the changes and represent another route for the voice of individuals and communities to be involved in our planning.

As the ICB develops we will explore how we ensure our equality and quality impact assessments remain integral to our development of services. This will include

- How we approach them in our governance to ensure EQIAs are completed in a comprehensive manner as the plans are being developed
- Train our staff to understand both the mechanics of developing a best practice EQIA, and the importance of why it is necessary.

In addition to EQIAs, Healthwatch locally are able to develop Patient Public Impact Assessments to ensure all needs of local populations are considered in planning

There is a wider piece of work taking place to develop a "gateway approach" to the projects and programmes of the ICB, providing consistency across the organisation and ensuring that all work adheres

to a standard set of principles. EQIAs and Patient Public Impact assessments are likely to form part of this approach to embed involvement, individuals and communities at the heart of everything we do.

Actions for development in 2022/23

- Supporting the development of the good engagement charter
- Further work to embed EQIAs within our governance

3. Understand our community's needs, experience, ideas and aspirations for health and care

Understanding the diverse communities within Coventry and Warwickshire and delivering joined up services based on their needs and priorities is at the heart of our Population Health Management strategy. Involvement plays a key role in this approach, supplying the qualitative data on community priorities, experience, ideas and aspirations to accompany the quantitative information and giving us a clear route to embed it into our planning.

Gaining the trust of local communities will be a key part of this work and ensuring that once we do understand the priorities of communities, we act on them.

This insight will be gathered in several ways:

- Across the ICS partner organisations, particularly in the local authorities, there are strong links with many communities. Through developing our system approach to involvement and pooling our engagement and insight knowledge between ICS partner organisations, both the ICB and ICP will be able to access a much wider breadth of insight to inform decision making.
- The Communications and Engagement function within the ICB retains a strong outreach function, with community champions across the area and positive links to local community groups and organisations. Through a combination of targeted engagement on priority areas, and an ongoing calendar of community health and wellbeing events, we can build connections with our organisations and feed that information back into our service development and quality functions.
- Our Healthwatch organisations gather wide reaching insight into community priorities through their ongoing work programmes, which will be shared with the ICB to inform our planning and service development.
- Voluntary, community and social enterprise organisations across Coventry and Warwickshire have a deep understanding of local community priorities. As the Voluntary, Community and Social Enterprise Alliance develops, we will be able to equip them with the tools and resources they need to share that insight and be involved in our planning and decision making on behalf of the communities they serve.
- As Care Collaboratives, Places and PCNs develop, they will undertake their own local insight and engagement activities at place and neighbourhood level. We will explore how this can be linked into the wider information resource.
- We have many existing mechanisms in place in NHS organisations to hear from individuals and communities. This includes Patient Participation Groups, Patient Advisory Liaison services (PALs), experts by experience and community champions.
- In Coventry, through the One Coventry initiative there has been a collective commitment to community and resident collaboration agreed, which will take forward developing an engagement approach with Coventry residents

Link – Population Health Management Strategy

Actions for development in 2022/23

- Exploration of a shared repository of engagement information
- Ongoing work of our Care Collaboratives to develop new mechanisms for engagement

4. Build relationships with excluded groups, especially those affected by inequalities

As referenced in Objective one, building trust with local communities, particularly those who are within excluded groups, will be key to the success of the ICB. This work links directly with that of the Inequalities strategy and the development of our Core 20 plus 5 groups for Coventry and Warwickshire. Key to building trust is reaching out, listening and showing understanding and then demonstrating that something is done based on what people say, or we are clear and transparent when it can't be done.

Through developing our cultural competence, we will better build our relationships with excluded groups and understand and address their priorities.

The actions which fall under "Build trust and relationships through always listening and learning" (Page xx) will be instrumental in developing these relationships.

We are not starting from scratch and the work undertaken by the individual organisations which make up the ICS and our Care Collaboratives will be key. Our first step will be to map engagement and involvement activity and assets across the system to reduce duplication and identify gaps, cross referenced against the Core 20 plus 5 cohorts so we ensure that we can prioritise those groups most marginalized appropriately.

Link to Core20PLUS5 approach to reducing health inequalities

Actions for development in 2022/23

- Supporting the delivery plan against Objective One
- Ongoing work delivered by the Care Collaboratives to build relationships

5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners

Healthwatch

Healthwatch
Local Healthwatch organisations are the health and social care champion with functions set out in legislation. They exist to give people the opportunity to share their experiences of health and social care services, and make sure that this valuable feedback reaches those who run, plan and commission services. Healthwatch looks at things from the point of view of local people and communities and has a role in accountability and scrutiny.

The two local Healthwatch organisations have published a Memorandum of Understanding regarding closer working and the ICS is supportive of this work. We are fortunate to already benefit from strong positive relationships with both Healthwatch organisations and will seek to build on this to agree a system-wide approach to working effectively with them.

Healthwatch will be represented on both our ICB and ICP and help us to ensure that the patient voice is at the heart of everything that we do.

Link to Healthwatch Memorandum of Understanding

Voluntary, Community and Social Enterprise (VCSE) sector
Across Coventry and Warwickshire, we have a large and vibrant VCSE sector, ranging from small "grassroots" groups entirely staffed by volunteers to large organisations with a remit which spans the whole ICS area and beyond.

There are several structures which bring VCSE organisations together across geographical places. This includes "Thriving Communities" in Warwickshire, which brings together VCSE and public sector organisations to drive change, build relationships and create opportunities for all aspects of the VCSE in the area. In Coventry the VCSE organisations have formed a "VCSE leaders' group", a collective of leaders of medium – large voluntary, community and social enterprise providers who are committed to working together to bring about positive change for the whole city.

We have two organisations who work with our communities on a geographical place basis. Warwickshire Community and Voluntary Action (WCAVA) supports volunteers, groups, organisations, enterprises and charities across Warwickshire and Voluntary Action Coventry (VAC) promotes and supports social action and community resilience in Coventry, strengthening communities, building capability and improving quality of life for residents in the city.

Warwickshire County also invests in the Warwickshire Pan Equalities Service for which the contract is currently held by EQuIP. The Service works towards the elimination of unlawful discrimination, to promote equality of opportunity and good relations between people of different groups under each of the protected characteristics as set out in the Equality Act 2010 within and across the Public and Third Sectors.

VCSE organisations with a focus on mental health have worked together to form the "Mental Health Alliance", aimed at bringing together representatives with a mental health focus in one collaborative community and allow the whole of the VCSE mental health sector to be included in mental health transformation.

These diverse structures are all working individually to address the needs of our population across Coventry and Warwickshire but there is no single organisation or voice which could currently act as a representative for the VCSE across Coventry and Warwickshire. VCSE representatives working with the ICS had already identified the need for a group or alliance which brings together representatives from across both geographical places and is able to be a collaborative, representative voice for the voluntary sector at an ICS level.

Initial work has started on how we address this, bringing together a group of VCSE leaders with representatives from the NHS and local authorities to explore how we can facilitate representation of the VCSE within the ICS, who should be involved and how we can ensure that any group is truly representative of the VCSE across both Coventry and Warwickshire, and of the diverse communities which we serve. Additional work to support the involvement of the "grass roots" community sector is also in train, understanding what networks are already in place and what they need to be in place to support them to be involved on their terms.

Actions for development in 2022/23

- Ongoing development of mechanics to allow representation of the sector across the ICS
- Mapping of the current networks of within the sector across Coventry and Warwickshire
- Work with the grassroots organisations to understand priorities and promote involvement

6. Provide clear and accessible information about vision, plans and progress to build understanding and trust.

Ensuring all individuals and communities in Coventry and Warwickshire can access information about the work of the ICS, ICB and ICP, being clear where people can get involved, the decisions we are making and how they can be involved.

