NHS
Coventry and Warwickshire
Integrated Care Board

Coventry and Warwickshire Integrated Care Board

Papers for the Meeting

Wednesday 21st September 2022

Held via MS Teams

13.30 – 16.00

NHS
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Integrated Care Board

COVENTRY AND WARWICKSHIRE INTEGRATED CARE BOARD

Meeting Held on Wednesday 21st September 2022
13:30 – 16:00 via Microsoft Teams

A G E N D A

No	Time	Item	Presenter	Enclosure	Pack No	Purpose
1. Standing Items						
1.1	13:30	Welcome and Apologies	Chair	Verbal		
1.2	13:35	Confirmation of Quoracy	Chair	Verbal		
1.3	13:35	Declaration of Interests	Chair	Enclosure A	Pack 1	Information
1.4	13:35	Minutes of the meeting held on 20th July 2022	Chair	Enclosure B	Pack 1	Approve
1.5	13:35	Matters Arising/Action Schedule	Chair	Enclosure C	Pack 1	Information
1.6	13:40	Patient Story	Chair	Enclosure D	Pack 1	Information
Aim One: Improving outcomes in Population Health and Healthcare						
2.1	13:50	Report from Commissioning, Planning and Population Health Committee	Kevin Davis	Enclosure E	Pack 1	Assurance
2.2	13:55	Report from People Committee	Harry Hayer	Enclosure F	Pack 1	Approval and Assurance
2.3	14:00	People Report	Theresa Nelson	Enclosure G	Pack 1 Pack 2	Assurance
2.4	14:10	Implementing the Fuller Recommendations	Ali Cartwright	Enclosure H	Pack 1 (Slides)	Assurance
Aim Two: Tackling unequal outcomes, experience and access						
3.1	14:20	Autism Strategy Delivery	Phil Johns Angela Brady	Enclosure I	Pack 1 Pack 2	Information
3.2	14:40	Reports from Quality, Safety and Experience Committee	Pamela Bradbury	Enclosure J	Pack 1	Assurance
3.3	14:45	Quality Report	Tracy Pilcher	Enclosure K	Pack 1 Pack 2	Assurance

Aim Three: Enhancing productivity and value for money						
4.1	14:55	Cost of Living	Theresa Nelson Kirston Nelson Nigel Minns	Enclosure L	Pack 1 Pack 2	Assurance
4.2	15:25	Report from Finance and Performance Committee Better Care Fund	Sukhi Dhesi Madi Parmar	Enclosure M	Pack 1	Approval, Endorsement and Assurance Approve
4.3	15:35	Report from Audit Committee	Susan Noyes	Enclosure N	Pack 1	Approve and Assurance
4.4	15:40	Integrated Performance and Finance Summary Report	Madi Parmar Ali Cartwright	Enclosure O	Pack 1	Assurance
4.5	15:45	ICB Joint Committee Arrangements	Phil Johns	Enclosure P	Pack 1	Approve
Aim Four: Supporting the broader social and economic development of Coventry and Warwickshire						
5.1	15:50	Community Prototypes	Kirston Nelson	Enclosure Q	Pack 1	Information
Reports and Information						
6.1		ICS Chairs Report	Chair	Enclosure R	Pack 2	Information
6.2		ICS Chief Executive Officer Report	Phil Johns	Enclosure S	Pack 2	Information
6.3		Report from Integrated Care Partnership 26th July 2022	Chair	Enclosure T	Pack 2	Information
6.4		Communications, Engagement and Public Affairs Report	Anita Wilson	Enclosure U	Pack 2	Information and Assurance
7.1	15:55	Questions from visitors	Chair	Verbal		Information
8.1	15:55	Any Other Business	Chair	Verbal		
	16:00	MEETING CLOSES				

Dates of Future meetings:

Date	Time	Venue
Wednesday 19th October 2022 Development session	1.00 - 4.00pm	Face to Face. Venue TBC
Wednesday 16th November 2022 ICB Meeting (Public)	1.30 – 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)	1.30 - 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)	1.30 – 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 - Register of Interests **ENCLOSURE A**

All actions in response to declared conflicts of interests at ICB Board 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	Shade	Agboola	Observer/Participant	Nil						Jul-22	Current
Y	Chris	Bain	Observer/Participant	Nil						Jul-22	Current
Y	Pamela	Bradbury	Non-Executive Member	Daughter works for Adult Community Services, Out of Hospital Collaborative South Warwickshire NHS FT					✓	Apr-22	Current
Y	Angela	Brady	Chief Medical Officer	1. Joint owner of Lisle Court Medical Centre premises, Leamington Spa. Leased to Croft Medical Centre, Leamington Spa for healthcare provision	✓					Jun-22	Current
Y	Angela	Brady	Chief Medical Officer	2. Salaried retained GP employed by GPS Healthcare, Solihull		✓				Jun-22	Current
Y	Angela	Brady	Chief Medical Officer	3. Family member expert by experience on West Midlands CAMHs Provider Collaborative, Patient Participation, Engagement and Experience workstream		✓				Jun-22	Current

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					Financial Interest	Non-Financial Professional Interest	Non-Financial	Non-Financial Personal Interest	Indirect	Declared	To
Y	Angela	Brady	Chief Medical Officer	4. Spouse is Chair of Warwickshire Local Medical Committee					✓	Jun-22	Current
Y	Angela	Brady	Chief Medical Officer	5. Spouse is a committee member of Warwickshire Local Medical Committee					✓	Jun-22	Current
Y	Angela	Brady	Chief Medical Officer	6. Spouse is GP partner at Croft Medical Centre, Leamington Spa					✓	Jun-22	Current
Y	Angela	Brady	Chief Medical Officer	7. Spouse's business partner is Partner member Primary Medical Services - board member of the ICB					✓	Jun-22	Current
Y	Angela	Brady	Chief Medical Officer	8. Family member receives an individually funded package from Coventry and Warwickshire ICB					✓	Jun-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	Glen	Burley	Chief Executive of South Warwickshire NHS FT and George Eliot Hospital	Chief Executive of Wye Valley NHS Trus	✓					Jun-22	Current
Y	Bill	Butler	Non-Executive Member	1. Independent Director, GPDF Ltd		✓				Aug-22	Current
Y	Bill	Butler	Non-Executive Member	2. Independent Director, the Law Society		✓				Aug-22	Current

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					Financial Interest	Non-Financial Professional Interest	Non-Financial	Non-Financial Personal Interest	Indirect	Declared	To
Y	Bill	Butler	Non-Executive Member	3. Member, Coventry Stroke Support Group		✓				Aug-22	Current
Y	Bill	Butler	Non-Executive Member	4. Spouse - Committee Member, Coventry Stroke Support Group					✓	Aug-22	Current
Y	Bill	Butler	Non-Executive Member	5. Daughter in Law - Employee SWUNHST					✓	Aug-22	Current
Y	Melanie	Coombes	Chief Executive, Coventry and Warwickshire Partnership Trust	Nil							Current
Y	Rachael	Danter	Chief Tranformation Officer and Deputy Chief Executive Officer at Coventry and Warwickshire ICB	Nil							Current
Y	Kevin	Davis	Non-Executive Member	Director of Ladder Apprenticeship Foundation		✓				Apr-22	Current
Y	Sukhdeep	Dhesi	Partner Member - Primary Medical Services	1. GP Partner at Croft Medical Centre, Leamington Spa	✓					Mar-08	Current
Y	Sukhdeep	Dhesi	Partner Member - Primary Medical Services	2. Croft Medical Centre is a Member of South Warwickshire GP Federation	✓					Mar-15	Current
Y	Sukhdeep	Dhesi	Partner Member - Primary Medical Services	3. Director of Dhesi Medical Ltd	✓					Jan-15	Current

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					Financial Interest	Non-Financial Professional Interest	Non-Financial	Non-Financial Personal Interest	Indirect	Declared	To
Y	Sukhdeep	Dhesi	Partner Member - Primary Medical Services	4. Husband is a Dental Surgeon					✓	Jan-15	Current
Y	Sukhdeep	Dhesi	Partner Member - Primary Medical Services	5. CEO of NEC in Birmingham, relative.					✓	Jan-07	Current
Y	Sukhdeep	Dhesi	Partner Member - Primary Medical Services	6. Chief Information Officer at McKesson UK, brother in law.					✓	Jan-18	Current
Y	Sukhdeep	Dhesi	Partner Member - Primary Medical Services	7. The CMO for the ICB is the wife of my business partner at Croft Medical Centre					✓	Jul-22	Current
Y	Sukhdeep	Dhesi	Partner Member - Primary Medical Services	8. Business partner is Chair of Warwickshire LMC					✓	Jul-22	Current
Y	Sukhdeep	Dhesi	Partner Member - Primary Medical Services	9. Trustee at MIND South Warwickshire and Worcestershire		✓				Aug-22	Current
Y	Allison	Duggal	Director of Public Health, Coventry City Council	1. Member of QSAC (resigning from this Committee in July 2022)		✓				Jul-22	Current
Y	Allison	Duggal	Director of Public Health, Coventry City Council	2. Unit Leader - Girl Guides			✓			Jul-22	Current
Y	Allison	Duggal	Director of Public Health, Coventry City Council	3. Occasional Leader - Scouts			✓			Jul-22	Current

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Y	Allison	Duggal	Director of Public Health, Coventry City Council	4. Association Director Public Health		✓				Jul-22	Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	1. Director/Trustee, Albany Theatre Trust			✓			01-Apr-15	Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	2. Non Executive Board Member/Trustee at Extracare			✓			Nov-21	Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	3. Board Director at NHS Elect	✓					Aug-22	Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	4. Non-Executive Board Member at Beamtree Global Impact Committee				✓		Aug-22	Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	5. Chair of University Hospitals Association		✓				Aug-22	Current
Y	Harry	Hayer	Non-Executive Member	1. Executive Director, Sustrans	✓					Sep-22	Current
Y	Harry	Hayer	Non-Executive Member	2. Independent Non-Executive Remuneration Committee Member - The Royal Institute of British Architects (RIBA)		✓				Sep-22	Current

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					Financial Interest	Non-Financial Professional Interest	Non-Financial	Non-Financial Personal Interest	Indirect	Declared	To
Y	Harry	Hayer	Non-Executive Member	3. Vice Chair and Trustee, Brunelcare		✓				Sep-22	Current
Y	Harry	Hayer	Non-Executive Member	4. Fellow, Chartered Institute of Personnel and Development		✓				Sep-22	Current
Y	Philip	Johns	Chief Executive Officer, Coventry and Warwickshire ICB	1. Member of Chartered Institute of Public Finance Accountants (CIPFA)		✓				Dec-20	Current
Y	Philip	Johns	Chief Executive Officer, Coventry and Warwickshire ICB	2. Member of Healthcare and Financial Management Association (HFMA)		✓				Dec-20	Current
Y	Philip	Johns	Chief Executive Officer, Coventry and Warwickshire ICB	3. Wife is employed as an Occupational Therapist at South Warwickshire General Hospital Foundation Trust					✓	Dec-20	Current
Y	Philip	Johns	Chief Executive Officer, Coventry and Warwickshire ICB	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	Kirston	Nelson	Chief Partnerships Officer/ Director of Education and Skills at Coventry City Council	Nil						Jun-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

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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	Susan	Noyes	Non-Executive Member	5. Daughter works as a Care Worker for Warwickshire Care Services Ltd					✓	Jun-22	Current
Y	Susan	Noyes	Non-Executive Member	6. Member of Associationn for Coaching		✓				Sep-22	Current
Y	Susan	Noyes	Non-Executive Member	7. Member of Association for NLP		✓				Sep-22	Current
Y	Susan	Noyes	Non-Executive Member	8. Member of Healthcare Finance Management Association		✓				Sep-22	

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					Financial Interest	Non-Financial Professional Interest	Non-Financial	Non-Financial Personal Interest	Indirect	Declared	To
Y	Susan	Noyes	Non-Executive Member	9. Member of Institute of Chartered Accountants of England and Wales		✓				Sep-22	
Y	Danielle	Oum	Chair of Coventry and Warwickshire ICS	1. Chair of Birmingham and Solihull Mental Health FT		✓				Sep-22	Current
Y	Danielle	Oum	Chair of Coventry and Warwickshire ICS	2. Member of Healthwatch England Committee		✓				Sep-22	Current

NHS
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Unconfirmed Minutes of the Coventry and Warwickshire Integrated Care Board Meeting Held in Public

On Wednesday 20th July 2022 at 14.00pm, by Microsoft Teams

Members	
Ms Danielle Oum	Chair, Coventry and Warwickshire Integrated Care Board
Mr Philip Johns	Chief Executive Officer, Coventry and Warwickshire Integrated Care Board
Dr Angela Brady	Chief Medical Officer, Coventry and Warwickshire Integrated Care Board
Ms Madi Parmar	Chief Finance Officer, Coventry and Warwickshire Integrated Care Board
Ms Rachael Danter	Chief Transformation Officer, Coventry and Warwickshire Integrated Care Board
Ms Melanie Coombes	Partner Member - Chief Executive, Coventry and Warwickshire NHS Partnership Trust
Mr Glen Burley	Partner Member -Chief Executive, George Eliot Hospital NHS Trust and South Warwickshire NHS Foundation Trust
Ms Justine Richards	Chief Strategy Officer, University Hospital Coventry and Warwickshire
Ms Kirston Nelson	Partner Member - Director of Education and Skills/Chief Partnership Officer, Coventry City Council
Mr Nigel Minns	Partner Member -Strategic Director for People, Warwickshire County Council
Dr Sukhdeep Dhesi	Partner Member - Primary Medical Service
Ms Susan Noyes	Non-Executive Member, Coventry and Warwickshire Integrated Care Board
Ms Harry Hayer	Non-Executive Member, Coventry and Warwickshire Integrated Care Board
In Attendance:	
Mrs Anita Wilson	Director of Corporate Affairs, Coventry and Warwickshire Integrated Care Board

Mrs Cheryl Brand	Executive Assistant, Coventry and Warwickshire Integrated Care Board (Minute taker)
Ms Theresa Nelson	Chief People Officer, Coventry and Warwickshire Integrated Care Board
Ms Liz Gaulton	Chief Officer Population Health and Inequalities, Coventry and Warwickshire Integrated Care Board
Ms Ali Cartwright	Chief Officer Performance and Delivery, Coventry and Warwickshire Integrated Care Board
Ms Debbie Dawson	Population Health Management Transformation Officer, Coventry City Council
Mr Jamie Soden	Director of Nursing and Clinical Transformation, Coventry and Warwickshire Integrated Care Board
Ms Michelle Gorrell	Acting Director of Nursing and Quality, Coventry and Warwickshire Integrated Care Board
Mr Adrian Stokes	Improvement Director, Coventry and Warwickshire Integrated Care Board
Ms Rose Uwins	Senior Communications Lead, Coventry and Warwickshire Integrated Care Board
Mr Chris Bain	Chief Executive, Healthwatch, Warwickshire
Dr Allison Duggal	Director of Public Health, Coventry City Council
Mr David Eltringham	Managing Director, George Eliot Hospital NHS Trust
Ms Karen Winchcombe	Chief Executive, Warwickshire CAVA
Apologies:	
Mr Andy Hardy	Partner Member - Chief Executive Officer, University Hospital Coventry and Warwickshire
Ms Shade Agboola	Director of Public Health, Warwickshire
Ms Ruth Light	Chief Officer, Healthwatch Coventry
Ms Rebecca Bartholomew	Interim Chief Nursing Officer
Ms Pamela Bradbury	Non-Executive Member, Coventry and Warwickshire Integrated Care Board

Mr Kevin Davis	Non-Executive Member, Coventry and Warwickshire Integrated Care Board

Item No:		Action
1.	**Standing Items:**	
1.1	**Welcome and Apologies** The Chair welcomed all attendees to the Board meeting. Apologies were noted as above.	
1.2	**Confirmation of Quoracy** The meeting was confirmed as quorate.	
1.3	**Declarations of Interest** There were no items raised. Members were reminded of the need to declare their interest in any items requiring a decision and to remove themselves from such decision making.	
1.4	**Minutes of the meeting held on 18th May 2022 and 1st July 2022** The Minutes of the 18th May 2022 Board were approved by members. The 1st July 2022 minutes were approved by Members. Ms Oum will email Ms Brand to re-word a phrase in the minutes. **Action: DO**	**DO**
1.5	**Matters Arising/Action Schedule** The action log was updated.	
1.6	**Patient Story** The board were shown a video about a patient who had been diagnosed with cervical cancer. The patient explained the importance of screening and prevention to improve the chances of a successful outcome. The Chair thanked colleagues who had organised the video and noted the importance of using our priorities to prevent and support people to have treatment as early as possible. ICB Members: **RECEIVED** the patient story for **INFORMATION.**	

1.7	**System Risk Register** Ms Danter presented the risk register to give assurance to the board that risks to the system priorities are being identified and action is being taken to manage those risks. The highlights were as follows: • 15 open risk with 10 classed as high risks • One new risk about maternity recruitment • Two risk scores have increased re: Ockenden funding and Transforming Care • Two risks have been de-escalated and being overseen by local teams. Nominations have been received from all partners across the system for membership of the System Risk Management Group meetings which will start to meet in August. The Board development session in August will be on risk and that will begin the process of developing the board assurance framework. Mr Hayer asked about Ockendon and noted the residual risk had increased due to a shortfall in funding and queried if the shortfall is the same requirement for additional staff in maternity or something different? Mr Hayer also asked about a residual risk going up, what is mitigating that risk and what is the cause that is preventing it being met? Ms Danter confirmed that the same level of funding has not been received and trying to get midwifes to deliver services at an enhanced level is difficult so there is an associated risk. A further piece of work is required to understand the ideal situation and what is realistic to expect to be able to achieve. Ms Noyes noted the table of open risks was helpful and suggested that it would be useful to see this each month so progress can be seen. Ns Noyes referred to the Ockenden risk and asked if we are picking up the potential inequality of quality of services across the system and how do we know that we are incorporating the risk around inequality within that service. There may be one risk that covers several areas. Ms Noyes asked how the risks compare to what is on the provider risk register and are the priorities the same. Ms Danter explained the access versus the impact on inequalities is new in terms of grading the risks and it is a learning curve she added and the risk group will help to establish a cultural change. Ms Coombes agreed that the risks on the system register did reflect the same risks as on the providers register; although the narrative may differ and noted that further work on mitigations for transforming care is needed as it is a risk that is increasing. Ms Oum suggested it may be beneficial to discuss undertaking a deep dive conversation about transforming care. **Action: TP** Mr Eltringham reassured the board that George Eliot Hospital are reviewing the risk register at their Executive Risk Committee. The articulation of the risks in the system risk register is good and having a consistent way of articulating the risks is the right approach. Risks affect different organisations in different ways, so some scores may be different. Dr Brady noted that this is an excellent opportunity to develop the conversations about how we access and look at inequalities in the system. Dr Brady will consider which Committee will be best to discuss this. **Action: AB.**	**TP** **AB**

	Ms Richards acknowledged that it is about providing assurance back to the system, mitigations and plans are in place to address those risks and what additionality does a system lens give to the assurance that equity of outcome is being delivered to the population of Coventry and Warwickshire. A further piece of work if required to understand the ideal situation and what is realistic to expect to be able to achieve. **Action: RD** ICB Members: **RECEIVED** the System Risk Register for **ASSURANCE**	**RD**
2.1	**Quality Report** Mr Soden explained that Ockenden is a key system challenge with workforce remaining a key focus of that work. Work is continuing to develop system wide Speak Up Guardians and there is excellent support, enthusiasm, and engagement from partners across the system. Regular meetings are taking place to ensure that there is full awareness and engagement of the quality of oversight and challenges. The Learning Disability and Autism Programme (LDA) is an increasing challenge with more activity and remains a high priority across the system. Dr Dhesi asked if the issues with workforce were in relation to recruitment or retention and what work is being done to address this. Mr Soden explained there is a national shortage of staff and people are moving to agency working so they can work across the country and get better salaries as the demand is high. Actions are in place to try and improve recruitment. Dr Dhesi referred to the LDA programme and asked what areas of the system needed to focus on. Mr Soden reported that one of the key challenges was the autism agenda. Ms Coombes agreed that autism strategy delivery poses a risk to the system and there is a need to decide how we fund the strategy as a system when there is no funding attached. Dr Brady noted the potential support that the System Quality Group could provide. Mr Minns added that it would be helpful to undertake a piece of work to understand who spends what and how it is spent and look at the options beyond that. Ms K Nelson noted that the conversations that are taking place about mental health strategies and where the funding will come from has to be a collective discussion about pooling resources and determining the right priorities. Decisions will have to be made about which will make the biggest difference along with pragmatism and transparency, so everyone is clear. Ms T Nelson reported that there has been increased interest in the number of students who want to train as learning disabilities nurses and that is positive. The challenge remains in finding placements. Mr Johns explained it would be beneficial to do a piece of work about the openness and transparency about what is spent on learning disabilities and autism. Ms Brand to add to the 21st September ICB. **Action: CB** ICB Members: **RECEIVED** the Quality Report for **INFORMATION.**	**CB**

3.1	**Population Health Management Roadmap** Ms Gaulton introduced the Population Health Management (PHM) Roadmap and explained that it is the capability through which we improve the health of our population and is an enabler to reduce the costs of health and social care. It is a five-year plan and sets out detail that has been developed across the system to embed what the ICB priorities are there to do. It focuses on the nationally defined core capabilities – known as the four I's. Mapping against the maturity matrix has taken place and this gives an indication of how we are dealing with this now and then it can be completed annually to track progress. Going forward, a PHM approach should be at the forefront of everything that takes place as an ICB. It will drive the Integrated Care Strategy and is a core workstream within the digital transformation strategy and the alignment with digital must not be underestimated. The digital data platform will be a key enabler which will provide live linked data; however, this does pose a cost and a challenge. Issues include capacity for the platform, the technical resource and using data differently across the system to get ahead of understanding the needs rather than responding to demands. Funding for future delivery will require a culture shift by working differently with communities, patients and clinicians. Engagement with communities and wider stakeholders about what PHM means which will be taking place over the coming months. The governance will be through the Population Health Management Programme Board which feeds into the Commissioning, Planning and Population Health Committee of the ICB. Dr Dhesi asked about the financial and workforce risks and how much a risk are they and what mitigations are in place. Ms Gaulton explained that it's the capacity of the small team to enable this to happen plus the capacity of other staff; Clinicians, Analysts and financial colleagues to embed it and do things differently. The financial element of the risk relates to the platform is commissioned through a two-year pilot and the proof of concept will need to be proved within the next 12 months and if evidence cannot be provided, consideration to an alternative delivery method will be required. Mr Minns noted his support of the strategy but stated nervousness about the building of teams and capacity as there is a shortfall of data analysts and there is a need not to just move people around the system but to create additional capacity. Ms Gaulton said it is about using analytical capacity in a different way and more efficiently. Ms Noyes asked about the funding gap and clarified if the understanding is that after two years, we can walk away as we are not committed. Ms Noyes also asked about the information sharing protocols and reassurance that this would work. Ms Gaulton confirmed that we can walk away after two years and are currently in negotiations to extend that from two-year window to get proof of concept without any additional cost. The risk being they would need to find another way to link data and deliver our Population Health Management function and requirement. For information governance, there is excellent leadership from George Eliot Hospital. The Information Governance Group and the whole information governance workstream ensure that consent and information sharing is correctly undertaken.	

