Coventry and Warwickshire Integrated Board (Shadow)

Papers for the Meeting

16 March 2022, held via MS Teams

14.00 – 16.00

Coventry and Warwickshire
Health and Care Partnership

COVENTRY AND WARWICKSHIRE INTEGRATED CARE BOARD (SHADOW)

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

A G E N D A

No	Time	Item	Presenter	Enclosure	Pack No	Purpose
1. Standing Items						
1.1	14:00	Welcome and Apologies	Chair	Verbal		
1.2		*Confirmation of Quoracy*	*Chair*	*Verbal*		
1.3		Declaration of Interest	Chair	Enclosure A	Pack 1	Information
1.4		Minutes of the meeting held on 26 January 2022	Chair	Enclosure B	Pack 1	Endorse
1.5		Matters Arising/Action Schedule	Chair	Enclosure C	Pack 1	Information
1.6		ICS Chair Designate Report	Chair	Verbal		Information
1.7		ICS Chief Executive Designate Report	Phil Johns	Enclosure D	Pack 1	Information
1.8	14:15	Risk Register	Rachael Danter	Enclosure E	Pack 1	Endorse
Aim One: Improving outcomes in population health and healthcare						
2.1	14:25	Quality Update	Rebecca Bartholomew	Enclosure F	Pack 1	Information
Aim Two: Tackling unequal outcomes, experience and access						
Aim Three: Enhancing productivity and value for money						
3.1	14:35	People Workstream Update	Theresa Nelson	Enclosure G	Pack 1 Pack 2 (Dashboard)	Information

3.2	15.45	Medically Fit for Discharge	Rachael Danter	Enclosure H	Pack 1	Discussion
3.3	15.00	Finance Update	Adrian Stokes	Enclosure I	Pack 1	Information
3.4	15.15	Digital Strategy	Adrian Stokes	Enclosure J	Pack 1	Endorse
Aim Four: Supporting the broader social and economic development of Coventry and Warwickshire						
4.1	15.25	Transition to ICB Update	Rachael Danter	Enclosure K	Pack 1 Pack 2	Discussion
Transition to ICS						
5.1	15.45	Constitution and Scheme of Reservation and Delegation	Phil Johns	Enclosure L	Pack 1 Pack 2 (SORD and Constitution)	Information
6.	15:55	**Any Other Business**	Chair	Verbal		

Dates of Future meetings:

Date	**Time**	**Venue**
Wednesday 20th April 2022 Development session	2.00 - 4.00pm	Virtual by Microsoft Teams
Wednesday 18th May 2022 ICB Meeting	2.00 - 4.00pm	Virtual by Microsoft Teams
Wednesday 22nd June 2022 Development session	2.00 - 4.00pm	Virtual by Microsoft Teams
Friday 1st July 2022 ICB Meeting	10.00-12.00am	Virtual by Microsoft Teams
Wednesday 20th July 2022 ICB Meeting	2.00 - 4.00pm	Virtual by Microsoft Teams
Wednesday 17th August 2022 Development session	2.00 - 4.00pm	Virtual by Microsoft Teams
Wednesday 21st September ICB Meeting	2.00 - 4.00pm	Virtual by Microsoft Teams
Wednesday 19th October 2022 Development session	2.00 - 4.00pm	Virtual by Microsoft Teams
Wednesday 16th November 2022 ICB Meeting	2.00 – 4.00pm	Virtual by Microsoft Teams
Wednesday 21st December 2022 Development session	2.00 - 4.00pm	Virtual by Microsoft Teams
Wednesday 18th January 2023 ICB Meeting	2.00 - 4.00pm	Virtual by Microsoft Teams
Wednesday 15th February 2023 Development session	2.00 – 4.00pm	Virtual by Microsoft Teams
Wednesday 15th March 2023 ICB Meeting	2.00 – 4.00pm	Virtual by Microsoft Teams

Declarations of Interest

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

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

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

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

Current	First Name	Surname	Current position held	Declared Interest (name of the organisation and nature of business)	Type of Interest					ate of Interest	
					Financial Interest	Non-Financial Professional Interest	Non-Financial	Non-Financial Personal Interest	Indirect	Declared	To
Y	Councillor Margaret	Bell									
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	Kamran	Caan	Councillor, Coventry City Council	Nil							Current
Y	Melanie	Coombes	Chief Executive, Coventry and Warwickshire Partnership Trust	Nil							Current
Y	Rachael	Danter	System Tranformation Director	Nil							Current
Y	Jeremy	Gould	Non-Executive Director - UHCW	Nil							Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	1. Director of CCAB (Consultative Committee of Accountacy Bodies)				✓		07-Jul-20	Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	2. Non Executive Board Member, Global Health Data at Work (registered in Holland)				✓		01-Jul-20	Current
Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	3. Director/Trustee, Albany Theatre Trust			✓			01-Apr-15	Current

Y	Andy	Hardy	Chief Executive, University Hospitals Coventry and Warwickshire	4. Non Executive Board Member/Trustee			✓			Nov-21	Current
Y	Russell	Hardy	Chair, George Eliot Hospital/South Warwickshire NHS Foundation Trust	1. Chairman and majority owner of Maranatha 1 Ltd (trading as Fosse Healthcare Ltd and Fosse ADPRAC)	✓						Current
Y	Russell	Hardy	Chair, George Eliot Hospital/South Warwickshire NHS Foundation Trust	2. Chairman of Cherished			✓				Current
Y	Russell	Hardy	Chair, George Eliot Hospital/South Warwickshire NHS Foundation Trust	3. Chairman of Wye Valley NHS Trust							Current
Y	Julie	Houlder	Non-Executive Director, George Eliot Hospital	1. Non-Executive- Derbyshire Community Health Foundation Trust		✓				Oct-18	Current
Y	Julie	Houlder	Non-Executive Director, George Eliot Hospital	2. Chair of trustees-Sir Josiah Mason Trust		✓				Mar-14	Current
Y	Julie	Houlder	Non-Executive Director, George Eliot Hospital	3. Director Windsor Academy Trust		✓				Jan-19	Current
Y	Julie	Houlder	Non-Executive Director, George Eliot Hospital	4. Owner Elevate Coaching Ltd		✓				Oct-16	Current
Y	Julie	Houlder	Non-Executive Director, George Eliot Hospital	5. Associate Charis Consultants		✓				Jan-19	Current
Y	Philip	Johns	Accountable Officer, Coventry and Warwickshire CCG	1. Member of Chartered Institute of Public Finance Accountants (CIPFA)		✓				Dec-20	Current
Y	Philip	Johns	Accountable Officer, Coventry and Warwickshire CCG	2. Member of Healthcare and Financial Management Association (HFMA)		✓				Dec-20	Current
Y	Philip	Johns	Accountable Officer, Coventry and Warwickshire CCG	3. Wife is employed as an Occupational Therapist at South Warwickshire General Hospital Foundation Trust					✓	Dec-20	Current
Y	Philip	Johns	Accountable Officer, Coventry and Warwickshire CCG	4. Wife is Director of Seren Melyn - providing OT services					✓	Dec-20	Current
Y	Stella	Manzie	Chair, University Hospitals Coventry and Warwickshire	1. Associate, Global Partners Governance (no health related work)	✓						Current
Y	Stella	Manzie	Chair, University Hospitals Coventry and Warwickshire	2. Local Government Association executive support (no health related work)	✓						Current

Y	Stella	Manzie	Chair, University Hospitals Coventry and Warwickshire	3. Associate AS Associates (no health related work)	✓						Current
Y	Stella	Manzie	Chair, University Hospitals Coventry and Warwickshire	4. Various public sector management consultancy activity – not health related	✓						Current
Y	Stella	Manzie	Chair, University Hospitals Coventry and Warwickshire	5. Visiting Fellow Open University Business School		✓					Current
Y	Stella	Manzie	Chair, University Hospitals Coventry and Warwickshire	6. Trustee, Esmee Fairbairn Foundation (does not deal with health)		✓					Current
Y	Stella	Manzie	Chair, University Hospitals Coventry and Warwickshire	7. Trevor McCarthy (Partner) Independent Consultant in Addictions					✓		Current
Y	Stella	Manzie	Chair, University Hospitals Coventry and Warwickshire	8. Trevor McCarty (Partner) Associate Consultant, Figure 8 Consultancy – health and social care					✓		Current
	Nigel	Minns	Strategic Director, Warwickshire City Council								Current
Y	Danielle	Oum	Chair of Coventry and Warwickshire ICS	1. Chair of Birmingham and Solihull Mental Health FT	✓					Oct-21	Current
Y	Danielle	Oum	Chair of Coventry and Warwickshire ICS	Member of Healthwatch England Committee	✓					Oct-21	Current
Y	Simon	Page	Vice Chair at SWFT	Nil						Feb-22	Current
Y	Richard	Percival	Governing Body Lay Member - Finance and Audit	1.Independent Audit Committee Chair QueenAlexandra College, Harborne, Birmingham (No longercurrent as at October 2021, to be removed in April 2022)				✓		Apr-21	October 2021 - to be archived in April 2022
Y	Richard	Percival	Governing Body Lay Member - Finance and Audit	2.Governor Queen Alexandra College,Harborne, Birmingham				✓		Jul-21	Current
Y	Richard	Percival	Governing Body Lay Member - Finance and Audit	3.Member of Diabetes UK (no executive or decisionmaking responsibilities)				✓		Apr-21	Current
Y	Sarah	Raistrick	Chair, Coventry and Warwickshire CCG	1. Non voting member of GP Board		✓				Jan-19	October 2021 - to be archived in April 2022
Y	Sarah	Raistrick	Chair, Coventry and Warwickshire CCG	2. Member of West Midlands Clinical Senate		✓				Dec-19	October 2021 - to be archived in April 2022

Y	Sarah	Raistrick	Chair, Coventry and Warwickshire CCG	3. GP Partner Willenhall Primary Care Centre	✓					Jul-15	Current
Y	Sarah	Raistrick	Chair, Coventry and Warwickshire CCG	4. Practice is a Member of GP Alliance	✓						Current
Y	Sarah	Raistrick	Chair, Coventry and Warwickshire CCG	5. Husband is leader (I am a member) of a Church in Coventry supporting Hope Coventry initiatives.					✓		October 2021 - to be archived in April 2022
Y	Sarah	Raistrick	Chair, Coventry and Warwickshire CCG	6. Practice is a Member of Sowe Valley Cluster		✓					October 2021 - to be archived in April 2022
Y	Jagtar	Singh	Chair, Coventry and Warwickshire Partnership Trust	1. Jagtar Singh Associates Ltd, Consultancy Business to Fire, Police, NHS Bodies	✓					2005	Current
Y	Jagtar	Singh	Chair, Coventry and Warwickshire Partnership Trust	2. Chair of Bedford Police Audit	✓					2015	Current
Y	Jagtar	Singh	Chair, Coventry and Warwickshire Partnership Trust	3. Trustee of NHS Providers		✓				2017	Current
Y	Adrian	Stokes	Interim Chief Finance Officer, Coventry and Warwickshire CCG	1. Director of Flexible Solutions	✓					2004	November 2021 - to be archived in May 2022
Y	Dianne	Whitfield	NED - CWPT Representative	1. Trustee Rape Crisis England and Wales		✓				2009	Current
Y	Dianne	Whitfield	NED - CWPT Representative	2. Trustee West Mercia Rape Crisis		✓				2016	Current
Y	Dianne	Whitfield	NED - CWPT Representative	3. Investigator Board for national research project by Coventry University		✓				2018	Current
Y	Dianne	Whitfield	NED - CWPT Representative	4. Advisory Board member of The Centre for Child Sexual Abuse		✓				2019	Current

Unconfirmed Minutes of the Coventry and Warwickshire Integrated Care Board (Shadow) Held on Wednesday 26th January 2022 at 14:00 – 16:00 held by Microsoft Teams

Present		
Danielle Oum	Chair Designate, Coventry and Warwickshire ICS (Chair)	DO
Philip Johns	Accountable Officer, Coventry and Warwickshire Clinical Commissioning Group, CEO Designate Coventry and Warwickshire ICS	PJ
Dr Sarah Raistrick	Chair, Coventry and Warwickshire Clinical Commissioning Group	SR
Adrian Stokes	Interim Chief Finance Officer, Coventry and Warwickshire Clinical Commissioning Group	AS
Richard Percival	Lay Member - Governance and Audit, Coventry and Warwickshire Clinical Commissioning Group	RP
Rachael Danter	System Transformation Director, Coventry and Warwickshire Health and Care Partnership	RD
Dame Stella Manzie DBE	Chair, University Hospitals Coventry and Warwickshire NHS Trust	SM
Julie Houlder	Non-Executive Director, George Eliot Hospital NHS Trust	JH
Dianne Whitfield	Non-Executive Director, Coventry and Warwickshire NHS Partnership Trust	DW
Kirston Nelson	Chief Partnership Officer, Coventry City Council	KN
Melanie Coombes	Chief Executive, Coventry and Warwickshire NHS Partnership Trust	MC
Glen Burley	Chief Executive, George Eliot Hospital NHS Trust and South Warwickshire NHS Foundation Trust	GB
Jagtar Singh	Chair, Coventry and Warwickshire NHS Partnership Trust	JS
Russell Hardy	Chair, George Eliot Hospital NHS Trust and South Warwickshire NHS Foundation Trust	RH
Bruce Paxton	Non-Executive Director, South Warwickshire NHS Foundation Trust	BP
Councillor Margaret Bell	Warwickshire County Council	MB
In Attendance:		
Cheryl Brand	Executive Assistant, Coventry and Warwickshire Clinical Commissioning Group (Minutes)	CB
Jean McLeod	Work-shadowing the Chair	JM
Justine Richards	Chief Strategy Officer, University Hospitals Coventry and Warwickshire NHS Trust (in attendance for Andy Hardy)	JR
Ali Cartwright	Chief Planning and Performance Officer, Coventry and Warwickshire Clinical Commissioning Group	AC
Anita Wilson	Director of Corporate Affairs, Coventry and Warwickshire Clinical Commissioning Group	AW
Rebecca Bartholomew	Acting Chief Nurse, Coventry and Warwickshire Clinical Commissioning Group	RB
Rachel Chapman	Consultant in Public Health, University Hospitals Coventry and Warwickshire NHS Trust	RC
Pete Sidgwick	Assistant Director, Adult Social Care (Delivery), Warwickshire County Council	PS
Apologies:		