As an organisation we are open and accountable to the population we serve and ensuring all individuals and communities in Coventry and Warwickshire can access information about the work of the ICS, ICB and ICP is vital in supporting involvement. We publish our "Functions and Decisions Map" so that anyone who wishes to be involved can understand where all the decisions that we make are made, in addition to clear information about our ICS and its structures.

Our website has been developed in line with all the latest accessibility guidance and in line with our principles for clear, accessible language. It contains all board meetings and papers in an easily searchable document library. It also offers lots of ways to get in touch, including how to attend board meetings, where we welcome questions from the public, places to submit complaints, comments or Freedom of Information requests, and an up-to-date list of all the current engagement and consultation being undertaken by the Board and opportunities to get involved. It also includes the details of the two Healthwatch organisations and how to speak to them if people need to.

When developing information on our vision, plans and progress we strive to communicate in a way which is clear, simple, impactful, and self-evidently useful – using normal language, not jargon.

Our ICB will continue to produce an annual report through which we will demonstrate public involvement in our activities. In addition to our statutory annual report we also aim to produce an Engagement Annual Report, offering a more in-depth look at our involvement activities and how we are fulfilling our statutory obligations to the public.

COVID-19 has meant the way that people consume information has changed, although not always for the better. Digital has become the default for organisations broadcasting information, but we are mindful that there is a potential to exclude those who are unable to access online information. As a new organisation we will reassess our current communications tools in light of the changes in how people access information due to COVID-19. The channels which we will assess include:

- Website and intranet
- Printed documentation
- Design & digital
- Social media
- The media
- Questionnaires and surveys
- Marketing and campaigns
- E-newsletters/newsletters
- Face to face engagement
- Outreach and health intervention work

Actions for development in 2022/23	
• Reviewing and strengthening implementation of the NHS Information Standard across the ICS • Adoption of Plain English standards across the ICS, including guidance for writing for the public for web and other formats	• Ongoing assessment of our communications channels across the ICS to reduce digital exclusion and ensure they are fit for purpose

7. Use community development approaches that empower people and communities, making connections to social action.

It is important that we support and build on our existing community assets, rather than attempting to overlay new structures. Across Coventry and Warwickshire there is a wealth of assets which already bring people together whether faith groups or those based around a specific culture or communities, our two universities, many diverse schools and community venues. Local voluntary and community organisations also play a vital role in supporting individuals and communities across the area, often reaching people that statutory organisations will never be able to engage.

There are already groups in place to support health and care, for example Patient Participation Groups have already established links around GP practices reaching out to their local communities, and we would build on the development of these groups in an inclusive way to reach out to communities.

The core of community development is building trust and meaningful relationships with local communities. This is an area where our local authorities have taken the lead and the structures and connections they have developed will be the bedrock of engagement for the ICB, driven by the two Care Collaboratives for Coventry and Warwickshire.

In Coventry the Community Resilience Team (CRT) has set up a range of new community orgs and charities with a focus on supporting people. Support given is from idea right through to running the first project and includes help with setting up a charity or group, opening bank account, obtaining first small pot of funding, planning how to deliver their passion. CRT Also supports the many (around 300) groups and orgs a year who once set up need help continuing to run which can include help with recruiting trustee and volunteers, help running a premises, fundraising or becoming a trading charity as just a few examples.

Recent examples of new groups set up include Park Warriors – Support Group set up by women with Parkinson's Disease. Fortnightly citywide group who provides exercise & friendship, Confidence Through Photography – Support group for people with mental health and anxiety issues. Chit Chat Group Canley – Supported set up of new group for residents to meet new people and reduce feelings of loneliness.

Community centres in Coventry are valuable as they host the majority of the small community support groups such as lunch clubs, friendship and self-help groups. To ensure the centres stay open the City Council have created the Community Centre Consortium where they work together collectively – including joint funding bids and commissions and hopefully in the future procure together to gain economies of scale. This consortium is well linked in with the groups its hosts so provides another engagement mechanism.

In Warwickshire the County Council has a long-established community development function, taking an asset-based approach in priority areas, and employing 9 dedicated workers, backed up by specialist roles including Time Bank Co-ordinators. Some of the Borough and District Councils also have dedicated community development resources, most notably North Warwickshire Borough and Warwick District.

Various County Council initiatives including "Start with Strengths" and "Child Friendly Warwickshire", and work to embed principles of restorative practice across much of Social Care, also reflect asset-based approaches, empowering people and communities and encouraging social action.

At the heart of the Community Powered Warwickshire programme is the principle that communities have the skills, knowledge, and assets to identify and put forward solutions to their own priorities. Community Power is a cross-cutting theme in the new Council Plan.

The new VCSE Sector Support Service from 1 April 2022 include a section devoted specifically to building social action in priority communities.

Actions for development in 2022/23

- Build upon the work already in place to support and develop our community development pathways

8. Use co-production, insight, and engagement to achieve accountable health and care services

We must choose the best approach to engagement depending on the specific circumstances, ensuring it is fair and proportionate, and takes place at a time and in a way that means it has a genuine role in decision-making.

We are clear that one-size fits all is not an option when it comes to involving the diverse communities which make up Coventry and Warwickshire and that we must tailor our approach appropriately, not assuming we know best and listening to what people tell us their priorities are. How we will come together as a system to develop our ways of engaging forms a key part of our first objective detailed on page xx

The JSNA forms a vital part of the insight which will be used to make a difference. For example, in Warwickshire the completion of place based JSNA assessments (22 local assessments) in 2019, which involved community engagement to help identify local priorities and solutions, are used to target resources at appropriate health and care services. A further round of thematic JSNA assessments will help build to build the insight and evidence base.

Making services accountable also means feeding back the change's involvement makes to communities and continuing a cycle of feedback and involvement. More information on this can be found on pg. xx

Actions for development in 2022/23

- Progress the work outlined in Objective 1 (Pg. xx) building on the mechanisms already in place

9. Co-produce and redesign services and tackle system priorities in partnership with people and communities

We know that people who use health and care services have knowledge and experience that can be used to help make services better. Co-production is a relationship where professionals and citizens share power to plan and deliver support together, recognising that both have vital contributions to make to improve quality of life for people and communities.

Across the ICS we have many groups which we already interact with who feed into our services and support us to make the services better. Most of these work directly with individual organisations and form part of the engagement process from PPGs to community-based organisations. As outlined above the Local Authorities in the ICS have championed the use of co-production for our system and much of the engagement will be taken forwards though the two Care Collaboratives, linking closely to our ICB.

In Coventry there are community stakeholder meetings in keys areas of the city such as Willenhall, Foleshill and Hillfields. These are in the main run by the community resilience team and where possible (and there is a community appetite) run by community org. These meeting help the various groups and organisations in the voluntary sector of that community work better together as a collective as well as working with statutory partners to communicate and deliver their priorities.

The Healthy Communities Together project (pg. xx) in Coventry is an example of how services are being co-designed with residents to meet system priorities.

In Warwickshire the County Council has established a Co-production collaboration and discussion group and has an aspiration to establish a co-production framework. Parts of the Council now routinely co-produce services.

The coproduction and redesign of services in partnership with people and communities is a core feature of the County Council's Community Powered Warwickshire programme. The Social Value Policy approved in September 2021 is likely to drive forward more co-productive approaches.

Developing how we deliver co-production as an ICB in Coventry and Warwickshire will form part of the work of the involvement network (Pg. xx), building on the work of the Local Authorities and health providers in this space.

To move to a system where we work with individuals and communities as partners in the production and design of services is a long-term objective which, as detailed on pg. xx involves a cultural shift across the organisations of the ICS to put people at the heart of everything we do.