	ICB Members: **APPROVED** the Population Health Management Roadmap	
4.1	**Finance Update and Contract Report** Ms Oum introduced Ms Parmar, the new Chief Finance Officer. Ms Parmar reported that the paper focuses on the financial plan that has been submitted to NHSE/I. There was a deficit plan in the original April submission and now there is a balanced plan due to additional £16.8m recurrent funding that was received. Furthermore, there is an additional £6.1m for non-current regional support. As with any financial plan, it will not be without risk. As at month three, there is a forecast £8.3m full year deficit driven largely by slippage on the delivery of efficiency programmes. Further financial risk relates to if the elective recovery fund is clawed back for underperformance. In addition, the pay award was announced yesterday which could bring inflationary pressures into the system. Whilst there is a balanced plan for 2022/23, it has been supported by some non-recurrent income streams and gives rise to an underlying deficit position that will need tracking closely to bring it down before planning for 2023/24. There are risks associated in 2023/24 onwards with the devolution of specialised services and direct commissioning and how that will be managed. There will be a need to develop approaches to productivity, efficiency and value to ensure the system is getting the best value for money in order to be able to maximise patient care. Capital remains an issue for the healthcare economy. There is currently a balanced capital plan, and there will have to be some difficult decisions made about prioritising capital going forward. Mr Hayer asked for more information about the funding for the pay award and noted that would be centrally funded but it comes with some risk and potential cost pressures. Ms Parmar explained the pay award would come into the system and then the ICB passes those payments on. There is no indication yet if there will be an increase in ICB running costs and there is sometimes an in-balance of what flows through and the reality of what is seen. Ms Oum noted it would be of benefit to develop a system response in anticipation of potential risks which may arise and asked for an update at the next ICB meeting. **Action:** Ms Parmar Dr Sukhi referred to the Fair Shares Reduction and asked if this will be realistic to achieve and what support could be given to these organisations to improve their productivity and efficiency? Ms Parmar noted that the role of ICB would be to help all the organisations to work together in a consistent way and examine productivity and efficiency, using information to support colleagues and look for additional opportunities. Ms Noyes suggested that given the change in the capital regime, it would be useful to know what that means for other developments and the implication for risks. Ms T Nelson noted the impact on social care of the pay award and asked for any intelligence from local authority members and some of the systematic risks that may arise.	**MP**

	Ms K Nelson noted that this will affect the whole sector as the additional pressures on top of pressures that are already there, could mean an increased risk of retention of staff. Ms Oum stated that it is important to think about how we can work together as a system to address these issues and think about the priorities we are setting and address what needs to change. Mr Burley reported that there is an opportunity to use visa flexibility that has not previously been used much. ICB Members: **RECEIVED** the Finance Report for **INFORMATION.**	
4.2	**Delegation of Services from NHSE to ICS Boards** Ms Cartwright explained the paper details the progress that has taken place on the delegation of primary care functions including an overview of the operating model for the delegation of Pharmacy, Optometry and Dental services and Acute Specialised services. Oversight of the delegation process will be overseen by the Commissioning, Planning and Population Health Committee and reported back to this board. Ms Oum asked if there would there be an opportunity for wider involvement in understanding potential opportunities and the benefits for wider thinking, collaborative working and pathway re-design. Ms Cartwright confirmed that this would be discussed in the relevant regional and system groups,but noted that for the primary care commissioning services can be restricted by the national contract. Mr Minns noted that it is likely that pharmacy, optometry and dental services are under-funded and we will be inheriting a problem but that doesn't mean it cannot be solved. Elected members would be keen to receive regular updates. ICB Members: **NOTED** the content of the report and **APPROVED** the approach being taken for the Delegation of Services from NHSE to ICS Boards	
4.3	**Performance Report** Ms Cartwright reported on key areas for members to be sighted of. • Pressures remain throughout the system on urgent care and particularly with ambulance handovers. • Total elective waiting lists are increasing, although the system is maintaining the reduction in long waiters. • Cancer waiting times is still a key area of concern although the backlog is slowly reducing. NHSE are giving additional support; • Autism assessments – the Neurodevelopmental service remains challenged with additional funding being provided to support additional capacity. This should increase the number of assessments undertaken. ICB Members: **RECEIVED** the Performance Report for **ASSURANCE**	
4.4	**Hospital Flow and Discharge**	

	Mr Johns introduced the paper and explained that it highlights the current system situation and challenges at each point of the pathway. It is about being open and honest about what works and what doesn't, and it is important to commit to solve issues collectively and not fall into silos. Ms Danter thanked everyone who had been involved in contributing to the paper and noted that mental health had not been included in the paper. Ms Danter went through each stage of the pathway, highlighting the key points and recommendations for consideration. **Primary Care** There is national evidence that shows the direct association between access to Primary Care and Accident and Emergency (A&E) attendances with better Primary Care access associated with less A&E attendances and decreased hospital admissions. Data shows that the number of Primary Care appointments are back to pre-pandemic levels with a significant number now seen as same day or next day appointments, demonstrating a more responsive service. The paper highlights the pressures Primary Care are facing and the data shows that GPs are providing significant capacity of NHS 111 appointments, which does prevent the need for patients to seek alternatives such as Emergency Departments (ED). Dr Dhesi noted that GPs have different strengths and are good at triaging patients to the correct place. Dr Brady highlighted the need to be thinking about whether this disproportionately effects certain groups within the population and an ongoing analysis would be useful to do. What is the root cause and why is the population using the services in that way? What are the patients not getting from the conventional routes? Ms Cartwright explained that as part of the Winter Resilience Fund process, 24 practices were identified and a targeted support packages and additional funding was put in place for those practices. **Pre-Hospital/Alternative to the Emergency Department(ED)** Ms Danter explained that this section summarises available data regarding attendances and patient types to the ED and the difference in facilities, services and the types of patients they treat. The national evidence shows that where a provider introduces GP led Urgent Treatment Centres (UTC), there is improved flow through ED, and this has worked well at George Eliot Hospital (GEH). Mr Burley noted that SWFT are trying to find a compromise where they don't create a new front door for Primary Care on site at hospitals that stops existing pathways. Mr Burley noted that he supports this recommendation, but not the same arrangement that is in place at GEH as they want to encourage patients to use Primary Care first. Dr Dhesi noted what is proposed in the South is a bespoke Primary Care working strategically to maximize resources and patients' outcomes and educating patients to ensure that resources are appropriately used. It is imperative that the right authority is at the front door. Dr Duggal stated that it is important to understand why patients use ED. Ms Richards added that the Urgent Treatment Centre (UTC) in Coventry City Centre has proved very beneficial and learning through this approach would be helpful. The plan is to do something similar at the UHCW site to ensure the right outcome. We also need to understand why health seeking behaviour drives people to go to locations.	

Ms Cartwright noted that it is important that the correct people are on the front door to manage risk and there are GPs who would be keen to do this portfolio of work in line with the national UTC model.

The Board agreed recommendation One understanding there will be differences at each acute setting with the benefit of reviewing the arrangements later.

Recommendation One: It is recommended that work is undertaken to implement a GP-led UTC model at SWFT and UHCW main site in-line with GEH to allow type-3 activity to be more appropriately managed by GPs.

Mr Burley asked if this would be going through the UEC Delivery Board. Ms Danter confirmed that it would be covered as part of the UEC programme. Mr Burley confirmed he would be happy to support this.

The Board agreed recommendation Two:

Recommendation Two: It is recommended that each Trust nominates a representative to engage with this agenda and help lead the work in their organisation.

Ambulance Handover

Ms Danter noted that we are still not meeting the trajectory for ambulance handover targets and that is reflected in the quality of care for patients. Performance is not consistent with periods of significant underperformance.

Ms Richards asked about the recommendation in terms of a consistent approach across the system and is this the objective? Ms Danter reported that that would be useful to have a consistent set of principles that could be flexed depending on what an organisation is managing at that time and how those risks are managed in an escalated way. Ms Richards noted her concern that if those principles were applied at a system level, it could take autonomy away for those managing the clinical risks. It would need to be very clear where the system adds value and how providers manage the risk presented in front of them.

Dr Brady added that it is not only about understanding internally the functions and having principles, but it is also how we present ourselves as a system at a regional level to be able to work with other ICSs. A collegiate view can then be presented for the risks to be suitably mitigated alongside partners at region.

Ms Noyes would be pleased to support this piece of work, but would like to understand at what pace this will happen as there was no timeframe noted. It is also important to note that there are three cohorts of patients – the patients in corridors, the patients in ambulances and the other patients in the community that nobody can get to. Ms Danter explained that they want to try and do this as soon as possible.

The Board agreed recommendations three and four:

Recommendation Three: It is recommended that work is undertaken jointly with West Midlands Ambulance Service (WMAS) to assess the risk of delayed ambulance handover 'v' patients being managed in hospital corridors.

Recommendation Four: It is recommended that a joint piece of work is undertaken with WMAS to consider an alternative model for reducing the risk in the management of these patients.

Hospital Flow and Discharges

Ms Danter explained that a previous paper was discussed had been presented to the Board regarding partners working together to support improved timely discharges, so to enhance this further, they have been asked to consider the work that's been undertaken by the National Health and Social Care Discharge Taskforce who have been working with providers. Ten best practice initiatives have been published which demonstrate improved flow and which they want to be review and embed them into the system before winter.

Dr Duggal reported that Local Authority Public Health are keen to progress this but is worried about the financial risk. Ms Danter explained that they recognise the challenges that are raised.

Mr Minns agreed with the ten best practice initiatives, but they would need to be applied with some sense such as managing the social care workforce to meet demand. Mr Minns also agreed with recommendation Six for a system dashboard as it would be very helpful.

Mr Burley noted that the ten best practice initiatives are great, but in relation to the seven-day service, more detail would be required about what is provided across the weekend and capacity and demand assessments. Ms Danter acknowledged that more detail would be required.

Ms Danter explained that the dashboard will prove very helpful to get a consistent set of data that really shows where the challenges are.

The Board agreed recommendation Five and Six:

Recommendation Five: It is recommended that the system ensures the adoption of the Ten best practice initiatives and data is collected to demonstrate adoption and the associated benefits.

Recommendation Six: Providers work with the system to provide a system dashboard to show in detail where the discharge delays reside and support the system to seek specific solutions/actions to address these delays.

Hospital Discharge Fund (HDF), Better Care Fund (BCF) and Improved Better Care Fund (IBCF)

Ms Danter explained that the Hospital Discharge Fund (HDF) was an additional nonrecurrent fund provided through the NHS National Discharge programme to support timely discharge; mainly over the COVID period. It ended on 31st March 2022 and we were asked to work together as a system to plan and deliver those discharges in an affordable way going forward from within existing budgets.

There has not been any robust collection of key performance indicators to demonstrate the impact of the services paid for by the HDF on the overall health and social care system.

The two recommendations in the paper state that no further funding should be made and a review needs to be undertaken to look at underspend and all schemes should be reviewed to see if they are fit for purpose.

Ms Richards noted that there was a paper on the BCF presented to Coventry Care Collaboratives colleagues and it was the first-time colleagues saw what the BCF is

	made up of and it raised several questions such as what work is taking place to resolve some of these issues in a more sustainable way? Delegating urgent and emergency care budgets to Care Collaboratives and other issues are not reflected in the paper. It appears that we are trying to solve the same thing but with different perspectives. Ms Danter acknowledged the point and explained that as winter is fast approaching, there is a phased approach and two different perspectives can add value by working together and needed to be done in the next four to six weeks. Mr Minns added that the BCF and IBCF are not about hospital discharge, parts of them are, but most of the funding is for other purposes. Mr Minns agreed that a review of the funding needs to take place. A lot of the money is already committed form those schemes, so having the opportunity to look at what is done next year would be helpful. Dr Duggal asked that recommendation is seven is re-worded as having an underspend may not be correct. Ms Oum summarised the feedback for recommendation seven and noted recognition of the role of the upcoming Care Collaboratives and the importance of Place should be added. In addition, neutral phrasing should be used rather than using the assumption of underspend. The Board agreed that recommendation Seven needed to be amended to reflect the comments summarised by Ms Oum. Recommendation Seven: It is recommended that any further funding would be subject to a review of schemes associated with the BCF and IBCF and if underspends or slippage was apparent, they could be utilised in the first instance. The Board agreed recommendation Eight. It is recommended that a full, in-depth review of the financial support to services for discharge, rehabilitation, reablement and recovery is undertaken. ICB Members **APPROVED** the recommendations noted in the Hospital Flow and Discharge paper subject to the suggested amendments agreed above.	
5.1	**Consolidated System Wide Green Plan** This item will be dealt with electronically. **Action: Ms Brand**	**CB**
	Reports and Information The following reports and information were shared with the members of the board:	
6.1	**ICB Chairs Report** ICB Members: **RECEIVED** the Chairs Report for **INFORMATION.**	
6.2	**ICB Chief Executive Officer Report** ICB Members: **RECEIVED** the Chief Executive Officer Report for **INFORMATION.**	

6.3	**Communications, Engagement and Public Affairs Report** ICB Members: **RECEIVED** the Communications, Engagement and Public Affairs Report for **ASSURANCE** and **INFORMATION.**	
6.4	**Quarterly System Review Meeting 11th May 2022** ICB Members: **RECEIVED** the Quarterly System Review Meeting for **INFORMATION.**	
6.5	**Report from the Clinical Quality and Governance 30th June 2022** ICB Members: **RECEIVED** the Report from the Clinical Quality and Governance 30th June 2022 for **INFORMATION.**	
6.6	**DRAFT Public Governing Body Minutes 15th June 2022** ICB Members: **RECEIVED** the DRAFT Public Governing Body Minutes 15th June 2022 for **INFORMATION.**	
6.7	**2022/23 Month Three Coventry and Warwickshire CCG Finance Report** ICB Members: **RECEIVED** the 2022/23 Month Three Coventry and Warwickshire CCG Finance Report for **INFORMATION.**	
7.1	**Questions from Visitors** There were no questions raised.	
8.1	**Any Other Business** Mr Hayer suggested that it would be beneficial as a system to reflect on and learn lessons from the heatwave as it is likely this will connect directly with the green plan and the sustainability group. It will be helpful to see how the system operated and if there is anything that could be done differently next time. Mr Johns noted that Communications will be sent out today reporting on the transfer of 111 services from West Midlands Ambulance Service to DHU (Derbyshire Healthcare) and a fuller briefing will be communicated to the board about mitigating any risk in the transition between the two services.	

	Date of the Next Meeting Held in Public: **Date:** 21st September 2022 **Time:** 13:30 **Venue:** Virtual	

ACTION SCHEDULE - COVENTRY AND WARWICKSHIRE INTEGRATED CARE BOARD - ENC C

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	Sep-22	In progress	Meeting held bewtween WCAVA and VAC on 14/9/22 to discuss activities and future discussions. Work with Local authoritiy, ICB and sector colleagues with the possibility of discussion at the ICP.
24	8/12/2021	1.5	Philosophy of care development	Phil Johns	Ongoing	In progress	The CNO and CMO will work together for our population prioritising care over individuals organisations. The CNO starts on 30th August. This work forms part of the Clinical Care professional Leadership framework.
38	16/03/2022	2.1	Trauma Recovery Vanguard update	Tracy Pilcher	Nov-22 or Jan 2023	In progress	Update on the Trauma Recovery Vanguard to be included in the Quality Report if significant.
41	18/05/2022	3.2	It was agreed that it would be beneficial to have Cancer Performance Report - Deep Dive	Ali Cartwright	Nov-22	In progress	Scheduled for the November and March ICB Meetings
45	01/07/2022	8	Fair Processing Notice - Review to ensure data sharing agreements and the process is clear	Angela Brady	Nov-22	In progress	IG lead informed and will be monitored via the Information Governance Steering Group and it will be brought forward to a future ICB meeting
44	Carried over from Governing Body 15th June 2022	2.4	Public Health Coventry and Warwickshire Joint Report – Asylum Seekers and Refugees Mrs Wilson suggested that the Executive team could review the recommendations from this report and then they could be built into an ICB agenda going forward.	Phil Johns	Nov-22 or Jan 2023	In progress	Added to the ICB Executive Team agenda for the 26th July meeting. Report to come to November or January ICB
45	20/07/2022	1.7	System Risk Register - Transforming Care mitigations and descriptions	Tracy Pilcher	Nov-22	In progress	CNO started on 30th August and to be picked up with Mel Coombes
46	20/07/2022	1.7	System Risk Register - Develop conversations about how we access and look at Inequalities in our system	Angela Brady	Nov-22	In progress	System risk group met in August for its inaugural meeting with good membership and discussion.
48	20/07/2022	2.1	Autism Strategy and progress to be presented to the September ICB Board	Phil Johns/ Mel Coombes	Sep-22	In progress	On the 21st September ICB agenda
49	20/07/2022	4.1	Pay award - Given the potential risks, develop an agreed system response	Madi Parmar	Nov-22	In progress	To be included in the Finance Update paper at the November meeting
50	20/07/2022	5.1	Consolidated System Wide Green Plan - Comments to be sent to Phil Johns and Laura Nelson	Phil Johns	Sep-22	Closed	

Enc D

Report Title:	Patient Story – Frailty Virtual Ward
Report From:	Danielle Oum, Chair of Coventry and Warwickshire Integrated Care Board
Author:	Simon Lefevre, Communications and Media Manager, Coventry and Warwickshire Integrated Care Board
Previous Considerations and Engagement:	
Purpose:	For Information

Contribution to meeting the aims of the ICS:

Improving outcomes in population health and healthcare:

Dawn's story demonstrates the benefits of providing the best possible care within available resources as close to home as possible, joined up around the people that we serve.

There are several types of "Virtual Ward" model within the system, referring to different types of care. In the context of this patient story the "Frailty Virtual Ward" is a service where patients receive care in their own homes where previously they would have needed a hospital admission. The ward delivers hospital-level care for acute conditions that would normally require an acute hospital bed, in a patient's home for a short episode through multidisciplinary healthcare teams. Although it makes use of technology such as remote monitoring where appropriate, care is delivered face to face.

The service is managed by the acute trust with staff going into the community where they can assess, monitor and treat patients at home. In addition to the ongoing care they deliver, they are able to keep conditions from escalating and requiring un-scheduled hospital admission.

This benefits the patient because they are able to remain in familiar surroundings and connected to their own support networks, causing less disruption to their lives, whilst receiving a high level of care. It can also help patient recovery because they're more comfortable, they don't lose as much muscle mass from the reduced mobility of spending time in a hospital bed, and they're not exposed to hospital-acquired infections like covid and pneumonia.

The care is co-ordinated holistically around the patient through a clinical team of acute and community staff, remaining in contact with primary and secondary care providers, which means that the patient does not need to attend multiple appointments or explain their needs to different professionals, improving their experience.

Enc D

The frailty virtual ward enables the demand on our hospital beds to be managed more effectively but more importantly focuses on delivering on our ICS vision of the best possible joined up care, closer to home.

Enhancing Productivity and value for money:

As above, by treating the patient in their own home it reduces the need for emergency bed days and therefore improves flow, while still ensuring the patient receives a high standard of care.

Contribution to meeting the priorities of the ICB:

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

Frailty virtual wards protect patients, like Dawn, by reducing the disruption of care on their lives and reducing the stress and anxiety involved in being admitted to hospital.

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

Dawn was able to be treated at home because of the support of the Urgent Community Team and their access to virtual wards. The team's access to integrated care records and their ability to speak with the patient's GP and their orthopaedic consultant meant Dawn could receive the treatment she needed both to improve her health in the short term, but also to ensure she was well enough to undergo her knee surgery.

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

Treating Dawn in her own home meant that she did not need to be admitted to an emergency bed. By reducing the number of people whose conditions need to be assessed in person, it opens up bed space for people who truly need to be hospitalised which ultimately improves hospital flow. The use of virtual wards where clinically appropriate will help us deliver value for money whilst maintaining a high standard of care.

Recommendation:

Members are requested to **NOTE FOR INFORMATION**

Implications

Enc D

Conflicts of Interest:	None						
Financial and Workforce:	Through watching this video and understanding the case study we see the financial benefits of virtual wards.						
Performance:	Through watching this video and understanding the case study we see that virtual wards can free up both ambulance and hospital bed capacity.						
Quality and Safety:	None						
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:	To raise awareness of virtual wards and the benefits it can have on patients.						
Clinical and Professional Engagement:	To raise awareness of virtual wards and how they can be used effectively.						
Risk and Assurance:	None						

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Enc E

Commissioning, Planning and Population Health Committee **Report for the meeting held in PUBLIC on 27 July 2022**		
Key Information		
Committee Chair: Kevin Davis	**Committee Executive Lead:** Alison Cartwright	**Date of Next Meeting** 28 September 2022
Quoracy met?	**Yes**	
Purpose of the report	For **ASSURANCE** in respect of key decisions taken/issues raised at the 27 July 2022 Commissioning, Planning and Population Health Committee PUBLIC meeting.	
Recommendation	Members are requested to be **ASSURED** in respect of the matters set out within this report.	

Key highlights of discussions and decisions held during the meeting:	
Agenda item description & key discussion points	**Assurance achieved and sources / Gaps in assurance and action agreed**
Committee Terms of Reference – Minor amendment to wording of the Health Inequalities responsibility to promote clarity.	NOTED and ACTION AGREED to for further discussion to take place regarding the wording of the responsibilities relating to Health Inequalities. Discussion held and agreed that the Terms of Reference as presented to the Committee were suitable.
Delegation of Direct Commissioning Functions from NHS England to Integrated Care Boards – process towards delegated commissioning. – proposed model for local delivery of contracts.	ASSURANCE achieved regarding the process towards delegated commissioning and the proposed model for local delivery of contracts.
Primary Care Assurance Report – Primary Care additional roles. – Impact on estates capacity. – Digital First Primary Care budget.	ASSURANCE achieved regarding the management of delegated commissioning responsibilities for Primary Care and ACTION AGREED to provide data on recruitment of primary care additional roles. APPROVAL given for delegated decision-making in terms of a contract award for the one practice outside of a Primary Care Network.
Primary Care Finance Report – System level clinical primary care transformation lead role.	ASSURANCE achieved regarding the Finance Report, and the process for ongoing recruitment to the System personnel structure and aim to achieve System level equality in clinical primary care transformation.

Primary Care Quality Report – Collection of primary care incident data System-wide. – Cervical screening uptake imbalance.	ASSURANCE achieved regarding the management of quality in primary care. ACTION AGREED for the Quality Team to discuss how to further understand the challenges of screening uptake in some local populations.
General Practice Estate Planning and Delivery – Approval of General Medical Services Space Expansion Proposals – Impact of any variation in requests from practices. – Support for practices who are time pressured – Progress of applications. – Timescale for delegation.	APPROVAL given to delegate decision making for small scale GMS space expansion proposals from GP practices to the Chief Delivery and Performance Officer for the financial year 2022/23. ASSURANCE achieved regarding the listed discussion points.
General Practice Estate Planning and Delivery - North Leamington Spa/Cubbington Road Surgery – Request for the delegation of decision making in the Surgery development business case, including impartiality of decision-making and need for it being based on affordability, holistic importance, health inequality principles, equity of funding distribution.	APPROVAL given for decision making in relation to the North Leamington Spa/Cubbington Road Surgery development business case to be delegated to the ICB Chair, or nominated other, and the Chief Delivery and Performance Officer. The Committee Deputy Chair, Pamela Bradbury, also to be included in the discussion. ASSURANCE achieved regarding discussion points and financial oversight.
Role of the Population Health Inequalities and Prevention Board – Adequacy of funding allocation for tackling inequalities.	NOTED. Regarding funding, assurance was received that the ICS would be considering inequalities as a collective and utilisation of budgets in a way that supports that agenda.

Items for escalation to Board:		
Item or issue	**Purpose for escalation**	**Escalated to**
None		

Items referred to the Board for Consideration/Approval
None

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Integrated Care Board

Enc F

People Committee Report for the meeting held on 24 August 2022		
Key Information		
Committee Chair: Harry Hayer	**Committee Executive Lead:** Theresa Nelson	**Date of Next Meeting** 26 October 2022
Quoracy met?	**Yes**	
Purpose of the report	For **ASSURANCE** in respect of key decisions/issues raised at the 24 August 2022 People Committee meeting. For **APPROVAL** of the recommendations set out within this report.	
Recommendation	Members are requested to be **ASSURED** in respect of the matters set out within this report. Members are requested to **APPROVE** the recommendations set out in this report.	

Key highlights of discussions and decisions held during the meeting:	
Agenda item description and key discussion points	**Assurance achieved and sources / Gaps in assurance and action agreed**
ICB Risk Register Report - The importance of retention across all sectors of workforce. - The importance of the Maternity Support workforce. - The need for community engagement.	ASSURANCE achieved regarding the mitigating actions in place for the risks relating to Maternity Recruitment and Workforce Shortages however an ACTION was agreed for the Maternity Recruitment risk to be amended to reflect the balance between funding and resourcing.
Committee Terms of Reference (ToR) - Reviewed suggested changes to the ToR and proposal of Deputy Chair.	RECOMMENDATIONS made to Board for : o the addition of a second Non-Executive Member to the Committee's membership as they had been unintentionally omitted from the ToR presented to the Board on 1 July 2022; o the addition to the ToR of responsibilities regarding receiving assurance on ICB workforce matters. APPROVAL was given for the appointment of Kevin Davis as the Deputy Chair of the Committee.

	ACTION AGREED to discuss proposal to include "Culture" in the title of the Committee with ICB Chair
Committee Schedule of Business (SoB)	NOTED and ACTION AGREED to undertake further work to ensure the SoB: o reflects the output from the People Plan work; o makes a clearer distinction between the assurance and strategic role of the Committee o captures the ICB's response to the cost-of-living crisis
People Board - Briefing on the People Board's existing remit as the main governance group for Health Education funding and that this remit may need to change to address broader employability once the recommendations from the People Plan were adopted. Changes to be presented to the Committee for approval.	NOTED.
Any other Business	ACTION AGREED for a regular report to be included on the SoB to understand workforce position (turnover, absence, vacancies, etc)

Items for escalation:		
Item or issue	**Purpose for escalation**	**Escalated to**
None		

Items referred to the Board for Approval
Board Members are requested to APPROVE the following additions to the People Committee Terms of Reference: - a second Non-Executive Member added to the Committee's membership; - receiving assurance on ICB workforce matters added to the Committee's responsibilities.

Enc G

Report Title:	People Report
Report From:	Theresa Nelson Chief People Officer
Author:	Fiona Rowntree Head of Workforce
Previous Considerations and Engagement:	Exec committee People Board
Purpose:	For Information

Contribution to meeting the aims of the ICS:
Workforce availability impacts the delivery of all aims of the ICS, without a secure pipeline of skilled people who are supported and valued will compromise all sectors of health and care services. • 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:
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 – **Recruitment, training and creation of opportunities for our communities.** **Work together**, as partners, at system and Place to identify and address health inequalities and variations in health and care provision – **Develop collaborative cultures with shared ambition to reduce health inequalities** **Protect the most vulnerable**, ensuring inclusivity runs through everything we do **including our workforce.** **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) **recruiting and supporting staff is critical for delivery of services** **Restore elective care** to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics **recruiting and supporting staff is critical for delivery of services**

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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- **Delivery of well being programmes, cost of living support, resilient recruitment and retention plans** **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 **with workforce our biggest expenditure it is critical we increase substantive employment to reduce reliance on expensive agency costs**
Recommendation:
Members are requested to • **NOTE FOR INFORMATION**

Implications							
Conflicts of Interest:	None						
Financial and Workforce:	Links to the cost of living paper and financial commitment						
Performance:	Impacts the delivery of all performance measures						
Quality and Safety:	Workforce capability and capacity will impact the quality and safety of 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:	NA						
Clinical and Professional Engagement:	Clinical colleagues are leading and supporting the recruitment delivery plans.						
Risk and Assurance:	Links to the corporate risk register for workforce availability.						

Coventry and Warwickshire Integrated Care Board

Enc G

Executive Summary

1. Key points and purpose

The purpose of this report is to inform the Integrated Care Board of the key issues relating to retaining and growing the health and care workforce in Coventry & Warwickshire.
Ensuring that there is a robust pipeline of skilled workforce, having great experiences at work supports the delivery of all four of the ICB outcomes.
The board has previously asked to understand the scale of the recruitment challenges facing the system and in particular what action is being taken to address them. This report therefore brings some of the data from the appendix to illustrate the challenges.

2. Items for noting by the board – Workforce numbers

For context purposes we have included a broad summary of numbers.