Andy Hardy	Chief Executive Officer, University Hospitals Coventry and Warwickshire NHS Trust	AH
Nigel Minns	Strategic Director for People, Warwickshire County Council	NM
Councillor Kamran Caan	Coventry City Council	KC
Jeremy Gould	Non-Executive Director and Chair of the Trust's Audit Committee, University Hospitals Coventry and Warwickshire NHS Trust	JG

Item No:		Action
1.	**Standing Items:**	
1.1	**Welcome, Introductions, Apologies** As above	
1.2	**Confirmation of Quoracy** While the meeting is in shadow form, providing there is one Chief Executive, Chair or Council member (for local authorities) from each organisation in attendance the meeting will be quorate.	
1.3	**Declarations of Interest** None.	
1.4	**Minutes of the meeting held on 8th December 2021** The members were happy to approve and agree the accuracy of the minutes.	
1.5	**Matters Arising/Action Schedule** The action log was updated.	
1.6	**ICS Chair Designate Report** Ms Oum welcomed all attendees to the first Board meeting of 2022 and noted that she had continued to meet with members and has welcomed the time, honesty and openness of those discussions. Ms Oum noted that it has been a particularly challenging operating environment and thanked everyone for informing her of the current issues in the system. Key areas of response are: - The response to leaders and colleagues in maintaining services during the current pandemic wave, which has been outstanding - The mutual aid that our system is providing to others has been very good and she very much appreciates the work that everybody is doing to stay afloat. - Workforce sustainability challenges would benefit from a system by default approach and would encourage a coordinated system approach. - The formal timetable of the ICS has been delayed until 1st July 2022 which gives us the opportunity to make the most of the time to tackle some of the issues which are holding us back. We will work together as a system to agree values and behaviours and strengthen governance and decision making. - We are continuing to progress on documents that need to be submitted to NHSE/I. The increased focus needs to be our strategic direction and the documents help to underpin that and we continue to work on shaping papers that helps us to do our job. - Recruitment of the Non-Executive roles have been taking place with 11 candidates being interviewed next week. Mr Singh noted that the recruitment agency process was poor and an understanding of stakeholders and their feedback needs to be taken on board. Ms Oum assured Mr Singh that stakeholder feedback was considered by the interview panel.	

Item No:		Action
1.7	**ICS Executive Report** Mr Johns outlined the following priority issues and key business items: The start date of the ICS has been put back to 1st July 2022 which gives some extra flexibility to prepare for the new statutory arrangements. The first quarter of 2022/23 will serve as a continued preparatory period and will give the system further time to develop and engage on several key programmes of work namely the establishment of our Care Collaboratives (Place based partnerships). The level four response to the pandemic remains in place and our organisations continue to work hard at keeping going despite high staff absences. One of the most challenging areas remains the medically fit for discharge patients. A longer-term system plan is needed detailing how we are going to approach it. Mr Johns noted that vaccinations and conditions of employment has several sensitivities surrounding it. Mr R Hardy noted that it would be useful to know how many members of staff could be lost from the frontline and what the consequences are; especially on the medically fit for discharge and elective capacity. Mr Johns explained that once the detail of the numbers are known, there will be a better position to say what that means for the system overall. Ms Oum noted that understanding the impact of the vaccination and the impact as a system would need to be considered once the information is available. Ms Nelson noted that in terms of mutual aid and workforce capacity, a partnership approach working across the whole health and social care sector to support each other is required. Mr Percival asked if the Health Care Bill was certain to receive Royal Assent ready for the 1st July 2022? Mr Johns noted that the system is confident that everything will be ready for 1st July, although this will depend on amendments between the Commons and the Lords. Mr Singh asked if our board will be looking at the risks associated with mandatory vaccinations and which services may have the greatest risk to patients and which groups of staff are hesitant. What is the process for managing this risk and how will we deal with them? Ms Oum noted that a report detailing the latest position of staff vaccination uptake and the implications would be beneficial; even if that means the report is before the next ICS Board meeting on 16th March 2022. **ACTION: Mr Johns/Ms Cartwright to write report on staff vaccination uptake and the implications including where domiciliary care fits within that**	**PJ/AC**
2.1	**<u>Strategy and Planning</u>** **Inequalities Plan** Ms Chapman noted that the Coventry and Warwickshire Inequalities plan is being developed by the Inequalities task group, which is a subgroup of the system Population Health and Prevention group. A set of principles is being proposed: 1: Addressing inequalities is core to, and not peripheral to, the work of the Coventry and Warwickshire ICS 2: Based on the King's Fund model of Population Health 3: Built around the Core 20+5 health inequalities framework	

Item No:		Action
	4: Evidence-based approach 5: Encourage innovation 6: Community co-production 7: Embed inequalities across all ICS work 8: Reducing inequalities is key to decisions on the prioritisation and allocation of resources There is a legal, moral and financial duty to reduce health inequalities and must be explicit and central to our work and in everything they do. The NHS has to look at what it can do to reduce health inequalities in terms of access, experience, outcomes and focus efforts on the core 20+ 5 framework. The causes of health inequalities are very complex and multi-functional, so there is a need to take a population health approach to reducing health inequalities. The NHS has to work with partners to look at the wider determinants of health and lifestyle behaviours in our populations and communities. Ms Chapman explained that the development of the strategy is being done by Population Health and Prevention Group at a system level and the work is being carried out by the Inequality task group. There is an engagement plan in place and engagement is taking place as widely as possible across the whole system including Health and Wellbeing Boards and Health Overview Scrutiny Committees. Ms Chapman reminded colleagues that the Core 20+ 5 are nationally set. The plus groups are for local determination and this is an area that is being worked on. The plus groups will be chosen based on local and national data plus those groups who are marginalised and not picked up through the core 20 or +5. Ms Manzie noted that there is evidence to show the impact on people's health from early years interventions, babies and young children, and the whole system could focus on this as it can have a big impact on health outcomes at a later stage. The actions need to be measurable, so they can be evaluated for impact. Mr Johns noted that the 20+5 are the five areas to look at as a system and maternity is one of those and we need to be mindful of not adding to the system priorities. If these are expanded then there is a danger that efforts are diluted and don't impact on those people who suffer the greatest. Ms Oum confirmed the ICB were happy with the principles with a number of clarifications to make the terminology more accurate and with an understanding that the areas of focus should be reviewed every 12 months. It would also be beneficial to have an evidence-based approach and to evidence the outcomes and the decisions we take about inputs. The plan can be updated and bought back to the ICB at a later date. **Action: Ms Chapman** Members **NOTED** the update, agreed the principles and were **SUPPORTIVE** of the work being done.	**RC**
2.2	**Transition Update and Plan** Ms Danter gave an update on the progress towards transition to ICS. It was announced in December that the ICS establishment is now delayed until 1st July 2022. The exact revised timeline is not yet available and this detail is currently being worked through by regional and national NHSE/I teams. Considerable progress is being made	

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	towards transition, with developed plans in place. A readiness to operate (ROS) self-assessment submission was made in December 2021 to NHSE/I outlining good progress towards meeting requirements of an ICS. A robust plan is being put together around clinical and professional leadership framework and that can be bought back to this group at the next meeting. **Action: Ms Danter** Members **NOTED** the update.	**RD**
2.3	**Developing the Quality Strategy** Ms Bartholomew joined the meeting to advise members of progress to date within the Quality Workstream in preparation for the establishment of the Integrated Care Board in July 2022. The Quality Strategy is still under development and is a dynamic document that will develop further and change. Ms Bartholomew noted that the governance slide only referenced two geographic collaboratives. No formal approval has been taken on this and confirmed that it does not exclude any other types of care collaboratives being included going forward. The Quality Assurance Framework has been to the System Quality Group noting how the principles would look and how issues would be escalated and deescalated. Work will be undertaken to align working around the clinical leadership and quality strategy as they are inextricably linked. The key principles for change are as follows: 1. Create an open culture and learning system that enables improvement across a shared understanding of needs and issues 2. Use an improvement culture to support assurance of sustained quality of care, rather than a performance management one 3. Be clear on accountabilities and responsibilities for quality 4. Ensure a clear line of sight of quality performance, good practice, concerns, risk and mitigations form the point of care to leaders 5. Have a clear and agreed understanding of when to act on signals 6. Respond together in a timely and proactive way, addressing any gaps in intelligence Mr Burley referred to the Quality Escalation Matrix and asked if it would be applied to individual services or individual providers and how will we be clear about who is responsible to act? Ms Bartholomew confirmed that the Quality Assurance Framework is discussed within committees with providers and it details what the provider and the CCGs actions are. Ms Coombes suggested it would be useful to do further thinking about what system risks do the ICB board need to see in the future (not just an individual provider risk). Ms Bartholomew confirmed that the strategy would be shared at the provider committees, the LMC and Primary Care Committee to discuss next steps, working collaboratively to get more of a strategic oversight on quality assurance. Members **NOTED** the progress and is **SUPPORTIVE** of the work being done, noting that further input about where the system added value would be of benefit.	
2.4	**Developing the Engagement Strategy** Ms Wilson explained that the report describes the approach about embedding the ten principles around engaging with people and communities, which the strategy will be formed around. These principles are:	

Item No:		Action
	• Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS. • Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions. • Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect. • Build relationships with excluded groups, especially those affected by inequalities. • Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners. • Provide clear and accessible public information about vision, plans and progress, to build understanding and trust. • Use community development approaches that empower people and communities, making connections to social action. • Use co-production, insight, and engagement to achieve accountable health and care services. • Co-produce and redesign services and tackle system priorities in partnership with people and communities. • Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places. The paper notes a number of exciting opportunities and details the intent. The strategy will be shared in March 2022 and will include the vision and mission. Mr Hardy noted that as SWFT is a Foundation Trust with a Council of Governors and a membership, could this be referred to as the 'Council of Governors at SWFT'. This will recognise the importance of engaging with the membership of the Foundation Trust. Mr Hardy stated that there is some excellent patient engagement work taking place (for example around Diabetes) and it is important that we keep that knowledge and experience going as we move from the CCG into the ICS. Ms Coombes noted that for mental health, there are a number of user patient groups they regularly use for development of services, so it would be of benefit to think about how we engage with our people in a meaningful way using the existing opportunities that are already out there. Ms Wilson noted that this is an opportunity to build on all the existing mechanisms ensuring that all the networks and patient and care groups have an opportunity to input. Members **NOTED** the update.	
3. **3.1**	**<u>Finance and Performance</u>** **Finance Update** Mr Stokes gave an update about year-end forecasts, Community Diagnostic Hubs (CDH) funding approaches and a forward look to 2022/23. In respect of the year-end forecast, there will be a £8m surplus and deficit, and the forecast remains to break even or a relatively small surplus. The CCG have been offered more money, should it be needed and this is a good position to be in. For 2022/23, the full information is not available yet, but there is enough to say that efficiency savings of around 4% will be required. The biggest unknown will be the Elective Recovery Fund (ERF); it is the biggest risk and the biggest opportunity as the rules are unknown. Nationally, there is more money in ERF than last year, so that does give opportunities. The pieces of work undertaken on incentive contracts and transformation working together on urgent and elective care at a system level	

Item No:		Action
	will enable us to be in a better position to break even as a system. This will be continually managed through the Financial Advisory Board and at each of the Finance Committees. Mr Stokes noted that for the Community Diagnostic Hubs, Mike Richards wrote a report that recommended doubling diagnostic capacity and prevention programmes to stop people coming into hospitals as a way to manage future growth and demand. Bids were submitted based on a million population and for Coventry and Warwickshire, it was £50 million. The NHS have given us £16 million, so prioritisation work needs to be undertaken about where that needs to be spent. There has also been some work looking at inequalities, where some of the resources can be targeted. The strategy ambition is to have three diagnostic hubs. Mr R Hardy noted that it was very important to get back to model hospitals referenced costs and productivity so that we understand what is happening on an underlying basis and getting value for money. Mr R Hardy noted that it would be helpful for this group to discuss what are we doing on left shifting to lower cost health care settings. This will help us get assurance about the local term trajectory of the system. Mr Johns explained that work has taken place but it has not been shared with the senior leaders in the organisation. It also needs to be discussed with organisations to get buy in. Mr Johns noted the timing of this work needs be agreed and then bought back to the ICB. **Action: Mr Johns** Mr Percival asked if we are confident that we will achieve the ERF funding in line with what is expected and can we achieve the balance between recurrent and non-recurrent. Mr Percival asked what progress had been made about a return to signed contracts and local ownership for payment flows and has agreement been made about managing this. Mr Stokes noted that it feels deliverable to make the 4% efficiency savings, based on the ambition of flatlining emergency growth which would deliver half savings and in addition to taking the COVID costs outs would enable us to make those savings. Mr Burley referred to the elective care recovery strategy and noted that this will provide an opportunity for the system to provide mutual aid. The strategy states that a premium will be paid for those organisations that offer mutual aid. Members **NOTED** the update.	**PJ**
3.2	**System Performance Update** Ms Cartwright provided a brief update on the key points from the circulated report about performance against national targets and priority indicators for the CCG. All areas of the system remain under pressure; however, the peak seems to be flattening for COVID in the acute trusts. There has been improved performance on elective waits and the waiting lists are down to 90,000 with 4,500 waiting over 52 weeks. Key areas of concern are on cancer services and cancer delivery. Members **NOTED** the update.	
3.3	**Vaccination Assurance** Ms Cartwright provided a brief update on the key points from the circulated report 1.99 million vaccines have been administered in Coventry and Warwickshire. Inequalities uptake data is produced which helps to improve vaccine uptake. For those areas which need extra focus, different approaches are used. All members agreed that this has been an excellent piece of work and a great achievement. Members **NOTED** the update.	