Actions for development in 2022/23

- Progress the work outlined in Objective 1 (Pg. xx) building on the mechanisms already in place

10. Learn from what works and build on the assets of all health and care partners

As has been referenced throughout this document there is excellent practice taking place within all member organisations of the ICS and we are not starting from scratch in developing how we do things.

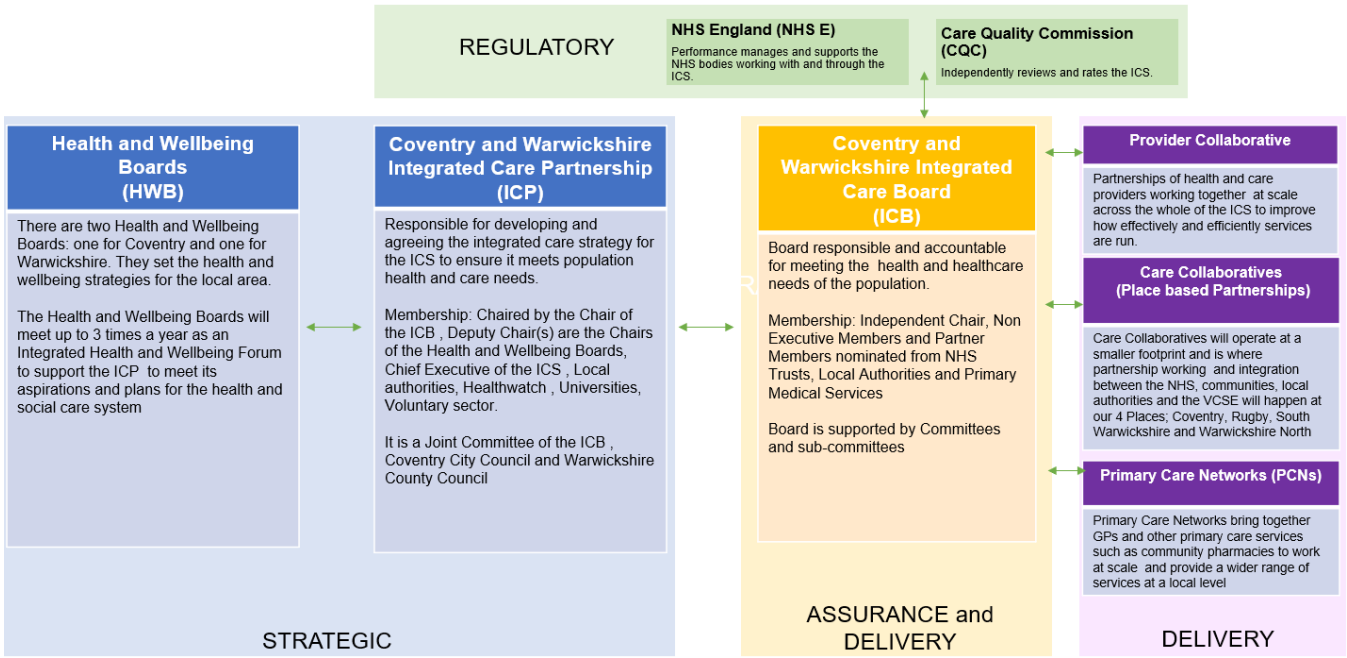
The development of an Involvement Network (pg. xx) will support collaboration between all system partners, building on our collective skills, knowledge, and networks.

An exercise to identify all the activities currently happening across partner organisations will support us to understand best practice, identify any duplication and gaps, and share best practice through our Involvement Network (pg. xx). Through understanding what is already in place we can start to build a culture and mechanism for sharing and planning together as and ICS, removing silos and fragmented approaches and working across organisational boundaries when this is the best thing to do.

Actions for development in 2022/23

- Ongoing development of an Involvement Network for sharing best practice

Roles, responsibilities and resources



The above Functions and Decision map outlines the various structures and organisations which make up Coventry and Warwickshire ICS.

Roles and responsibilities

The ICB holds the responsibility for the delivery of this strategy, ensuring people and communities are involved in the planning of services, proposals and decisions having an impact on services, using the methodology outlined in this document. It is also responsible for demonstrating that the legal duties are being met at all levels outlined in the Function and Decision map, and will do so using the framework approach outlined on pg. xx.

Full details of how the ICB and ICP will deliver on their responsibilities to put people at the heart of everything they do can be found on pg. xx.

Within the members of the Integrated Care Board, there will is an SRO for Engagement and Involvement who will be responsible for championing the strategy at the ICB and with the senior leaders within the ICS to support the cultural shift outlined in Objective 1.

Also within the membership of the Board will be an ED&I champion, a Wellbeing champion, and PPI champion, drawn from the Non-Executive or Partner members. These roles will also retain responsibility for ensuring that the requirements around patient involvement are met.

The work of the ICB will be supported through the Communications and Engagement team currently with the Clinical Commissioning Group.

Although the ICB holds the responsibility for the strategy, through the Involvement Network, all partner organisations of the ICS will take responsibility for wider implementation of the strategy, agreeing and operating within the framework approach.

As the Care Collaboratives and Provider Alliance continue to develop, they will hold responsibility for ensuring that their work is developed with individuals and communities, in line with their legal duties and as part of the agreed framework for Coventry and Warwickshire.

The Integrated Care Board	Integrated Care Partnership	Care Collaboratives	Provider collaborative
Delivery of this strategy, ensuring people and communities are involved in the planning of services, proposals and decisions having an impact on services, using the methodology outlined in this document. Demonstrate legal duties are being met at different levels Develop health and care plans with and for individuals and communities	Development of the Coventry and Warwickshire Integrated Care Strategy with individuals and communities Include wider public representation in their membership Ensure strong connections to communities and democratic representatives	Engage with individuals and communities on their plans and decisions Build on existing ways of working to involve people in decision making Support PCNs and neighbourhoods to engage and involve their local communities	Build on existing ways of working from across the partner organisations in involving local communities Ensure their work is informed through insight and feedback Use the Coventry and Warwickshire framework as it is developed to involve and meet legal duties when planning and delivering change

Resources

The work of the ICB will be supported through the Communications and Engagement team currently with the Clinical Commissioning Group. The strategy will be delivered through the involvement teams from the partner organisations of the Integrated Care System and the Involvement Network as it develops.

Monitoring and evaluating the strategy

Approach to reviewing engagement activity & impact

This strategy outlines a change of approach and a cultural shift in how we do things, building trust with our communities and putting people at the heart of everything we do. The first year of this strategy will be focused on working with individuals and communities to create the conditions in which that can take place and there are agreed deliverables through which we will monitor the initial success

- Development of a framework / set of principles, informed by engagement with our local communities, which all partner organisations within the ICS have agreed to operate within
- Establishment of an involvement network

Following the successful development of these two areas, we will use them to monitor the other areas identified in as key actions to achieve our vision

- Promote cultural change across the ICS to put people at the heart of everything we do

- Build trust and relationships through always listening and learning
- Equip everyone with the tools they need
- Demonstrate the difference that community involvement makes

We will develop an evaluation methodology to support ongoing monitoring of our work based on the framework / set of principles mentioned above, the Healthwatch Good Engagement Charter and using a logic model based methodology as shown in Appendix xx. This process will be used to not only monitor the effectiveness of this strategy understanding outcomes for individuals and communities, as well as our workforce, but also applied as part of the ongoing evaluation of all involvement activities.

Plans for feeding back to individuals and communities

As referenced throughout the strategy, feedback is essential in building trust and this must be a principle that is enacted through all levels of activity. As part of the Healthwatch Good Engagement Charter, we are committed to ensuring that feedback throughout our work is delivered throughout all of our work, not only at the end.

As noted in Action 3 (pg. xx) establishing culturally competent routes for feedback is vital and will form part of our ongoing engagement work.