C&W Workforce Numbers	WTE
NHS Trust Providers	18,869.02
Primary Care	2,091.00
Adult Social Care*	23,500.00
ICB	331.32
Total workforce	**44,791.34**

2.1. NHS Trusts -Nursing workforce

- The Nursing workforce grew by 4.69% (255 WTE) in 2021/2. M3 2022/3 workforce is 5672 WTE.
- Adult Nursing staff in-year growth of 0.38% (21 WTE). Currently 3634 WTE.
- Midwifery staffing is stable at 490 WTE, with a vacancy rate of 47.6 WTE.
- Nursing growth is primarily attributable to international recruitment.

2.2. Key risks

- Vacancies within trusts reduced by a total of 14 WTE in 2021/2 despite significant nursing workforce growth, this deviation was due to establishment changes.
- The system has a planned growth of 456 WTE for 22/23
- The current nursing vacancies across the system are **749** WTE of which Adult Nursing are **450** WTE and Mental Health nursing vacancies are **122** WTE.
- Coventry University are recruiting widely to nursing programmes and in particular driving local recruitment to ensure conversion into employment within Coventry and Warwickshire.

2.3. Mitigation - Project 1000

The Chief Nursing Officers and Chief People Officers with representation from primary and social care have agreed a programme of work to eliminate adult nursing vacancies through recruitment and retention of 1000 nurses by 2026. This is an ambitious target and the approach has the following streams of activity.

2.3.1. Placement capacity/ Education transformation

Student nurse placement capacity has increased by circa 150 places in 2021/2. To date previous placement expansion has not resulted in increased numbers of newly qualified nurses due to NQN's returning to their hometown/city.
A joint nursing event took place at Coventry University bringing together Trusts, primary & Social Care nursing leads with the University and student representatives to plan towards increasing capacity & local recruitment. This is being taken forward in three workstreams, each with a Chief Nurse as an SRO: Education transformation, Recruitment and Retention. Partnerships with other adjacent universities are also being explored.

2.3.2. **Recruitment –** The development of a proactive recruitment campaign to market all nursing and entry level nursing routes to Coventry and Warwickshire and surrounding areas commenced in August with extensive social media posting and an open day event to attract applicants to nursing degree courses starting in September 2022. This received coverage in local media and the Nursing Times and has shaped the future delivery of such events.

2.3.3. **International recruitment** - International recruitment continues to be a core part of recruitment activity. Trusts have built a coherent offer to international recruits that includes education, training and pastoral support. Trusts are also supporting overseas trained nurses working in the NHS in non-registered nursing roles to pass their English Language assessments.

2.3.4. **New roles, new pathways and skills mix** -Each Trust has developed a plan that enables entry a range of entry points for new recruits, some examples of which are detailed below:

- Apprentice Nurse Associate – open to new and existing staff including health care assistants to train towards Band 4 Nursing Associate role
- Top-up – open to qualified Nursing Associate to train towards a Nursing degree
- Apprentice Nurse – A four year course to registered nurse

These roles are attractive to candidates as they offer the opportunity to earn and learn. However, places are limited due to the additional costs to employers, unlike the traditional undergraduate route.

Qualified nursing Associate roles are now being built into establishments as part of the registered staffing.

2.3.5 **Retention -** Coventry & Warwickshire has led the national pilot of the Nursing retention self-assessment toolkit. This toolkit has now been launched as part of wider retention resources. The aim is to determine priorities for retention and optimise retention opportunities. This toolkit will be used alongside a refreshed preceptorship programme for early career nurses and legacy mentoring to support late career nurses to extend their career. Coventry & Warwickshire will also focus on student experience, identified through the workshop.

3. NHS Allied Health Professional workforce

3.1. The AHP workforce grew by 2.5% (35 WTE) in 2021/2. Workforce at M3 is standing at a total of 1468 WTE. The vacancy rate is currently - 97 WTE

3.2. Key risks to note

The demand for elective recovery and Community Diagnostic Centres requires us to grow our **diagnostic radiography capacity**, current establishment is 273 WTE with 29 FTE vacancies.
Occupational Therapy reported as 288 WTE with a vacancy figure of 17 WTE
Operating Department Practitioners reported as 135 WTE with 19 WTE vacancies

3.3. Mitigation

- The AHP Faculty program is aiming to boost placement capacity and student experience thus supporting our newly qualified recruitment; efforts to improve retention within system include;
- Imaging Academy to boost imaging training
- Diagnostic radiography course introduced at Coventry University
- International recruitment funding secured for 30 diagnostic radiography and 15 Occupational Therapy.

4. NHS Medical Workforce

The Medical workforce grew by 3.8% (76 WTE) in 2021/2 and at M3 stands at 2072 WTE. There are vacancies in medical workforce at both consultant and junior roles across the system. Whilst vacancy numbers in specialist areas may be low, the vacancies may be significant due to speciality and fragility (e.g. psychiatry, paediatrics, pathology, radiology etc)

5. Administration & Clerical Workforce

As the economy rebuilds following covid, all employers are experiencing difficulties in recruiting administration staff. As major employers we are planning a recruitment event in October to attract the local population to health and care entry level administration roles. The aim is to make this as inclusive and straightforward as possible with a simplified application route and recruitment decisions made on the day.

6. Primary Care workforce

6.1. The primary care workforce numbers stand at 2109 WTE. Vacancies are not captured in system data reporting and this is being corrected via the training hub, there are however known risks with recruitment and retention.

6.2. Key risks

The numbers of GPs in post (excl Registrars) has reduced by 1.5% and nursing staff has decreased by 0.7%. Of note is that 29.4% of the primary care workforce are within the 55 & over age group with a high expectation of retirement.

6.3. Mitigation

The GP retention programme is very comprehensive and includes support at the beginning, end and mid-career points.
The Nursing strategy has recently been developed and the work to increase system nursing will reduce vacancies in primary care.
The implementation of additional (ARRS) roles to provide wider professional support in primary care is progressing well and the ambition remains to achieve 556 WTE.

7. Adult Social Care workforce

7.1. Key risk

The risks in social care are well known and nationally reported on and greatly impact the flow of patients across the system. The vacancy rate in the West Midlands is 10.7%, and has gone up by 3.7% since March 2021 with similar levels of vacancies for nurses, care assistants and registered managers. The positions for Coventry and Warwickshire are slightly nuanced in that the risks for Warwickshire are in the provision of home care support and for Coventry it is staffing within care homes.

7.2. Mitigation

Local authorities, with some central government funding, have provided extensive support to recruitment and education of care staff and we are working with Skills for Care in the provision of system wide development opportunities.

8. Workforce Wellbeing

8.1 NHS Absence risk

Keeping our staff well and supporting them in the work environment has become increasingly critical both in workforce availability and retention. We can see continued growth in sickness linked to burnout and exhaustion.

- Sickness Absence – The 12 month rolling Sickness Absence has an increasing trend at M3 within the range of 5.5-6.99%.
- Turnover has also been increasing and is above 10% across all Trusts. Current range 11-15%.
- Cost of living – The impact of cost of living increases in cost of living, NHS pay rises and increase in pension contributions is adversely affecting peoples' wellbeing. See separate paper for discussion

8.2 Mitigation - All employers have a full wellbeing programme and absence management plans in place. Proposals to extend support associated with cost of living are included in the agenda.

9. Conclusion

The health and care workforce continues to face significant challenges both in recruitment and retention. Wide-ranging action plans are in place to grow the supply and support staff to stay with us. It should be noted that these risks are further compounded by the cost of living crisis and potential industrial action.

10. Recommendation

The Board is asked to note the scale of the recruitment and retention challenges and support the actions described to mitigate these key risks.

11. End of Report

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Pack 1

Coventry and Warwickshire
Integrated Care System

The Fuller Stocktake

Alison Cartwright

Chief Delivery and Performance Officer

Context

NHS Long Term Plan

January 2019

We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services. As part of a set of multi-year contract changes individual practices in a local area will enter into a network contract, as an extension of their current contract. The result will be the creation – for the first time since the NHS was set up in 1948 – of fully integrated community-based health care.

Framework for GP Contract Reform

January 2019

Primary Care Networks are an essential building block of every Integrated Care System. **PCN Clinical Directors will play a critical role in shaping and supporting their Integrated Care System and dissolving the historic divide between primary and community services**. The success of a PCN will depend on the strength of its relationships, and in particular the bonds of affiliation between its members and the wider health and social care community who care for the population

ICS Design Framework

June 2021

PCNs play a fundamental role improving health outcomes and joining up services. They have a close link to local communities, enabling them to identify priorities and address health inequalities. **PCNs will develop integrated multidisciplinary teams** that include staff from community services and other NHS providers, local authorities and the VCSE sector to support effective care delivery. Joint working between PCNs and secondary care will be crucial to ensure effective patient care in and out of hospital

Integration White Paper

February 2022

GP practices are already working together with community health services, mental health, social care, pharmacy, hospital and voluntary services in their local areas in PCNs. They are enabling greater provision of proactive, personalised, coordinated and more integrated health and social care for people closer to home. Dr Claire Fuller [has been asked] to lead a stocktake of how systems can enable more integrated primary care at neighbourhood and place, making an even more significant impact on improving the health of their local communities.

Overview

- The Fuller Stocktake was commissioned by NHS England (NHSE) Chief Executive Amanda Pritchard in November 2021.
- Context as set out on **Slide 2** – overarching purpose of the Stocktake to review and make recommendations as to how each Integrated Care System can:
  - Accelerate implementation of the primary care, out of hospital and prevention ambitions in the NHS Long Term Plan;
  - Drive more integrated primary, community and social care services at a local level.
- Report was submitted to NHSE alongside a letter of support signed by all 42 Integrated Care Board Chief Executives, which recognised that the stocktake:
  - Challenges all systems to rethink their approach to change in primary care;
  - Gives every system *"a clear vision of where we are going and a clear framework for what now needs to happen";*
  - Will require *"really significant support"* from systems, NHSE and the Department for Health and Social Care (DoH) if it is to be implemented successfully on local footprints.
- The letter concludes with a commitment from all systems to take forward the actions in the Stocktake report.

https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

Approach

In Scope?

- What is working well?
- Why is it working well?
- In the above context, how can the implementation of integrated primary care be accelerated as ICSs move on to statutory footing?

Out of scope?

- The partnership model.
- The GP contract.
- The national funding formula for general practice.

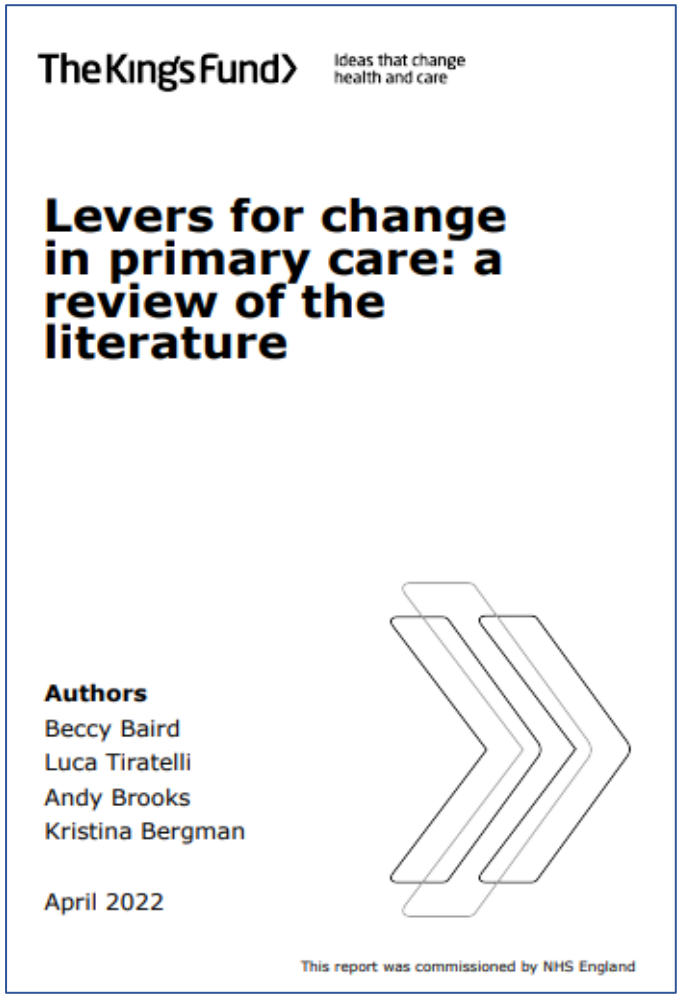
How?

- Engagement with circa 1,000 people directly through workstreams, round tables and one to one meetings.
- Dedicated online engagement platform which attracted over 12,000 individual visits.
- Over 1.5 million Twitter impressions of **#FullerStocktake**.

What?

- Broad consensus on:
  - What's not working well – access and continuity;
  - What is working well;
  - What needs to be done differently, harnessing the opportunities that Integrated Care Systems bring – see **Slide 8**.

Approach



- Alongside the Stocktake report NHSE commissioned the King's Fund to undertake a literature review setting out *"the evidence base for what actually works when it comes to driving change and improvement in primary care".*
- The report makes the case for an approach to change built around four principles:
  - Changes work best when they are driven from the bottom up;
  - Financial incentives and targets can distort priorities;
  - The 'soft' stuff is important;
  - People need capacity and capability to make change happen.
- Under each of the four principles the King's Fund has identified a series of actionable ideas for general practice and for ICSs.

https://www.kingsfund.org.uk/sites/default/files/2022-05/Levers-change-primary-care-literature-review.pdf

Output

A new vision for **integrating primary care** and **improving access, experience and outcomes** for communities centred around three offers:

Streamlining access to care and advice…	for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it.
Providing more proactive, personalised care…	with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions.
Helping people to stay well for longer…	as part of a more ambitious and joined-up approach to prevention.

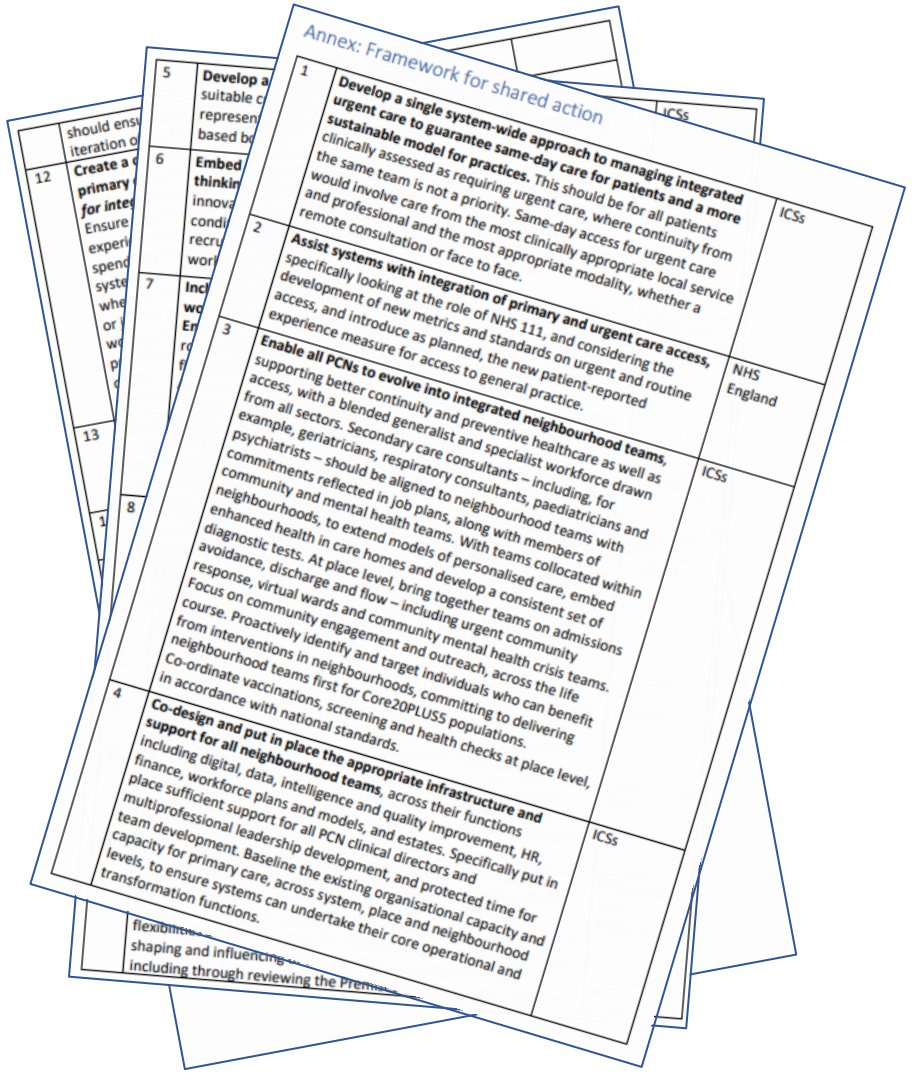
Alongside an overarching conclusion that **primary care must be at the heart of** and **is fundamental to the delivery of the four core purposes of each Integrated Care System.**

Output

1. Enable PCNs to evolve into integrated neighbourhood teams with shared ownership for improving health and wellbeing.
2. Work with local people and communities to tackle ill health.
3. Primary care workforce should be an integral part of system and national level strategy.
4. System wide approach to single integrated urgent care pathway.
5. Create a clear development plan to support primary care sustainability
6. Improve data flow and embed digital transformation in holistic care.
7. System wide estate plan to support fit-for-purpose buildings.
8. System leadership to become driver of primary care improvements.
9. Legislative, contractual, commissioning and funding frameworks.

https://www.carnallfarrar.com/next-steps-for-integrating-primary-care-fuller-stocktake-report/

Output



- The report concludes with a **Framework for Shared Action** incorporating 15 recommended action areas – 8 of which apply to ICSs, with the others being for NHSE and/or DHSC and/or Health Education England.

- Key areas of focus for ICSs are:
  - The development of so-called **Integrated Neighbourhood Teams** – the *"teams of teams"* which need to evolve from PCNs and which are identified by ICB Chief Executives in their supporting letter as the *"golden thread"* tying the report together;
  - Putting in place a clear delivery plan to translate the **Framework for Shared Action** into reality within the ICS footprint.

- Left as it is, the Stocktake concludes that *"primary care as we know it will become unsustainable in a relatively short period of time"* – the call to action in the Stocktake report is therefore an urgent one, with the formal establishment of Integrated Care Systems seen by Dr Fuller as creating *"a moment of real opportunity"* that must be seized.

Coventry and Warwickshire
Integrated Care System

Reception

“Today's report is appropriately ambitious given the scale of the crisis in general practice. It shares a number of key aspirations with the College about the future of general practice, and how general practice fits within the new ICS structures and the wider NHS – and the College looks forward to working with partners to help make it a reality.”

Royal College of General Practitioners

“It is positive to see this report recognise and champion the invaluable part that practices play in the health of their local areas, and why it is so vital that general practice is given a leading voice and role when it comes to overhauling health systems locally. With the NHS undergoing significant changes, it is vital that high-quality general practice is able to thrive, collaborating with colleagues as part of the wider system to deliver and meet the needs of patients.”

British Medical Association

“This review must be a watershed moment for establishing primary care as an integral part of local systems, working across boundaries to deliver population-based care, and a demonstration of the benefits of the integration agenda.”

NHS Confederation

“Trust leaders will welcome the findings of the Fuller ‘stocktake’ which sets out how primary care can work with partners across health and care to best meet the needs of their local communities. The welcome focus in the stocktake on creating neighbourhood teams to offer continuity of care and support those with complex, ongoing health needs is essential and will help to tackle the health inequalities which have been exacerbated by the Covid-19 pandemic.”

NHS Providers

NHS England Response

- NHSE's business plan for the remainder of 2022/23, published on 8 August 2022, signals NHSE's intention to:
  - Develop a national implementation plan for the Stocktake report;
  - While at the same time seeking to achieve a number of identified *"quick wins"* relating to improving access to primary care.

- Dr Amanda Doyle, Director of Primary and Community Care, will take on the role of SRO for the Fuller Stocktake/ NHSE implementation plan for NHSE.

- Locally the NHS England Midlands Primary Care Team is planning to convene a workshop to look at Fuller implementation in September/October – part of the focus will be on sharing the Team's support offer to systems around the **Framework for Shared Action**.

- The Midlands Primary Care Transformation Board will act as a key forum for engagement between systems and NHSE on the Stocktake report.

- The assurance approach that will be taken by NHSE in relation to the implementation of Fuller is likely to become clearer over the remainder of this year.

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1733_Our-2022-23-Business-Plan_July-2022.pdf

Next Steps in C&W

- The Stocktake report itself and the King's Fund evidence review offer each ICS a clear vision in terms of integrating primary care and a 'toolkit' to drive that vision.

- In terms of the approach that needs to be taken in relation to implementing the Stocktake report locally there are a couple of key messages:

1. ***The Stocktake report is about system change not primary care change so implementing it must be and be seen as a system effort not a primary care effort.***

   As they presented the Stocktake report to the NHS England Board on 19 May 2022 Amanda Pritchard observed that implementing Fuller presents *"a real moment for [systems] to get around primary in a different way."* Dr Claire Fuller emphasised that the change that needs to happen is *"bigger than primary care".*

2. ***Systems need to take a 'with' not 'to' approach to working with primary care on implementing the Stocktake report.***

   The Stocktake report is clear that primary care leadership must be embedded throughout every ICS and, more specifically, primary care leaders must be enabled to play a key role in driving the implementation of Fuller. Developing a primary care forum at system level is one of the identified actions in the **Framework for Shared Action** – in Coventry and Warwickshire we began working with leaders from within general practice on the formation of a system-wide Primary Care Collaborative during the spring of this year. The new Collaborative met for the first time in July.

https://www.england.nhs.uk/publication/video-of-the-nhs-england-and-nhs-improvement-board-meeting-in-common-19-may-2022/

Next Steps in C&W

Today we are asking the ICB the following:

- To reiterate Coventry and Warwickshire ICB's commitment to implementing Fuller.
- To agree that the implementation of the Fuller Stocktake requires a system response which will support the delivery of the key aims of the ICB.
- To note that a single system programme approach to the implementation of Fuller in Coventry and Warwickshire, with development and oversight of the local delivery plan to translate the **Framework for Shared Action** sitting at system level – albeit that actions within the plan will sit at different spatial levels of our system (system, Care Collaborative, Place, PCN, etc) and link to other existing programmes and plans. Progress will be overseen by the Commissioning Committee.
- To note that the Coventry and Warwickshire Primary Care Collaborative will take a leadership role in relation to local implementation of Fuller for primary care.

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Report Title:	Coventry and Warwickshire's All Age Autism Strategy Update
Report From:	Rachel Jackson, Lead Commissioner for Vulnerable People and Communities, Warwickshire County Council Michelle Cresswell , Senior Joint Commissioner for Disabilities and Autism, Warwickshire County Council
Author:	Amy Danahay, Interim Autism Strategy Programme Lead, Warwickshire County Council
Previous Considerations and Engagement:	Coventry and Warwickshire's All Age Autism Strategy Partnership Board (24 August 2022) Learning Disabilities and Autism Executive Board (8 September 2022)
Purpose:	For information

Contribution to meeting the aims of the ICS:
The Autism Strategy will enable and contribute to all the four core aims of the ICS and, as the strategy is enabled and embedded, it has the potential to support the achievement of all ICB Priorities. The ICS vision of a whole person, whole life approach, with a greater emphasis on proactive and preventative activity, underpins all Autism Strategy activity. • Improving outcomes in population health and healthcare: The strategy will enable autistic people to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents. • Tackling unequal outcomes, experience, and access: A Joint Strategic Needs Analysis for Autism and ADHD, completed in 2019 highlighted the inequalities in health, education and social outcomes of autistic people compared to non-autistic groups for almost all conditions studied including mortality, self-harm, suicide, obesity, smoking, bullying, social isolation, education, criminal justice, employment and homelessness. 80% of autistic adults and 70% of autistic children and young people will experience a mental health condition including anxiety or depression and there is more to be done to reduce the numbers of autistic people admitted to mental health hospitals. • Enhancing productivity and value for money: Promoting prevention and early intervention and making all existing services and pathways of support more accessible and effective for autistic people will be informed by outcomes-based commissioning and supporting finance models. • Supporting the broader social and economic development of C&W: The strategy supports a holistic model of care, which embraces the wider determinants of health.

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Contribution to meeting the priorities of the ICB:
The content of the paper and recommendations meet and provides the potential to support the following 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
Recommendation:
Members are requested to • NOTE FOR INFORMATION progress outlined within this report and contained within the highlight report (appendix one) and minutes presented to the Autism Partnership Board on the 11 August 2022 (Appendix two). • NOTE FOR INFORMATION the overall Autism programme status as rated as amber with progress made but some minor concerns. • ACKNOWLEDGE the concerns relating to the programme status and links to the risks for the programme. • NOTE FOR INFORMATION the governance approach approved by the LDA Executive Board on 8 September 2022.