Item No:		Action
4.	**Assurance and Governance**	
4.1	**ICB Draft Constitution, decisions and function map** Ms Wilson explained that the draft constitution was submitted to NHSE/I on 19th November and 3rd December 2021. Formal feedback was received on 24th December and as a result, extra detail has been added. The feedback received was very good and detailed three areas for further consideration: partner nomination process, expanding eligibility for wider primary care partners and remuneration for non-executive members. The decisions and functions map is complementary to the scheme of reservation and delegation and does not form part of the constitution but is a document that is required to sit alongside it. The scheme of reservation and delegation is currently being drafted with the terms of references for the various committees in draft format. The aim is to have a final draft by March 2022, where it will be submitted to NHSE/I. The intent is to have a whole suite of documents which will come through Shadow board for endorsement before the ICB adopts them formally in July. Ms Manzie noted it would be helpful to see a draft of the scheme of reservation and delegation as early as possible and the financial governance arrangements for Care Collaboratives. **Action: Ms Wilson** Mr R Hardy asked if Coventry and Warwickshire could involve Non-Executive Directors (NED) at sub-committees? Ms Wilson noted that the breadth and expertise from NEDs is very important to harness and the intention is inclusion of system Non-Executives and will be considered whilst drafting the terms of reference. Mr Singh noted the constitution says it can be changed at any time if the meeting is quorate and he would advise that this is looked at again. Once the constitution has been agreed, he would recommend that the constitution cannot be changed without a three-quarter majority. Ms Wilson to look at best practice. **Action: Ms Wilson** Ms Oum asked Mr Johns to look at developing the SoRD prospectively. **Action: Mr Johns** Members **NOTED** the update.	**AW** **AW** **PJ**
4.2	**Risk Register** Ms Danter noted that there had been work across December and January to build a Shadow ICB risk register. Predominantly this is a combined CCG Corporate risk register and the existent risk register for the STP. Ms Danter noted there is still further work to do around the type of risks and the owners. Members **NOTED** the update.	
5.	**<u>Any Other Business</u>** Mr Singh asked if these meetings should be public and with published minutes and how we may in future consider public attendance. Ms Oum asked Ms Wilson to look at the guidance and best practice and then come back for the ICB to agree at the next meeting. **Action: Ms Wilson**	**AW**
	<u>Date of the Next Meeting:</u> **Date:** Wednesday 16th March 2022 **Time:** 14:00 – 16:00	

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

ACTION REF	MEETING DATE	AGENDA ITEM	ACTION	RESPONSIBLE OFFICER	COMPLETION DATE	CURRENT STATUS	UPDATE
19	13.10.2021	2.3	VCSE Delivery plan to be presented at a future meeting	Nigel Minns	Jul-22	In progress	CB emailed Nigel Minns on 2nd and 28th Feb to ask when he could present this item
24	08.12.2021	1.5	Philosophy of care development	Phil Johns	Ongoing	In progress	PJ confirmed on 26/1/22 that this will be discussed at the next Clinical Forum and he will then provide feedback
24	08.12.2021	1.5	Referencing inequalities within the People Workstream	Theresa Nelson	Mar-22	In progress	Theresa Nelson will be presenting a People Workstream Update at the 16th March ICB meeting
24	08.12.2021	1.5	Development of health inequalities plan	Rachel Chapman	May-22	In progress	This was presented at the 26th January 2022 ICB Board and agreed the various groups to develop a plan to be bought back to the ICB Board
25	26/01/2022	1.7	Ms Cartwright to write report on staff vaccination uptake and the impact on the workforce including on domiciliary care	Phil Johns/Alison Cartwright	Mar-22	Completed	Following the ICB Board the mandated requirement for NHS staff to be vaccinated has been removed at present and there is therefore no impact for the system
27	26/01/2022	2.2	Transition Plan - A robust plan is being put together around clinical and professional leadership framework and that can be bought back to this group at the next meeting	Rachael Danter	Mar-22	Completed	On the agenda for the 16th March ICB meeting
27	26/01/2021	2.4	Draft Community Engagement Strategy	Phil Johns	Mar-22	In progress	In progress - removed from 16th March agenda for ongoing dialogue and discussion
28	26/01/2022	3.1	Finance Update: Agree the timing of when items need to be bought back to the ICB	Phil Johns/Adrian Stokes	Mar-22	Complete	Finance report to be included at every ICB meeting and to include updates against transformational plans
29	26/01/2022	3.1	Discussion required about what are we doing on left shifting to lower cost health care settings will help us get assurance about the local term trajectory of the system.	Phil Johns/Adrian Stokes	Mar-22	In progress	Discussions helds with CEOs on agreement of a shared view of acute services for the future to be informed by a vision for left shift
30	26/01/2022	4.1	The draft scheme of reservation and delegation to be brought to the next meeting	Anita Wilson	Mar-22	Complete	On the agenda for the 16th March ICB meeting
31	26/01/2022	4.1	To look at best practice in regards to proposed amemdments to the constitution	Anita Wilson	Mar-22	Complete	Constitution amended
32	26/01/2022	5	ICB meetings - should they be public and with published minutes and how we may in future consider public attendance. Ms Oum asked AW to look at the guidance and best practice and then come back for the ICB to agree at the next meeting.	Anita Wilson	Mar-22	In progress	Work to update the HCP website to house shadow ICB papers is in progress

Report Title:	Chief Executive Officer Report
Report From:	Philip Johns, Chief Executive Officer Designate ICB, Accountable Officer Coventry and Warwickshire CCG
Author:	Philip Johns, Chief Executive Officer Designate ICB, Accountable Officer Coventry and Warwickshire CCG
Previous Considerations and Engagement:	N/A
Purpose:	For Information

Contribution to meeting the aims of the ICS:

The day-to-day management and leadership of the Coventry and Warwickshire Integrated Care System through such groups as the Partnership Executive Group (PEG) know known as the ICS Executive Group, as well as other fora are a critical enabler for the ICS and the ICB to deliver on the four aims for the citizens of Coventry and Warwickshire (C&W), namely.

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

Contribution to meeting the priorities of the ICB:

The Chief Executive Officer report is a means by which the CEO can report on decisions and recommendations on key business items made by the ICS Executive Group who act as a leadership 'cohort' and who will, once established formally from July 22, adopt an approach in being responsible for the day to day running of the Integrated Care Board (ICB) and co-ordination of the Integrated Care system. This month's report has a focus on:

- White Paper – Health and Social care integration: joining up care for people, places and populations
- ICB Board Recruitment Update
- C&W Covid Situation
- Care Quality Commission Oversight
- Medically Fit For discharge
- Elective Recovery

Recommendation:

Members are requested to:

- RECEIVE the report for INFORMATION

Implications							
Conflicts of Interest:	Members may hold an interest in relation to the appointment process for the Board.						
Financial and Workforce:	Financial implications regarding year-end forecast for revenue and capital and 2022/23 planning updates are contained within the Finance Paper. Workforce Implications are contained within the People Update						
Performance:	Understanding where there is deterioration or improvements in performance is a key focus for the ICS Executive.						
Quality and Safety:	Quality Oversight is undertaken at both organisational and system level via the System Quality Group						
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:	Engagement continues to support vaccination rollout, elective recovery and establishment of the ICB and ICP						
Clinical and Professional Engagement:	Engagement continues to support vaccination rollout, elective recovery and establishment of the ICB and ICP						
Risk and Assurance:	If the most beneficial leadership and governance arrangements are not put in place the ICB may not operate at its optimum resulting in reduced effectiveness in achieving its priorities and the four aims.						

1. Executive Summary - ICS Chief Executive Designate Report

1.1 To provide a briefing to the Integrated Care Board (Shadow) on priority issues and key business items.

2. Key Points

2.1 Briefing on current position relating to emerging/ongoing issues:

- White Paper – Health and Social care integration: joining up care for people, places and populations
- ICB Board Recruitment Update
- C&W Covid Situation
- Care Quality Commission Oversight
- Medically Fit For discharge
- Elective Recovery

3. White Paper – Health and social care integration: joining up care for people, places and populations

3.1 This policy paper published on the 11 February 2022 describes learning the lessons from the pandemic and the need to do more to bring the resources and skills of the NHS and local government together to better serve the public. Successful integration is the planning, commissioning and delivery of co-ordinated joined up seamless services to support people to receive the right care, in the right place, at the right time. This paper sits alongside the adult social care reform paper 'People at the Heart of Care' which sets out plans to make integrated health and social care a reality for everyone across England and to level up access, experience and outcomes.

3.2 The White Paper sets out the approach to:

- designing shared outcomes which will place person-centred care, improving population health and reducing health disparities at the centre of our plans for reform, and ensuring that accompanying oversight arrangements and regulatory structures have a clear focus on the planning and delivery of these outcomes
- proposals to strengthen the health and care services in places that feel familiar to the people living in them. While strategic, at-scale planning is carried out at the integrated care system (ICS) level, places will be the engine for delivery and reform
- introduces an expectation for a single person, accountable at place level, across health and social care, accountable for delivering shared outcomes and strong, effective leadership

- sets out how we will make progress on the key enablers of integration (workforce, digital and data and financial pooling and alignment) required to further join up services around people and populations
- reinforces the role of robust regulatory mechanisms to support the delivery of integrated care at place level

3.3 The CCG will have regard to the content of this white paper in its activities to transition to an Integrated Care system (ICS) and to an Integrated Care Board (ICB).

4.0 ICB Recruitment Update

4.1 Our recruitment to the new ICB Board is well underway. Four designate Non-Executive Members have been successful and their induction to Coventry and Warwickshire ICS will begin in April with activities to welcome them to the system and opportunities to partners. Executive recruitment is also underway with interviews this month for a Chief Medical Officer, Chief Nursing Officer and a Chief Finance Officer. Whilst the parliamentary process is still underway to finalise the draft Health and Care Bill and for it to receive royal assent, the final arrangements to recruit to Partner Members on the Integrated Care Board have been delayed until May. We will be continuing to discuss the nomination and selection process for these roles over the next two months.

5.0 Coventry and Warwickshire COVID-19 Situation

5.1 Coventry and Warwickshire COVID-19 cases remain broadly stable in the week beginning 7 March with just under 140 patients with COVID-19 in our hospitals, patients with COVID-19 requiring an ITU bed remain low. However, the ongoing burden of COVID-19, coupled with increased emergency presentations for non-COVID conditions whilst continuing to reduce our waiting lists means our services remain under pressure. Our ambulance services are also continuing to experience significant pressures resulting in patient handover delays at hospitals. We continue to work as a system with our acute Trusts to support rapid ambulance handovers, increasing speed of patient discharges to support the flow of patients through the hospital.

6. Care Quality Commission (CQC) Oversight of Integrated Care Systems

6.1 The CQC are currently developing their methodology for how they will change the way they regulate to improve care for everyone with two core ambitions; to tackle inequalities in health and care and to assess local systems.

6.2 The Health and care Bill also give the CQC new powers to assess local authorities on the delivery of their social care duties and to have oversight of ICSs. In recognising that this new regulatory aspect to ICSs needs conversations to design the approach collaboratively I along with the ICS Chair Designate, Danielle Oum have met with the CQC to agree a workshop in early April in which the methodology can be thought through and discussed in detail. This workshop will provide an opportunity for system partners to also engage and discuss how CQC assessments can really add

independent assurance to inform people about how health and social care partners within an ICS are working together to meet its aims.

7. Reducing the number of medically fit for discharge (MFFD) patients in hospitals

7.1 The drive to reduce the numbers of medically fit for discharge (MFFD) patients residing in acute beds was a requirement outlined in the letters to the NHS and Local Authorities, '*Preparing the NHS for the potential impact of the Omicron variant and other winter pressures'* 13th December 2021, '*Enabling safe and timely discharge from acute settings*' 22 December 2021 and '*For action – accelerating the numbers of people discharged home'* 22nd December 2021.

7.2 The requirement was a reduction of 50% of MFFD patients to the end of January 2022. Whilst improvements have been made the target has not been achieved and continues to be challenging. COVID-19 has had a significant impact with outbreaks affecting domiciliary care in Warwickshire and care home sectors across Coventry and Warwickshire.

7.3 System colleagues continue to further a number of programmes of work to support meeting the 50 % reduction target including; nursing home support and revisiting and mapping of pre-hospital and discharge from hospital pathways.

8. Elective Recovery

8.1 Elective recovery is a key area of focus across our ICS around our 104 week position, 52 week position and total waiting list size our current position is detailed below.