Appendices

Appendix XX – Additional Case Studies to show Involvement in Action across the ICS

COVID Community Action in Warwickshire

In response to the restrictions of the first lockdown in March 2020, and the resulting urgent need to support vulnerable and isolated people, many communities formed local support groups, providing food and essential household items, transport, prescription deliveries, and mental health support including befriending services.

The resulting informal network of some 300 groups across Warwickshire provided a lifeline to many people, but also a means of community engagement for Local Authorities and Health. This widespread mobilisation is a lesson to public agencies in the ability of communities to recognise their own priorities and challenges, to act with pace in designing services, and to deliver services with high levels of efficiency. Outside of the pressure of a pandemic, this reinforces the value of coproducing services to ensure focus on the correct priorities, good design and efficient delivery.

There is also considerable innovation and examples of best practice at an organisational level where successful involvement and engagement has led to better outcomes and shown new ways of doing things which improve service access and reduce health inequalities.

Compassionate Communities (Community Connections) in Coventry and Rugby

The Compassionate Communities movement seek to improve the mental wellbeing of young people through Narrative Inquiry models. Our research has shown that those involved report an improvement in wellbeing and increased social inclusion and attribute this to 'being given a voice'.

Based on the above experiences and evidence different forms of 'narrative/story circles' have been facilitated with approximately 400 young people since July 2021; these story circles have largely been based around the experiences of young people through the pandemic. Groups of 6-8 people come together and are invited to share their story uninterrupted, others then, respectful of what has been offered engage with this story. The participants decide the themes that are important to them. They in effect create a new and previously unspoken narrative that belongs uniquely to them. The group themselves then decide what this means to them and their life experience and the 'so what' moving forward.

The majority have been secondary school age but significant numbers of students in further and higher have also participated. Participants have come from schools and colleges, uniformed organisations, the Positive Youth Foundation, faith groups and individuals that have responded to social media.

The themes that were recognised within the story circles included bereavement and loss, depression, isolation and loneliness, suicide, negative and positive impact on education,

positive and negative impact on family life, impact on eating disorders, sexuality, relationships/friendships, loss of hope for the future etc.

Depending on the context of the group different forms of wellbeing measurement are used. These range from simple 'emojis', to in other groups the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) is used to measure perceived wellbeing at the start and after the group.

Vaccine work with African and Caribbean Communities

From the start of the vaccination programme, it was clear that uptake levels were often vastly different between demographics. One of the groups identified as having low uptake was the diverse African Caribbean communities in the area and, through engaging with the communities, we learnt that one of the major concerns was not seeing the vaccine drawn out of the vial as pre-drawn syringes were used to maximise efficiency.

We decided to co-produce a video, along with members of the African Caribbean community, explaining the vaccine process which included showing what happens behind the scenes in a vaccination clinic. To ensure maximum effectiveness, we used healthcare professionals from the African Caribbean communities in the video.

The response was overwhelmingly positive, and the feedback indicated that members of the community felt reassured by being able to see the vaccination process and this resulted in an increase in trust in the vaccines.

Involvement in Service Change in South Warwickshire

South Warwickshire NHS Foundation Trust (SWFT) is currently undertaking a review of the inpatient beds at community hospitals within South Warwickshire; Ellen Badger Hospital and the Nicol Unit at Stratford Hospital. The focus of this review is to ensure that SWFT are providing the services that meet the health and care needs of the people of south Warwickshire, both now and in years to come.

The first stage of the review was exploring previous, current, and future use of the community hospital beds. Involvement and engagement of people who have used or may use Community Hospital services was central to guiding the review process. To support this SWFT commissioned Healthwatch Warwickshire to distribute and promote surveys to target groups, previous patients, potential patients and wider public and stakeholders. Healthwatch also independently analysed all survey results. Healthwatch are skilled at engaging with communities, groups, and individuals and reaching a broad range of stakeholders. To support accessibility respondents were offered the opportunity to complete a paper based, online or telephone-based survey.

To gain further rich and in-depth insight into current patients experience of Community Hospitals a series of face-to-face patient interviews were conducted across Ellen Badger Hospital and the Nicol Unit. Staff and wider professional stakeholders who either work at one of the current Community Hospital sites or professionals working closely with or referring to the Community Hospital provision were also asked for their views.

In November 2021 a technical panel, which included clinicians, therapists, operational and governance leads, staff side and HR representatives, as well as representatives from social

care and Healthwatch Warwickshire, met. The role of this panel was to assess the viability of proposals taking into consideration patient safety, workforce delivery, local and national strategies and affordability. Only proposals that were felt to be viable were taken forward at this stage.

In December 2021 SWFT invited representatives from across the community to be involved in a community panel to further review and refine the proposals in line with what members of the community feel is important for us to think about as we progress the review. This panel had stakeholders from various voluntary organisations and community groups. Following the community panel, the technical panel re-met in January 2022 to consider the proposals in light of the feedback from community representatives and identify which of the proposed solutions should be investigated in more depth.

This review is still on-going and as it develops there will be further community involvement and engagement.

Community engagement the Coventry way

In summer 2020, Coventry City Council launched a community-led response to communications and messaging around Covid-19 that's seen the development of more than 320 community messengers across the city. They share information in the way they know works for their communities and neighbourhoods and provide feedback and intelligence about how it really feels on the ground in these extraordinary times. The programme secured further funding from the Ministry of Housing, Communities and Local Government to build on this approach and recruit organisations and community organisations to assist as community champions.

Community messengers were recruited through existing faith, voluntary and community networks in the city. A series of webinars were held to provide initial advice and training and focus groups were held with young people to help develop specific messaging.

A weekly news update is emailed to messengers to share with their networks. The email update is long and detailed, messengers pick and choose the items they would like to share. One messenger creates a weekly email for her neighbours and rewrites the information we provide into her style. Weekly webinars provide a forum for sharing and discussions for the messengers.

The network provides valuable feedback about what's really going on in neighbourhoods. They tell us about the latest false news and disinformation that's being shared on social media on things like the vaccine. It helps us make sure we're myth-busting when we need to.

When a walk-in test centre was set up in Foleshill, a ward with high levels of deprivation, it led to a backlash from the community. They thought we were stigmatising them. The decision to position a walk-in test centre was because of low levels of car ownership, but this hadn't been explained. The feedback helped us address the problem and to explain fully.

Alongside the messengers' network, voluntary and community groups are working with the council to share communications. Webinars to brief community centres and places of