Implications							
Conflicts of Interest:	None						
Financial and Workforce:	Financial implications are included within the supporting appendices. There is a gap in recurrent funding to support the strategy.						
Performance:	Monitoring and evaluation is overseen within the existing LDA Governance.						
Quality and Safety:	None						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached – appendix three)	✓	**No**		**N/A**	
Patient and Public Engagement:	This strategy is informed by a range of co-production and mapping activity undertaken to build a shared understanding of the experience of autistic people of all ages and their families and carers in accessing support appropriate to their needs and getting a formal diagnosis of autism. A robust co-production approach will be used throughout all stages of Strategy delivery to ensure that we build on strengths,						

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<table>
<tr><td></td><td>experience, and voice of individuals with direct experience of using health and social care services in supporting them in relation to autism related needs. Parent and carers will be equally supported and will be recognised as experts in experience.</td></tr>
<tr><td>Clinical and Professional Engagement:</td><td>
<table>
<tr><th>Name</th><th>Role</th><th>Organisation</th></tr>
<tr><td>Rachel Jackson</td><td>Chair/ Lead Commissioner - Vulnerable People</td><td>WCC</td></tr>
<tr><td>Amy Danahay (temporary until August)</td><td>Programme Manager</td><td>WCC</td></tr>
<tr><td>Gorgeous Thompson</td><td>Administrator /Commissioning Support Officer</td><td>WCC</td></tr>
<tr><td>Marie Rooney</td><td>Head of SEND and inclusion and education entitlement</td><td>WCC</td></tr>
<tr><td>Jeanette Essex</td><td>Head of SEND and Specialist Services</td><td>CCC</td></tr>
<tr><td>Sarah Reilly</td><td>Adult Social Care and Support (also representing childrens)</td><td>CCC</td></tr>
<tr><td>Sally Caren</td><td>Adult Social Care and Support (also representing childrens)</td><td>CCC</td></tr>
<tr><td>Pawlina Clemons</td><td>Service Manager - Disabilities</td><td>WCC</td></tr>
<tr><td>Michelle Cresswell</td><td>Senior Integrated Commissioning Manager</td><td>WCC, CCC, CCG</td></tr>
<tr><td>Jane Grant</td><td>Housing</td><td>NBBC</td></tr>
<tr><td>Dr Shade Agboola</td><td>Director of Public Health</td><td>WCC</td></tr>
<tr><td>Allison Duggal</td><td>Director of Public Health</td><td>CCC</td></tr>
<tr><td>Adam Phillips</td><td>Finance Lead</td><td>ICB</td></tr>
<tr><td>Samuel Keong</td><td>General Manager – Community Learning Disabilities and Neurodevelopment</td><td>CWPT</td></tr>
<tr><td>Ashok Roy</td><td>Consultant Psychiatrist and Associate Medical Director</td><td>CWPT</td></tr>
<tr><td>Dr Elizabeth Shea</td><td>Consultant Clinical Psychologist, Neurodevelopmental Services</td><td>CWPT</td></tr>
<tr><td>Helen Harban</td><td>Children’s Speech and Language Therapist</td><td>SWFT</td></tr>
<tr><td>Karen James</td><td>Provider Collaboratives</td><td>CWPT</td></tr>
<tr><td>Adrian Hutchins</td><td>Transformation Programme Manager</td><td>CWPT</td></tr>
<tr><td>Julie Brotherton</td><td>General Manager</td><td>SWFT</td></tr>
</table>
</td></tr>
</table>

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	<table><tr><td>Dawn Kimberley</td><td>OT Lead</td><td>SWFT</td></tr><tr><td>Sumi Subramaniyan</td><td>Consultant</td><td>SWFT</td></tr></table>
Risk and Assurance:	Risks relate to future delivery as a result of non-recurrent funding allocations and the achievement of the Autism assessment and diagnosis waiting list There is a risk register that is regularly reviewed with assigned risk owners.

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NHS
Coventry and Warwickshire
Integrated Care Board

Executive Summary

Coventry and Warwickshire's All-Age Autism Strategy sets out the intention and ambition for key statutory organisations, in improving lives of Coventry and Warwickshire citizens living with autism, and their parents and carers. It emphasises that all partners will be equally responsible and accountable for the delivery of this strategy.

The Autism Strategy contributes to all the four core aims of the ICS and, as the strategy is enabled and embedded, it has the potential to support the achievement of all ICB Priorities. The ICS vision of a whole person, whole life approach, with a greater emphasis on proactive and preventative activity, underpins all Autism Strategy activity.

The Autism Partnership Board has been established to oversee delivery of the strategy, providing strategic assurance to the Learning Disabilities and Autism (LDA) Executive Board.

This report provides an overview of the Autism Strategy progress and includes draft minutes from the Autism Partnership Board, a recent highlight report presented to the Learning Disabilities and Autism (LDA) Executive Board members, and minutes, whereby it was recommended that this and future assurance reports are submitted to the Integrated Care Board (ICB) for information and assurance.

1. Why we need the Autism Strategy

1.1 Autism touches the lives of many people living in Coventry and Warwickshire and can affect many aspects of life, from school to healthcare to employment, housing and social lives. As such, this Strategy takes an all age and whole life approach and encompasses children, young people, adults, older adults and their parents and carers with the following vision:

Autistic people and their families are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents.

1.2 Being autistic does not mean you have an illness or a disease. It means your brain works in a different way from other people. Autism is not a medical condition with treatments or a "cure", but autistic people often need support to varying levels across four main areas: social communication, social interaction, social imagination, and sensory processing. There are positive aspects to autism including attention to detail; an ability to focus deeply and avoid distractions; keen observation skills; an ability to absorb and retain facts, linked to high levels of expertise in particular topic areas; unique thought processes and creativity leading to innovative solutions; tenacity and resilience; and integrity and honesty.

1.3 It is recognised that not all autistic people require support, and that many lead independent and fulfilled lives without any help from specialist statutory or community services. This strategy builds on existing skills and capabilities of autistic people and advocates for a strength based and person-centred approach.

1.4 The joint five-year strategy is owned by Warwickshire County Council, Coventry City Council, NHS Coventry and Warwickshire ICB and Coventry and Warwickshire Partnership Trust and has been informed by a range of co-production and mapping activity undertaken to build a shared understanding of the experience of autistic people of all ages and their families and carers in accessing support appropriate to their needs and getting a formal diagnosis.

1.5 The Autism Strategy contributes to all the four core aims of the ICS and, as the strategy is enabled and embedded, it has the potential to support the achievement of all ICB Priorities. The ICS vision of a whole person, whole life approach, with a greater emphasis on proactive and preventative activity, underpins all Autism Strategy activity.

1.6 This strategy incorporates the statutory duties outlined in the Autism Act, Care Act, Children and Families Act and the NHS Long Term Plan and builds on the previous Warwickshire All Age Autism Strategy (2014 -2017) 'Fulfilling & Rewarding Lives' and the joint commissioning plan developed by Warwickshire County Council and Coventry City Council in 2017.

1.7 Based on the evidence base gained through the coproduction and research activity, as well as statutory responsibilities for partner organisations, five priority areas were identified, and a number of objectives developed against each priority underpinned by a delivery plan that requires further development to focus on place and delivery within the local context of services and support.

1.8 This report provides an overview of the Autism Strategy progress and includes draft minutes from the Autism Partnership Board, a recent highlight report presented to the Learning Disabilities and Autism (LDA) Executive Board members, and minutes, whereby it was recommended that this and future assurance reports are submitted to the Integrated Care Board (ICB) for information and assurance.

2. Autism Programme Status

2.1 The overall Autism programme status is rated as amber[i] with progress made but some minor concerns.

2.2 A review of the year one Delivery Plan highlighted significant progress to achieve the shared vision of the Coventry & Warwickshire Joint Strategy for Autistic people 2021-

2026. There were also notable gaps and concerns relating to funding and the current Autism assessment and diagnosis waiting list challenge.

See table 1 for an overview of progress against each priority.

	Priority 1: Support autistic people and people with social, communication and emotional health needs to help themselves pre and post diagnosis
	Priority 2: Reduce inequalities for autistic people and make Coventry and Warwickshire autism friendly places to live
	Priority 3: Develop a range of organisations locally with the skills to support autistic people
	Priority 4: Develop the all age autism specialist support offer
	Priority 5: Co-produce, work together and learn about autism

2.3 Significant system investment of over £10m has been committed over the next two years to reduce the back log of assessments, deliver timely diagnostic assessment, and deliver improved pre assessment and post diagnostic support for children and adults. The additional funding is enabling us to increase capacity for diagnostic assessments and post diagnostic support to meet demand. We are working closely with Coventry and Warwickshire Partnership NHS Trust to reduce the longest wait for a diagnostic assessment to 13 weeks, by March 2024

2.4 Further detail is provided in Appendices 1 and 2, recent highlight report submitted to the Autism Partnership Board on 24 August 2022 including minutes.

2.5 Members of both the Autism Partnership Board and subsequently the LDA Executive Board, were sufficiently assured by programme progress, acknowledging the significant amount of work required, commitment from all key stakeholders to deliver, and the risks to delivery of the strategy.

3. Governance

3.1 There are system leads overseeing the development of each of the 5 priorities of the strategy and all leads are members of the Autism Partnership Board. The Chair of the Autism Partnership Board is also a member of the LDA Executive Board.

3.2 The Coventry & Warwickshire LDA Executive Board are due to receive a Governance paper on 8 September 2022 with recommendations for embedding the LDA programme within the ICB governance.

3.3 The Learning Disabilities and Autism (LDA) programme continues to be a priority for the new Coventry & Warwickshire Integrated Care Board.

4. Autism Strategy Next Steps

4.1 The review of year one's Delivery Plan is informing the production of the 2022-2024 delivery planning. Work continues to understand and scope recurrent and non-recurrent funding to support delivery of the strategy, in partnership with finance and system priority leads.

4.2 The following events will continue to inform, shape and develop the implementation of the Autism Strategy:

- Shaping the Future for Autism and ADHD for Coventry and Warwickshire – 22 September 2022 and 12 October 2022
- Together with Autism Conferences – 10 September 2022 and 19 November 2022

Conclusion

This a joint strategy between key statutory organisations, all partners will be equally responsible and accountable in improving lives of Coventry and Warwickshire citizens living with autism, and their parents and carers.

The All-Age Coventry and Warwickshire Autism Partnership Board have responsibility for overseeing the delivery of this strategy and receive highlight reports on progress that will be feed into the wider LDA governance, LDA Executive and ultimately NHS Coventry and Warwickshire's ICB.

The Autism Strategy is now driving the underpinning delivery plan, but further work is required to adequately resource further implementation and development of work across the five years.

Key areas of priority and investment are not without their challenges, but progress is being made against the autism waits but this will require ongoing support, monitoring and differentiated models that will improve access to support and formal diagnosis in the future.

Recommendation

ICB members are requested to:

- NOTE progress outlined within this report and contained within the highlight report and minutes presented to the Autism Partnership Board on the 24 August 2022 and LDA Executive Board on the 8 September 2022 (Appendix 1 and 2).
- NOTE the overall Autism programme status as rated as amber with progress made but some minor concerns.
- ACKNOWLEDGE the concerns relating to the programme status and links to the risks for the programme.
- ENDORSE the recommendations for embedding the LDA programme within the ICB governance.

End of Report

[i] The RAG status used for reporting purposes is below:

Not on target, significant concerns
Progress made, minor concerns
On target, no concerns
Completed

This RAG rating is also used to update against progress on the Autism Delivery Plan.

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Integrated Care Board

Enc J

Quality Safety and Experience Committee Report for the meeting held on 26 July 2022		
Key Information		
Committee Chair: Pamela Bradbury	**Committee Executive Lead:** Rebecca Bartholomew	**Date of Next Meeting** 23 August 2022
Quoracy met?	**Yes**	
Purpose of the report	For **ASSURANCE** in respect of key decisions taken/issues raised at the 26 July 2022 Quality Safety and Experience Committee meeting.	
Recommendation	Members are requested to be **ASSURED** in respect of the matters set out within this report.	

Key highlights of discussions and decisions held during the meeting:	
Agenda item description & key discussion points	**Assurance achieved and sources / Gaps in assurance and action agreed**
Committee Terms of Reference	NOTED.
Committee Schedule of Business	APPROVED with ACTION AGREED for the incoming Chief Nursing Officer, Committee Chair and Chief Medical Officer to review the schedule to ensure it covers the developing remit of the Committee. Any suggested changes to be presented to the October meeting of the Committee.
ICB Risk Register - Supporting people with Leaning Difficulties and/or Autism in the community. - Mobilising a robust service to support children in a mental health and/or an emotional crisis. - Continuing shortage in the provision of bedded placements and domiciliary care in Warwickshire. - Maturity of system, governance and assurance arrangements in place to monitor and drive delivery of Ockenden. - Providing alternatives to admission and facilitating timely discharge for those with Acute mental Health problems.	ACTION AGREED to move the risk relating to cancer referrals to the Finance and Performance Committee. ASSURANCE achieved regarding mitigating actions in place for all other risks assigned to this Committee.

- Utilising capacity and manging cancer referrals to reduce waits for diagnosis and treatment.	
Clinical Quality and Governance Committee Legacy document Key points included: - Key achievements made during 2021/22. - Key Risks and Mitigations relating to the remit of the Committee. - Reflections of good practice/lessons learned. - Actions issues for handover.	NOTED and ACTION AGREED for a piece of work to be undertaken around the Ockenden risks and the Local Maternity and Neonatal Service (LMNS) to triangulate governance arrangements which will then feed into the existing LMNS governance arrangements. ACTION AGREED for the current LMNS governance arrangements to be reviewed when the new Chief Nursing Officer commences in post and within their first two months.
Handover of outstanding issues from Due Diligence (DD) submission - DD evidence presented and confirmation received of submission to NHS England on 30 June 2022. The submission outlined the governance process ensuring all areas of the previous CCG work were safely transitioned to the ICS.	NOTED.
System Quality Group Update - Verbal update on System Quality Group (SQG) meeting of 18 July 2022 where ideas for future meetings of SQG were captured. - Chief Nursing Officer to chair SQG going forward.	NOTED.
Health and Care Act (2022): Safeguarding Duties Within the Integrated Care Board - Duties outlined.	ASSURANCE achieved that the safeguarding duties and processes aligned to these duties were already in place to comply with the requirements of the Act.
Ockenden – One Year On - Summary of the submission by the LMNS in conjunction with providers, George Eliot Hospital, South Warwickshire NHS Foundation Trust and University Hospitals Coventry and Warwickshire to NHS England. - Programme of work had progressed since report was circulated and therefore, Committee required a further up-to-date report to be able to consider whether or not to endorse the recommendations : o In line with supporting staff members and the Ockenden Final report, the	DISCUSSED and ACTION AGREED for more information to be provided.

	ICB should consider implementing system level Freedom to Speak Up Guardians. o The ICB seeks assurance from providers on the impact of a new Digital system on Maternity and its ability to meet Ockenden and Clinical Negligence Scheme for Trusts.	

Items for escalation to Board:		
Item or issue	**Purpose for escalation**	**Escalated to**
None		

Items referred to the Board for Consideration/Approval
None

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Integrated Care Board

Enc J

Quality Safety and Experience Committee Report for the meeting held on 23 August 2022		
Key Information		
Committee Chair: Pamela Bradbury	**Committee Executive Lead:** Rebecca Bartholomew	**Date of Next Meeting** 27th September 2022
Quoracy met?	**Yes**	
Purpose of the report	For **ASSURANCE** in respect of key decisions taken/issues raised at the 23 August 2022 Quality Safety and Experience Committee meeting.	
Recommendation	Members are requested to be **ASSURED** in respect of the matters set out within this report.	

Key highlights of discussions and decisions held during the meeting:	
Agenda item description & key discussion points	**Assurance achieved and sources / Gaps in assurance and action agreed**
ICB Risk Register - Supporting people with Leaning Difficulties and/or Autism in the community. - Mobilising a robust service to support children in a mental health and/or an emotional crisis. - Maturity of system, governance and assurance arrangements in place to monitor and drive delivery of Ockenden. - Providing alternatives to admission and facilitating timely discharge for those with Acute mental Health problems. - Report noted that the following risk had been removed from the Register to be managed locally: o Continuing shortage in the provision of bedded placements and domiciliary care in Warwickshire.	ASSURANCE achieved regarding mitigating actions in place for all other risks assigned to this Committee. ACTIONS AGREED: - social care market to be considered to see if there are any risks which should be added to the register; - update on work of system-wide risk group.
Safeguarding Assurance Report - Solihull Joint Targeted Area Inspections (JTAI) – Following a JTAI, a decision was then made to complete a quality assurance review for Coventry in July 2022 which resulted in recommendations that are being	ASSURANCE achieved that proportionate actions have been implemented to address the issues identified and mitigate identified areas of risks. ACTIONS AGREED:

progressed and monitored. One issue that came out of this review was that health mash representatives did not always contact GPs in relation to safeguarding, so this is being looked at and progress is already being made. A Warwickshire quality assurance view is due to be held in October 2022. - Ukrainian asylum seekers: The safeguarding teams both within the ICB and partner agencies are collating information and oversight of people from the Ukraine placed into area and ensuring that appropriate safeguarding education and monitoring is being delivered. - West Midlands Multi Agency Risk Assessment Conference (MARAC) Independent Review: There have been a range of recommendations proposed which are currently being reviewed across the system and managed through MARAC steering group and Domestic Abuse Board. - Levels of Safeguarding Activity data provided. - Safeguarding Training Compliance: An increase in compliance across all providers has been noted.	- update on safeguarding compliancy to be provided in report to next meeting; - report to be reviewed to consider what information is provided and how it should be presented.
Integrated Provider Reports: Trusts, Care Homes, other providers - Quality and Safety concerns identified as a result of a Care Quality Commission (CQC) Inspection to Brooklands Hospital site. West Midlands Ambulance (WMAS) increase in serious incident (SI) reporting. Local Maternity and Neonatal Service (LMNS) and Ockenden Review. - Whether or not an Equality and Quality Impact Assessment (EQIA) should be completed for some of the elements the report covers.	NOTED and ACTION AGREED for report authors to assess need for EQIA.
Integrated report inhouse services (including Referral Support Services (RSS), Prescription Ordering Direct (POD) and Continuing Healthcare (CHC) - CHC team workforce – In progress recruitment remains challenging. HR deep dive on recruitment and retention in progress. - No issues raised in respect of RSS or POD. - A discussion took place on which Committee(s) should have oversight of this	NOTED and ACTION AGREED to consider of report oversight and how services are held to account.

report and how internal services are held to account.	
Learning Disability and Autism (LDA) Assurance Report - The Learning from Lives and Deaths – People with a Learning Disability and Autistic People or 'LeDeR' team successfully transitioned to the new approach that came into effect from April 2022 and the LeDeR review target has been met. - The transforming care reduction of admissions with people with a Learning Disability has slipped slightly on some key targets. - Challenge in completing Care Treatment Reviews. Work underway to consider how data can be streamlined and to improve the situation. - The Annual Health Checks for people with a learning disability increased 25% on quarter one from last year. - Key Performance Indicators (KPI) schedule for the LDA Programme and quality impact. - Clinical commissioning capacity on quality linked KPIs.	NOTED.
Research - Three GP research champions funded by the National Institute for Health and Care Research and currently employed by the ICB up to end of October 2022. - The ICB acts as research governance sponsor for seven research studies. All are overseen by the Academic Research GP and ICB Quality Nurse and all are within timescale. - Two research proposals have been submitted and are awaiting confirmation of whether they have been successful. - A discussion took place on how research can be used within Coventry and Warwickshire and it was agreed to have a verbal update in 3 months.	NOTED and ACTION AGREED for an update on Research to be provided to within 3 months.
Escalation from: • Provider Quality Committee/Care Collaborative. • Safeguarding Children Partnership Executive Board.	ACTION agreed for escalation route to be confirmed by the next meeting of the Committee, with a verbal update provided.

• Safeguarding Adult's Board. • Local Maternity and Neonatal Service. • System Infection, Prevention and Control. • System Quality Group. • Mortality Oversight Group. No escalations were received however it was discussed that this may be due to arrangements not having been confirmed as opposed to their being none. Safeguarding Lead confirmed any safeguarding escalations would be captured by the report already presented.	

Items for escalation to Board:		
Item or issue	**Purpose for escalation**	**Escalated to**
None		

Items referred to the Board for Consideration/Approval
None

Enc K

Report Title:	Quality Report
Report From:	Tracy Pilcher, Chief Nursing Officer
Authors:	Rebecca Bartholomew Director of Nursing and Quality Jamie Soden, Director of Nursing and Transformation
Previous Considerations and Engagement:	Coventry and Warwickshire CCG, Quality, Safety and Experience Committee 23rd August 2022 – item 2.3
Purpose:	For information and noting

Contribution to meeting the aims of the ICS:
The Quality programmes of work across the system support the delivery of the four aims of the ICS in ensuring out population experiences safe, effective, value for money providing a positive experience. The surveillance and triangulation of the clinical outcomes for our population inform our escalations and actions. They provide valuable information for the planning of future services to move towards a population prevention agenda thus supporting broader health and social development.
Contribution to meeting the priorities of the ICB:
This paper seeks to contribute to improving outcomes in population health and healthcare by highlighting areas of quality where system quality concerns suggest management assurance systems may not be operating effectively. This includes seeking assurance that system management systems are effective in order to ensure unequal outcomes, experience and access are identified and addressed in a timely way for our population.
Recommendation:
Members are requested to **NOTE FOR INFORMATION**

Implications	
Conflicts of Interest:	Not applicable
Financial and Workforce:	Identified workforce issues in the Transforming Care Programme component of Learning Disability and Autism and implementation of Ockenden recommendations
Performance:	Transforming Care Programme component of LDA, performance is slightly above trajectory in both adults and Children and Young people (CYP) cohorts.

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Quality and Safety:	The quality programmes of work continue to triangulate quality indicators, experience and effectiveness,						
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:	System Quality Group has achieved good engagement in order to further develop the system quality strategy						
Risk and Assurance:	Any risks identified are identified on the system risk register						

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Integrated Care Board

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Executive Summary

1.1 Key points and purpose

The purpose of this quality report is to inform the NHS Coventry and Warwickshire Integrated Care Board of the key areas of importance and note within Quality.

The Quality programmes of work across the system support the delivery of the four aims of the ICS in ensuring out population experiences safe, effective, value for money providing a positive experience. The surveillance and triangulation of the clinical outcomes for our population inform our escalations and actions. They provide valuable information for the planning of future services to move towards a population prevention agenda thus supporting broader health and social development.

2. Items for noting by the Board

2.1 Learning Disability and Autism (LDA) Programme

The ICB and Coventry and Warwickshire Partnership Trust (CWPT) teams continue to work together to harmonise systems and processes across the Coventry and Warwickshire system to further enhance the delivery of personalised and supportive care to the population we serve. Working towards delivering the system trajectory, ensuring that our LDA population live their best possible lives, enhancing their lives in the least restrictive environment.

The Transforming Care Programme component of LDA performance is slightly above trajectory in both adults and children and young people (CYP) cohorts. This has been impacted by greater post-admission diagnoses and prison transfers in year than modelled. The system is experiencing difficulties in recruiting robust staff teams to support discharge for individuals with complex community support needs. This is reflective of a national workforce challenge for this extremely demanding area of specialist practice.

2.2 LeDeR Annual Report

The 2021-2022 LeDeR Annual Report was published on the ICB website on 1 July 2022; an easy read version is currently being developed. In Spring 2021, a new national LeDeR policy was launched outlining a revised approach to the programme, and one of the key changes was the inclusion of autistic adults who have died from 1 January 2022. Learning from reviews most frequently highlighted themes related to the application of the Mental Capacity Act, the use of reasonable adjustments, the transition from paediatric to adult care, and the quality of annual health checks. The LeDeR reviews also highlighted examples of best practice, such as support provided by the hospital learning disability nurse, following patient wishes to remain at home, reasonable adjustments applied by the GP and breast screening service.

LeDeR reviews often identified actions to address small, quick-fix issues that were implemented following discussion with providers. The key priority actions from learning in 2022-23 include a focus on respiratory illness, enabling people to be supported in decision-making, supporting people to make informed choices about lifestyle factors that impact their health and continuing collaboration with ICS partners to understand the health inequalities experienced by people with a learning disability.

The Annual Report is available on the ICS website at: LeDeR Annual Report 2021_22Final.pdf (happyhealthylives.uk)

2.3 Ockenden

All three maternity insight visits have been completed. There is now to be a collation of the outcomes to facilitate system learning and sharing of best practice across the system. There is variation across the providers in the stages of implementation of Ockenden one. The system action plan is reviewed monthly by the Local Maternity and Neonatal Services (LMNS) Board. The letter (enclosed within Pack 2) from our system Chief Nursing Officers has been sent to the Chair of Coventry and Warwickshire ICB and to the regional team.

2.4 System Quality Group

The changes in the leadership across the system has created challenges and opportunities in achieving effective system culture change. The group is developing a more collaborative and engaged approach. Quality Strategy priorities are focussing on culture engagement and system working. Including workforce challenges, Covid recovery, patient flow, urgent and emergency care, population and individual experience

Recommendation

In conclusion the Board is requested to receive and note this information.

End of Report

Enc L

Report Title:	Cost of living and its impact on population health and health and care services.
Report From:	Kirston Nelson Nigel Minns Theresa Nelson
Author:	Liz Gaulton – Chief Officer Population Health and Inequalities ICB Theresa Nelson – Chief People Officer ICB
Previous Considerations and Engagement:	None
Purpose:	For discussion and Information

Contribution to meeting the aims of the ICS:

The escalating cost of living impacts on all four aims of the ICB

1. **Improving outcomes in population health and healthcare**:

The escalation in the cost of living will have a detrimental impact on the health of the population of Coventry and Warwickshire, including our staff. And on the cost and in some cases the sustainability of providing health and care services

2. **Tackling unequal outcomes, experience and access**:

The increase in the cost of living will have a disproportionate impact on the most deprived and vulnerable within local communities and specifically those who spend the highest proportion of their income on energy and food.