- 104 week position is at 86 patients with plans in place prior to the end of March with trajectory on track to delivery zero by end March 2022.
- 52 week position is at 4,132 which is ahead of trajectory
- Total waiting list size is at 91,629 which is stable

8.2 A Targeted Investment Funding (TIF) submission was completed supporting 4 schemes across our system although given our relatively strong waiting list position is it unlikely schemes not supporting other areas will be considered. Bids submitted included;

- Expansion of George Eliot Hospital (GEH) with 2 additional theatres and one ward to protect elective activity capacity within Warwickshire North
- Expansion of Rugby St Cross site with 2 additional theatres and an increase in beds available for elective care supporting the enhanced care pathways for both trauma and surgical specialties. Redesign and co-location of breast services to support productivity opportunities and improved patient experience and waiting times through effective clinical pathways and use of on-stop clinics.
- University Hospitals Coventry and Warwickshire (UHCW) bid for BMI capacity in total to assist in support pan system whilst maintaining our ICS elective recovery and cancer pathways
- South Warwickshire Foundation Trust (SWFT) Surgical hub development

8.3 Cancer performance has seen deterioration in the 62-day standard measure over the winter months and is now a key area of focus across the system to recover. Current performance sits at 54.4% across the system for December with key areas of pressure in terms of long waiting patients and diagnostic pathway constraints. Operational assurance has been provided through our System Review Meeting to ensure recovery and is tracked through bi-weekly system level cancer manager meetings feeding into the Elective Care Delivery Board and weekly operational Chief Officer group for weekly escalations.

Recommendation

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

End of Report

Report Title:	Integrated Care Board Corporate Risk Register
Report From:	Rachael Danter, Chief Transformation Officer
Author:	Andrew Wilkins, Head of Governance and Corporate Affairs
Previous Considerations and Engagement:	The Corporate Risk Register is currently being presented to every Board meeting of the Integrated Care Board. It was last presented to January Integrated Care Board
Purpose:	For information

Contribution to meeting the aims of the ICS:

Effective risk management arrangements enable the identification and management of risks to the objectives of the Integrated Care Board (ICB), which in turn supports the achievement of the four aims of the Integrated Care System (ICS).

The development of the Corporate Risk Register of the Integrated Care Board as a specific aspect of the developing system risk management arrangements is enhancing system working and shared ownership of risks across the system. This is creating sound foundations to deliver the further developments required to drive shared ownership of risks that threaten the achievement of the four objectives of the ICS.

As a developmental and responsive process, the Corporate Risk Register will continue to be developed with a clear focus on the achievement of the four aims of the ICS. To help drive this focus the four aims have been added to the header of the risk register so that they are at the forefront of people's minds when considering the risks facing the population of Coventry and Warwickshire.

Contribution to meeting the priorities of the ICB:

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

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

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

Recommendation:

Members are requested to:

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

Implications							
Conflicts of Interest:	Non identified.						
Financial and Workforce:	Please see the finance related risks identified in the Risk Register.						
Performance:	Please see the performance related risks identified in the Risk Register.						
Quality and Safety:	Please see the quality and safety related risks identified in the Risk Register.						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	Risks are identified from a range of information and sources, a key source being the insights, feedback, and outputs of engagement activities with our patients and communities.						
Clinical and Professional Engagement:	The Corporate Risk Register receives considerable input and ongoing scrutiny from our clinical colleagues.						
Risk and Assurance:	Effective risk management arrangements will be essential to the ICB's ability to deliver its statutory functions and achieve its priorities for the patients of Coventry and Warwickshire.						

1. Executive Summary

1.1 This paper provides an update on the corporate level system risks and the arrangements in place to mitigate those risks. It also provides and update on the work underway to further develop the system risk management arrangements to enable readiness to operate from 1 July 2020.

2. Shadow Integrated Care Board Corporate Risk Register

2.1 The Risk register presented to January's ICB captured the 12+ risks from the CCG's Corporate Risk Register and the STP Transformation Risk Register. Further work has since taken place in the development of the system risk register, including updating the Risk Leads and Risk Owners to reflect the increased integrated working arrangements in the management of system risks. Risks are in the process of being reviewed and updated by Risk Leads and Owners to ensure that they are appropriately articulated, graded and that the action and oversight arrangements reflect the current position.

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

3.

Total Open Risks	**16**
Total open extreme risks ≥15	4
Total open high risks = 12	12
Number of new risks	1
Number of increased risks during the period	0
Number of risks decreased	1
Number of risks closed/deescalated during the period	6*

*P/002 Elective Care and P/003 Referrals into Elective Care were merged into one risk: 'PC/002 Elective Care Recovery'.

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

- STP/23 - Cancer Waiting Times.

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

- F/002 System Deficit – risk deceased to 12 due to planning guidance issued in December 2021 for 2022/23 which set the System revenue allocation based on H2 x 2, adjusted for Distance from Target fair share and for Convergence fair share of the overall NHS funding envelope. This allocation (rather than the previously published lower allocation) reduced the risk of a System deficit in

2022/23 and provided an additional year for the System efficiency programme to embed for an improved financial outlook in 2023/24 onwards

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

- Q/016 Infection Control – C-Difficile: was removed from the CRR and will be managed locally on the CCG nursing risk register. The severity and impact is now lower and therefore less of a clinical impact.
- Q/002 COVID-19: was removed from the CRR and will be managed locally on the CCG nursing risk register. The risk and consequences of transition has been managed through the vaccination programme which lowers the impact on health services even during a surge.
- Q/017 Ockenden – was removed from the CRR and will be managed locally on the CCG nursing risk register. After review it was noted that the risk sits with and is being regularly monitored by the provider organisations delivering care.
- PC/003 Integrated Care Record – was removed from the CRR and will be managed locally on the Integrated Care Record Programme Risk Register. This was due to an improving situation due to transfer of PMO support from BSOL to SWFT PMO to provide more control and structure to the programme board.
- STP/16 Workforce Vaccination Requirement – this risk was closed due to the government revoking the COVID-19 mandatory vaccination for health and care staff.

4. Draft Integrated Care Board Risk Management Policy

4.1 To ensure that our approach to system risk management incorporates the latest best practice the ICB's Risk Management Policy is being developed with the support and guidance of the Good Governance Institute.

4.2 Discussions are taking place with system partners in relation to the development of a System Risk Group. This group will have responsibility for promoting and supporting collaboration in the sharing, identification, and management of risks across the system. It will ensure that the ICB Board Assurance Framework (BAF) and Corporate Risk Register is effectively maintained and will consider risks escalated from system partners to the ICB for inclusion on the ICB Corporate Risk Register. It is proposed that the System Risk Group will be chaired by an ICB executive with membership being made up of those involved in the management of risks in different aspects of the system, including providers, Primary Medical Services and Local Authority.

5. Board Assurance Framework (BAF) and Risk Appetite

5.1 The setting of the Board Assurance Framework and Risk Appetite are key activities in the ICB Board development programme. The BAF will identify the key risks to the ICBs strategic objectives and set out the details of how these risks are being

managed along with any gaps in assurances in the effectiveness of the controls in place. The risk appetite statement will set out the level of risk that the ICB is willing to take in the pursuit of its objectives. The intention is for the System Risk Group, once formed, to consider and help inform the Board Assurance Framework and the appropriate level of risk appetite across different areas of responsibility of the ICB with the ICB Board taking the final decision on these matters.

6. Conclusion

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

7. Recommendation

Members are requested to:

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

End of Report

Coventry and Warwickshire Integrated Care Board (Shadow) Corporate Risk Register

NHS Coventry and Warwickshire Integrated Care Board

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

The four aims of the ICS:

Improving outcomes in population health and healthcare

Tackling unequal outcomes, experience and access

Enhancing productivity and value for money

Supporting the broader social and economic development of Coventry and Warwickshire

						Unmitigated Risk Score				Residual (Current) risk Score				Target Risk Score							
Date added	Reference	Risk description	System priority	Risk Lead	Risk Owner	Initial Impact Score	Initial Likelihood Score	Unmitigated Risk Score	Measures in place to Manage the Risk Preventative - stops the problem occurring Detective - detects the problem when occurs Directive - written/verbal instructions/ policies, etc. Monitoring - reporting and oversight arrangements	Residual Impact Score	Residual Likelihood Score	Residual risk Score	Further Actions Planned including Timescales	Target Impact Score	Target Likelihood Score	Target risk Score	Status (Change from previous residual risk score)		Assurances	Update (current statement on effectiveness of actions in place, justification for current risk score or change in score)	Last Reviewed (Date and by whom)
Apr-21	F/002	**System deficit** Due to the system-wide deficit of c£80m pre-Covid, £149m underlying deficit post covid, coupled with additional revenue costs made recurrent through covid, there is a risk that this could lead to a undeliverable level of transformational and efficiency requirements resulting in failure to achieve medium term financial balance.	Live within our means	Adrian Stokes, Chief Finance Officer	Chris Lonsdale, Director of Finance, Liz Flavell-Smith, Deputy Chief Finance Officer Alistar Flemming, Head of System Financial Planning	5	5	25	**Preventative:** - Investment Panel meeting in place to sign off all proposed investments. - National Covid-19 and budget guidance being applied. - Continued assessment of national guidance. **Detective:** - Finance position to be reported monthly. - Monthly review and financial reporting mechanisms for main budgets (although planning position suspended). - Process of confirmation with NHSE/I. **Directive:** - Budget setting national guidance followed and implemented. - National guidance position is continuously assessed and implemented with Assurance given to F&P Committee. **Monitoring:** - Monthly Finance and Performance meetings. - Bi-monthly Governing Body meetings.	4	3	12	Review and acting on the planning guidance issues in Dec 21 for 22/23 system revenue allocation.	3	3	9	No change	↔	**Operational** - Financial reporting mechanisms **Oversight** Reports to Finance and Performance Committee, Audit Committee, FAB, Governing Body **External** External Audit, NHSE/I review process	**February 2022:** Planning guidance: issued in Dec 21 for 2022/23 sets the System revenue allocation based on H2 x 2, adjusted for Distance from Target fair share and for Convergence fair share of overall NHS funding envelope. This allocation (rather than the previously published lower allocation) reduces the risk of a System deficit in 2022/23 and provides an additional year for the System efficiency programme to embed for an improved financial outlook in 2023/24 onwards .	February 22 (Liz Flavell-Smith)
Apr-21	P/001	**Urgent and Emergency Care** **If** there is a demand and capacity deficit across urgent and emergency care services, **there is a risk that** patients will not be seen in the right care setting within the right timeframes, **resulting in** patients receiving sub-optimal care, a poorer patient experience, the system incurring more costs for these services and capacity being compromised for new presenting patients.	Successfully Manage Urgent and Emergency Care	Rachael Danter, Chief Transformation Officer	Helen Lancaster, Head of Transformation	5	5	25	**Preventative Actions in Place:** - Local Urgent Care Boards at Place to plan demand and capacity required - CCG urgent care commissioners give assurance and oversee delivery/frame future direction as set out in Commissioning intentions. - Contracting teams set baseline activity levels within contracts across providers. - Daily MFFD meetings with providers and LA to identify solutions and ensure actions - Discharge task and finish group established meeting weekly - System wide virtual ward group to be established to maximise Virtual ward capacity across the system and provide mutual aid and expand remit to include Frailty, heart failure, respiratory, general medicine, OPAT expansion - Pre hospital pathway workstream developed to provide alternatives to ED conveyancing - Community urgent response workstream implemented and further recruitment to maximise capacity on going **Detective/Monitoring, Associated Measures** - Large number of associated process tracking performance measures that are routinely reviewed and reported on to assure the the UEC system is working effectively/ - Contract team monitor delivery through mandated contracting meetings, and issue query notices, and requests for Remedial Action Plans, where necessary. - The CCG has led development of community based step down isolation beds to support Covid+ care home admissions from hospital. - Domiciliary care resilience action plan developed and monitored through discharge task and finish group - system approach to UTCs to be established - methodical review of pathway 0-1 patients to establish care needs and identify alternative solution. - System MADE week commencing 17th January - Plans in place for surge capacity - Operational end of life group in place - Review of hospice provision and capacity to be completed - Reduction in category 3 ambulance conveyancing program in place - Criteria to admit audit undertaken	5	3	15	- 7 day a week service for UHCW and GEH for pathway 3 and EOL discharges, working with the LA's in the commissioning of sufficient pathway 2, 3 and EOL provision. - Q20System wide work programme to address care home and dom care provision shortage including expansion of Mockely Manor, and review of system delivered service based at Ellen Badger (or alternative location).	3	4	12	No change	↔	**Operational assurance:** - Contract team monitor delivery against process tracking performance measures through mandated meetings. - Business Intelligence, Planning and Performance Team collate performance across all providers. **Oversight:** - Clinical Quality and Governance Committee - Finance and Performance Committee - CCG Governing Body **External:** - Regional assurance processes, Health Oversight Committee (HOSC), NHS I/E reviews of the system through system review meetings (SRM). - Performance is also reported across Coventry and Warwickshire as a whole, through the STP urgent Care Board , reporting to PEG, and also reporting against key targets through to the Regional NHS I/E urgent care forum and system leads.	**February 2022:** Clinical Assessment and Placement team are working closely at place and across the system to ensure that we support effective discharges. There remains challenges due to CQC restrictions and the limited availability of insurance for care homes receiving Covid+ admissions and the team are working with NHSE/I and the LA's to resolve this.	February 22 (Rebecca Chislett)
Apr-21	P/002	**Elective Care - Recovery** **If** we are not able to align our elective recovery programme to the national recovery proposals **there is a risk that** patients will not be seen in the right care setting within the right timeframes, **resulting in** patients receiving sub-optimal care, a poorer patient experience, the system incurring more costs for these services and capacity being compromised for new presenting patients.	Restore Elective Care	Rachael Danter, Chief Transformation Officer	Laura Nelson, Director of Operational and Financial Recovery	5	5	25	**Preventative Actions in Place: -** - Contracting teams to set baseline activity levels within contracts across providers. Clear specification of required quality and performance measures within the contract documentation, and SDIPs. - A clinical review of all inpatient waiters has been undertaken through a system called E-Review, this allows the system to be clear around the clinical priority of patients, and the system is working collectively to ensure no part of the system is working in a way that increases inequity across the system. - Successful application and delivery of both accelerator and first phase of TIF allocation to aid delivery - Bid for TIF phase 2 funding **Detective/Monitoring, Associated Measures:** - Large number of associated process tracking performance measures are routinely reviewed and reported on to assure that the Planned Care system is working effectively. - Contract team monitor delivery against these through mandated contracting meetings, and issue query notices, and requests for Remedial Action Plans, where necessary. - Business Intelligence, Planning and Performance Team request updates on issues, risk and mitigation actions being taken by lead commissioner or contract lead. - Monthly system Elective Care Board in place including all partners across the system to support elective recovery. - Effective workstreams in place to support operational delivery at system level aligned to operational planning guidance. - Weekly COO escalation meetings with overall system review of waiting lists and mutual aid / transfer of priority patients as needed to support equitable delivery of priority patients and reduction of 104 weeks waits across the system. - Shared PTL monitoring current position assisting in enacting mutual aid between Providers to enable equity and manage systemlevel waiting list risks - Use of IS capacity across the system based on highest risk speciality areas including transfer of whole orthopaedic pathways. - Effective use of digital and AI platforms system wide to focus on 'digital first' opportunities. - System wide theatre productivity group in place to share best practice and learning ensuring we utilise all capacity effectively - GIRFT focus on pathway opportunities linked to Midlands Elective Delivery Programme focus on Gynae, Ophthalmology and Urology. - System theatre oversight group with KPIs to improve theatre utilisation and delivery of the first system wide 'perfect week' focused on daycase utilisation. - Review of Day Surgery Units across system complete with opportunity to share best practice and ensure correct/all procedures are being carried out as day surgery - Outpatient Transformation targets for Advice & Guidance and virtual apts and PIFU met - Health Inequalties being addressed within Elective Delivery Board and system priorities are - data, HEAT and roll out of Elective Prioritisation tool for IE **Directive Actions in Place:** - Contract Documentation, activity schedules, quality schedules, SDIPs - Query Notices, Remedial Action Plans (RAPs)	5	4	20	Consistent review of position and any opportunities to share best practice. System led GIRFT engagement with clear focus on HVLC procedures and productivity opportunities.	3	4	12	No change	↔	**Operational** - Contract team monitor delivery against process tracking performance measures through mandated contracting meetings. - Business Intelligence, Planning and Performance Team collate performance across all providers. - Elective Care Delivery Board **Oversight** - Finance and Performance Committee. **External** - Restoration plans submitted to NHSE/I.	**March 2022:** Whilst the waiting list continues to grow, the activity throughput is also increasing. In Feb 22 there was an improvement in RTT position demonstrated across the System with significant reduction reported in ur longest waiting patients (104 weeks and 52 week position), although it is recognised that it will take a considerable amount of time to reduce the waiting list back to pre-covid levels the teams are committed to recovering the position as quickly as possible thorugh effective transformation.	March 2022 (Laura Nelson)