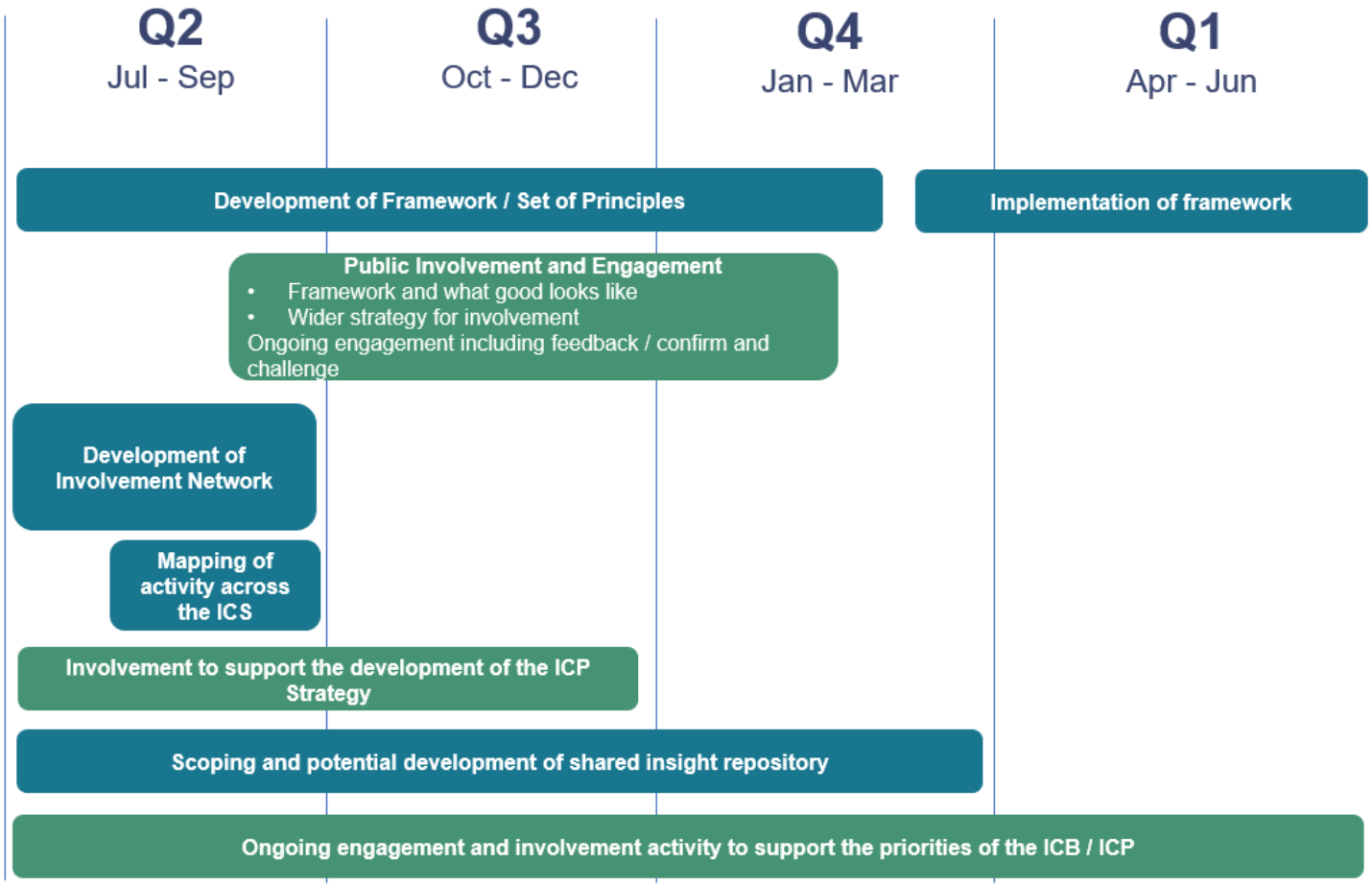
worship are held when there's a change in guidance and they are provided with regular phone advice and weekly update emails.

This work is just as important as our engagement with community messengers. Community centres and places of worship are supporting people through these difficult times by providing social supermarkets and other crisis support and they're an excellent way to get stay safe messages out as they are hubs in their communities.

The true measure of success is that this is more than engagement. Our community messengers and the community and voluntary groups are not simply passing on messages. They are actively complaining to big business where they see failures, recruiting people in the network to help and the voluntary and community groups are peer supporting each other as well as working collectively with us. We hope these benefits will continue long after the pandemic is over.

Appendix XX – Delivery Timeline

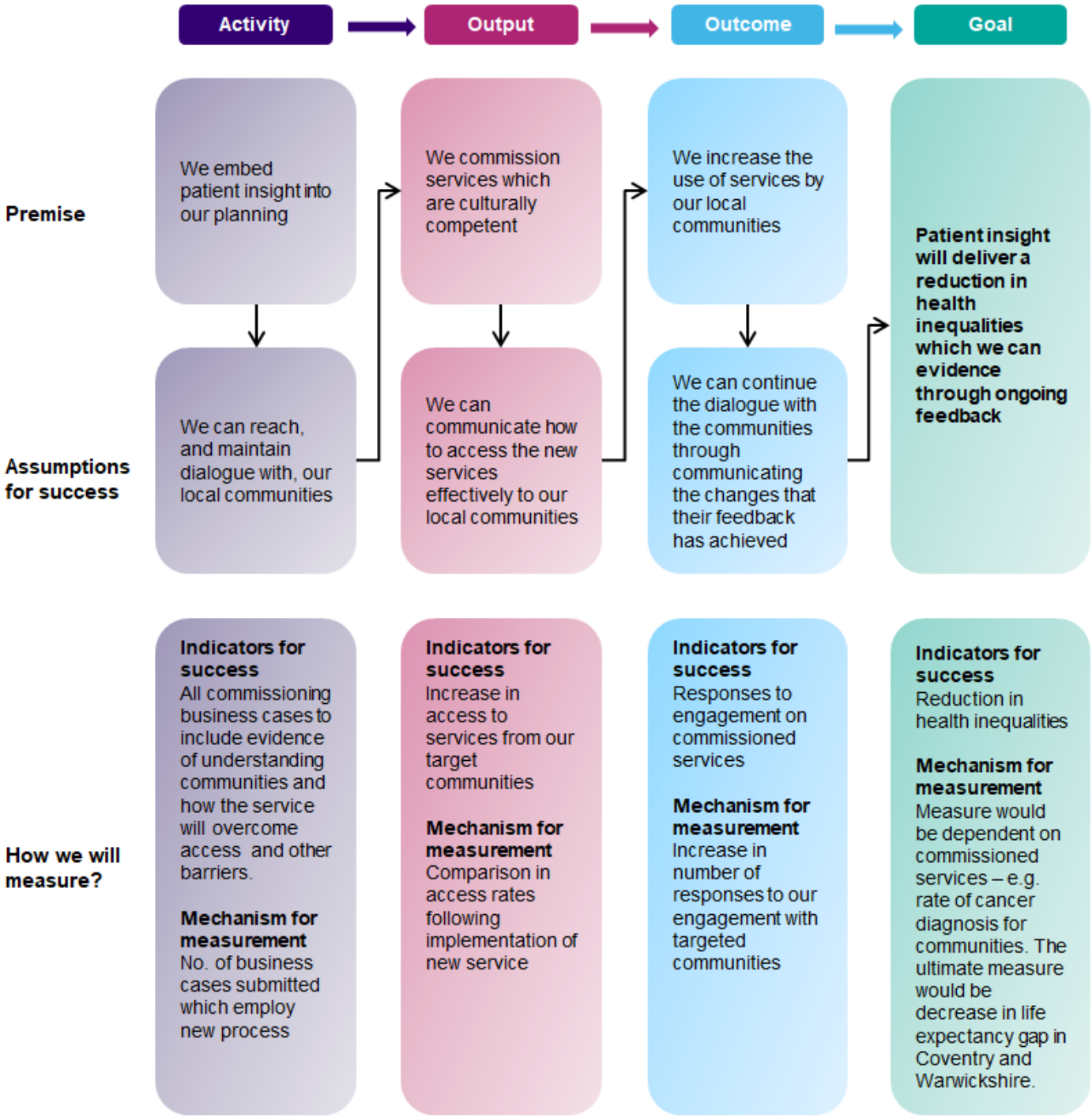
This delivery timeline reflects the immediate key activities within this strategy and not the breadth of ongoing involvement across partner organisations