3. **Enhancing Productivity and value for money**:

Increasing consumable, medicine, infrastructure and salary costs will impact on providers of health and care and in some cases on their future viability

4. **Supporting the broader social and economic development of C&W**:

In addition to the direct impact on population health and sustainability of health and care services the wider impact of escalating cost of living impacts across our local economy and social infrastructure

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Contribution to meeting the priorities of the ICB:
The escalating cost of living impacts across a number of the ICB priorities. **Accelerate preventative programmes** lifestyle choices are impacted by affordability, mental wellbeing is impacted upon by the stress and uncertainty of cost of living escalation. **Work together**, the integrated care system is working collaboratively to minimise the harm caused to population and workforce of the escalating cost of living. **Protect the most vulnerable**, escalating cost of living will have a disproportionate impact on those where the greatest proportion of their income is spent on energy and food. **Focus our delivery on Place-based care**, local authorities are best placed to provide financial advice and support to local communities. **Successfully manage urgent emergency care (UEC),** Escalation in cost of living is likely to cause a surge in demand for urgent care as long-term conditions are exacerbated and the most vulnerable turn to health and care services for help and support. The financial sustainability of some providers is at risk as costs spiral. **Restore elective care** those facing greatest financial pressures may not access elective care and diagnostics due to the cost and mental distress. Leading to widening inequalities in health outcomes. Cost pressures on providers may limit their capacity for transformation. **Care for and develop our workforce** our workforce will all be impacted upon by the escalating cost of living with those on lowest income disproportionally impacted. Across the Integrated Care System, a range of support is being developed by employers. '**Live within our means'** our ability to live within our means will be significantly challenged as infrastructure, consumable and salary costs escalate. There is a concern as to the fragility of some smaller providers.
Recommendation:
Members are requested to: - • **Note** the information within this report and specifically the impact on the health and wellbeing of the population and our workforce and the actions already in place and planned to support both communities and workforce. • **Note** the potential impact of inflation on health and care services and the potential fragility of some smaller providers • **Approve** that all health and care providers should be appreciative of the impact of the escalating cost of living on individuals and be equipped to provide signposting to local support available. • **Discuss** what further measures should be taken collectively by the Integrated Care Board and Integrated Care System to support our workforce including; a) Consider the development and funding for a system "Financial support grant" for those most in need. b) Discuss how we influence partner organisations and agencies to reduce the costs of public transport and car parking subsidies for health and care staff and students.

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c) Discuss how the system influences housing availability for key workers in all places. d) Support the development of a simple script or set of questions that nudge individuals to spot when a colleague may need support and direct them accordingly.

Implications							
Conflicts of Interest:	None						
Financial and Workforce:	Costs of providing health and care services will increase due to infrastructure, consumable, and workforce cost increases. Impact on workforce is both in the escalating cost of living and the cost of 'being at work' travel, refreshments etc.						
Performance:	How and when people access health and care will be impacted upon by the escalating cost of living. With potential surge in demand for urgent and emergency care and late or no presentation for elective care and diagnostics.						
Quality and Safety:	None						
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:	None						
Clinical and Professional Engagement:	CPO's & CFO's						
Risk and Assurance:	The potential ICB risks of the escalating cost of living are • Widening of health inequalities with those who spend most of their income on heat and food disproportionality effected. • Fragility and financial sustainability of some providers potentially leading to market reduction pressures and limited investment in transformation etc. • Reduction in workforce availability due to poor well being linked to anxiety, fuel and food poverty						

Coventry and Warwickshire Integrated Care Board

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Executive Summary

1.1 This report outlines the impact of the escalating cost of living on the health and wellbeing of the population with a specific focus on inequalities and those who are vulnerable and upon our workforce. The report acknowledges the impact of increased costs and potential fragility brought about by significant inflation on some health and care services. The report describes what is already in place and planned both financially and from a wellbeing perspective to support Coventry and Warwickshire residents and what is in place and planned to support our workforce. The recommendations invite a discussion as to what more we can do collectively in relation to the rapidly increasing cost of living.

1.2 The escalating cost of living impacts across all the aims of the ICS and ICB priorities and should be considered within the context of aim 4 'supporting the broader social and economic development of Coventry and Warwickshire.'

2. Impact of significant inflation on health and care

2.1 The rapid increase in cost of living is driven by; a sharp increase in global energy prices, higher good prices including supply chain disruption and salary increases. The increase is having a detrimental impact on health and care via multiple routes: -

Population and patients	**Health and care workforce**	**Cost of health and care provision**
Cost of good nutrition	Wellbeing and moral	Energy, transport and infrastructure costs.
Energy costs Housing costs (rising interest rates)	Cost of at 'being at work' travel and sustenance	Pay settlement and pay differentiation across the system
Mental wellbeing	Salary and pension contribution changes	Construction costs
Expenditure of health e.g. prescriptions	Recruitment retention and retirement	Interest rates
Access to health and health and care services e.g. transport, time off work	Impact on unpaid carers	Medicines and consumables
	Housing costs (rising interest rates)	Provider fragility

2.2 The escalating cost of living is, and will as we head into winter, continue to have a significant impact upon the health and wellbeing of the population of Coventry and Warwickshire, the staff working within our health and care system and the cost and sustainability of public service provision.

The negative physical and mental impact on population health of the increase in cost of living cannot be underestimated and comes at a time when the NHS is rightly shining a spotlight on inequalities.

In the short term the impact of the increase in cost of living will be experienced most acutely by the lowest income households who spend the highest proportion of their income on energy and food. Those within our population who are vulnerable for example due to pre-existing health conditions or frailty are most likely to experience poor health outcomes related to cold homes and poor nutrition and will subsequently increase demand on health and care services. Whilst the uptake of diagnostics and elective care in more deprived communities may reduce due to the costs associated with accessing health care.

Over the medium-term increased wages, infrastructure and consumable costs and supply chain logistics are likely to leave some providers fragile and poses significant risk upon the sustainability of some health and care services at a time of increased demand. Any level of market reduction will put enormous pressure on the rest of the health and social care system. Cost pressure on already stretched budgets may lead to providers not being able to invest in transformative schemes etc.

The NHS Confederation, a membership organisation who speak on behalf of the whole NHS, have written to the Chancellor to warn of the public health risks unless the government takes action to limit the impact of further energy price increases by shielding households from spikes in fuel cost increases.

3. Supporting communities

3.1 Across the integrated Care System Local Authorities and placed based partners are best placed to support people and families facing financial hardship. Support is already in place and more is planned within both Coventry and Warwickshire.

3.2 In Coventry there is a breadth of support available to residents. A summary of this can be found on the council's website: https://www.coventry.gov.uk/cost-living-wellbeing-support and includes financial support with energy and housing costs, support with food, fuel and other essential items, support to households at financial risk, and information and advice on benefits, debt and housing matters.

In addition, a working group of council officers and representatives from partner organisations (statutory, community and voluntary sector) co-ordinates opportunities to collaborate and join up existing and new initiatives to respond to the current crisis. Through our wider work, taking a place-based approach, we are developing more joined-up and locally relevant support and services, testing out new ways of working and engagement through community prototypes (please see further item on the agenda re. community prototypes). Current and proposed activity in this area will further contribute to our ability to respond locally to the Cost of Living crisis and to enable local people to achieve better outcomes.

3.3 The response within Warwickshire is similarly muti-agency based and prioritised. Similar to Coventry there are multiple support offers available to local residents, provided by a range of partners within the county. The County Council is developing a position statement in relation to Cost-of-Living which will aim to further understand the potential impact and set out immediate, medium and long term actions which will aim to address these. Taking a Community Powered approach will be key in the near-term as alignment of key strategies such as Levelling Up, Sustainable Futures, Education, Health inequalities and other will be to addressing the impact of cost of living on the medium to long term.

3.4 All health and care providers in the ICS should be mindful of the impact on the cost of living during their interactions with the public and patients and take a 'make every contact count approach' to enquiring about an individuals wellbeing and personal situation

3.5 All health and care providers should be aware of and able to signpost to what support is available within a local place.

4. Supporting our Workforce

With over 50% of our workforce categorised in lower income levels, both food and fuel poverty significantly impacts wellbeing and workforce availability. We have heard many stories where staff are skipping meals, losing sleep and becoming ill due to financial distress. Over the last year colleagues in organisations across the system have developed a comprehensive set of resources to advise and steer those staff who are experiencing difficulty. The attached document provides a snap shot of support offers and is regularly reviewed to ensure we are learning from national best practice.

The following highlights the specific issues contributing to household poverty and the impact for working lives and staff availability for Coventry and Warwickshire. Each section is detailed with specific considerations for the board.

4.1 **Pay**

Almost all health care unions are balloting for strike action on the basis of improving the NHS pay award. The retrospective impact of the award causes additional financial distress for those on lower income or receiving benefits. The pay award coupled with the pension's changes mean that many staff will see no change to their net pay and in some instances individuals will receive a pay cut.

The cost of living crisis also brings into sharp focus the pay differentiation across sectors who work in multi professional teams across health and social care. Having staff from primary care, community services and social care working collaboratively to deliver care but facing significant differences in pay, terms and conditions is a sizeable risk to retention and transformation.

Across health and care we know we are losing staff to the hospitality industry where rates of pay are more competitive.

The NHS pensions agency have also reported that more staff are requesting to leave the pension scheme due to contribution levels and impact on disposable income.

Board Consideration: Could we develop, fund and administer a system "Financial support grant" for those most in need.

4.2 **Travel**

Travel costs are a key contributor to the stress people are experiencing, particularly in our student population. We know that students are failing to attend lectures and placements due to travel and car parking costs. This will inevitably impact the pipeline of future clinicians. This situation is exacerbated by the removal of the bursary and the fact that many clinical students have fewer opportunities to take on part time work.

Board Consideration: Review public transport and car parking subsidies with a view to increasing them for health and care staff and students.

4.3 **Housing**

There are several important housing factors to consider both for our current and future workforce.

The health effects of living in cold homes creates additional stress impacting general well being and ability to attend work.

In addition, one's ability to meet rental obligations as costs increase creates an added risk of homelessness and therefore ability to work.

Our ambition is to create greater employment and training opportunities for disadvantaged communities, critical to this are housing partnerships and offers of support.

The employability subgroup are working with two housing associations and other agencies to improve access to employment from disadvantaged groups.

Board Considerations: Review how the system influences housing availability for key workers in all places.

4.4 **Food**

With less disposable income people are making difficult choices about feeding themselves and their families. We have shared details of community food banks and other support offers. Whilst some sites offer subsidised meals this is not a universal offer.

Board Consideration: Review the possibility of creating and funding meal vouchers and/or further restaurant subsidies for staff and students.

4.5 **Mental Health**

There is robust evidence linking poverty with depression and anxiety, this is already the highest cause of staff sickness across health and care and as the crisis becomes more severe the risk is greater.

Across the system there are a number of initiatives to encourage physical activity to support better mental well being and the ***With Staff in Mind hub*** are providing a broad range of direct psychological support to staff and teams.

4.6 **Working Carers**

We already know that staff with caring responsibilities experience greater challenges balancing personal and work commitments and this layered onto poverty challenges could severely impact wellbeing and retention.

The system will continue to champion the carers passport to ensure that managers are cognisant of the specific needs of working carers.

4.7 **Every Contact Counts**

Recognising that we may not be aware of the additional financial stress and pressure our colleagues may be experiencing we felt it important to recognise everyone's role in supporting each other.

The creation of safe cultures where people can share worries and experiences will create a more compassionate environment where people feel supported and valued.

Board Consideration: Do we develop a simple script or set of questions that nudge individuals to spot when a colleague or service user may need support.

5. Conclusion

The escalating cost of living is having a detrimental effect on the health and wellbeing of the population of Coventry and Warwickshire, including our workforce. The impact is disproportionately affecting those who spend the highest proportion of their income on energy and food and those who are frail. Local Authorities are providing and coordinating place-based support to residents. The impact will be seen across all health and care providers, all providers should be appreciative of the impact of the escalating cost of living on individuals and be equipped to provide signposting to local support available.

6. Recommendation

Members are requested to:-

- **Note** the information within this report and specifically the impact on the health and wellbeing of the population and our workforce and the actions already in place and planned to support both communities and workforce.
- **Note** the potential impact of inflation on health and care services and the potential fragility of some smaller providers
- **Approve** that all health and care providers should be appreciative of the impact of the escalating cost of living on individuals and be equipped to provide signposting to local support available.
- **Discuss** what further measures should be taken collectively by the Integrated Care Board and Integrated Care System to support our workforce including:
    - Consider the development and funding for a system **"Financial support grant**" for those most in need.
    - Discuss how we influence partner organisations and agencies to reduce the costs of **public transport and car parking** subsidies for health and care staff and students.
    - Discuss how the system influences **housing availability** for key workers in all places.
    - Support the development of a simple **script** or set of questions that nudge individuals to spot when a colleague or member of the public may need support and direct them accordingly.

End of Report

NHS
Coventry and Warwickshire
Integrated Care Board

Finance and Performance Committee Report for the meeting held on 3 August 2022		
Key Information		
Committee Chair: Dr Sukhi Dhesi (standing in)	**Committee Executive Lead:** Madi Parmar	**Date of Next Meeting** 7 September 2022
Quoracy met?	**Yes**	
Purpose of the report	For **ASSURANCE** in respect of key decisions/issues raised at the 3 August 2022 Finance and Performance Committee meeting. For **APPROVAL** of the recommendation set out within this report.	
Recommendation	Members are requested to be **ASSURED** in respect of the matters set out within this report. Members are requested to **APPROVE** the recommendation set out in this report.	

Key highlights of discussions and decisions held during the meeting:	
Agenda item description & key discussion points	**Assurance achieved and sources / Gaps in assurance and action agreed**
Legacy CWCCG and System Finance Report - Break-even position reported for the end of Month 3. - Discussion on oversight of issues in respect of the relationship between the Committee and the Financial Advisory Board (FAB) and the groups which feed into FAB. - Failure to deliver efficiencies is greatest risk to achieving system's financial plan. In this regard, work is underway to develop a plan with all organisations (through FAB). This and further work being undertaken on programmes will be reported to Committee via the regular Finance Report.	NOTED.
ICB Risk Register Risks overseen by the Committee: - System Deficit - Urgent and Emergency Care - Elective Care Recovery - Autism/ADHD - General Practice Estate – discussion about significant financial risk to planned developments due to national situation around building costs.	ASSURANCE achieved.

Presently, one development cannot proceed and a second is under review. Work underway to attempt to resolve. - Cancer	
NHS System Oversight Framework - The NHS Oversight framework was published in June and is underpinned by a Memorandum of Understanding (MOU) between ICS and NHS England (NHSE). MOU being drafted and engagement with different groups underway. - Inclusions: Local performance priorities included Mental Health and Learning Disabilities, Cancer, Discharge and Ambulance Handovers. - The MOU supports the move to from a regional to a system assurance role, as was the current approach to managing performance and supporting providers to deliver.	NOTED and ACTION AGREED for Audit Committee to receive a report on the NHS System Oversight Framework and MOU it's August meeting.
Performance Report - Key performance areas of concerns were noted. - A Children and Adolescent Mental Health Services (CAMHS) Transformation programme, led by ICB in collaboration with CWPT and Warwickshire Local Authority, in place to improve CAMHS performance. Supporting action plan is managed via system-wide group. - System plan in place to improve Ambulance Handover performance resulting in significant improvement at GEH Urgent Care Board has oversight of plans. - Regarding A&E targets it was confirmed that the Board would be considering the GP-led urgent treatment centre approach, Stratford Minor Injuries Unit was reopening in September and conversations with SWFT and UHCW were ongoing. - Additional capacity in place to address Autism assessment backlog. Capacity with regards to future demand to be considered. Support services available to patients (and their family) whilst awaiting diagnosis.	ASSURANCE achieved. ACTIONS AGRRED: - A deep dive to be undertaken on the CAHMS programme and presented to the Committee. - A deep dive to be undertaken on Ambulance Handovers and presented to the Committee.
Procurement Update Report - 21 procurement recommendations were detailed within the report. - A Procurement Group is in place which receives external expert advice. - Discussion concerning financing of some bids beyond the period identified and how reviews would be undertaken to determine this.	APPROVAL given to the 21 procurement recommendations set out within the report.

- Discussion about extending services offered in one or more areas within Coventry and Warwickshire if shown to have an impact to all areas within the footprint.	
111 Contract Award - Previously, Coventry and Warwickshire Clinical Commissioning Group (CWCCG) had delegated the decision regarding awarded the contract to its Accountable Officer (Phil Johns) and Chair of the Primary Care Commissioning Committee (Zubair Khan). - The decision was taken to agree the award and so was reported to the Committee for information.	NOTED.
Extra Care Housing Support Contract Award - Discussed the contract value and Committee's delegated limit. - Suggestion for future reports to include which Place investment was going to.	APPROVAL given to award the Contract, subject to an ACTION AGRRED To confirm the contract value was within the Committee's delegated limit. N.B. The limit was checked and the value confirmed to be within the limit.
Clinical Waste Procurement – Primary Care Providers - Opportunity to join a national procurement project. - Discussed the absence of information regarding finance, risks and local impact. Assurance given that improvements and costs would be detailed as part of the process of reviewing the service specification and requirements. Withdrawal from the project would occur were benefits not realised.	ENDORSEMENT given to join the national procurement project.
Out of Hospital Contract Approach - Discussed whether or not the approach aligns to the role that the developing geographical Care Collaboratives would play in this. - Confirmed that a lessons learnt exercise would be completed at the end of the process.	APPROVAL given to Strategy and Approach.
GP IT Futures 2022 Procurement Scoping Paper	NOTED.
Committee Terms of Reference - Reviewed suggested change to increase the Local Authority Membership of the Committee.	RECOMMENDATION made to Board to increase in the number of Local Authority members from one to two.
Committee Schedule of Business	APPROVAL given.

Financial Advisory Board - No matters escalated to the Committee.	NOTED.

Items for escalation:		
Item or issue	**Purpose for escalation**	**Escalated to**
None		

Items referred to the Board for Approval
Board Members are requested to APPROVE the increase of Local Authority Membership of the Committee from one to two.

NHS
Coventry and Warwickshire
Integrated Care Board

Enc M

Finance and Performance Committee Report for the meeting held on 7 September 2022		
Key Information		
Committee Chair: Dr Sukhi Dhesi (standing in)	**Committee Executive Lead:** Madi Parmar	**Date of Next Meeting** 5 October 2022
Quoracy met?	**Yes**	
Purpose of the report	For **ASSURANCE** in respect of key decisions/issues raised at the 7 September 2022 Finance and Performance Committee. For **ENDORSEMENT** of the APPROVED recommendations set out within this report.	
Recommendation	Members are requested to be **ASSURED** in respect of the matters set out within this report. Members are requested to **ENDORSE** the APPROVED recommendations set out in this report.	

Key highlights of discussions and decisions held during the meeting:	
Agenda item description & key discussion points	**Assurance achieved and sources / Gaps in assurance and action agreed**
ICB Risk Register Risks overseen by the Committee: - System Deficit - Urgent and Emergency Care – discussion about public awareness of virtual wards, development of the winter plan (to be presented Committee once complete) and about cost of living affecting nursing/residential homes, including possible impact on hospital discharge. - Elective Care Recovery - Autism/ADHD - General Practice Estate - Cancer Risks overseen by Other Committees: - Workforce Shortage (People Committee) – discussion concerning plans. Paper on the One People Plan to be presented to Board.	ASSURANCE achieved and ACTION agreed for Chief People Officer to attend future meeting to provide more information on assurance, retention, and recruitment for student nursing and the One People Plan.
Finance Report - Month 4 Report. - The forecast breakeven position for the ICB and it was highlighted that the key risks to this position	NOTED.

related to the continued overspend on Continuing Health Care and Individual Packages of Care. - The ICS forecast was a net deficit position of £5.6m driven by under delivery of provider efficiency and continued need for work in this area. - Risks around CHC and Prescribing particularly the efficiency challenge.	
Coventry and Warwickshire Better Care Funds (BCF) - Review to be undertaken of both schemes in 2023/24 as to their value add. - Proposed that the Committee approved both BCF schemes including planning templates.	APPROVAL given and RECOMMENDATION to Board for ENDORSEMENT (Appendix M).
Performance Report - The increasing waiting list position and cancer backlog was noted. - The Winter plan was discussed particularly in relation to impact on performance and also regarding primary care provision. Some local funding was available but no confirmation of additional regional funding had yet been received. As yet there was no planned de-escalation of service. The potential scale of unmet need was also noted. - Progress of the implementation of Urgent Treatment Centres was discussed.	ASSURANCE achieved. ACTION agreed that assurance is sought from providers on progress of the implementation of Urgent Treatment Centres.
Ambulance Handover (AH) Deep Dive - Findings were presented which identified that systemic pressures impact upon performance. - George Eliot Hospital NHS Trust had improved performance. - Discussed and reassurance given regarding 'corridor nursing approach' in terms of patient safety and engagement.	NOTED.
Warwickshire Written Statement of Action – Progress Report - Month 6 - Noted concerns in mental health performance particularly Autism waits. New referrals for assessments tracking at a higher rate than originally anticipated which will potentially exacerbate the waiting list issues but additional capacity in place to address. Further analysis of this capacity and cost was awaited.	NOTED.
Sustainability and Innovation	NOTED and ACTIONS agreed:

- A Financial Transformation Plan in development to identify all transformation programmes, and their activities, expected benefit realisations and trajectories. - One programme is the Estates and Green Sustainability Transformation Programme, which supports the Green Development Plan approved by the Board.	- Programmes discussed at Board to be made available to subsequent meeting of the Committee. - Financial Transformation Plan to be presented to the Committee for approval.
NHS System Oversight Framework (SOF) and Memorandum of Understanding (MOU) - Verbal update given on further instruction from NHSE since the report was written, with final national SOF dashboard awaited from NHSE Regional to inform provider segmentation by the end of October 2022.	NOTED and APPROVAL given for: - The MOU to be signed once final confirmation of approval from NHSE Regional is received. - The evolving provider segmentation assessment process.
Procurement Update Report - Recommendations related to: o Warwickshire Community Equipment Service – delegation to Chair and Chief Delivery and Performance Officer for signing-off on the final ITT documentation. o Patient Transport Services – approving direct award to AFJ Limited and Castlebrand Ltd t/a Phoenix Private Ambulance Service for six months from 01/10/2022. o West Midlands Trauma Vanguard Project: Social Prescribing Entrepreneurial Training - approving direct award to Creative Optimistic Visions for duration of project (up to March 2024). o Dementia Nursing Beds – approving direct award to Willow Tree Nursing Home for 6 dementia beds. o End of Life Nursing Beds – approving direct awards to St. Marys Nursing Home, Priors House, Bentley House and Flexi Complex Nursing Home. o Extension of Rushcliffe Out of Area Acute Beds – approval of direct award to Rushcliffe Hospital Trust to extend to 31/12/2022.	APPROVAL given to all recommendations.
Finance Advisory Board - A review and refresh of the ICB and ICS financial strategy in the autumn, to address governance, financial stewardship, transformation and sustainability, will be presented to the Committee once available.	NOTED.

Items for escalation:		
Item or issue	**Purpose for escalation**	**Escalated to**
NONE.		

Items referred to the Board for Approval
Board Members are requested to ENDORSE: - the **Coventry** Better Care Fund Plan 2022/23 (Appendix M). - the **Warwickshire** Better Care Fund Plan 2022/23 (Appendix M).

Enc M

Report To and Date:	Integrated Care Board Meeting – 21st September 2022
Report Title:	Coventry Better Care Fund (BCF) Plan 2022/23
Report From:	Madi Parmar, Chief Finance Officer
Author:	Ewan Dewar (Finance Manager) Coventry City Council
Previous Considerations and Engagement:	Finance and Performance Committee 7th September The Better Care Fund was launched in 2015 and is subject to an annual planning process previously between the City Council and CCG and now between the City Council and ICB.
Purpose:	For Approval

Contribution to meeting the aims of the ICS:

- Improving outcomes in population health and healthcare: The BCF underpins a number of integrated schemes in delivering national planning priorities and in improvements on delivery of urgent care
- Tackling unequal outcomes, experience and access: The plan includes schemes to manage accessibility to support and unequal outcomes. This is an area that remains continually under review
- Enhancing Productivity and value for money: An integrated approach and further review of existing schemes will enhance both aims.
- Supporting the broader social and economic development of C&W: Plans include work programmes across wider partners and providers.

Key Points:

To update Coventry and Warwickshire ICB on the:

- Better Care Fund (BCF) Policy Statement and Planning Requirements for 2022/23 published on the 19th July 2022;
- The plan for resources made available through the additional social care monies Improved Better Care Fund (iBCF), Disabled Facilities Grant (DFG) and NHS Contributions;
- Proposed metrics; and the
- Approach to local approval and regional assurance.

The Better Care Fund (BCF) National Conditions require the NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution and also agreement to invest in NHS commissioned out-of-hospital services to achieve National Condition 4 which

Enc M

requires local partners to have an agreed approach to implementing the two policy objectives for the BCF. These are:

i. Enable people to stay well, safe and independent at home for longer.
ii. Provide the right care in the right place at the right time.

The BCF Plan details how the schemes contribute to these objectives, by improving outcomes, tackling inequalities and preventing admission into or supporting timely discharge from acute settings. These schemes and objectives align with the wider aims of the ICS.

The deadline for submission of the BCF to NHS England is the 26th September 2022. The plan requires sign off by Coventry Health and Wellbeing Board which will be completed retrospectively on 3 October 2022 due to the timescales of the process.

The report and it's appendices have been reviewed by the Finance and Performance Committee with the appendices available to members on request.

Recommendation:

Members are requested to endorse the recommendations of F&P Committee to the ICB Governing Body:

- Approval of the draft Better Care Fund (BCF) plan for 2022/23 including the plan for resources made available through the additional social care monies Improved Better Care Fund (iBCF), Disabled Facilities Grant (DFG), NHS minimum contributions and confirms that the mandatory funding contributions and national conditions are met.
- Approval of the attached draft BCF Planning Template and Narrative Plan outlining the BCF Plan for 2022/23 (Appendices 1 & 2) so that the conditions are met and the BCF Plan can be submitted to NHS England by the 26th September 2022 submission deadline and the Health and Wellbeing Board.
- Approves that, following regional moderation and assurance from NHS England and receipt of formal permission to spend, the ICB enters into a new Section 75 Partnership Agreement with Coventry City Council for the delivery of the Better Care Fund Plan in 2022/23.
- The ICB continues to align Out of Hospital service provision and funding with Coventry City Council to support closer integration and plans to move to an Integrated Care System.