						Unmitigated Risk Score				Residual (Current) risk Score				Target Risk Score							
Date added	Reference	Risk description	System priority	Risk Lead	Risk Owner	Initial Impact Score	Initial Likelihood Score	Unmitigated Risk Score	Measures in place to Manage the Risk Preventative - stops the problem occurring Detective - detects the problem when occurs Directive - written/verbal instructions/ policies, etc. Monitoring - reporting and oversight arrangements	Residual Impact Score	Residual Likelihood Score	Residual risk Score	Further Actions Planned including Timescales	Target Impact Score	Target Likelihood Score	Target risk Score	Status (Change from previous residual risk score)		Assurances	Update (current statement on effectiveness of actions in place, justification for current risk score or change in score)	Last Reviewed (Date and by whom)
Apr-21	P/004	**Autism/ ADHD** Due to capacity outstripping demand alongside sustained and increasing demands for adult and children neurodevelopmental (autism/ADHD) diagnostic assessments, **there is a risk that** waiting times will remain long and are increasing. For patients awaiting an ADHD assessment they are long wais to access medication and for Adult ASD and ADHD assesments individuals are excluded if they have a previous diagnosis, if they are open to MH/ LD or if they have ceased their medication. The consequences/results of this from a patient care perspective are: poor patient satisfaction, reduction in opportunity for early intervention. **Resulting in** a reputational risk to the CCG and impact on commissioner capacity due to high levels of complaints to respond to. Additionally, patients are seeking a quicker assessment via Patient Choice, exposing CCGs to uncontrolled financial risk and inequity in patient experience. The CCGs have taken legal advice and patients are entitled to request an alternative provider under the patient choice initiative.	Accelerate Preventative Programmes	Ali Cartwright, Chief Planning and Performance Officer	Matt Gilks, Director of Commissioning	5	4	20	**Preventative:** Commissioners are working with CWPT to review the neurodevelopmental diagnostic service to optimise performance of the service, to increase throughput and reduce waiting times. A multi-agency steering group has been established to redesign the neurodevelopmental diagnostic pathway and explore options for upskilling a wider group of relevant professionals in undertaking diagnostic assessments. Additional capacity for the Warwickshire pre-school service has been commissioned. **Detective:** Commissioners have requested additional data to understand current capacity with existing resource. CWPT have developed a data dashboard which is due to complete to improve the data available on waiting times and activity. **Monitoring:** CWPT contract monitoring process, additional information with additional information requested on the CAMHS and pre-school service. Commissioners have presented assurance to both Coventry and Warwickshire Overview and Scrutiny committees with updates on progress around improving the waiting times positions. The adult service is monitored as part of the CWPT contract monitoring process,	3	4	12	Delivery of the Austim Waiting Times Business Case to begin and to continue over the period of the next two years in order to reduce the risk in line with the delivery of the trajectory.	3	2	6	No change	↔	**Operational:** Weekly trajectory monitoring meetings with CWPT **Oversight:** Learning Disability and Austim Board/Finance and Performance Committee **External:** Warks SEND Steering Committee/NHSEI	**February 2022:** The business case has been finalised and signed off by the CCG and Warks SEND Inspection Statement of Action has been approved by NHSEI. Now moving to implementation stage, however the deliverables will take time and we expect this position to continue in the medium term for the next two years.	February 2022 (Matt Gilks)
Apr-21	Q/003	**Deprivation of Liberty Safeguards and Court of Protection applications** **If** the action is not delivered for recovery of DOLS and Court of Protection applications, **there is a risk that** Court of Protection applications are delayed, **resulting in** patient dignity not being achieved and unlawful depriving of their liberty, posing a potential legal challenge.		Jo Galloway, Chief Nursing Officer.	Manjeet Garcha, Associate Director Continuing Health Care Team	4	4	16	**Preventative:** - Additional resources have been agreed to support delivery of phase one of the three-phase action plan. (WN/CR) - Training on DOLS and Liberties Protection and Safeguards completed. (WN/CR) - A competency framework has been introduced. (WN/CR) - Mentorship of nurses in place. (WN/CR) - A senior commissioning manager aligned to the Court of Protection work. (WN/CR) - Joint working with the CHC team to ensure that care is being commissioned/delivered by the provider under the principles of the Mental Capacity Act (MCA) (SW) - Process for prioritisation of individuals where care potentially amounts to a DOLs is currently being development. WCC Prioritisation matrix reviewed by CCG's safeguarding lead. (SW) - Personnel identified to progress applications. (SW) **Detective:** - Tracker against caseload. (WN/CR) - Weekly oversight by Associate Director of CAPT and Chief Nursing Officer. (WN/CR) - Patient cases identified and risk rated. (SW)	4	3	12	Assessment of the new DOLS received and arrangements for handling to balance capacity across backlog and new caseloads.	3	3	9	No change	↔	**Operational:** Weekly highlight report to Associate Director of CAPT, Weekly meeting with CNO and monthly monitoring at CAPT Business Meeting **Oversight:** Regular reporting to CQG Committee. **External:** Internal Audit planned	**February 2022** COP backlog of work is on track for completion end of March 2022. Additionally cases received from the TCP team have resulted in extra work and case management and these cases are also being progressed; due to their complexity and delay they are requiring a significant amount of time	February 22 Manjeet Garcha
	Q/003 - Continued								**Directive:** - Mental Health Capacity Act 2019. - Procedure approved by GB (SW) **Monitoring:** - Monitoring by Associate Director of CAPT, CNO and regular reporting to CQG Committee . (WN/CR) - Capacity plan to be reviewed regularly in context of step down and then restoration of CHC functions during COVID-19 outbreak (SW) 01.04.21 A interim dedicated Court Protection Team is in place, in addition CHC Nursing Workforce have completed a significant amount of training WN &CR.												
Apr-21	Q/001	**Transforming Care** **If** the CCGs are unable to bring to bare the necessary support to maintain those with a Learning Disability and/or Autism in the community **then** there is a risk that more people with a Learning Disability and/or Autism will be admitted to hospital or the that number of people in hospital will not reduce **resulting** in significantly adverse impacts on the quality of life for these people and their families.	Accelerate preventative programmes Protect the most vulnerable Restore Elective Care	Jo Galloway, Chief Nursing Officer	Jamie Soden, Director of Nursing and Clinical Transformation	4	5	20	**Preventative:** - Increased operational capacity for delivery of effective discharge and admission avoidance alongside increased rigour - Swift action to ensure admissions avoidance offer is commissioned - Intensive Support Team & Community Forensic Service being established on recurrent basis to support all-age people with learning disabilities and/or autism **Detective:** - Local Government Association peer review in early 2021, discharge assurance process under review, weekly system discharge planning and admission avoidance meeting, Root Cause Analyses for all admissions; Review of 12 point discharge plan in operation; Review of system Dynamic Support Register in operation **Directive:** - 21/22 Operational plan and 3 year road map, system wide governance arrangements, National guidance, Building the right support (2015), Long Term Plan Objectives **Monitoring:** - LD and Autism Board, strategic steering group and LD/A finance meeting every month . Operational Steering Group every 2 weeks. Weekly Discharge Assurance and Admission Avoidance meeting - Escalation meetings with NHSE/I. Monthly regional SRO meetings. - Monthly performance reports regarding key metrics to Finance and Performance Committee. Bi-monthly Clinical Quality and Governance Committee reports.	4	4	16	• Development of the system sustainability plan before the end of March 2022 to make the programme more resilient within the ICS • New market development approach before the end of March 2022 to ensure Coventry and Warwickshire whole system approach to market development • Implementing the DSR for autistic adults across the system • Putting in place extra social work capacity and funding for autistic adults using the Community Discharge Grant	3	3	9	No change	↔	**Operational** - 21/22 Operational Plan, and 3 year LDA roadmap - Plan overseen by Operational and Strategic Steering Groups in place with regular review - Operational and Strategic Steering Groups overseeing working groups: Admission Avoidance and Discharge Assurance Groups, LDA Finance Group, Autism Risk of Admission Workstream, Keyworker Pilot, Accommodation and Support Workstream. **Oversight** - Reports to CQG Committee, Arden LDA Board, Finance and Performance Committee, CW HCP and Collaborative Commissioning Boards. **External** - LDA Executive Board (System-wide group) - Coventry and Warwickshire Partnership Executive Group - CWPT LDA Transformation Board - NHSE Regional Oversight Panels, Deep Dives and Escalation Meetings.	**March 2022**: No change in overall risk score. In February there were no community admissions in any cohort, and there were 3 adult discharges. A new system escalation process has been agreed through the operational steering group, which will reduce delays around discharge assurance and admission avoidance. DSR implementation continues autistic adults, and the system continues to work on the actions outlined in the further actions column to make the programme more resilient within the ICS.	March 22 (Jamie Soden)
Jul-21	Q/012	**Children in Crisis** **If** the system is unable to mobilise a robust service to support children experiencing a mental health and/or an emotional crisis **there is a risk that** community services, A&E's and paediatric wards will be overwhelmed by the number of children requiring support, **resulting in** children and young people with extreme emotional challenges not receiving the timely care they need in an appropriate environment.	Accelerate preventative programmes Protect the most vulnerable Restore Elective Care	Nigel Minns, Strategic Director for People, Warwickshire County Council	John Gregg, Director of Children's Services Jamie Soden, Director of Nursing and Clinical Transformation	4	5	20	**Preventative:** Daily Multiagency calls to manage those in A&E/paediatric wards Bronze, Silver and Gold system escalation calls in place Weekend plans for all sites and organisations collated and shared at the Thursday Silver call Additional youth workers deployed to acute hospitals where needed Additional resources diverted from core CAMHS service to support crisis intervention Deployment of the Director of Nursing and Clinical Transformation to lead Bronze and the operational response across the system Additional governance has been established through Bronze, Silver and Gold to provide additional leadership, oversight and rapid decision making. **Detective:** Paediatric Wards reviewed against a recent CQC visit to another hospital and actions talked to ensure appropriate support is in place Daily monitoring of the number of children in crisis in community settings, A&E and on Paediatric wards Independent review of mental health services for Children In Crisis	4	3	12	Satisfied that the correct measures are in place and will take time to take effect.	3	2	6	No change	↔	**Operational** Multiagency daily calls Bronze **Oversight** Silver and Gold Reports to CQG Committee **External** CAMHS Transformation Board	**March 2022:** Continued high numbers of admissions to Paediatric wards are stretching services but reduced Tier 4 delays has improved flow.	March 22 Jamie Soden
Aug-21	Q/018	**Increased Quality Concerns Post COVID in Community Care Providers across Coventry and Warwickshire** **If** the CCG/LA as an integrated system are unable to meet the capacity currently required to both proactively and reactively deliver a robust integrated assurance monitoring programme across Coventry and Warwickshire, **there is a risk** that the CCG is unable to provide robust assurance that residents across Coventry and Warwickshire are receiving the level of care they require in a safe environment, **resulting in** the potential for patients experiencing unmet needs and poor care and negative media coverage for both the CCG and LA.	Protect the most vulnerable	Jo Galloway, Chief Nursing Officer	Rebecca Bartholomew, Director of Nursing and Quality	4	5	20	**Preventative:** CCG Clinical Care Home Team staff and LA QMO have prioritised (by known risk) providers for planned joint QM visits. However, due to increased resource required to manage existing providers with quality concerns follow up visits conducted to monitor the quality provision and provider progress against their SIP are being delayed. Therefore the following detective action is in progress: **Detective:** The number and level of risk of providers on escalation Assessment of other quality assurance activity demands and the resources currently available noting gaps An assessment of our teams ability to meet these demands and the level of risk this presents Recommendations that will be agreed via AQS and presented to Care EAG. **Monitoring:** A SEP/PEP meeting monthly providing CCG/LA/CQC oversight monthly (and virtually if required) to share intelligence and coordinate reactive quality monitoring and assurance.	4	3	12	The team will update our workplace to reflect the new starters.	3	3	9	No change	↔	**Operational assurance:** oversight via operational SEP Multiagency daily presence **Oversight** Service Escalation Panel Provider Escalation Panel Reports to CQG Committee **External** WCC/CQC	**March 2022:** Outbreaks have reduced and therefore the impact on staffing challenges has improved. Staff have now been recruited into quality post to support recovery.	March 22 Jamie Soden
Dec-21	Q/023	**Care Home Provision and Domiciliary Care availability/capacity** **If** there is a continued shortage in the provision of bedded placements and domiciliary care in Coventry & Warwickshire, **there is a risk that** vulnerable service users will be placed out of area and/or at an increased cost. **This could result in** delays that could impact on discharges, including EoL and the general welfare of patients. "	Protect the most vulnerable Restore Elective Care	Nigel Minns, Strategic Director for People, Warwickshire County Council Kirston Nelson Director of Education/Chief Partnerships Officer, Coventry City Council	Becky Hale, People, Strategy & Commissioning, Warwickshire City Council Jon Reading, Head of Commissioning and Provision, Warwickshire City Council	4	4	16	Full range of interventions, including increasing students numbers, nurse associate to nurse conversion, international recruitment, maintaining support to nursing at or near full establishment. AHP strategy implementation. Establishment validation. Follow up on Palliative training places. Social care ongoing recruitment support to all providers and the development of a reservist workforce .	4	3	12	Discussions will continue on a commissioner wide basis and review of individual patient packages daily to identify individual solutions where possible.	2	3	6	No change	↔	**Operational Assurance:** Daily joint local and health meetings **Oversight:** System, bronze and gold **External:** NHSEI	**March 2022:** Provider capacity due to COVID and staffing remain a significant problem. There is no easy or straight forward answer that currenty is creating delays for discharge for health and social care. Discussions continue on a comissioners wide basis and individual paitient packages are reviewed daily to identify individual solutions where possible.	March 22 Jon Reading
	STP2	**Workforce shortages** If we are unable to recruit and retain the required workforce there is a risk that the pressure on our workforce increases, resulting in increased sickness and higher turnover therefore impacting service delivery.	Care for and develop our workforce	Theresa Nelson, HR Director, Coventry and Warwickshire Health and Care Partnership	Chief Nurse, People Board and Chief Nursing Officers	4	4	16	Full range of interventions, including increasing students numbers, nurse associate to nurse conversion, international recruitment, maintaining support to nursing at or near full establishment AHP strategy implementation. Establishment validation. Follow up on Palliative training places. Social care ongoing recruitment support to all providers	3	4	12	Satisfied that the correct measures are in place and it is a case of allowing them time to take effect.				No change	↔	**Oversight:** People Board	**March 2022:** New risk lead assigned and risk reviewed and updated. Risk scores remain the same.	March 22 Theresa Nelson