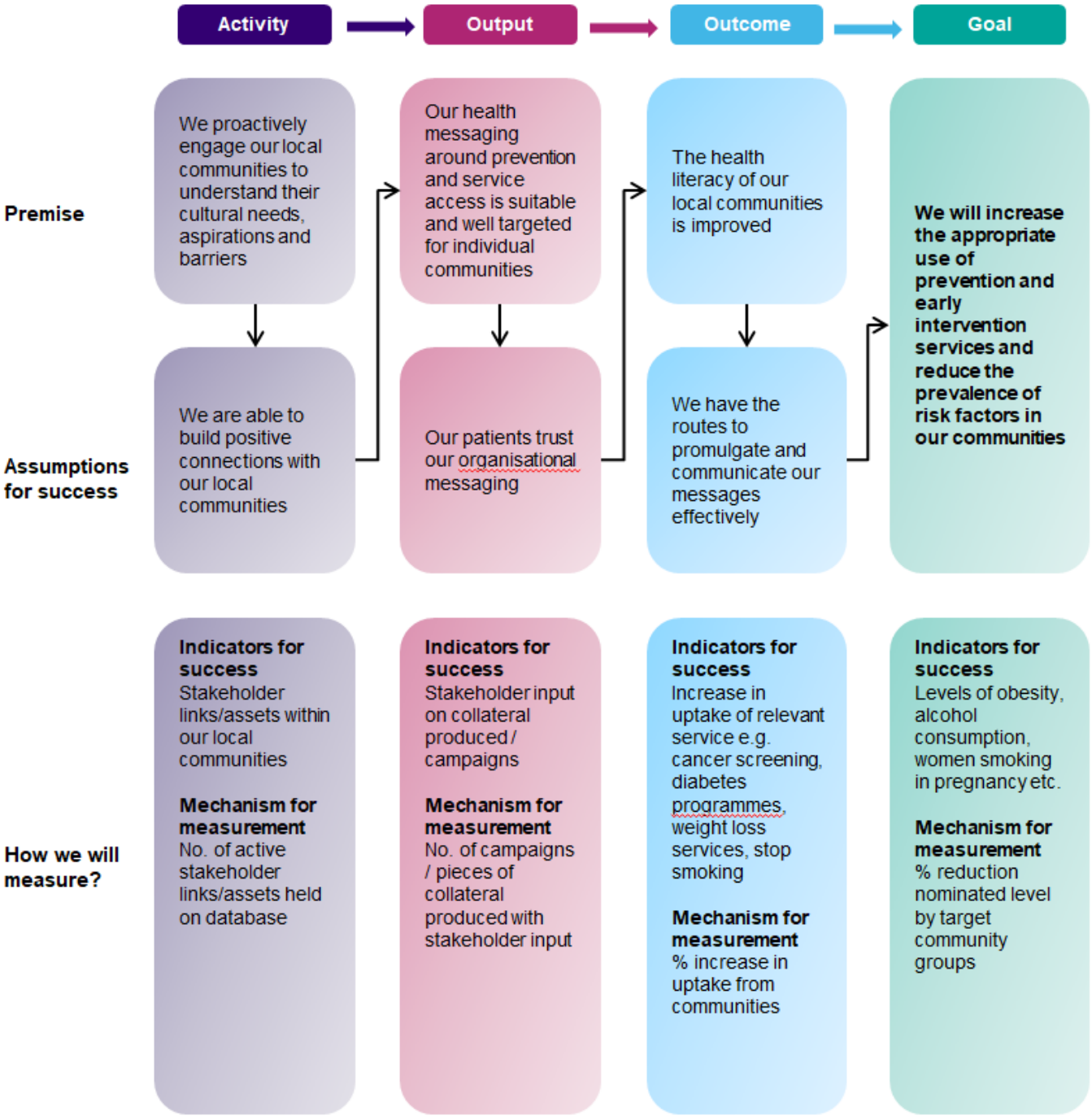
Appendix XX – Involvement supporting health inequalities – example methodology

How involvement supports a reduction in health inequalities using a logic model methodology.

EXAMPLE: Use patient insight to deliver and evidence a reduction in health inequalities



EXAMPLE: Reduce the prevalence of risk factors in our communities through improving our population's health literacy



Appendix XX – The Healthwatch Good Engagement Charter

1. We will be clear about why there is a need to engage with our community
The reasons for involving people must be clear from the start.

2. We will make sure that we work with partners when engaging with our community
People do not like being asked about the same thing over and over again. A joined-up approach is efficient and increases the likelihood of people taking part.

3. We will make sure there is plenty of time for engagement
We will give people plenty of time to give their opinions and will arrange events at different times so that more people can take part.

4. We will use a range of different ways for people to have their say
Some people like to talk in groups, while others prefer to complete an online survey or to tell one person their ideas. We will be inclusive and tailor our activities to the people we are hoping will take part.

5. We will be open, honest and transparent when engaging with our community
Agencies carrying out engagement activity should be open and honest about what can and cannot be influenced – including any constraints and boundaries – giving reasons for this.

6. We will make sure that information is accessible by all
Information needs to be accessible, clear, understandable, and relevant. It also needs to be presented in the correct format for the audience.

7. We will provide people with regular feedback when engaging with them
Results of engagement should be easily accessible to people who wish to view it – especially those people affected by the results of the consultation activity.

8. We will recognise best practice and make sure that it is used to inform future engagement with our community
Engagement that has worked well should be celebrated, shared between partners and also be used to develop future engagement activities.

9. We will evaluate the engagement process and make sure that any lessons learned are used to make engagement better in the future
Engagement will be reviewed to see how well it worked and if it has achieved what it set out to do. The process will also be assessed against the standards outlined in this charter.

Report Title:	Constitution and Governance Handbook (including Decisions and Functions Map)
Report From:	Philip Johns, Chief Executive Officer Designate ICB, Accountable Officer Coventry and Warwickshire CCG
Author:	Claire Jones Corporate Governance Manager, Coventry and Warwickshire Clinical Commissioning Group
Previous Considerations and Engagement:	Constitution: NHS Coventry and Warwickshire Integrated Care Board (Shadow), 15 September 2021, 13 October 2021, 10 November 2021, 26 January 2022, 16 March 2022) Health Watch of Coventry and Warwickshire: 3 December, 11 and 18 February 2022.
Purpose:	For consideration and endorsement

Contribution to meeting the aims of the ICS:

The setting of effective ICB governance and leadership arrangements, recorded in the Constitution, is a critical enabler for the ICB to deliver on the four aims for the citizens of Coventry and Warwickshire (C&W), namely:

- Improving outcomes in population health and healthcare
- Tackling unequal outcomes, experience and access
- Enhancing Productivity and value for money
- Supporting the broader social and economic development of C&W

The Governance Handbook includes key arrangements for the exercise of the ICB Statutory Functions, such as the functions and decisions map (FDM), ICB committee structure, and the scheme of reservation and delegation (SORD); all of which are focussed on enabling the ICB to achieve the system aims through the setting of clear responsibilities and accountability and oversight arrangements in the delivery of the ICB Statutory Functions.

Ensuring that the ICB is accountable and demonstrates transparency to local people and stakeholders is critical to its success and the key arrangements and principles of how the ICB will ensure accountability and transparency in its work are set out in the Constitution and its supporting Governance Handbook.

Contribution to meeting the priorities of the ICB:

The Constitution makes reference to the arrangements for the management of conflicts of interest and standards of business conduct, the policies for which are included in the Governance Handbook, and which are important to ensuring that decision making is concerned with meeting the statutory duties of the ICB at all times.

The Constitution provides clear governance and leadership arrangements that enable the effective setting, delivery and monitoring of the ICB's strategic priorities. Supporting documents such as the Functions and Decision Map, ICB committee structure and committee

Terms of Reference are held within the Governance Handbook. Along with the SORD which captures the arrangements for delegating the Powers and Duties of the ICB so that responsibilities, decisions and oversight arrangements can be held at the most appropriate level of the ICB or within the wider ICS to effectively achieve the ICB priorities.

Recommendation:

Members are requested to:

- CONSIDER the content of this latest draft of the Constitution and provide feedback;
- ENDORSE the plan set out in 2.7 for the engagement and endorsement of the final draft Constitution;
- ENDORSE the SORD, FDM and Committee Structure set out in the Governance Handbook.