Implications	
Conflicts of Interest:	None
Financial and Workforce:	NHS minimum contributions to the Coventry BCF pooled budget are set nationally each year and equate to £28.941m in 2022/23. Additional NHS Contributions of £39.733m bring the total NHS contribution to £68.675m.
Performance:	The BCF planning template includes targets for performance on unplanned hospitalisations for chronic ambulatory care sensitive conditions and

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	improvements on the proportion of people discharged home alongside metrics applicable to Adult Social Care						
Quality and Safety:	The BCF schemes support improved quality and safety by for example: • supporting timely discharges to reduce deterioration of patient's who no longer meet the criteria to reside in an acute setting, • the effectiveness of care by preventing admission to an acute setting, and • patient experience by enabling them to remain independent at home						
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:	Not applicable						
Risk and Assurance:	Risks – BCF funding is currently only confirmed nationally on an annual basis. In order to counter the risk inherent in temporary funding, all new initiatives are temporary or commissioned with exit clauses. There are, however, a number of areas where the funding is being used to maintain statutory social care spending and health care expenditure and this would require alternative funding if the Better Care Fund was removed without an equivalent replacement. Risks and issues impacting the BCF Programme of work are managed at two levels: at a Coventry & Warwickshire system level through the Joint Commissioning Group and at a Project and Programme level via the relevant lead officers.						

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NHS
Coventry and Warwickshire
Integrated Care Board

Executive Summary

1. Key points and purpose

Better Care Fund Policy Framework 2022/23
For 2022-23, BCF plans will consist of:

- A narrative plan
- A completed BCF planning template, including:
  - Planned expenditure from BCF sources.
  - Confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams.
  - Ambitions and plans for performance against BCF national metrics.
  - Any additional contributions to BCF section 75 agreements.
- New for 22/23 - an intermediate care capacity and demand plan.

The deadline for submission of the BCF plan to NHS England is 26th September 2022. The submissions will be further developed leading up submission with updated versions to be submitted in time for ICB Governing Body meeting on 21st September.

2. The draft Better Care Fund Plan 2022/23 for Coventry meets the four national Better Care Conditions and funding contributions which the ICB is required to deliver:

2.1 National Conditions:

- NC1: Jointly agreed plan - A jointly developed and agreed plan that all parties sign up to, a clear narrative for the integration of health and social care, and a strategic, joined up plan for Disabled Facilities Grant (DFG) spending
- NC2: Social Care Maintenance - the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution
- NC3: NHS commissioned Out of Hospital Services - the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution
- NC4: Implementing the BCF policy objectives – an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:
  i. Enable people to stay well, safe and independent at home for longer
  ii. Provide the right care in the right place at the right time

2.2 Funding contributions:

The funding contributions for the BCF are summarised in the table below with confirmation following of specific minimum spend requirements. A detailed breakdown of the planned scheme budgets is provided in the supporting Planning Template.

Funding Type	NHS Contribution £	Coventry City Council (CCC) Contribution £	Total Pool £
NHS Minimum Contribution	28,941,709		28,941,709
CCC Minimum Contribution DFG		4,181,686	4,181,686
CCC Minimum Contribution iBCF		15,787,327	15,787,327
Subtotal: Minimum BCF contributions	**28,941,709**	**19,969,013**	**48,910,722**
Additional NHS Contribution	39,732,860		39,732,860
Additional CCC Contribution		49,182,700	49,182,700
Subtotal: Additional Contributions	**39,732,860**	**49,182,700**	**88,915,560**
Total BCF pool	**68,674,569**	**69,151,713**	**137,826,282**

NHS minimum contribution
The planned ICB contribution to the BCF pooled budget meets the minimum contribution required in the planning requirements.

Social care maintenance
The planned spend on social care from the ICB minimum contribution meets the planning requirements

NHS commissioned Out of Hospital services
The planned spend on NHS Commissioned Out of Hospital services from the ICB minimum contribution meets the planning requirements

2.3 Performance

The key ICB performance metrics within the BCF are 8.1 Avoidable Admissions and 8.3 Discharge to usual place of residence. Detail of these can be found on tab6. Metrics

Timetable

Regional and National Assurance - NHS England will approve BCF plans in consultation with the Department for Health and Social Care and the Department for Levelling Up, Housing and Communities. Assurance processes will confirm that national conditions are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed. Assurance of plans will be a single stage exercise based on a set of key lines of enquiry. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region. Once approved - NHS England, as the accountable body for the NHS minimum contribution to the fund, will write to areas to confirm that the NHS minimum funding can be released.

Assurance activity	Date
BCF planning requirements received	19th July 2022
Optional draft BCF plans submitted to regional Better Care Manager	By 18th August 2022
BCF planning submission from local HWB areas (agreed by ICB and WCC) sent to national BCF Team at NHS England	26th September 2022
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	26th September to 24th October 2022
Cross regional collaboration	1st November 2022
Approval letters issued giving formal permission to spend (NHS minimum)	30th November 2022
All section 75 agreements to be signed and in place	31 December 2022

Assurance of expenditure against the Better Care Fund is through the Coventry Adult Joint Commissioning Group.

As in previous years, a Section 75 Legal Agreement will underpin the financial pooling arrangements. This cannot be signed until the Plan is nationally approved. In order to avoid under delivery and underspends, schemes and initiatives have to be entered into prior to the legal agreement being signed, but this is no different to previous years.

3. Conclusion

The draft local BCF Plan for 2022/23 meets the requirements set out in the BCF Policy Framework and Planning Requirements published on 19th July 2022 and following approval by ICB Governing Body on 21st September it will be submitted to NHS England by the 26th September 2022 with retrospective sign off at Coventry Health and Wellbeing Board on 3rd October 2022.

Following approval of formal permission to spend, a section 75 agreement between the ICB and CCC will then then be entered into. At this point all BCF conditions will then be met

4. Recommendation

Members are requested to ratify the decision made by the Finance and Performance Committee to approve the BCF Plan for 2022/23.

There are 5 specific recommendations for approval relating to the above.

End of Report

Enc M

NHS
Coventry and Warwickshire
Integrated Care Board

Report To and Date:	Integrated Care Board Meeting – 21st September 2022
Report Title:	Warwickshire Better Care Fund (BCF) Plan 2022/23
Report From:	Madi Parmar, Chief Finance Officer
Author:	Rachel Briden, Integrated Partnership Manager, Warwickshire County Council on behalf of Becky Hale, Chief Commissioning Officer (Health and Care), Warwickshire County Council
Previous Considerations and Engagement:	Finance and Performance Committee 7th September The Improved Better Care Fund (IBCF) was agreed in principle (in advance of publication of the BCF Policy Framework) by the predecessor CCG's Finance and Performance Committee on the 28th February 2022 and Governing Body in March 2022. ICB colleagues on the Warwickshire Joint Commissioning Board have also been involved in reviewing the draft Better Care Fund Plan for 2022/23, at the meeting on the 17th August 2022.
Purpose:	For Approval

Contribution to meeting the aims of the ICS:

- Improving outcomes in population health and healthcare: The BCF underpins a number of integrated schemes in delivering national planning priorities and in improvements on delivery of urgent care
- Tackling unequal outcomes, experience and access: Particularly for those aged 65+
- Enhancing Productivity and value for money: An integrated approach and review of schemes to be undertaken will enhance both aims.
- Supporting the broader social and economic development of C&W: Plans include work programmes with wider partners, as outlined in the Financial plan.

Key Points:

To update Coventry and Warwickshire ICB on the:

- Better Care Fund (BCF) Policy Statement and Planning Requirements for 2022/23 published on the 19th July 2022;
- The plan for resources made available through the additional social care monies Improved Better Care Fund (iBCF), Disabled Facilities Grant (DFG) and NHS Contributions;
- Proposed metrics; and the
- Approach to local approval and regional assurance.

The Better Care Fund (BCF) National Conditions require the NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution and also agreement to invest in NHS commissioned out-of-hospital services, to achieve National Condition 4

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which requires local partners to have an agreed approach to implementing the two policy objectives for the BCF:

i. Enable people to stay well, safe and independent at home for longer.
ii. Provide the right care in the right place at the right time.

The BCF Plan details how the schemes contribute to these objectives, by improving outcomes, tackling inequalities and preventing admission into or supporting timely discharge from acute settings. These schemes and objectives align with the wider aims of the ICS.

The deadline for submission of the BCF plan to NHS England is the 26th September 2022.

The report and it's appendices have been reviewed by the Finance and Performance Committee with the appendices available to members on request.

Recommendation:

Members are requested to endorse the recommendations of F&P Committee to the ICB Governing Body:

- Approval of the draft Better Care Fund (BCF) plan for 2022/23 including the plan for resources made available through the additional social care monies Improved Better Care Fund (iBCF), Disabled Facilities Grant (DFG), NHS minimum contributions and confirms that the mandatory funding contributions and national conditions are met.
- Approval of the attached draft BCF Planning Template and Narrative Plan outlining the BCF Plan for 2022/23 and supporting Capacity and Demand Template (Appendices 1, 2 and 3) so that the conditions are met and the BCF Plan can be submitted to NHS England by the 26th September 2022 submission deadline and the Health and Wellbeing Board.
- Approves that, following regional moderation and assurance from NHS England and receipt of formal permission to spend, the ICB enters into a new Section 75 Partnership Agreement with Warwickshire County Council for the delivery of the Better Care Fund Plan in 2022/23.
- The ICB continues to align Out of Hospital service provision and funding with Warwickshire County Council to support closer integration and plans to move to an Integrated Care System.

Implications	
Conflicts of Interest:	Not applicable
Financial and Workforce:	NHS contributions to the BCF pooled budget arrangements are set nationally each year and equated to £42.78m in 2022/23. In addition £112.12m of NHS income is also included in the BCF Plan for 2022/23 as aligned income.
Performance:	The BCF will include targets for performance on unplanned hospitalisations for chronic ambulatory care sensitive conditions and improvements on the proportion of people discharged home.

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Quality and Safety:	The BCF schemes support improved quality and safety by for example: • supporting timely discharges to reduce deterioration of patient's who no longer meet the criteria to reside in an acute setting, • the effectiveness of care by preventing admission to an acute setting, and • patient experience by enabling them to remain independent at home						
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:	Not applicable						
Risk and Assurance:	Risks - The iBCF is temporary. In order to counter the risk inherent in temporary funding, all new initiatives are temporary or commissioned with exit clauses. There are, however, a number of areas where the funding is being used to maintain statutory social care spending and health care expenditure and this would require replacement funding if the Better Care Fund was removed without replacement. Risks and issues impacting the BCF Programme of work are managed at two levels: at a Coventry & Warwickshire system level through the Joint Commissioning Board and at a Project and Programme level via a RAID log (Risks, Issues, Actions and Decisions) which are regularly reviewed and updated.						

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NHS
Coventry and Warwickshire
Integrated Care Board

Executive Summary

1. Key points and purpose

Better Care Fund Policy Framework 2022/23
For 2022-23, BCF plans will consist of:

- A narrative plan
- A completed BCF planning template, including:
  - Planned expenditure from BCF sources.
  - Confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams.
  - Ambitions and plans for performance against BCF national metrics.
  - Any additional contributions to BCF section 75 agreements.
- New for 22/23 - an intermediate care capacity and demand plan.

The deadline for submission of the BCF plan to NHS England is 26th September 2022.

2. The draft Better Care Fund Plan 2022/23 for Warwickshire meets the four national Better Care Conditions and funding contributions which the ICB is required to deliver:

2.1 National Conditions:

- NC1: Jointly agreed plan - A jointly developed and agreed plan that all parties sign up to, a clear narrative for the integration of health and social care, and a strategic, joined up plan for Disabled Facilities Grant (DFG) spending
- NC2: Social Care Maintenance - the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution
- NC3: NHS commissioned Out of Hospital Services - the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution
- NC4: Implementing the BCF policy objectives – an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:
  i. Enable people to stay well, safe and independent at home for longer
  ii. Provide the right care in the right place at the right time

2.2 Funding contributions:

The funding contributions for the BCF have been prepared by the Finance Sub-Group. A detailed breakdown of the planned scheme budgets is provided in the supporting Planning Template.

	Minimum BCF Pooled Budget 2022/23	Draft Total Pooled Budget 2022-23
Warwickshire	£63,040,809	£63,040,809

NHS minimum contribution
The planned NHS contribution to the BCF pooled budget meets the minimum contribution in line with the required inflationary increase of 5.66% across the 3 places.

NHS Minimum Contribution		Minimum Contribution to the Pooled Budget 2022/23	Agreed Contribution to the Pooled Budget 2022/23
NHS Coventry and Warwickshire ICB	Rugby Place	£8,286,000	£8,286,000
	South Warwickshire Place	£20,154,000	£20,154,000
	Warwickshire North Place	£14,344,000	£14,344,000
Total NHS Contribution		**£42,782,742**	**£42,782,742**

Social care maintenance
The planned spend on social care from the BCF NHS minimum contribution is also set out in line with inflation. This equates to 5.66% in 2022/23.

NHS commissioned Out of Hospital services
Our activity and scheme spending plans demonstrate that we have committed an amount which exceeds the minimum contribution for NHS commissioned out-of-hospital services.

	Minimum Required Spend	Draft Planned Spend
Adult Social Care services spend from the minimum NHS allocation	£15,273,989	£15,275,000
NHS Commissioned Out of Hospital spend from the minimum NHS allocation	£12,206,206	£15,970,000

Assurance of expenditure against the Better Care Fund is through the Warwickshire Joint Commissioning Board, which maintains an up- to-date risk log.

2.3 Performance

The key performance metrics within the BCF are outlined below.

- unplanned hospitalisation for chronic ambulatory care sensitive conditions

(avoidable admissions to hospital)	20-21 Actual	21-22 Plan	21-22 Actual	**22-23 Plan**
Indirectly standardised rate (ISR) of admissions per 100,000 population (NHS Outcome Framework indicator 2.3i)	212	187	192	**170**

The target will enable Warwickshire to maintain a better annual level than the England value at 761 against 771 and is improved from 19/20 (767) pre-pandemic levels.

- improving the proportion of people discharged home using data on discharge to their usual place of residence.

	21-22 Q1 Actual	21-22 Q2 Actual	21-22 Q3 Actual	21-22 Q4 Actual	**22-23 Plan**
% of people resident in the HWB, discharged from acute hospital to their normal place of residence	95.3%	95.5%	95.2%	95.7%	**95.5%**

The plan will enable Warwickshire to maintain higher than the national performance, 95.5% compared to 92.6% nationally.

2.4 Timetable

Regional and National Assurance - NHS England will approve BCF plans in consultation with the Department for Health and Social Care and the Department for Levelling Up, Housing and Communities. Assurance processes will confirm that national conditions are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed. Assurance of plans will be a single stage exercise based on a set of key lines of enquiry. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region. Once approved - NHS England, as the accountable body for the NHS minimum contribution to the fund, will write to areas to confirm that the NHS minimum funding can be released.

Assurance activity	**Date**
BCF planning requirements received	19th July 2022
Optional draft BCF plans submitted to regional Better Care Manager	By 18th August 2022
BCF planning submission from local HWB areas (agreed by ICB and WCC) sent to national BCF Team at NHS England	26th September 2022
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	26th September to 24th October 2022
Cross regional collaboration	1st November 2022
Approval letters issued giving formal permission to spend (NHS minimum)	30th November 2022
All section 75 agreements to be signed and in place	31 December 2022

As in previous years, a Section 75 Legal Agreement will underpin the financial pooling arrangements. This cannot be signed until our Plan is nationally approved. In order to avoid under delivery and underspends, schemes and initiatives have to be entered into prior to the legal agreement being signed, but this is no different to previous years. The intention is that the Section 75 agreement will also be drafted so that it can be signed by the partner organisations as soon as approval is granted.

3. Conclusion

The draft local BCF Plan for 2022/23 meets the requirements set out in the BCF Policy Framework and Planning Requirements published on 19th July 2022 and following approval by Warwickshire County Council's Corporate Board on 7th September 2022 and Cabinet on the 8th September 2022, will be submitted for approval to the Health and Wellbeing Board on the 22nd September 2022 and then NHS England for assurance by the 26th September 2022 deadline.

Following approval of formal permission to spend, a section 75 agreement between the ICB and WCC will then then be entered into. At this point all BCF conditions will then be met

4. Recommendation

Members are requested to ratify the decision made by the Finance and Performance Committee to approve the BCF Plan for 2022/23.

End of Report

Coventry and Warwickshire Integrated Care Board

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Audit Committee Report for the meeting held on 30 August 2022		
Key Information		
Committee Chair: Sue Noyes	**Committee Executive Lead:** Madi Parmar	**Date of Next Meeting** 11 October 2022
Quoracy met?	**Yes**	
Purpose of the report	For **ASSURANCE** in respect of key decisions/issues raised at the 30 August 2022 Audit Committee meeting. For **APPROVAL** of the recommendation set out within this report.	
Recommendation	Members are requested to be **ASSURED** in respect of the matters set out within this report. Members are requested to **APPROVE** the recommendation set out in this report.	

Key highlights of discussions and decisions held during the meeting:	
Agenda item description & key discussion points	**Assurance achieved and sources / Gaps in assurance and action agreed**
Chair's Briefing	NOTED.
Committee Terms of Reference - Clarity of wording regarding which responsibilities relate to the organisation and which to the system. - Appointment of Deputy Chair and the national conversation concerning the role of Finance and Performance Committee Chairs in Audit Committees.	NOTED and ACTION AGREED to revisit responsibilities wording as part of the planned review in February 2023. APPROVAL given for the appointment of the proposed Deputy Chair with ACTION AGREED for enquiries to be made regarding national conversation.
Committee Schedule of Business	APPROVAL given.
Internal Audit Plan 22/23 and Service Charter - Four areas of focus still to be confirmed.	APPROVAL given and ACTION AGREED for discussion to take place concerning the focus on the four areas yet to be identified .
External Audit Plan Update	NOTED.

Auditors' Annual Report (previously Annual Audit Letter) for Coventry and Warwickshire CCG) for the period to 31/03/2022 and 30/06/2022.	NOTED and ACTION AGREED for Value for Money to be added as a future meeting agenda item.
Draft Coventry and Warwickshire CCG Head of Internal Audit Opinion - April-June 2022	NOTED.
Audit Brief for NHS England and Financial Sustainability Review	APPROVAL given.
Financial Sustainability Plan (2022/23) - Individual organisations will be undertaking a self-assessment exercise against a national sustainability checklist and this will inform ongoing work to develop the ICS financial strategy (encompassing a culture of financial stewardship, investment appraisal governance and transformation) within which context the system financial sustainability plan will be set.	NOTED and ACTION AGREED to consider how work could be progressed across both Audit and Finance and Performance Committees.
Counter Fraud Progress Report – Confidential - Reported on three live issues.	ACTIONS AGREED to consider: - how confidential matters are reported; - further mitigations in respect of electronic registration system.
Security Management Progress Report - Local Security Management Team supporting the CHC team in terms of verbal abusive and threatening behaviour and update on which will be provided at next meeting.	NOTED.
Financial Accounts Report - Month 4 data presented - Recommendations to write off Holbrooks Health Team (£22,290), Woodway Surgery (£11,700) and cancellation of supplier Individual Packages of Care invoices (£287,083). - Discussion about how Committee could be assured in respect of appropriate repayment profiles for those practices who were required to repay monies relating to premises' costs.	NOTED and APPROVAL given to the recommendations given.
System Oversight Framework	NOTED.

- Verbal update being received on further instruction from NHSE since the report was written.	
ICB Risk Register - Arrangements to manage risk as an ICB in development. - Involvement of Chairs of Audit Committees within the ICS to be sought.	ASSURANCE achieved and ACTION AGREED for a report on risk management architecture within the ICB, and the wider system to be presented to the October meeting of the Committee.
Quarterly Governance Report - Freedom of Information Report. - Gifts and Hospitality Report. - Conflicts of Interest Report. - Information Governance Report.	ASSURANCE achieved.
CCG Closure/ICB Establishment Due Diligence Programme Report - All activities closed and therefore programme complete.	ASSURANCE achieved.
CCG's *Draft* Annual Report - *Draft* report for period 01/04/2022 to 30/06/2022 required to be submitted on 05/10/2022 presented to the Committee. - *Final* report for the same period to be submitted on 24/06/2023.	RECOMMENDATION made to Board that it delegates approval of the *draft* and *final* CCG Annual Reports for 2022/23 to the Audit Committee. APPROVAL given to *draft* Annual report, subject to Board's delegation of approval to the Audit Committee.
Complaints, Comments, Concerns and Enquiries Report - There has been a delay in responding due staff sickness. The arising backlog was being addressed and progress would be set out in future reports. - Resilience of the Complaints etc function was being considered.	ASSURANCE achieved.
Legal Cases Quarterly Report	ASSURANCE achieved.

Items for escalation:		
Item or issue	**Purpose for escalation**	**Escalated to**

System risk architecture	To provide assurance to the Board on the development and timeframe for the process for managing system risk	ICB Board

Items referred to the Board for Approval
Board Members are requested to DELEGATE to the Audit Committee approval of: - the *draft* CCG's Annual Report for submission on 05/10/2022; and - the *final* CCG's Annual Report for submission on 24/06/2023.

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Report Title:	Integrated Performance and Finance Summary Report
Report From:	Alison Cartwright, Chief Officer Performance and Delivery Madi Parmar, Chief Finance Officer Coventry and Warwickshire Integrated Care Board
Author:	Kerry Doughty, Head of Performance and Delivery Kay-Speed Andrews/Alistair Fleming, Finance Coventry and Warwickshire Integrated Care Board
Previous Considerations and Engagement:	N/A
Purpose:	For Assurance and Information

Contribution to meeting the aims of the ICS:

This report provides a summary of the activity and performance against the national performance standards and local priority indicators and provides information on the System Oversight Framework and overarching assurance process.

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.

The report outlines that the system is forecasting a £6.9m deficit at month 4 and the current actions being taken across the system to analyse and improve the position.

This summary aims to deliver the following ICS aims:

- Improving outcomes in population health and healthcare;
- Tackling unequal outcomes, experience and access;
- Enhancing productivity and value for money

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

Recommendation:

Members are requested to

- to note **the contents of the report for assurance** and to note the actions to improve performance as required.
- to note the financial position and actions being undertaken to mitigate the current forecast deficit and risks.

Implications							
Conflicts of Interest:	Not Applicable						
Financial and Workforce:	See detail within the report						
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:	Not applicable						
Clinical and Professional Engagement:	Not applicable						
Risk and Assurance:	High risk areas given current level of finance and 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 full reports which are reviewed at the ICB's Finance & Performance Committee.						

PERFORMANCE UPDATE

The full monthly performance pack with detailed exception reporting is sent to members of the Integrated Care Board's Finance and Performance (F&P) Committee on a monthly basis. The committee members of F&P have been asked to note the following areas of concern which are summarised below along with the associated actions to mitigate risks to the delivery of these standards.

1.1 Current delivery of local and national priorities

1.2 Delivery of the national constitution and local performance priorities continues to be challenging. In June 2022 only a small number (2 out of the 17 Constitutional and Acute priority indicators) were achieved, however Coventry and Warwickshire performance continues to generally benchmark well against regional and national peers. Full benchmarking information is contained within the Finance & Performance Committee main report to provide context and exception reports with recovery actions for the areas not achieving the required standard are detailed within this. The main NHS constitutional standards dashboard is included for information in Appendix 1.

1.3 In response to the 2022/23 NHS Operational Planning guidance, the System has agreed a set of improvement trajectories against the national priorities. In June, the majority of these indicators have been delivered, with the key areas of underperformance being 52 week waits and a slight decline in the 28 day faster diagnosis target for cancer. The current performance against the 2022/23 Operational Planning aspirations is included in Appendix 3.

Key areas of concern are:

1.4 ***Urgent and Emergency Care**:*
Urgent and Emergency services remain under pressure. While overall attendances have increased for the C&W population from 2021 by 3.3% when comparing the same period in 2022, there has been a decrease of 2.8% when comparing the latest year to pre-covid activity in 2019. However, this picture is different when comparing Trust level activity for the main acute providers. If we compare the activity for the first 3 months in 2021 to 2022 there is an increase of 9.2% and an increase of 2.2% comparing to pre-covid activity. This signals an increase in out of area activity from other commissioners which has increased from 14% of the total Trust activity to 20% when comparing current patient activity to those accessing A&E in 2019. This has particularly increased for both South Warwickshire Foundation Trust (SWFT) and the George Eliot Hospital (GEH). This continues to put pressure on the front door and is challenging delivery of the 4 hour target.

Undertaking a like for like comparison with urgent care data is difficult as there have been changes to the national coding of activity that is now classed at Same Day Emergency Care (SDEC) added to changes to the pathways following the pandemic. This makes a full impact analysis challenging. While non-elective admissions have increased, this is mainly to do with this coding change. As would be expected with an increase in A&E attendances from out of area, especially at SWFT and GEH, admissions from out of area have also grown. While the acuity of patients does not appear to have increased, the ability to discharge patients quickly due to locality of patient is compromised.

A number of actions are in place to support discharges, and therefore flow, through the System. A monthly Urgent and Emergency Care Board is in place which is attended by all partners.

1.5 ***Ambulance Handovers**:*
Ambulance Handovers continue to pose a significant risk across the System. None of the handover indicators are currently meeting the Operational Plan standards, however the System has agreed a local trajectory with NHS England to work to achieving these targets through 2022/23. The number of ambulances waiting longer than 60 minutes is currently not meeting the trajectory, and the position remains challenged.

An action plan at Provider and System level is in place to sit alongside the submitted trajectory to improve performance and clinical quality colleagues work closely with Providers to ensure there are robust

processes in place for identification and reduction of clinical harm. Trusts are maximising referrals through their SDEC route to support the reduction of these waits and total conveyances. Ongoing work with local authority colleagues continues on supporting timely discharges and maximising packages of care, although this remains an area of concern.

Winter plans are currently being finalised which will support urgent care system sustainability including the reduction in ambulance handovers.