						Unmitigated Risk Score				Residual (Current) risk Score				Target Risk Score							
Date added	Reference	Risk description	System priority	Risk Lead	Risk Owner	Initial Impact Score	Initial Likelihood Score	Unmitigated Risk Score	Measures in place to Manage the Risk Preventative - stops the problem occurring Detective - detects the problem when occurs Directive - written/verbal instructions/ policies, etc. Monitoring - reporting and oversight arrangements	Residual Impact Score	Residual Likelihood Score	Residual risk Score	Further Actions Planned including Timescales	Target Impact Score	Target Likelihood Score	Target risk Score	Status (Change from previous residual risk score)		Assurances	Update (current statement on effectiveness of actions in place, justification for current risk score or change in score)	Last Reviewed (Date and by whom)
	STP15	**Mental Health - Inpatient capacity** **If** we are unable to provide the correct in patient bed capacity for those with Acute mental Health problems **then** we may deliver poor quality services and a need for patients to receive their care in suboptimal out of area placements.	Protect the most vulnerable	Sonia Gardiner, Chief Operating Officer CWPT	Bie Grobet, Deputy Chief Operating Officer, CWPT	3	4	12	A refreshed and revised local OOA trajectory is in place for C&W. A bronze, gold and silver system escalation process has been established. Continued focus on Red to Green on wards Additional Crisis House support (admission avoidance) System partners are focused on the following areas to promote admission avoidance and support discharges: Strengthened Gatekeeping •Identified the themes for the list of long waiters to progress delays •Plan and mobilise additional bed capacity within C&W bed base and right sizing MH bed based offer •Strengthening the flow team to deliver an enhanced wrap around discharge across Coventry and Warwickshire with: -A dedicated complex Discharge Case Manager -Social Worker (2.00 wte) and Neurodiversity MDT support -Joint brokerage •Liaising with housing colleagues to strengthen input and outcomes •Scoping bespoke provider offer for Neuro diversity	3	4	12	Satisfied that the correct measures are in place and it is a case of allowing them time to take effect.				No change	⟷	**Operational Assurance:** Bronze, gold and silver system escalation process **Oversight:** System, bronze and gold **External:** NHSEI	**March 2022:** Risk owner reasigned to Sonia Gardiner, Chief Operating Officer CWPT. Risk now to be reviewed and updated by new risk owner. There was a national expectation to reach a zero Acute OOA ambition by 30.09.2021, which has not been achieved. Current operating conditions are leading to bed pressures in local acute MH services including suboptimal bed flow, delayed discharges and longer than average length of stay; impact of NHS infection Prevention Control on available bed numbers and staffing pressures.	Risk Review Required
	STP19	**General Practice Estate** There is a risk that estate constraints, specifically lack of effective general practice estate, will impact on: ** The ability of local Primary Care Networks to fully deploy funding available via the national Additional Roles Reimbursement Scheme to create expanded, bespoke multi-disciplinary teams; and/or ** The ability of General Practice to build collaborative partnerships with secondary, community and voluntary partners through multi-disciplinary working based in general practice estate assets.	Maximise all enablers	Ali Cartwright, Chief Planning and Performance Officer	Hannah Willetts, Director of Primary Care	4	4	16	* Staff resource aligned to estates agenda within CCG Primary Care Team. * General Practice Estates Programme in place and being managed by the CCG. Programme incorporates; (1) A number of priority projects at individual GP practice level, and (2) Options development and appraisal work in a number of prioritised localities to identify future estates solutions. * The CCG has a systematic and well-developed approach to responding to planning applications and has demonstrated success in securing developer contributions via both Section 106 Planning Obligations and the Community Infrastructure Levy. * The CCG is a partner in both the system-level Coventry and Warwickshire Health and Care Partnership Estates Strategy Group and Place-level Estates Groups. * The CCG is working with PCN Clinical Directors and Community Health Partnerships to progress work around PCN estates planning, in line with national guidance.	4	3	12					No change	⟷	**Operational Assurance:** General Practice Estates Programme **Oversight:** NHS Coventry and Warwickshire CCG Primary Care Committee	**March 2022:** Risk in process of being reviewed by Risk Lead.	Risk Review Required
	STP20	**General Practice Workforce** There is a risk that workforce pressures relating to both recruitment and retention will impact on the ability of General Practice to progress transformation activity to enable General Practice to become the foundation for well-functioning, integrated out of hospital care as envisaged in the NHS Long Term Plan and the Coventry and Warwickshire Primary Care Strategy, and/or the ability of General Practice leaders to engage and play a key role in relation to both the broader system transformation & development agenda, and the development & delivery of system programmes/projects.	Focus our delivery on Place based care.	Ali Cartwright, Chief Planning and Performance Officer	Sue Phillips, Head of Primary Care	4	4	16	* Staff resource aligned to workforce agenda within CCG Primary Care Team. * Primary Care Workforce Strategy and associated Delivery Programme in place - Delivery Programme incorporates broad range of schemes. * Coventry and Warwickshire Training Hub established to support the General Practice workforce across Coventry and Warwickshire with relevant education, training and development opportunities. * Governance structure established including Primary Care Workforce Operational Group and Primary Care Workforce Steering Group.	4	3	12					No change	⟷	**Oversight:** NHS Coventry and Warwickshire CCG Primary Care Committee	**March 2022:** Risk in process of being reviewed by Risk Lead.	Risk Review Required
	STP21	**General Practice Workload** There is a risk that a range of factors impacting general practice at the current time which are over and above the demands identified in the Coventry and Warwickshire Primary Care Strategy will impact on the ability of General Practice to progress transformation activity.	Focus our delivery on Place based care.	Ali Cartwright, Chief Planning and Performance Officer	Sue Phillips, Head of Primary Care	4	4	16	* Primary Care Strategy and aligned work programmes relating to PCN Development, Workforce, Estates and GP ICT. * 100% population coverage of Primary Care Networks in place.	4	3	12	Large and comprehensive workforce programme under way. Signficant investment in GP ICT. PCN Estates process in place to identify any capacity pressures.	3	3	9	No change	⟷	**Operational Assurance** GP IT Groups (SW/Coventry, Rugby and WN) Training Hub Board Local Estate Forum **Oversight Assurance** Primary Care Commissioning Committee Digital Transformation Board People Board **External Assurance** NHSE/I Health Education England	**March 2022:** Work ongong to support primary care in all areas	March 22 Sue Philips
	STP22	**General Practice Information and Communications Technology (ICT)** There is a risk that the digital transformation ambitions set out in local GP ICT plans/programmes (including in relation to infrastructure) are not delivered in full, meaning that efficiency opportunities will not be realised impacting transformation activity.	Maximise all enablers	Ali Cartwright, Chief Planning and Performance Officer	Sue Phillips, Head of Primary Care	4	4	16	* Staff resource aligned to GP ICT agenda within CCG Primary Care Team. * GP ICT plans/programmes established and governance in place. * National Primary Care (GP) Digital Services Operating Model in place.	4	3	12	Awaiting the 2022 GP IT Operating Model. Further funding has been secured for business continuity and Voice over Internet Protocol (VoIP) Telephany.	4	2	8	No change	⟷	**Operational Assurance** GP IT Groups **Oversight Assurance** Primary Care Commissioning Committee Digital Transformation Board **External Assurance** NHSE/IDX	**March 2022:** Implementation of second HSCN lines underway planning for VoIP implementation active.	March 22 Sue Phillips
Feb-22	STP23	**Cancer** - Arrangements for 62 day cancer waiting time standard to still be met - Reduction in Cancer Treatments compared to previous years	Restore Elective Care	Rachael Danter, Chief Transformation Officer	Laura Nelson, Director of Operational and Financial Recovery	4	4	16	• Cancer Managers and teams continue to review 62day & 104+ day • Systemwide oversight included as standing agenda item at C&W Cancer Board. A range of initiatives currently under review to support improved position. • Regular oversight of 62 day PTL backlog • Based on 20th February PTL (Urology 30% , Lower GI 17%, Lung 12% , Gynaecology 11% and Head & Neck 10%) GEH - 13% of PTL SWFT - 32% of PTL UHCW - 54% of PTL Actions in place to support improved position • Development of plan and establishment of audits to understand impact of referral surges and reasons for this e.g. lack of patient examinations in primary care and knock on impact on 62 day performance • Advice and Guidance • Lower GI - straight to test pathways and use of FIT • Non- recurrent funding to support waiting list initiative clinic (UHCW) • Additional theatre and CT capacity (lung at UHCW) • Use of IS to support clearance of cystoscopy (UHCW) • Urology mapping exercise across all trusts, providers focusing on quick wins and a follow-up systemwide workshop planned for April/May • Funding allocated for one stop hysteroscopy service at UHCW • Systemwide Gynaecology mapping exercise to be undertaken with providers, starting with SWFT • Care Navigators to improve patient compliance at the front end of the pathway (Colorectal UHCW case study) • Linking GIRFT recommendations across specialities • A range of interventions to support Head and Neck pathways shared with the teams, await feedback • ICS/providers establish access to weekly COO group (escalation) • Activity monitored via governance boards. •Cancer Patient Collaborative Forum - A refresh of TOR, membership and focus; linking with WMCA and ICS Inequalities workstream. • Mapping pathways to identify delays including patient DNA, diagnostic capacity issues and administrative. • Ongoing Comms strategy in place • Initial conversation with Macmillan; focusing on potential funding opportunities associated with Inequalities agenda	4	4	16	Satisfied that the correct measures are in place and it is a case of allowing them time to take effect.	3	3	9	New Risk		**Operational Assurance** Local Cancer Manager and operation teams peformance reviews. Regular oversight of 62 day PTL backlog Cancer Patient Collaborative Forum **Oversight Assurance** ICS/providers establish access to weekly COO group (escalation) Activity monitored via governance boards **External Assurance** NHS Coventry and Warwickshire Finance and Performance Committee NHSE	**March 2022:** New risk.	March 22 Laura Nelson

Report Title:	Quality report
Report From:	Rebecca Bartholomew, Interim Chief Nurse, Coventry and Warwickshire Clinical Commissioning Group
Author(s):	Michelle Gorrell, Jamie Soden, Lyn Parsons, Jackie Channell, Lexi Ireland, Michelle Cresswell and Rebecca Bartholomew
Previous Considerations and Engagement:	Coventry and Warwickshire Clinical Commissioning Groups Clinical Quality and Governance Committee – 27th January 2022
Purpose:	For Information

Contribution to meeting the aims of the ICS:

Effective quality surveillance and robust frameworks to inform improvement across the system are an essential and core component of the Integrated Care System. They are an essential enabler to the delivery of the four aims for the citizens of Coventry and Warwickshire (C and W) namely.