Implications							
Conflicts of Interest:	Members may hold an interest in relation to the appointment process for the Board.						
Financial and Workforce:	The creation of effective leadership and governance arrangements for the ICB is a key enabler for the ICB and ICS to enhance productivity and value for money.						
Performance:	The creation of effective leadership and governance arrangements for the ICB is a key enabler for the ICB to address the most challenging performance issues and achieve the priorities of the ICB and aims of the ICS.						
Quality and Safety:	The creation of effective leadership and governance arrangements for the ICB supports the delivery of the ICBs Statutory objectives and four aims with the ultimate benefit of improving the quality and safety our services.						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	Drafts of the Constitution have been shared with representatives from the local Healthwatch organisations and feedback has been received and considered. Once adopted by the ICB on 1 July 2022 the Constitution and Governance Handbook will be publicly available.						
Clinical and Professional Engagement:	Drafts of the Constitution have been shared with representatives from the Local Medical Committee, CCG Governing Body GPs, members of the Shadow Board and feedback has been received and considered.						
Risk and Assurance:	If the most beneficial leadership and governance arrangements are not put in place the ICB may not operate at its optimum resulting in reduced effectiveness in achieving its priorities and the four aims.						

1. Executive Summary

1.1 On its first day of establishment the Integrated Care Board's (ICB) Constitution will come into effect and the Board will be asked to approve the Governance Handbook.

1.2 To support the creation of these key documents NHS England (NHSE) has issued a Model Constitution, which it periodically revises to reflect changes in the Health and Care Bill and feedback from systems. It has also provided guidance and facilitated workshops on the development of required elements of the Handbook such as the Functions and Decisions Map (FDM).

1.3 Coventry and Warwickshire ICB's Constitution and Governance Handbook have been developed in accordance with the guidance provided.

2. Constitution

2.1 A draft of the Constitution was last circulated to Members of Coventry and Warwickshires' NHS Integrated Care System Body on 16 March 2022 ahead of its submission to NHSE by the then deadline of 31 March 2022.

2.2 The paper accompanying the Constitution asked the Body to allow that any revisions mandated by the mid-March release of the Model Constitution to be signed off by the ICB Chair Designate and CCG's Accountable Officer.

2.3 The release of the revised Model Constitution and Supporting Notes was delayed to mid-April, following which the ICB Chair Designate and CCG's Accountable Officer signed off the revisions to the ICB's draft Constitution and it was submitted to NHSE by their revised deadline of 22 April 2022. For information amendments made were:

- Addition of a Foreword;
- Requirement for an up-to-date list of eligible providers of primary medical services to be included in the Governance Handbook;
- Requirement for at least one of the Ordinary Board Members to have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness;
- Requirement for Board to keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess;
- Requirement of the Chair to approve appointments and consider where appointment would reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise;
- Mandated nomination, assessment, selection, and appointment and approval processes for Partner Member roles.

2.4 NHSE feedback on the 22 April 2022 has been received and the draft amended accordingly. This amended draft accompanies this report.

2.5 Since March's report, NHSE FAQs have been published and confirm that the CCGs' Governing Bodies are required to make a formal decision to propose the ICB Constitution to NHSE on 20 May 2022.

2.6 NHSE current timeline states that final versions of the Model Constitution and Supporting Notes will be released on 13 May 2022. It is anticipated that at least the text currently in green font in the draft will be addressed by this release. It is not known at this point in time whether any additional amendments will be mandated by NHSE.

2.7 At March's meeting of this Body a plan for endorsement of the ICB's Constitution was agreed, however as a result of NHSE schedule being delayed and the guidance provided by the FAQs, the following amended plan is proposed:

13 May	Deadline for the Local Medical Committees and the two local Healthwatch organisations to provide feedback.
13 May (indicative)	Final Model Constitution and Supporting Notes is released.
16-17 May	Feedback received from the Local Medical Committees and the two local Healthwatch organisations is considered. Draft is amended* to reflect mandated revisions resulting from release of final Model Constitution and Supporting Notes.
18 May am	The draft Constitution is presented to the CCG's Governing Body who are verbally informed of *amendments. Members are asked to formally propose the draft for submission to NHSE, allowing for any final revisions as a result of their feedback or that received from the ICS Body meeting later the same day to be approved by the ICB's Chair Designate and CCG's Accountable Officer.
18 May pm	The draft Constitution is presented to the ICS's Body who are verbally informed of *amendments. Members are invited to provide feedback and are asked to endorse the draft for submission to NHSE, allowing for any final revisions as a result of their feedback or that received from the CCG's Governing Body meeting earlier the same day to be approved by the ICB's Chair Designate and CCG's Accountable Officer.
18-19 May	If feedback was received from either meeting of 18 May this is considered and the draft amended accordingly.
19 May	A revised draft is reviewed and signed-off by Chair Designate and CCG's Accountable Officer.
20 May	Draft is submitted to meet NHSE's deadline.

3. Governance Handbook

3.1 It is an NHSE requirement that ICB Constitutions are supported by Governance Handbooks. The Governance Handbook brings together all the ICB's governance documents so it is easy for interested people to navigate.

3.2 NHSE requires The Governance Handbook to be approved by the ICB on its first day of establishment.

3.3 The table below lists the key component products of the Handbook, briefly identifies how the product has been developed and confirms the endorsement pathway:

Product	**Development**	**Endorsement**
The Scheme of Reservation and Delegation (SORD)	Developed from NHSE list of CCG functions and with input from the Good Governance Institute (GGI). March 2022 – first draft presented to Members of the CCG's Executive and Senior Leadership Teams and ICB Body. Revisions made in response to feedback.	**Here for endorsement.**
The Functions and Decision Map (FDM)	Based on NHSE guidance and with input from the GGI. March 2022 – first draft presented to Members of the CCG's Executive and Senior Leadership Teams and ICB Body. Revisions made in response to feedback.	**Here for endorsement.**
The Standing Financial Instructions	Based on NHSE Model.	Endorsed by the CCG's Audit Committee.
The ICB's committee structure	Based on NHSE guidance and discussions at meetings of ICS Body.	**Here for endorsement.**
Terms of Reference for all committees and sub-committees of the Board that exercise ICB functions.	Based on NHSE guidance and Models where provided and developed with input from the GGI. Engaged upon with colleagues from across the system. Engagement ongoing with the designated Non-Executive Member (NEM) of ICB to Chair the committee. **Feedback is invited.**	Terms of Reference to be endorsed by NEM Chair prior to approval by ICB on 1 July.

Delegation arrangements for all instances where ICB functions are delegated.	No delegations as of 1 July. To be developed in due course.	
Up-to-date list of eligible providers of primary medical services.	Produced from CCG lists as per NHSE guidance.	Not required.
Standards of Business Conduct and Conflicts of interest Policy and Procedures Policy.	Based on best practice and current guidance.	Endorsed by the CCG's Clinical Quality and Governance Committee.
Communities Strategy.	On agenda as separate item for endorsement.	
Inequalities Strategy.	On agenda as separate item for endorsement.	

3.4 NHSE stipulates the Handbook should also include:

- descriptions of Board roles, which reflect the role descriptors used to advertise the roles;
- processes for submitting and managing petitions and for using the ICB's seal, which are based on best practice and current guidance.

It is not considered necessary to seek endorsement for these elements, albeit any feedback provided by the Body will be attended to.

4. Conclusion

4.1 The Constitution is as close to being finalised as possible pending the release of NHSE's final version of its Model Constitution and Supporting Notes. The component parts of the Governance Handbook are well developed, have been thoroughly engaged upon and will be ready to be present to the ICB Board on 1 July 2022.