1.6 ***Elective Waiting Lists****:*

There has been positive work within Coventry & Warwickshire on the Elective recovery position and treating the long waiting patients with zero 104 week waiters at the 3 System Acute Providers. There are currently 23 patients waiting outside the Coventry & Warwickshire System at out of area providers, in line with patient choice and treatment pathways. There has also been a positive decrease in the number of patients waiting 78 weeks with the operational planning trajectory being met and exceeded by all providers.

As a result of the positive decrease of the long waiting position, the System providers continue to support other West Midlands acute hospitals in providing capacity for treatment of patients waiting over 104 weeks in order to reduce waiting time inequity across the region.

Although the longest waiters are being treated, the total waiting list size continues to grow and was 103,087 in June with 5,523 of those patients waiting over 52 weeks, compared with 5,300 in May. There has been an increase of 15,692 patients to the waiting list comparing June 2022 to June 2021. Both SWFT and University Hospitals Coventry and Warwickshire (UHCW) are not yet meeting recurrent demand which is resulting in an increase to the waiting list with patients requiring to wait on average longer. The ICB is working collaboratively with providers to review the waiting list, specifically where there are areas/specialties with significant growth, and linking with referrers.

Plans are in place to expand the digital offer and Advice and Guidance, to improve access to specialists without the need for a referral. In addition, demand and capacity work is being undertaken to identify where there are capacity gaps within specialties.

Digital and Health Inequalities remain represented at Elective Care Delivery Board (ECDB) on a monthly basis. The ECDB is working on practically enacting digital health inequalities work into operational delivery, and this is in the early phase of work and included in all workstream programmes. The Index of Multiple Deprivation (IMD) score profile is also now included within the System Patient Tracking List (PTL) and the variation is being tracked by Trusts in order to reduce inequalities. Looking at the IMD distribution against average waiting times, patients from a more deprived area are generally waiting longer but this trend varies from geographical place.

1.7 Cancer

Cancer is a challenging area for Coventry & Warwickshire. With the exception of two of the 31 day performance targets, all remaining targets are not achieving the constitutional standards and this has been a concerning and sustained position since the pandemic. While the two week targets have been missed, Coventry & Warwickshire performed more favourably than the Regional and National average in June. The introduction of the 28 day faster diagnosis target and its aim to diagnose at least 75% of cancers by March 2023 aims to support recovery of this target, although there was a slight decrease when comparing Q1 2022/23 to Q4 2021/22. There is a System 28 Day Faster Diagnosis Delivery Group which provides leadership and oversight of the delivery of changes to support the successful move towards this standard.

As with the overall elective waiting list, demand is increasing due to a return to pre-pandemic levels in the level of referrals. Demand and capacity plans are being developed to reflect a post-pandemic position with regards to this increase in both activity and complexity.

1.7.1 62 Day Cancer Standard

In June, Coventry and Warwickshire achieved 59.9% against the 85% target, which benchmarks above Regional (49.9%) and in line with National (59.9%) performance. 95 patients were required to wait more than 62 days (out of 237 patients treated). Of these patients, 31 waited more than 104 days.

While the 62 day cancer backlog is performing better than the operational planning trajectory and is showing a declining position, the number of patients remains high. Delivery of the 62 day standard remains a key risk for the system moving forward. While the number of treatments during the year to date so far compared to levels in 2019 have been exceeded for the System, this varies by provider and is being monitored closely.

There is a System wide action plan with all providers engaged. Urology is an area that is being prioritised due to the complexity of the pathway and the proportion and high volume of patients that constitute the current backlog.

Due to the increase in backlog, the System has been included in Tier 2 (with Tier 1 being the most challenged providers with the highest risk of delivering the Operational Targets). Consequently, the regional team will work with the System to identify additional support and oversight to deliver improvement. This may include on-site visits and expert advice with a number of delivery expectations being set.

1.8 Mental Health

Delivery of the Mental Health targets is also challenging with 6 of the 17 national/local targets meeting the required standard (please see Appendix 2). Areas of particular concern are:

1.8.1 Autism Assessments

There is a long term action plan in place and a trajectory has been agreed with NHSE/I. However, the Neurodevelopmental service remains challenged, with additional funding being provided to support additional capacity needed to be able to deal with the backlog and the increase in referrals. Additional external providers have been commissioned, with five contracts currently running and a further four to come online to provide further assessment capacity.

Recruitment to specialised posts remains a risk, but this is being mitigated by contract negotiations with external providers, reviewing developmental roles and skill mix within teams.

1.8.2 Improving Access to Psychological Therapies (IAPT)

The access target continues to be missed with patients then experiencing length delays for secondary treatment.

A weekly steering group has been established. The purpose is to identify, track and monitor seps to create additional capacity to increase treatment slots. Areas with less waits are supporting those with longer waits to meet the waiting times trajectory and reducing inequity across places.

1.9 Primary Care

General Practice remain under pressure and activity continues to be above pre-pandemic levels; total face to face appointments have increased from 2021 levels and continue to rise. Primary Care activity in June 22 was at 117% of pre-pandemic levels.

FINANCE UPDATE

3.1 Year-To-Date and Forecast Outturn System Position

3.2 The System has reported a £0.9m deficit at month 4, £6.9m adverse to Plan and is currently forecasting a Year-End (Y/E) deficit of £6.9m against the breakeven plan.

Table 1 – System Financial Summary

	System Summary Financial Position Month 4					
	Year-to-date			Forecast		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
UHCW	(£3.55m)	(£9.46m)	(£5.91m)	(£14.80m)	(£20.43m)	(£5.63m)
SWFT	£1.00m	£0.01m	(£1.00m)	£3.00m	£3.00m	£0.00m
GEH	(£0.57m)	(£1.06m)	(£0.49m)	£0.00m	£0.00m	(£0.00m)
CWPT	£7.68m	£8.19m	£0.51m	£7.40m	£7.40m	£0.00m
Total Providers	**£4.55m**	**(£2.33m)**	**(£6.89m)**	**(£4.40m)**	**(£10.03m)**	**(£5.63m)**
CWCCG / CW ICB	£1.47m	£1.36m	(£0.11m)	£4.40m	£4.40m	£0.00m
Total	**£6.02m**	**(£0.98m)**	**(£7.00m)**	**(£0.00m)**	**(£5.63m)**	**(£5.63m)**

4.0 Efficiency Programme Performance

4.1 Efficiency Programme Performance is a key area of risk for the System, requiring ongoing scrutiny and focus. Year-To-Date (YTD) there is a 38% shortfall (driven by UHCW, ICB and SWFT), with UHCW forecasting a Y/E £10.1m efficiency undershoot. NB: UHCW report a focus on efficiency scheme

4.2 Development, through external consultancy support and a series of internal events.

Table 2 – System efficiency programme summary as at M4

	System Efficiency Summary Month 4					
	Year-to-date			Forecast		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
UHCW	£8.18m	£4.86m	(£3.32m)	£38.79m	£28.67m	(£10.12m)
SWFT	£3.35m	£1.12m	(£2.23m)	£10.05m	£10.05m	£0.00m
GEH	£1.74m	£2.34m	£0.60m	£8.43m	£8.43m	£0.00m
CWPT	£3.58m	£4.00m	£0.41m	£14.36m	£13.99m	(£0.36m)
Total Providers	**£16.85m**	**£12.31m**	**(£4.54m)**	**£71.62m**	**£61.14m**	**(£10.48m)**
CWCCG / CW ICB	£4.14m	£0.71m	(£3.44m)	£12.46m	£12.46m	£0.00m
Total	**£20.99m**	**£13.02m**	**(£7.97m)**	**£84.08m**	**£73.60m**	**(£10.48m)**

4.3 The key areas of efficiency risk that the System needs to address are:

- 47% (£39.8m) of Plans are Non-Recurrent (NR) and include mitigations
- 21% (£17.7m) of Plans are unidentified (reduced from 41% - £34.7m @ M3).

4.4 An updated system efficiency deep dive is being actively undertaken and includes:

- Understanding of NR schemes and if feasible to either implement recurrently or identify mitigations proposed by each provider; the ICB are utilising NR mitigations within their Breakeven Efficiency Forecast Outturn (FOT).
- Organisational actions / internal plans to address unidentified schemes 'gap' in year.
- Developing recurrent transformation and productivity and efficiency plans to mitigate against non-recurrent schemes.
- Key system schemes by value detailed analysis.

4.5 Pay Run Rate and Agency Trajectory

4.6 The System is circa £12m above its planned pay expenditure at month 4, with a year-end forecast overspend of circa £30m. Further analysis is needed by organisations to review drivers of the pay overspends and mitigating actions, linking to operational performance. This will be scrutinised and evaluated in detail in the Month 5 System report.

4.7 There is a renewed focus on agency expenditure controls during 2022/23, driven by the increasing agency costs reported throughout the pandemic and an expectation that Systems will now focus on reducing these costs.

4.8 Agency ceilings have been set to reflect agency expenditure reductions across systems of at least 10% compared to 2021/22 which was reflected in the planning for C&W ICS. However, there is a £5.2m YTD overspend against this plan – therefore, there is a need to identify actions to reduce the current run rates

4.9 Elective Services Recovery Plan

4.10 The following table shows the YTD and forecast ESRF System position. Whereas there has been some improvement in performance (noted above) the System is not currently delivering the 104% of 2019/20 activity value required to secure the full payment – SWFT 93%; GEH 90%; UHCW 100%. However, NHSE/I have confirmed that H1 ESFR income is 'blocked' due to high Covid levels and emergency activity being experienced by Systems. The System has developed a provider lead ESRF forecasting model to provide an early indication of performance; this will continue to be tested to ensure no missed opportunity.

4.11 The System allocation was distributed to providers. However, the use of the Independent Sector and Other Acute for GP activity commissioned by the ICB is forecast £2m over plan and this needs to be offset against the ESRF allocation and actions taken to ensure this is correctly reimbursed to the system.

Table 3 – System ERF Position as at M4

	System ERF Position Month 4					
	Year-to-date			Forecast		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
UHCW	£7.56m	£7.56m	£0.00m	£22.69m	£22.69m	£0.00m
SWFT	£2.76m	£2.76m	£0.00m	£8.29m	£8.29m	£0.00m
GEH	£1.57m	£1.57m	£0.00m	£4.71m	£4.71m	£0.00m
CWPT	£0.02m	£0.02m	£0.00m	£0.07m	£0.07m	£0.00m
Total Providers	**£11.92m**	**£11.92m**	**£0.00m**	**£35.75m**	**£35.75m**	**£0.00m**
CWCCG / CW ICB	£0.00m	£0.00m	£0.00m	£0.00m	£0.00m	£0.00m
Total	**£11.92m**	**£11.92m**	**£0.00m**	**£35.75m**	**£35.75m**	**£0.00m**

5.0 Capital Updates

5.1 YTD the System is c. £1m underspent against the System capital allocation and c. £1.8m underspent against the net Capital Departmental Expenditure Limit (CDEL) - the CDEL is the budget limit and covers all capital spending (i.e. PDC funded schemes). The Y/E forecast is a breakeven spend against the System capital allocation and a £1.3m undershoot against the CDEL.

Table 4 – System Capital summary

	CWPT YTD Variance £000s	SWFT YTD Variance £000s	GEH YTD Variance £000s	UHCW YTD Variance £000s	Total YTD Variance £000s	CWPT Y/E Variance £000s	SWFT Y/E Variance £000s	GEH Y/E Variance £000s	UHCW Y/E Variance £000s	Total Y/E Variance £000s
Total Charge against Capital Allocation (including impact of IFRS 16)	1,378	1,177	412	(1,988)	**979**	-	-	-	-	**-**
Impact of IFRS	-	-	-	-	**-**	-	-	-	-	**-**
Total Charge against Capital Allocation (before impact of IFRS 16)	1,378	1,177	412	(1,988)	**979**	-	-	-	-	**-**
Other Capital	-	245	(5)	1,528	**1,768**	-	389	-	897	**1,286**
Net CDEL excl. PFI	**1,378**	**1,422**	**407**	**(460)**	**2,747**	**0**	**389**	**0**	**897**	**1,286**

5.2 There have been some significant in-year additional System capital bids:-

- CDC capital of £34.1m over the next three years has been confirmed by NHSE/I, with phasing discussions ongoing.
- The System has bid for circa £3m of General and Acute capital to support increased capacity for the Winter Plan.
- The System has also been invited to bid for Front Line Digitisation capital (submission due 9th September).

6.0 Programme spend

6.1 MHIS - The ICS plan is to hit the Mental Health Investment system target with improvements on the Mental Health targets and in line with joint prioritisations of investment between ICB and CWPT. Additionally supporting SDF funding has been prioritised with expenditure plans in place. This remains on target for the financial year. Any in-year slippage will be reported as well as how to mitigate and ensure that the funds are used appropriately in-year.

6.2 Autism - As outlined in the Performance section above additional funding has been provided to support additional capacity needed to be able to deal with the backlog and the increase in referrals. Additional external providers have been commissioned, with five contracts currently running and a further four to come online to provide further assessment capacity. This will continue to be re-forecast across the financial year.

6.3 Cancer - the ICB has received non-recurrent allocations of £2.3m to date. £1.1m is for the Lung Health Check programme run by UHCW with the remainder for Faster Diagnosis and Operational Improvement schemes at all three acute providers.

7.0 ICB position

7.1 The ICB summary financial position is outlined in table 5 and reflects the ICB position, showing forecast outturn breakeven against a surplus position of £4,320k.

7.2 There are a range of risks to be managed over the course of the year if the reported position is to be achieved. Notably managing growth and delivering efficiency in Continuing HealthCare (CHC) and Individual Packages of Care (IPOC), Prescribing and acute Independent Sector activity.

7.3 IPoC is showing an adverse variance to plan of £2.8m CHC, Mental Health Non-CHC and Long-Term Conditions. It should be noted that the use of non-recurrent measures have been utilised to achieve this position.

7.4 For CHC and Prescribing it is imperative that the efficiencies planned start to deliver over the course of the year. Early indications show there is some early slippage which is to be expected and can be mitigated but recurrently they need to be delivered to ensure a recurrent break-even position.

7.5 Forecast outturn for the year remains at breakeven, however the challenge is delivery of recurrent efficiencies. Should slippage continue the underlying deficit position will need to be addressed if non-recurrent measures continue to be utilised to achieve this position

Table 5 – ICB M4 Financial forecast

	FORECAST M4-12		
ICB Expenditure Analysis	Annual Budget	Forecast Actuals	Under / (Over) spend
	£000s	£000s	£000s
Revenue Resource Limit M4-12	(1,373,624)		
Acute Healthcare	715,417	716,408	(992)
Mental Health & LD	165,341	166,759	(1,418)
Community Services	112,832	113,851	(1,019)
Continuing Healthcare	78,232	80,001	(1,769)
Primary Care	19,382	18,853	529
Prescribing	113,581	112,422	1,158
Primary Care Delegated	124,755	124,755	(0)
Other Programme	26,173	22,726	3,447
Total Commissioning Services	**1,355,713**	**1,355,776**	**(64)**
Running Costs	13,591	13,591	0
Total ICB Net Expenditure	**1,369,304**	**1,369,368**	**(64)**
Allocation adjustment for reimbursable items		**64**	
TOTAL ICB Surplus/(Deficit)	**4,320**	**4,320**	**0**

End of Report

APPENDIX 1: NHS Constitution Rights and Pledges

June 2022 performance for Coventry and Warwickshire and its main providers is shown below:

Coventry & Warwickshire Clinical Commissioning Group NHS Constitution Measures

		21-22											22-23					
Measure	Annual Target	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Q1	Q2	Q3	Q4	21-22	Apr-22	May-22	Jun-22	Jul-22	Q1	YTD
Referral to treatment times (RTT)																		
Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral	92%	64.1%	64.5%	62.4%	62.6%	62.4%	61.9%	63.0%	65.6%	63.7%	62.3%	63.6%	60.8%	63.0%	61.8%		61.9%	61.9%
RTT > 52 weeks breaches - Incomplete Pathways (Snapshot)	0	5,766	5,034	5,360	4,781	4,677	5,078	5,428	5,553	5,360	5,078	5,078	5,484	5,300	5,523		5,523	5,523
Patients waiting less than 6 weeks from referral for a diagnostic test	99%	92.2%	94.3%	93.7%	92.2%	93.9%	93.7%	92.9%	93.3%	93.2%	93.3%	93.2%	91.7%	91.9%	91.2%		91.6%	91.6%
A&E Waits																		
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	70.9%	71.7%	73.2%	72.4%	72.9%	71.3%	85.3%	74.1%	71.9%	72.1%	76.5%	68.9%	71.7%	70.5%	70.9%	70.4%	70.5%
Number of patients spending >12 hours from decision to admit to admission	0	0	2	1	14	5	0	0	2	3	19	24	13	0	3		16	16
Cancer Waits																		
Cancer two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	86.2%	79.4%	88.4%	84.7%	83.3%	88.2%	85.5%	86.6%	84.4%	85.5%	85.5%	79.0%	90.0%	79.2%		83.2%	83.2%
Cancer two-week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	88.7%	58.2%	71.9%	86.7%	93.3%	87.9%	89.0%	95.3%	71.6%	89.2%	86.0%	89.2%	93.4%	84.1%		88.9%	88.9%
Cancer one month (31-DAY) wait from diagnosis to first definitive treatment for all cancers	96%	93.2%	95.5%	95.9%	93.0%	94.6%	95.0%	96.8%	95.0%	95.0%	94.2%	95.2%	94.5%	94.3%	96.5%		95.1%	95.1%
Cancer 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%	99.4%	100.0%	99.2%	99.2%	100.0%	100.0%	100.0%	99.8%	99.5%	99.8%	98.7%	100.0%	100.0%		99.5%	99.5%
Cancer 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	96.6%	98.6%	85.1%	69.9%	89.8%	92.4%	97.9%	95.8%	92.9%	84.4%	92.5%	96.1%	87.5%	88.1%		90.5%	90.5%
Cancer 31-day wait for subsequent treatment where that treatment is surgery	94%	92.5%	90.0%	92.1%	87.7%	93.9%	89.5%	89.9%	90.0%	91.5%	90.1%	90.4%	90.9%	92.9%	90.7%		91.8%	91.8%
Cancer two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	59.3%	57.1%	54.0%	48.4%	55.3%	61.9%	71.2%	59.8%	56.8%	55.7%	60.6%	51.5%	52.5%	59.9%		54.7%	54.7%
Cancer 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	64.9%	66.7%	55.0%	62.8%	60.4%	75.7%	72.9%	79.1%	62.0%	65.4%	69.6%	75.0%	69.6%	62.1%		69.4%	69.4%
Cancer 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient	85%	71.8%	76.2%	78.0%	77.3%	77.1%	77.8%	86.0%	77.9%	75.8%	77.4%	79.1%	75.6%	64.4%	84.8%		74.0%	74.0%

APPENDIX 2: NHS Local Mental Health Priorities

June performance for Coventry and Warwickshire at CWPT is shown below. Exception reports for non-compliant standards are detailed further on in the report.

Mental Health Dashboard

Indicator		Target	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Adult - % of service users experiencing a first episode of psychosis or ARMS (at risk mental state) who waits less than two weeks to start a NICE recommended package of care - Completed Pathways		60%	84.6%	83.3%	70.0%	94.7%	83.3%	71.4%	88.9%	100.0%	61.4%	47.1%	77.9%	42.9%	Not available
Dementia Diagnosis over 65 years		67%	56.2%	55.9%	56.0%	56.0%	55.7%	56.1%	55.7%	55.5%	55.5%	56.4%	56.3%	56.7%	56.5%
IAPT 6 weeks - Finished Treatment		75%	98.6%	97.0%	98.4%	97.8%	97.6%	95.8%	96.2%	94.4%	94.8%	93.8%	94.2%	90.0%	Not available, reporting month behind
IAPT 18 weeks - Finished Treatment		95%	99.3%	99.2%	100.0%	99.3%	100.0%	100.0%	100.0%	99.2%	100.0%	99.2%	100.0%	100.0%	
IAPT Access Rate (annualised)		25%	24.5%	22.8%	22.5%	21.6%	20.5%	22.2%	17.7%	19.7%	16.5%	16.2%	16.6%	18.6%	
IAPT Recovery Rate		50%	51.0%	54.0%	54.0%	53.0%	47.0%	50.0%	50.0%	47.1%	46.0%	51.0%	52.0%	50.0%	
CAMHS - Referral to Treatment (Emergency - 48 hours)		100%	97.8%	98.5%	97.5%	100.0%	100.0%	93.0%	95.7%	91.2%	80.9%	79.2%	78.4%	92.4%	87.3%
CAMHS - Referral to Treatment (Urgent - 5 working days)		100%	100.0%	100.0%	77.8%	90.9%	100.0%	78.6%	87.5%	87.5%	50.0%	42.9%	37.5%	60.0%	100%
CAMHS - Referral to Treatment (Routine - 18 weeks)		95%	100.0%	95.1%	97.7%	87.3%	82.7%	73.0%	83.9%	94.8%	95.1%	98.1%	93.1%	96.3%	100%
CAMHS - Referrals Received by Navigation Hub (All CAMHS)			944	943	567	729	926	985	850	587	468	403	1001	1004	803
CAMHS - Waiting time from initial appointment to follow up appointment (12 weeks)		95%	50.7%	48.7%	39.5%	37.1%	40.6%	44.2%	47.7%	42.1%	44.6%	38.1%	35.0%	33.8%	32.8%
CAMHS - ASD Waiting time from referral to assessment (Average wait)	School Age	TBC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	163	161	164	173	167	165
	Cov Pre-School		N/A	N/A	N/A	N/A	N/A	N/A	N/A	116	146	128	126	94	105
	Warks Pre-School		N/A	N/A	N/A	N/A	N/A	N/A	N/A	8	9	11	8	11	13
	Total		77	77	56	83	91	72	82	N/A	N/A	N/A	N/A	N/A	N/A
CAMHS - Number of ASD assessments undertaken each month			39	41	25	22	40	62	64	108	81	139	118	156	160
CAMHS - referrals for an assessment or treatment of any eating disorder will access NICE concordant treatment within 1 week for urgent cases		90% for 18/19	11.1%	33.3%			33.3%			21.7%			18.2%		
CAMHS - referrals for an assessment or treatment of any eating disorder will access NICE concordant treatment within 4 weeks for routine cases		90% for 18/19	24.5%	25.0%			19.6%			9.4%			8.3%		
CAMHS - patients will have an assessment within 48 hours of referral to ALT where medically fit		100%	97.8%	98.5%	97.5%	100.0%	100.0%	93.0%	95.7%	91.2%	80.9%	79.2%	78.4%	92.4%	87.3%
CAMHS - Looked After Children referred within 9 weeks - number of referrals			66		53			50			53			73	

APPENDIX 3: Trajectory Monitoring against the Operational Plan

The annual planning process requires trajectories to meet the requirements of the Operational Planning Guidance each year. The below shows the new standards, and the System's progress against achieving these within the required timescales. These trajectories are based on System providers in line with the submissions that were made and therefore do not take into account the waits at out of area providers, where patients may have chosen to go or for specialised treatment. These patients continue to be scrutinised as part of the regular monitoring mechanisms in place.

Indicator		Apr-22	May-22	Jun-22	03/07/2022	10/07/2022	17/07/2022	24/07/2022	31/07/2022
Deceasing trend of 52 week waits by March 2023	Actual	4198	4363	4767	5097	5299	5412	5536	5560
	Target	4515	4467	4470	4454	4454	4454	4454	4454
	Variance	**-317**	**-104**	**297**	**643**	**845**	**958**	**1082**	**1106**
Zero over 78 week waits by March 2023	Actual	433	313	164	175	184	200	179	155
	Target	456	452	429	382	382	382	382	382
	Variance	**-23**	**-139**	**-265**	**-207**	**-198**	**-182**	**-203**	**-227**
Zero over 104 week waits by June 2022	Actual	0	0	0	0	0	4	5	6
	Target	56	38	0	0	0	0	0	0
	Variance	**-56**	**-38**	**0**	**0**	**0**	**4**	**5**	**6**
Return the 62 day cancer backlog to the level in February 2020	Actual	382	421	474	475	455	447	442	454
	Target	512	520	527	527	527	527	527	527
	Variance	**-130**	**-99**	**-53**	**-52**	**-72**	**-80**	**-85**	**-73**
Data only available for current month									
Achieve the 75% 28 day faster diagnosis target by March 2023	Actual	*Data incomplete*	70.3%	69.9%					
	Target		70.3%	71.0%					
	Variance		**0.0%**	**-1.1%**					
Reduce 12 hour waits in ED towards zero and no more than 2%	Actual	0.2%	0%	0.04%					
	Target	2%	2%	2%					
	Variance	**-1.8%**	**-2.0%**	**-2.0%**					
Learning disability registers and annual health checks delivered by GPs	Actual	2.0%	3.3%	3.6%					
	Target	1.4%	1.4%	1.4%					
	Variance	**0.6%**	**1.9%**	**2.2%**					
Maximise 2 hour urgent community response	*Data source in the proces of being established*								
Reduction of community service waiting lists									

Validated data is provided for all indicators for April, May & June where available. Where Provisional data is provided weekly, this is shown in the table above to give a more up to date snapshot of the current position. The elective indicators are doing well against the trajectories with the exception of the over 52 week waiters.