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

The key arrangements through system quality monitoring and improvement need to demonstrate a system that has oversight and transparency in meeting the needs of its population. Through which the system achieves a description of need rather than a prescription of need.

Contribution to meeting the priorities of the ICB:

The quality agenda across the system has a number of improvement workstreams that requires system working to achieve the best possible outcomes. Working to reduce inequalities across many of the system which also embrace the 20%plus five priorities. Although some of these are National or regionally required the system quality approach can demonstrate where the system has pulled together to work with National or regional iniatives. Workforce is a golden thread that appears throughout the workstreams with the stated need to address local shortfalls within the context of national shortage.

Recommendation:

MEMBERS are asked to receive the report and note **for information**

Implications							
Conflicts of Interest:	Members may hold an interest in relation to the appointment process for the Board in the Chief Nursing Officer and Chief Medical Officer posts.						
Financial and Workforce:	Getting value for money from the right care at the right time is known to achieve high patient safety outcomes and is cost effective. The prevention agenda is a driving force for our population health including our workforce.						
Performance:	Performance indicators cannot be used in isolation. There has to be triangulation appropriately with quality outcomes. To ensure appropriate and proportionate actions to achieve continuous improvement. Robust measurement methodologies using statistically proven methods is essential to inform decision making.						
Quality and Safety:	The creation of effective leadership and quality outcomes governance and escalation arrangements for the ICB is essential. Supporting the delivery of the ICBs Statutory objectives and four aims with the ultimate benefit of continuously improving the quality and safety our services.						
Inclusion:	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	Where appropriate codesign with users has been utilised such as the Trauma Informed Recovery Support Framework (TIRS): NHSE Vanguard for the West Midlands. The patient voice is utilised at the Local Midwifery and Neonatal System (LMNS) Board.						
Clinical and Professional Engagement:	Clinical colleagues are engaged across the system in various meetings and groups. Where appropriate representation is invited at Boards and meetings. For example the LMNS board , The System Quality Group, Clinical Forum and the Getting to Outstanding work stream.						
Risk and Assurance:	The CCG quality risk register clearly articulates where risks may affect the desirable outcomes of projects and escalates to the board assurance framework as appropriate.						

1. Executive Summary

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

1.2 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. Continuing Health Care (CHC)

2.1 The CHC team continue to focus on supporting Discharge to Assess activity supporting flow from our Acute providers. Omicron has impacted on availability of packages of care and additional resources have been allocated to support both brokerage and assessments. This and the established workforce challenges in the service has impacted on reviewing activity and we do not expect all planned reviews will be completed for 2021-2022.

2.2 Court of Protection application and Appeals back log reduction is on target. Plans to transition to Liberty Protection Safeguards are being developed whilst awaiting national guidance. Workforce continues to be a significant issue locally and nationally. A dedicated paper is being developed to progress through governance processes.

3. Children in Crisis

3.1 Despite the diversion of resources from core CAMHs services during January and February, the average length of stay has increased at both UHCW and Warwick Hospitals who have also experienced extended delays in transferring CYP to specialist inpatient beds. System working through the MDT, Bronze and Silver groups remains very positive.

3.2. Our system escalation process, Paediatric MH dashboard and Children in Crisis Principles have all been identified as good practice regionally.

4. Community Provider Quality Assurance

4.1 Warwickshire have five and Coventry have seven providers on escalation due to quality and delivery issues. All of providers are being supported and overseen by joint health and social care quality teams and governance structures. Both Coventry and Warwickshire quality teams are now at fully established.

4.2 The team are focusing on establishing baseline quality positions of our providers as we move out of the pandemic. We are aware that this has had a significant impact across Coventry and Warwickshire.

5. Learning Disability Annual Health Checks (AHC)

5.1 In 2020- 2021 71% of people on an GP Learning Disability (LD) register in Coventry and Warwickshire received an annual health check.
A stark improvement on the 2019 - 2020 low figure of 39%. We have been working to maintain this quantity of checks and to ensure AHCs are of a high and consistent quality this year. There has been a focus too on ensuring that personalised Health Actions Plans are provided as an output of these checks. At the 31st December 2021, Coventry and Warwickshire were the highest performing area in the Midlands and the seventh highest performing area in the country for delivery of these checks and we have performed in advance of trajectory consistently to date. It is anticipated, as in previous years, that a number of LD AHCs will be completed during quarter four, to meet the year end trajectory.

6. LeDeR (Learning Disability and Autism Mortality Reviews)

6.1 The recruitment of substantive LeDeR Reviewer capacity and the new LeDeR Governance Group has secured the delivery of the new national LeDeR Policy requirements from 1st April 2022. LeDeR Reviews are being completed, learning identified and actions across the system implemented in response.
Recurrent learning themes include:

- Application of the Mental Capacity Act (MCA)
- Access to health checks and age-appropriate screening
- Self-neglect
- Sepsis awareness

LeDeR Reviews have not only identified areas for service improvement, on numerous occasions they have also highlighted examples of best practice. These include excellent co-ordinated care and use of reasonable adjustments to enable equal access to health care provision.

7. Learning Disabilities with or without Autism (LDA) - Reasonable Adjustment Flags

7.1 The CCG and CWPT have been working collaboratively to support NHSE's exploratory work around the development of reasonable adjustment flags on the NHS Spine, for LDA patients. The development of the IT infrastructure to support this has been delayed at the national level due to the pandemic. For any national flag approach to work we will need to ensure that reasonable adjustments are appropriately coded and recorded locally, based upon a SNOMED code set. Functionality to record reasonable adjustments has been built into the CWPT Care Notes system. Plans are being developed to ensure this recording becomes business as usual within the LD service. We are working closely with a South Warwickshire place GP practice and SWFT to develop and test this functionality within the local EMIS GP IT system, prior to wider roll out is considered for primary care. There has been an increased focus on the importance and application of reasonable adjustments within training delivered to primary and secondary colleagues. This is to increase understanding of how to apply reasonable adjustments to improve patient access and experience of services.

8. Getting to Outstanding Project

8.1 Coventry and Warwickshire system has been successful in being chosen as one of five early adopter sites, across the seven regions as part of the NHSE End of Life '*Getting to Outstanding programme'.* The six month long project will form the foundations for our local system commitment to improve outcomes, experience and safety.

Including access for our population by developing an all age, system wide End of Life and Palliative Care five year strategy

9. Leave No Doubt Campaign

9.1 A programme of work has been undertaken to ensure information and knowledge is available to residents of Coventry and Warwickshire on Advance Decisions, Advanced Care Planning, Mental Capacity Assessments and Best Interest Decisions. This has involved the dissemination of literature from Compassion in Dying to all Providers, a bus campaign.

9.2 A joint Coventry and Warwickshire system Safeguarding Partnership conference is planned for March 2022 covering the subject matter with National expert speakers.

10. Ockendon Review

10.1 Our system continues to strive to improve both the care outcomes and safety of women, babies and their families through pregnancy and labour. This is systemwide work to implement recommendations from the Ockenden Review. There is a second Ockenden report that is to be published imminently and a revised version of the report into the Morecambe Bay Trust, the Kirkup report, expected. This is needed as a number of the recommendations in the original Kirkup, March 2015 have been revealed to not to have been implemented in a sustainable way. This work will support the system to identify and tackle unequal outcomes, poor experience, accessibility of services and patient safety. There are challenges for our system, as a result of COVID 19 Pandemic. This is reflected in Local Midwifery and Neonatal Services being managed within the Quality Assurance Framework as a level two (moderate) concern. Robust monitoring and oversight are in place to work together to improve services.

11. Primary Care

11.1 All 119 CQC registered General Practices across Coventry and Warwickshire continue to be rated as 'Good' or 'Outstanding' overall, except for one practice rated requires improvement. Four practices are receiving targeted support. Currently incidents are reported via the DATIX system and a quality inbox robust monitoring and oversight are in place to work together to improve services.

12. Provider Quality

12.1 All providers (UHCW, CWPT, GEH and SWFT) are all currently jointly rated within the Quality Assurance Framework (QAF) as level two (moderate) concerns with a potential for impact on clinical outcomes. Place based Quality Leads have close oversight, open dialogue, and robust challenge with each provider to manage concerns and drive

improvement. Robust monitoring and oversight are in place to support to work together to improve services.

13. Safeguarding – Looked After Children

13.1 **Coventry:** There has been a sustained increase in children coming into care since April 2021 which commissioners are sighted on and additional paediatric capacity is in place to meet demand.

Warwickshire: The Birmingham Designated nurse formally notified CWCCG that due to Covid related absence and significant increases in demand, the Unaccompanied Asylum Seekers (UASC) nurse led pathway run by BCHC is now suspended for any young person placed into the BSOL area from other Local Authorities. There is an impact on the completion of Initial Health Assessments (IHA's) due to a notable delay to IHA clinics. Discussions are underway with the SWFT Children in Care team and the Local Authority as to the most effective way to address this issue.

Trauma Informed Recovery Support Framework (TIRS): NHSE Vanguard for the West Midlands:

13.2 In August 2021, the CCG/ICS were awarded Vanguard status for the West Midlands via the NSHEI Framework for Integrated Care, receiving £2.8 million September 2021-March 2024. The Framework, and the services it will underpin, have been developed as a response to the NHS England and NHS Improvement Long Term Plan (LTP) commitment to provide additional support for the most vulnerable children and young people with complex needs across multiple domains between the ages of 0-18. This is an opportunity to achieve cultural and organisational change, with the aim of developing and enhancing services that promote safeguarding, seek to prevent re-traumatisation and enable children and young people who have been disempowered to have their voices heard.

- Leadership: The CCG/ICS TIRS Leadership Team are in
- Governance: The TIRS Project Board and Stakeholder Groups have been established and the governance and reporting arrangements agreed.
- Trauma Needs Analysis: The TIRS Health Needs Analysis plan has been drafted and agreed by NHSE and will commence in Q1 2022 -2023.
- Financial Planning: Coventry and Warwickshire Children's Services have agreed to host the TIRS Practitioners. Speech and Language and Occupational Therapist will be embedded in the Youth Offending Teams.
- Training: Trauma Informed Training has been commissioned from Dr Jessica Taylor Victim Focus. The TIRS Practitioners will receive additional training, support and guidance from Craig Pinkney a Criminologist and Urban Youth Specialist.

Conclusion

In conclusion the board is requested to receive this information.

End of Report

Report Title:	People Workstream update
Report From:	Theresa Nelson, HR Director, Coventry and Warwickshire Health and Care Partnership
Author:	Fiona Rowntree, Head of Workforce Coventry and Warwickshire Health and Care Partnership
Previous Considerations and Engagement:	System HR Directors 01/03/22
Purpose:	For information

Contribution to meeting the aims of the ICS:

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

Contribution to meeting the priorities of the ICB:

This report updates on system workforce activity to:

Care for and develop our workforce ensuring they continue to have the resilience and support to deliver the best care to our patients and communities particularly our BAME employees.
Maximise all enablers that support us deliver our Five-Year Plan commitments - flexible working.

Recommendation:

Members are requested to

- **NOTE FOR INFORMATION**

Implications	
Conflicts of Interest:	None identified
Financial and Workforce:	Workforce availability is one of our critical risks and this update provides details to support the mitigation of this risk.

Performance:	This project aims to improve performance by ensuring that an effective workforce is available to deliver patient care.						
Quality and Safety:	This project aims to improve the patient safety of staff by ensuring that an effective workforce is available to deliver patient care						
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:							

1. Executive Summary

1.1 This report provides an update on the following workforce priorities to mitigate the workforce risk:

- Workforce readiness for the Integrated Care System
- Reservist Workforce
- Staff Health and Wellbeing
- Covid Vaccination
- Workforce data dashboard
- Equality, Diversity & Inclusion

1.2 This paper supports the achievement of the ICB priority to Care for and develop our workforce ensuring they continue to have the resilience and support to deliver the best care to our patients and communities particularly our BAME employees

2. ICB Readiness

2.1 The ICB Workforce workstream is in place and working effectively to implement the transition. With the extension of the deadline to 1st July 2022 projects plans have been adjusted accordingly.

2.2 NED recruitment closed and four strong appointments made.

2.3 Recruitment to executive roles is underway. CFO, CMO and CNO have now closed. Remuneration levels have now been confirmed.

2.4 The project plan is on track, to ensure the smooth transition of staff in scope to transfer to the ICB, from CCG's and HCP transformation team.

2.5 The ten expectations of the ICB People Function were confirmed in December and as agreed we are commissioning additional support to shape the form and function of the people board and supporting structures.

3. Reservist Workforce

3.1 NHSEI has introduced a national programme to support the recruitment of reservists. A reservist is an individual employed by a lead organisation or trust to NHS Employers national standards, under a specific contract which commits them to supporting the system for a number of days per year or under particular circumstances. This way of working differs from using volunteers or bank/agency staff as they are intended to be a trained, supplementary, paid workforce that can be deployed during peak times or during emergencies. Reservists provide employers with a flexible but reliable workforce, while having the opportunity to learn new skills, refine their knowledge and provide fulfilling care. Each Reservist pool will comprise of professional registrants and unregistered health and social care professionals and support workers.

3.2 Seed funding to initiate this programme of work is in place, to enable systems to determine the proposed approach to a range of potential models of operation.