Recommendation

Members are requested to:

- CONSIDER the content of this latest draft of the Constitution and provide feedback;
- ENDORSE the plan set out in 2.7 for the engagement and endorsement of the final draft Constitution;
- ENDORSE the SORD, FDM and Committee Structure set out in the Governance Handbook.

End of Report

Report Title:	ICB Schedule of Business
Report From:	Anita Wilson, Director of Corporate Affairs, CWCCG
Author:	Anita Wilson, Director of Corporate Affairs, CWCCG
Previous Considerations and Engagement:	Not applicable
Purpose:	For information

Contribution to meeting the aims of the ICS:

The proposed ICB Schedule of Business (SoB) sets out a list of items that are matters for the Board according to the ICB's constitution, scheme of reservation and delegation (SoRD) and terms of reference (ToR). Effective agenda planning and papers for the Board will ensure the Board of the Coventry and Warwickshire ICB are embedding the aims of the ICS into its work.

Contribution to meeting the priorities of the ICB:

The Schedule provides a guide to ensure that cyclical business of the ICB is planned assisting the Board in gaining the assurance it requires at the appropriate intervals and taking key decisions. The Schedule forms the basis of setting ICB Board meeting agendas in ensuring agenda's meet the ICB priorities.

Recommendation:

Members are requested to

- **RECEIVE** the proposed ICB Board Schedule of Business **FOR INFORMATION**

Implications							
Conflicts of Interest:	Register of Interests is a standing item of business for the Board						
Financial and Workforce:	The Schedule includes both regular reporting regarding finance and workforce and standing 'flash' reports of the relevant Committee of the ICB						
Performance:	A robust schedule of business for both the Board and Committees enhances Board effectiveness and performance.						
Quality and Safety:	The Schedule include regular reports regarding Quality and has a standing flash report from the Quality, Safety and Experience Committee.						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	Public and Staff stories are included as a standing item to being focus for the Board on its purpose.						
Clinical and Professional Engagement:	Engagement is via the Clinical Executive and the Clinical forum , along with the clinical members of the ICB						
Risk and Assurance:	Risk and Board Assurance are key matters for the Board and as such have been built into the Schedule.						

NHS Coventry and Warwickshire Integrated Care Board Schedule of Business

Activity	Purpose	Frequency	Lead/Author	18 May	20 July see bottom re 1.7.22	21 September	16 November	18 January	15 March
Meetings:									
Standing Items									
Welcome and Apologies		Monthly	Chair	✓	✓	✓	✓	✓	✓
Confirmation of Quoracy		Monthly	Chair	✓	✓	✓	✓	✓	✓
Declarations of Interests		Monthly	Chair	✓	✓	✓	✓	✓	✓
Minutes of previous meeting	Approve	Monthly	Chair	✓	✓	✓	✓	✓	✓
Matters Arising/Action Schedule	Note	Monthly	Chair	✓	✓	✓	✓	✓	✓
ICS Chair Designate Report	Information	Monthly	Chair	✓	✓	✓	✓	✓	✓
ICS Chief Executive Officer Designate Report	Information	Monthly	CEO	✓	✓	✓	✓	✓	✓
Risk Register	Endorse	Monthly	CTO	✓	✓	✓	✓	✓	✓
Schedule of Business	Approve	Annually	DOCA		✓				
Communications, Engagement and Public Affairs Report	Information and Assurance	Bi-monthly	DOCA	✓	✓	✓	✓	✓	✓
Patient or Staff story			Chair		✓				
Flash reports:-									
Flash report from Quality, Safety & Experience Committee, including Population Health Management	Assurance	Bi-monthly	NEM	✓	✓	✓	✓	✓	✓
Flash Reports from Finance and Performance Committee	Information	Bi-monthly	CFO	✓	✓	✓	✓	✓	✓
Flash Reports from Audit Committee	Information	5 times per annum	NEM	✓	✓	✓	✓	✓	✓
Flash Report from Commissioning, Planning & Population Health Committee	Information & Assurance	Bi-monthly	NEM	✓	✓	✓	✓	✓	✓

Flash Report from Remuneration Committee	Information	As and when	NEM		✓			✓	
Quality Report - System Quality Group - update and areas of issue/risk	Information	Annual			✓				
Aim One: Improving outcomes in population health and healthcare									
Integrated Care Strategy	Information	Annual	Chair ICP				✓		
Annual Report and Accounts	Approval	Annual	CFO	✓					
Annual Report and Accounts – Delegation Arrangements (if required)/Annual Audit Letter	Approval	Annual	CFO	✓					
Committee Effectiveness & Annual Report for all Committees	Information and Assurance	Annual	DOCA	✓					
Annual Plan	Approval	Annual							✓
Quality Report	Information	Bi-monthly	CNO	✓	✓	✓	✓	✓	✓
Aim Two: Tackling unequal outcomes, experience and access									
Finance Update and Contract Report Draft Budgets 15.3.23	Information	Monthly	CFO	✓	✓	✓	✓	✓	✓
Executive Board Annual Report/Warwickshire Safeguarding Children Partnership Executive Board	Approval	Annual	CNO	✓					
Safeguarding annual assurance report for Adults and Children	Approval	Annual	CNO						✓
Equality and Diversity Report (and WRES) (ED&I Statutory Elements 18 Jan 23)	Assurance	2 x per annum	CPO			✓		✓	✓
ICB Response to the Modern Slavery Act 2015	Approval	Annual	CEO					✓	
Freedom to Speak Up Guardian Report (Annual report 18 Jan 23)	Assurance	2 x per annum	CNO			✓		✓	✓
Oversight and Assurance Arrangements	Assurance	Annual	CFO		✓	✓			

Population Health Management	Information	Annual			✓				
Aim Three: Enhancing productivity and value for money									
System Risk Register +BAF	Assurance	Monthly	CTO	✓	✓	✓	✓	✓	✓
Consolidated system-wide green plan	Adoption	Annual	CEO		✓				
Performance Report	Assurance	Bi-monthly	COPD		✓	✓	✓	✓	✓
Review of SFIs	Assurance	Annual	CFO				✓		
Information Governance Toolkit Delegation for Submission	Information	Annual	CMO					✓	
Minutes from Commissioning, Strategy and Planning Committee	Information	Bi-monthly	NEM		✓	✓	✓	✓	✓
Minutes from Remuneration Committee	Information	As and when	NEM		✓			✓	
Report - People	Information	Bi-monthly	CPO			✓	✓	✓	✓
Minutes from People Committee	Information	Bi-monthly	CPO			✓	✓	✓	✓
IFR Report	Information	Quarterly			✓				
Aim Four: Supporting the broader social and economic development of Coventry and Warwickshire									
Public Health Update	Information and Assurance	Bi-monthly	DPH	✓	✓	✓	✓	✓	✓
Directors of Public Health Annual Reports to include Health+Wellbeing	Information and Assurance	Annual	DPH				✓		
Minutes of the ICP Board	Information and Assurance	Quarterley	Chair	✓	✓	✓		✓	
EPPR Core Standards	Information and Assurance	Annual	DOCA				✓		
For Information/Adhoc									
Policies	Approval	As and when	Various						

For 1 July 2022 meeting	Constitution and Governance Handbook (which includes TOR, ICP TOR, Prime Financial Policies, SFIs, COI Policy, Inequalities Strategy, Citizens and Community Engagement Strategy, Delegation Agreements) Adoption of organisational seal Key Strategies Delegation Arrangements/Agreements NHSE/I Staff and Property Transfer Scheme ICS JHS Board Appointments Fair Processing Notice Transition Due Diligence Due Diligence sign-off (including policies, joint com arrangements and ROS) Establishment Order NHSE/I MOU May require confi/closed meet too?

For Enquiries regarding these papers please email ccg.governance@nhs.net

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