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NHS
Coventry and Warwickshire
Integrated Care Board

Report Title:	Joint Committee arrangements between the West Midlands ICBs
Report From:	Philip Johns, Chief Executive Officer, Integrated Care Board
Author:	West Midlands CEO Group
Previous Considerations and Engagement:	West Midlands CEO Group July 2022
Purpose:	For Decision

Contribution to meeting the aims of the ICS:

- The purpose of the report is to inform the Integrated Care Board ('ICB') regarding the proposals for a joint committee arrangement between the six West Midland ICBs.
- The report summarises potential areas of joint working in section 3.6 of the report. A joint committee will provide the mechanism to enable the ICBs to both oversee, set objectives for, and review the work together.
- The proposal details where joint commissioning arrangements will aid decision taking and will be beneficial to support the delivery of the NHS Constitution, the triple aim as well the four aims of the ICS and the ICB 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 Coventry and Warwickshire

Contribution to meeting the priorities of the ICB:

- The joint committee is a committee of the six ICBs (not the six ICSs) and is accountable to the six ICB Boards.
- The joint committee will review efficiency opportunities and look to maximise benefits of working at scale as well as looking at shared arrangements for building intelligence capabilities, collaboration between systems and opportunities to work with the West Midlands Combined Authority.

Recommendation:

Members are requested to **APPROVE** the Terms of Reference (ToR) **NOTING** the expectation that the terms of reference will be reviewed as delegation arrangements progress in 2023/24.

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NOTE the Commissioning Framework and **APPROVE (**as part of the ToR) that the Committee will determine the most appropriate arrangements for each activity and/or function.

Implications							
Conflicts of Interest:	None relevant to this report						
Financial and Workforce:	None relevant to the report						
Performance:	None relevant to the report.						
Quality and Safety:	None relevant to 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**		**No**	✓	**N/A**	
Patient and Public Engagement:	Changes are governed by national policy and legislation.						
Clinical and Professional Engagement:	None relevant to this report						
Risk and Assurance:	None identified						

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NHS
Coventry and Warwickshire
Integrated Care Board

Executive Summary

1. Purpose:

1.1 This paper sets out the proposals for the initial joint committee arrangements between the six West Midlands ICBs.

1.2 There are a number of areas where it will either be beneficial, or necessary, for the six ICBs to collaborate and make joint decisions. It is the intention for this committee to provide this mechanism.

1.3 This proposal is to enable the six ICBs to put in place an initial arrangement with immediate effect, at the inception of the ICBs but it is anticipated that these arrangements will develop and be reviewed and revised by the ICBs together over time as circumstances an opportunities evolve.

1.4 The proposed Terms of Reference for the Committee is included as annex one.

1.5 The proposed initial commissioning framework against which the committee will operate and delegated activities will be conducted, is enclosed as annex two.

2. Key Principles for joint working:

2.1 The ICBs start from a shared principle of subsidiarity – so that joint arrangements will only be put in place where there is a clear demonstration of the added value that is being derived from the joint arrangement.

2.2 Consequently, the ICBs will expect to undertake a SWOT analysis comparing the pros and cons of undertaking functions on a West Midlands basis vs retaining those functions within their respective ICBs as a prerequisite.

2.3 The joint arrangements will be expected to support the delivery of the NHS constitution, the triple aim, as well as the four purposes of the ICBs, namely:

2.3.1 improving health outcomes;
2.3.2 improving health inequalities;
2.3.3 improving clinical effectiveness and/or value for money;
2.3.4 supporting the wider economic impact of the ICBs.

2.4 Any joint functions overseen by the joint committee will be organised in such a way that it both:

2.4.1 enables the delivery of expert capabilities at scale which would otherwise not be possible for the ICBs individually to undertake individually;

2.4.2 operates efficiently and effectively;

2.4.3 uses the best possible available (clinically led) intelligence to inform decision-making;

2.4.4 Is mindful of the ICBs public accountabilities and public opinion;

2.4.5 has clear governance and lines of accountability back to the ICBs (and to NHSEI for delegated functions).

3. Potential areas of joint working:

3.1.1 The ICBs will be expected to take on the delegation of all primary care from NHSEI from April 2023. So there needs to be a mechanism for join decision-making on both any areas of these services where the ICBs may decide to commissioning jointly; but also particularly in the coordination and oversight of any joint functions that are needed to discharge the ICBs' responsibilities in these areas. The delegation agreement between NHSEI and the ICBs specifically states that: '*The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies…'* and that '*The ICB must develop an operational scheme of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions.'*

3.2 The ICBs will also be expected to take on the delegation of some specialised services (likely from April 2023). So similarly there needs to be a mechanism in place both for the joint commissioning, and in the joint oversight, of shared support functions to enable the commissioning of these services.

3.3 The ICBs therefore need a shared mechanism in place in order to coordinate the joint preparation for these delegation arrangements.

3.4 The ICBs' are inheriting from their predecessor CCGs existing joint commissioning arrangements for 111/999 services which can therefore be incorporated into this new arrangement.

3.5 There are pre-existing cross-ICS collaborative arrangements in place which would most likely benefit from being repositioned to be aligned to this new joint ICB collaboration. So that there are clear lines of responsibility and accountability for such arrangements and to provide a clear mechanism for them to be reviewed (eg: joint clinical networks and alliances).

3.6 The ICB CEOs have begun to identify in joint discussions some areas which may benefit from shared collaborative efforts in the future and so a joint committee arrangement has the potential to provide any joint future oversight of such work. The areas that have been identified (in addition to primary care and specialised services delegation) are as follows:

3.6.1 Liaison with the West Midlands Combined Authority;
3.6.2 Review of future CSU arrangements / contract renewal / efficiency opportunities;
3.6.3 Shared arrangements for building intelligence capabilities and analysis – maximising the benefits of the existing Decision Support Network, working with East Midlands ICBs
3.6.4 Mutual aid on elective and cancer recovery and waiting lists, collaboration between systems;
3.6.5 Urgent and Emergency Care: looking at the interface with 111/999 arrangements, ambulance handover delays and the strategy on where people go/ conveyancing/ capacity distribution;
3.6.6 Provider productivity and provider collaboration arrangements – sharing intelligence, capabilities and oversight;
3.6.7 Workforce strategy: engagement on the HEE changes and new ways of working, standardising approaches across ICBs where appropriate;
3.6.8 Overall oversight of creating a new relationship with NHSEI on performance functions, transfer of functions, NHSEI/ICS collaboration.

3.7 There may also be opportunities in the future to receive NHSEI support / capacity / or bid proposals; or to work in partnership with other agencies (such as the West Midlands Combined Authority); which would require the ICBs to have collaborative arrangements in place (and which otherwise either would not be possible or available at an individual ICB level). This joint committee can therefore provide the mechanism for coordinating any such joint arrangements where this is mutually beneficial to the ICBs.

3.8 Most of these activities are areas which are either work-in-progress or which require further work to be done to clarify both existing and potential best-fit future arrangements. A joint committee will provide the mechanism to enable the ICBs to both oversee, set objectives for, and review this work together.

4. Terms of reference

4.1 Annex one sets out the proposed initial terms of reference for the joint committee.

4.2 The Joint Committee is a joint committee of the six ICBs (not of the six ICSs) and is therefore equally accountable to the six ICB Boards. As such the committee will report all decisions, actions and progress to the six ICBs.

4.3 The TOR of the joint committee is intended to be delegation-light at this stage, setting a direction of intent that can be built upon over time and as the new delegation requirements from NHSEI develop. Therefore, it should be noted that the TOR will need to be updated and reviewed on a regular basis initially – particularly once NHSEI have confirmed precisely how they expected the delegation of their services to be conducted and which services might be delegated.

4.4 The committee is intended to be an executive committee. However joint meetings will be held with ICB chairs when appropriate (potentially 3 times per year) to review strategic priorities and overall development of the ICB collaboration agenda.

4.5 Further consideration will also need to be given as to how this joint committee engages with and/or incorporates involvement of NHSEI (from a commissioning and development capacity) and other partners.

5. Commissioning Framework

5.1 There are a number of ways in which the activities that are overseen by the joint committee can be conducted. Annex two sets out the possible options and how governance and accountability arrangements would work in each instance.

5.2 It is proposed that whilst the ICB will determine the activities and functions that are delegated to the joint committee; it should be for the joint committee to determine the most appropriate arrangements for each activities/function.

5.3 It is also important to be clear that, by virtue of this being a joint committee, all of the ICBs will need to agree the same delegation of functions and services

6. ICB Decisions

6.1 The ICB is asked to **approve** the TOR and **to confirm** the expectation that the TOR will be reviewed as delegation arrangements progress through into 2023/24.

6.2 The ICB is asked to note the commissioning framework and to confirm (as part of the TOR for the committee) that it is for the committee to determine the most appropriate arrangements for each activity and/or function.

Annex one

West Midlands ICBs Joint Committee
Terms of Reference

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1. Joint Signatories:

1.1 This is the terms of reference for the Joint Committee between:

- Birmingham and Solihull ICB
- Coventry and Warwickshire ICB
- Herefordshire and Worcestershire ICB
- Staffordshire and Stoke-on-Trent ICB
- Shropshire, Telford and Wrekin ICB
- The Black Country ICB

1.2 Consequently the joint committee has responsibility for the functions delegated to it from the six ICBs covering the population of the six ICBs.

2. Delegated functions and activities:

The joint committee has delegated authority from the ICB for the following:

1.1 Preparation for the future joint collaborative arrangements with the other ICBs to support the delegation from NHSEI of primary care commissioning in accordance with section 13V and/or section 65Z6 of the NHS Act. This is with the expectation that the committee subsequently provides the joint governance oversight for such arrangements once they have been determined and subsequently approved by the ICBs.

1.2 Preparation for the future joint collaborative arrangements to enable the delegation from NHSEI of specialised services commissioning (also in accordance with section 13V and/or section 65Z6 of the NHS Act). This is with the expectation that the committee subsequently provides the joint governance oversight for such arrangements once they have been determined and subsequently approved by the ICBs, recognising that there will also still be an accountability for these arrangements back to NHSEI.

1.3 Oversight and co-ordination of the commissioning arrangements for the six ICBs in respect of 111 and 999 services and any associated shared commissioning functions.

1.4 Oversight and co-ordination of shared collaborative arrangements that may be determined by the ICBs (such as the co-ordination of clinical networks). This will include the production of proposals by the committee for approval by the ICBs for the appropriate alignment of accountabilities for any shared activities through the joint committee to the ICBs.

1.5 Provision of a forum for collective discussion, agreement and decisions by the constituent members of the committee that is consistent with the delegated limits of each ICB's standing financial orders. So enabling the ICBs to collaborate on areas of work and opportunities that arise.

1.6 Determination of the most appropriate commissioning governance and operation arrangements for any functions and services delegated to the committee by the six ICBs.

1.7 Determination of the most appropriate working group arrangements, reporting into the joint committee to enable the efficient and effective operation of the responsibilities that have been delegated to the committee by the six ICBs.

3. Accountability

3.1 The Joint committee is accountable to the six ICB Boards.

3.2 Consequently, and to assist with public accountability, the minutes of the joint committee, which will include a record of all actions and decisions taken by the committee, will be reported to the ICB public board meetings

4. Membership and quoracy

4.1 The joint committee will include the following members:

- The six ICB CEOs
- Consideration may be given to other members being in attendance at the committee. For example:
- The Senior Manager for the West Midlands ICB CEOs office
- NHSEI commissioning representative;
- West Midlands provider collaborative representative;

- West Midlands public health representative
- Finance and Clinical representatives from the ICBs

4.2 If an ICB CEO cannot attend then they will send a representative with full authority to act on their behalf.

4.2 For decisions that are made in relation to section1.5 then quoracy is not required as members are contributing based on their own limits of delegation.

4.3 Similarly for recommendations / and or proposals that are being submitted for approval by the ICBs, quoracy is not required.

4.4 For decisions in relation to the collective delegation of functions and/or services then all ICB CEOs (or their designated representative) would need to be in attendance for the decision to be quorate. All decisions will also need to be made in accordance with the delegation agreement between NHSEI and the ICBs where this is appropriate.

4.5 The meeting will be chaired by one of the ICB CEOs – to be determined by the committee.

5. Frequency of meetings

5.1 The committee will meet when and as often as determined necessary by its membership (most likely on a monthly basis).

Annex Two

Joint Commissioning Framework

1. Joint Principles

1.1 The ICBs start from a shared principle of subsidiarity – so that joint arrangements will only be put in place where there is a clear demonstration of the added value that is being derived from the joint arrangement.

1.2 The joint arrangements will be expected to support the delivery of the NHS constitution, the triple aim, as well as the four purposes of the ICBs, namely:

1.2.1 improving health outcomes;

1.2.2 improving health inequalities;

1.2.3 improving clinical effectiveness and/or value for money;

1.2.4 supporting the wider economic impact of the ICBs.

1.3 Any joint functions overseen by the joint committee will be organised in such a way that it both:

1.3.1 enables the delivery of expert capabilities at scale which would otherwise not be possible for the ICBs individually to undertake individually;

1.3.2 operates efficiently and effectively;

1.3.3 Uses the best possible available (clinically led) intelligence to inform decision-making;

1.3.4 Is mindful of the ICBs public accountabilities and public opinion;

1.3.5 has clear governance and lines of accountability back to the ICBs (and to NHSEI for delegated functions).

2 Commissioning arrangements

2.2 When considering the joint commissioning arrangements you need to consider both the joint commissioning governance arrangements as well as the joint operational delivery arrangements.

2.2.4 The former covers how the ICBs make joint decisions and conduct joint performance and assurance arrangements on the services that they are commissioning together.

2.2.5 The latter covers the means by which the ICBs conduct the functions and activities that enables the commissioning to take place.

2.3 It is important not to confuse these two sets of arrangements. For example it would be possible for different ICBs to take the lead (in governance terms) for different services; but for the operational functions that support these arrangements to be hosted by one ICB.

2.4 When planning to take on new services and/or functions the joint committee will need to undertake an options appraisal to determine the most appropriate model to use.

3 Joint Commissioning Governance options:

3.2 Lead Commissioner Model

3.2.4 In this arrangement one ICB (or potentially NHSEI for specialised services) hosts the commissioning of the service(s) and therefore takes responsibility for the commissioning of those service(s) on behalf of the other members.

3.2.5 This includes providing the sub-governance arrangements (such as quality assurance, financial and contractual management oversight). Ordinarily such sub-governance arrangements would be incorporated into the lead commissioner's committees, such as quality and assurance committee and finance and performance committee. Through these arrangements the lead commissioner is then able to take full responsibility for the commissioning of the service(s).

3.2.6 The relevant outputs from the lead commissioner's assurance processes would be reported to the ICB joint committee by the lead commissioner. This then provides the mechanism to enable clear lines of accountability from the lead commissioner to the six ICBs.

3.2.7 Note: it would be possible for different services to be led by different ICBs (eg: primary care arrangements by one ICB; specialised services by another; 111/999 by another) or for all to be led by one.

3.2.8 Such an arrangement would normally work well for the commissioning of a specific service from a single provider (such as 111/999).

3.2.9 Such an arrangement would normally be best supported by either a host provider or contracted provider model (see below).

3.3 Shared Commissioning Model

3.3.4 In this arrangement the six ICBs jointly share the responsibility for the commissioning of the service(s) so no individual ICB is leading on behalf of the others.

3.3.5 To enable this arrangement to work then there would need to be jointly organised sub-governance arrangements (such as joint quality assurance processed and joint financial management processes) which reports into the joint committee. This would therefore require the establishment of relevant joint working groups through which these joint processes would be conducted. These joint arrangements would be in place solely for the oversight of the shared services (ie: they stand apart from any other governance arrangements in the ICBs).

3.3.6 The relevant outputs from the joint working groups would report in to the joint committee.

3.3.7 Such an arrangement would normally work well for activities that do not require substantial/complex oversight and/or are delivering shared functions as opposed to delivering front-line services (such as oversight of shared clinical networks).

3.4 Network Commissioning Model

3.4.4 In this arrangement the six ICBs take a distributed leadership and governance approach to the commissioning of a service. So ICBs will make collective decisions on how a service is to be commissioned but then each ICB oversees the arrangements in their own system.

3.4.5 The sub-governance arrangements (such as quality assurance, financial and contractual management oversight) are undertaken by each ICB for their own local system. Note this may include acting on behalf of other ICBs where they are associates to the main ICB's contract.

3.4.6 The outputs, where relevant would be reported back by each ICB to the joint committee.

3.4.7 Such an arrangement would normally work well where you might want to make a joint policy decision but then enact it separately; or where you want to take the same approach to a service but it is provided by multiple organisations (ie: in several ICSs) so it makes sense for the oversight to be incorporated into each ICB's existing arrangements rather than undertaken separately.

4 Joint operational delivery arrangements:

4.2 Hosted Model

4.2.4 In this arrangement the lead ICB take full responsibility for the function. Therefore the host ICB is accountable to the joint committee for all of the outputs and performance of this function.

4.2.5 This would include the employment of staff and the organisation of financial arrangements.

4.2.6 Consequently the staff would be working in accordance with the host ICB's HR policies and procedures; similarly the financial arrangements would follow the host ICBs SOs and SFIs.

4.3 Hosted (subcontracted) model

4.3.4 In this instance the hosted model includes the host ICB subcontracting the functions from a 3rd party (such as a CSU). In this instance the host ICB retains responsibility for the function, manages the CSU contract and reports to the joint committee accordingly.

4.4 Shared model

4.4.4 In this arrangement the ICBs establish a shared resource/team that works to support shared arrangements across the ICBs.

4.4.5 You would still need there to be a single employer for the staff who are working in this shared team (and as such the team works in accordance with the host employers HR policies and procedures.

4.4.6 However the team (usually through a lead manager) would be held jointly responsible equally by all 6 ICBs, through the joint committee for the activities of the team working on behalf of all 6 ICBs.

4.5 Shared (subcontracted) model

4.5.4 It would similarly be possible for the shared model to be subcontracted from a 3rd party. In this instance the 6 ICBs would all agree the terms of the 3rd party contract (through the joint committee) and each ICB would be a joint contract-holder with the 3rd party.

4.6 Distributed model

4.6.4 In this arrangement the ICBs each take responsibility for the function in their own organisation but there is a collaborative arrangement whereby those functions work together for mutual benefit.

4.6.5 Each ICB employs their own staff working to their own HR policies, financial SOs and SFIs.

4.6.6 Each ICB makes a commitment to the others for their own individual contribution that they make to the collective effort.

End of Report

Enc Q

NHS
Coventry and Warwickshire
Integrated Care Board

Report Title:	Community Prototypes
Report From:	Kirston Nelson Chief Partnerships Officer and Director of Education and Skills, Coventry City Council
Author:	Michelle McGinty Strategic Lead for Transformation and Change, Coventry City Council
Previous Considerations and Engagement:	Not Applicable
Purpose:	For Discussion

Contribution to meeting the aims of the ICS:

The community prototypes enable the development of more preventative and better joined-up approaches to service delivery, across sectors and in collaboration with communities, supporting the ICB aims of:

- Improving outcomes in population health and healthcare
- Tackling unequal outcomes, experience and access
- Supporting the broader social and economic development of Coventry and Warwickshire

Contribution to meeting the priorities of the ICB:

Within the prototypes, organisations and services work closely together in local community settings, strengthening partnership approaches, and providing more immediate and wraparound support to residents, aligning with the ICB Priorities of:

- 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

Recommendation:

Members are requested to discuss and support the community prototype approach set out within this Report and commit to exploring opportunities for working together. This is about ensuring that, in line with the ICS priority 4, the ICB adds value to the work that the local authority is doing with partners to promote, health, wellbeing and socio-economic inclusion amongst the residents of Coventry.

Enc Q

Implications							
Conflicts of Interest:	Not Applicable						
Financial and Workforce:	Not Applicable						
Performance:	Not Applicable						
Quality and Safety:	Not Applicable						
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**	ü
Patient and Public Engagement:	Not Applicable						
Clinical and Professional Engagement:	Not Applicable						
Risk and Assurance:	Not Applicable						

Enc Q

NHS
Coventry and Warwickshire
Integrated Care Board

Executive Summary

1.1 **Key points and purpose**

The purpose of this paper is to provide information on Coventry City Council's ongoing place-based work with partners and communities to develop ideas for integration, stronger partnership working, and more effective use of our collective resources through community prototypes.

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**

The community prototypes enable the development of more preventative and better joined-up approaches to service delivery, across sectors and in collaboration with communities, supporting the ICB aims of:

- Improving outcomes in population health and healthcare
- Tackling unequal outcomes, experience and access
- Supporting the broader social and economic development of Coventry and Warwickshire

Within the prototypes, organisations and services work closely together in local community settings, strengthening partnership approaches, and providing more immediate and wraparound support to residents, aligning with the ICB Priorities of:

- 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

2. One Coventry Approach to delivering One Coventry Priorities

2.1 The need to work differently in order to respond to the future needs of our communities, and the changing role of the council, is well recognised. Through a One Coventry approach, our partnership and communities work ensures that we are well placed to make the best use of our collective capacity and resource across the city.

2.2 While this approach means that we are in a strong position to support our residents, we need to work more creatively with our collective resource, in collaboration with our residents, communities and partners to:

- make the biggest possible positive impact, and
- enable us to deliver our One Coventry Plan priorities, particularly 'to improve outcomes and tackle inequalities in our communities'.

2.3 Community prototypes are enabling us to develop that collective creativity and resourcefulness, drawing upon lessons learnt from both the city's collaborative response to the COVID pandemic and wider research. The approach is also actively enabling a practical response to the current Cost of Living crisis (please see earlier item on the agenda re. Cost of Living).

3. Vision & Scope

3.1 The community prototypes are underpinned by a vision:

'To increase earlier identification of issues and opportunities for prevention or early help, and to enable the delivery of integrated support and services, through a locality approach which focuses on improving the quality of the lives of local residents, building community capacity and making the most effective use of city-wide resources.'

3.2 The scope of the work encompasses:

- achieving the right outcomes through provision of the right support, in the right place, at the right time, and delivered through the right means;
- creating joined-up and locally relevant services;
- using insight and data for increased identification and prevention, targeting resources to those most in need; and
- prototyping new ways of working and delivery models within communities;

while ensuring clear correlation of delivery with other strategic priorities and the One Coventry Plan 2022 – 2030.

4. Community & Neighbourhood Integration: One Coventry, Delivered Locally

4.1 Consideration is given to both needs (insight and data) and opportunities when selecting the localities in which to deliver the community prototypes. A baseline is established and validated with partners to understand local levels of deprivation and health inequality, as well as drawing upon data and local insight to identify specific challenges, community assets and strengths. This baseline is then tested with communities to determine potential opportunities to work together to make a positive impact in the local area. The first community prototype commenced last year in the Bell Green, Wood End and Henley locality, followed by a second prototype this year in Canley and Tile Hill.

4.2 Council officers are working with and in the heart of the community alongside cross-sector partners to understand and collectively address priorities and to develop preventative and integrated approaches to improving resident outcomes. There has been strong commitment from all involved to try things out and develop and improve ideas as we go, informed by local need and feedback. Current and planned focus areas include:

- Effective partnerships – partners and communities working together in a One Coventry way, developing stronger networks and wraparound approaches, sharing insights and data, smoothing referral pathways and easing access between partners and specialist support, embedding services with partners, sharing learning and skills, and creating awareness of the range of help available in order to make every contact count
- Accessibility of services and support through co-location and touchdown, including community pop-up events. Services coming together include council community support workers, Children's Services youth worker, family hub 'here to help', digital inclusion support, job coach, PCSOs, social broker, mental health outreach, social prescribing team, Severn Trent community advisers.
- Specialist Advice – providing virtual and face-to-face access to specialist agencies from community settings, supporting our most vulnerable residents to access support for example

around debt and benefits entitlement and specialist legal advice, domestic violence, rape and sexual abuse

- Digital Inclusion – helping people to get online and to improve digital skills
- Health and Wellbeing – supporting CW Mind to develop mental health outreach, joining up around sexual health education for young people, community-informed smoking cessation campaign, local wellbeing4life campaign, DV support
- Supporting people into work – providing access to specialist job coaches, local job fairs and pop-ups designed around the community's needs, supporting people to secure jobs, training and apprenticeships, and to be work ready
- Schools and young people – partnering with local school leaders to better support them to help families and young people in need, developing the role of schools in supporting the wider community, and piloting a place-based approach to increasing attendance and improving support for vulnerable pupils
- Opportunities to develop health integration within prototypes including embedding ICS objectives and testing new ways of working and engaging with communities.

5. Emerging Lessons

5.1 Partners regularly review impact and adjust approach as needed, gathering lessons learnt to inform the wider roll-out of place-based partnership approaches in other parts of the city. Our ambition is to scale this up, learning and adapting as we go.

5.2 Key lessons learnt and success factors identified include:

- Collaboration: buy-in from partners is crucial from the outset; allowing sufficient time and space to exchange views, to listen to people, prioritise ideas as well as co-design activities and approach is fundamental to success
- Importance of place, social history, and local knowledge: recognising the significance of local buildings and places in the community and 'going where people already go' rather than starting afresh; acknowledging and learning from past successes and failures within the locality; extracting the knowledge and experience from partners on the frontline is just as important as gathering data insights
- Iteration: a 'design as we go' and 'fail fast' mindset is essential; evaluating the impact of work in progress can be challenging but listening to feedback and acting upon it instils confidence
- Relationships: building trusted relationships within the community and residents and also between partners (and allowing time to do so) is critical to success. Leveraging the existing trusted relationships between residents and community leaders has helped immensely.
- Engagement approach: informal, proactive, and conversational approaches have worked best, using people, community organisations, places, and channels that are already familiar and trusted. Embedding with community organisations and losing our formal 'front doors' and 'badges' has helped build trust both with community volunteers and residents.

Conclusion

Development of the community prototypes is ongoing. Early evidence (feedback and real-life stories) suggests that working in localities in the way that we are, is achieving positive outcomes. Partnerships have been strengthened through closer, more collaborative working in a way that is focused on resident outcomes. This work presents an exciting opportunity to make a real difference to the lives of local people.

Recommendation

Members are requested to discuss and support the community prototype approach set out within this Report and commit to exploring opportunities for working together. This is about ensuring that, in line with the ICS priority 4, the ICB adds value to the work that the local authority is doing with partners to promote, health, wellbeing and socio-economic inclusion amongst the residents of Coventry.

End of Report

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For Enquiries regarding these papers please email icb.cwgovernance@nhs.net

www.happyhealthylives.uk