3.3 In Coventry and Warwickshire, we currently have a temporary workforce recruited by CWPT to support covid vaccination, and substantial use of bank staff. This new approach may enable us to gain a further degree of commitment from reservist staff and enable support across the whole health and care system.

3.4 There is a risk for Coventry & Warwickshire as the approach is predicated on a lead employer model. To date a lead employer has not been agreed.

4. Staff Wellbeing support

4.1 **Wellbeing** continues to be a focus for all health and care providers. National and local offers remain in place including Employee Assistance schemes, Occupational Health and a wide range of self-help information and links to Apps. The Wellbeing sub-group is progressing extension of offer for themes identified in the Health Needs Assessment: Intervention on Sleep, weight loss initiatives, mental health/stress and NHS Health Checks. Webinars are being widely used and shared across the System.

4.2 **With Staff in Mind** uptake increased in January, as anticipated. There were 39 referrals, resulting in 35 clinical assessments. 8 referrals were from a BAME background. The service has been providing direct support to local critical care and theatre teams. Outreach sessions reached a further 75 staff with the main focus on stress management sessions delivered for GP nurses, Wellbeing champions, Freedom to Speak Up Ambassadors, Social care staff and Dieticians. Capacity is increasing and the new Clinical Lead started in February.

4.3 **Carers Passport** – To support working carers we have been developing a consistent approach to the carers passport and are pleased to announce that we held a launch on 31st January for NHS Trusts. The passport creates a record which identifies a carer and through discussions with their line manager leads to provision of support, services or other benefits in response. The consistent approach at system-level enables records to transfer with the employee if they change Trust.

4.4 The System is preparing to move to a single **Employee Assistance Programme** provider for Trusts and Primary Care from 1st April. The provider combines salary sacrifice employee benefits schemes, that provide savings to Trusts in NI contributions, combined with a high quality EAP scheme as part of the package. And through working together this has enabled primary care to provide an EAP scheme, not previously available to primary staff and the wider primary care (opticians, pharmacy and dentists), using wellbeing funding. It will provide On-line and App access with the ability to tailor content to provide a further accessible source for wellbeing information and resources.

5. Covid Vaccination

5.1 Mandatory vaccination for NHS staff was announced on 9th November and planned to come into force on 1st April 2022. In January, it was announced that the Legal requirement for health and social care staff to be double jabbed to be removed, subject to consultation and Parliamentary approval.

5.2 Health and care workers vaccinated continue to be urged to Get Boosted Now as a professional responsibility. Following substantial efforts by all employing organisations, vaccinations rates had increased significantly and were at 94.7% across NHS Trusts, Primary and Social Care (Care Homes and Domiciliary Care) when last updated.

6. Workforce Dashboard Highlights (December data)

6.1 Medical workforce has increased by 2.2% (43.73 WTE) in year.

6.2 Nursing workforce has increased by 3,53% (192 WTE) in year with a vacancy rate of 769 WTE. This is primarily due to increases at UHCW from monthly international recruitment programmes. HCA recruitment pipeline remains strong, however vacancies have increased to a high of 301 WTE, this is primarily due to retention issues.

6.3 Absence rates have been declining following and are currently (20 Feb) 5.9% for NHS Trusts, of which 1.4% is covid related.

7. Equality, Diversity & Inclusion

7.1 Equality, Diversity & Inclusion is a key pillar of the Coventry & Warwickshire People Plan. There is a cross-system EDI sub-group of the People Board that works with all other sub-groups to ensure that Inclusion is embedded in their programmes of work. Current priorities in respect of race equality are **inclusion in recruitment practices; career progression and leadership pipeline**; ensuing that we have and are supporting **networks** to engage and influence for change.

Conclusion

This report has updated on key people priorities identified to mitigate our system workforce risk.

Recommendation

ICB is asked to note the progress on People Workstream.

End of Report

Report Title:	Medically Fit For Discharge (MFFD) Update
Report From:	Rachael Danter, Chief System Transformation Officer
Author:	Helen Lancaster Director of System Transformation/SRO Urgent Care
Previous Considerations and Engagement:	Discussion have taken place within a number of committees including UEC committees, Silver and Gold Command and Partnership Executive Group (PEG)
Purpose:	For information

Contribution to meeting the aims of the ICS:

The drive to reduce the numbers of Medically Fit For Discharge (MFFD) patients was a requirement stated in the letters to the NHS and Local Authorities,

- Preparing the NHS for the potential impact of the Omicron variant and other winter pressures (13th December 2021)
- Enabling safe and timely discharge from acute settings (22 December 2021) and
- For action – accelerating the numbers of people discharged home (22nd December 2021)

By reducing the numbers of MFFD patients, the system meets the following ICS aims:

1. Improves outcomes in population health and healthcare
2. Tackle inequalities, in outcomes, experience and access
3. Enhances productivity and Value for Money (VfM)

Contribution to meeting the priorities of the ICB:

Priority - ***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)*

Reducing the number of Medically Fit For Discharge patients will certainly improve the quality of care for patients in terms of reducing deconditioning and improve outcomes (10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80). Reducing the MFFD will also free up beds for elective and urgent and emergency care.

Recommendation:

Members are requested to note for information

Implications							
Conflicts of Interest:	Not applicable						
Financial and Workforce:	Workforce – not applicable Finance – by reducing the numbers of MFFD patients, more elective work can be undertaken with the system seeking to recover costs through ERF.						
Performance:	There is now a target to reduce the number of MFFD patients to at least 30% of the baseline measured as 13th December 2021 by end of Mar 22. The system is being measured against this target. Any reduction will also support the delivery of more elective performance and thereby reduce waiting lists.						
Quality and Safety:	As mentioned earlier, discharging patients as early as safely possible improves the quality of their overall experience and reduces their physical decommissioning, thereby improving overall outcomes.						
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:	Work is required by the clinicians to review the appetite for organisational risk, in terms of where the greatest risk actually resides when there are large numbers of MFFD patients not being discharged and whether more could be done to safely discharge patients back to their homes or other facilities sooner.						
Risk and Assurance:	The risks associated with not reducing the numbers of MFFD patients are: • Increased risk of patient's physical health deteriorating due to decommissioning whilst unnecessarily residing in an acute bed • Increased risk for other patients either being held in Ambulances or in ED due to problems with flow through the hospital • Financial risk of acute beds being blocked and potential reduction in elective work • Reputational risk of not meeting target set						

1. Executive Summary

1.1 Introduction

The drive to reduce the numbers of Medically Fit For Discharge (MFFD) patients residing in acute beds was a requirement outlined in the letters to the NHS and Local Authorities, '*Preparing the NHS for the potential impact of the Omicron variant and other winter pressures'* 13th December 2021, '*Enabling safe and timely discharge from acute settings*' 22 December 2021 and '*For action – accelerating the numbers of people discharged home'* 22nd December 2021.

1.2 The aim of the guidance was to maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes.

The original ask was a reduction of 50% of medically fit for discharge (MFFD) numbers from the 13th December baseline to end of January 2022. This was later amended by NHSEI to 40%.

Hospitals were asked to eliminate avoidable delays for patients on Pathway zero, i.e. straight home without the need for social care support. Where necessary, this could include using personal health budgets, or use of hotel beds and to make full use of non-acute beds in the local health and care system including any spare hospice capacity including hospice at home.

The expectation is that all systems move to a 'home first approach,' where possible led by social care colleagues to reduce avoidable over-prescription of care and its associated delays.

The principles for safe discharge and associated actions are contained in the referenced letters.

Below is the performance against the amended target of 40% of medically fit for discharge (MFFD) numbers from the 13th of December baseline to end of January 22.

Trust	Benchmark 13.12.21	Target MFFD end Jan	MFFD no's end of Day on 31.01.22	MFFD no's end of Day on 25.02.22	Variance from Target
GEH	52	32	61	56	24
SWFT	91	57	86	92	35
UHCW	170	102	204	196	94
Total	**317**	**191**	**351**	**344**	**153**

Whilst some improvements have been made the target has not been achieved and continues to be challenging.

Data cleansing and robust reporting across the Trusts may have contributed to the rise seen during January. However, the peak of outbreaks was felt during that time and has taken considerable time to resolve.

Covid has had a significant impact on flow across the system with particular emphasis on the flow out of all discharge destinations. The impact felt within the domiciliary care and care home sectors has been great with over 78% of care home beds being affected by outbreaks and either closed or partially closed at the height of the pressure. Challenges with the domiciliary care market have been felt most profoundly in Warwickshire and less so in Coventry.

An NHSEI discharge intensive support review across all systems identified a number of themes specifically related to internal and external delays. Internal delays, were identified as, timeliness of swabs, TTOs, waiting for diagnostics, IV antibiotic usage, confidence to challenge for non MFFD, lack of support from specialities, lack of early in the day discharges, little or no criteria led discharge and poor medical documentation of plan

External delays/challenges identified were identified as insufficient trusted assessors, capping of admissions, refusal, time delay, trust by clinicians, plans, poor escalation processes regarding choice (family, patients) mental health response, transport, and ceilings of care.

At the point this report was written, the majority of the MFFD waits sat within pathway 1 particularly 1a- reablement social services, warmer homes, and pathway 2- usually bedded short term intermediate care, these being 80% of the total patients MFFD. Split by organisation responsible for the discharge, 37% local authority, 19% CCG, 44% other which includes out of area, Out of Hospital, patient, or family choice and some of the most complex patients many of which have complex behaviours which require specialist support.

2. Actions to date

- Robust governance arrangements in place at all levels of the ICS to support collaborative system working with a view to effectively managing MFFD patients
- Deep dives were carried out across each provider to establish themes for delay, whether there was an over prescription of need.
- Data cleansing exercise undertaken as it was established that organisations weren't counting the same data and a further explanation as to the description of each pathway was required.
- Daily review of Medically Fit for Discharge volumes and actions to improve discharge.
- Deep dive into all local authority discharge delays
- Review by therapy teams of all care/discharge needs
- Emergency Care Improvement Support Team visit to support Medically Fit for Discharge reduction
- Domiciliary care resilience workstreams in place
- Review of CHC delays
- Additional care home capacity commissioned
- Virtual ward; System meeting set up and expansion of capacity
- Hospice collaboration and expansion discussion
- Additional blue bed capacity commissioned
- Daily call with WMAS for escalations in place
- Increased mutual aid and support across the system.
- System escalation and resilience review, reported through the Coventry and Warwickshire A&E Delivery Board.

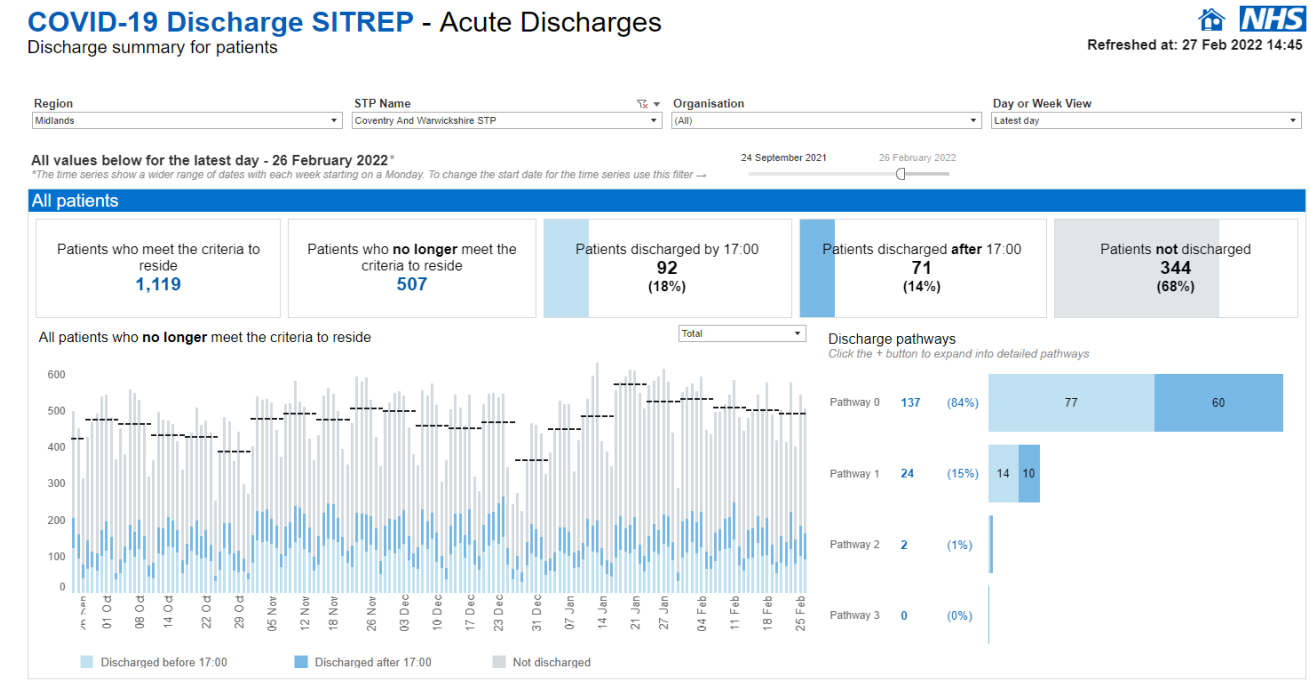
- SDEC expansion across all providers to ensure a minimum 12 hours per day 7 days per week
- Direct access to SDEC for WMAS/EMAS.
- Implementation of Respiratory Support Unit (RSU) at GEH
- Increase in ward rounds at weekends to maximise discharges and improve patient flow.
- System wide MADEs including community hospitals and Mental health
- Review of complex LLOS patients to establish learning
- Review of all delayed MH patients
- Review of fast track provision
- Discussion relating to establishment of co located UTCs across all sites
- Funding identified to implement SPA for hospices proof of concept
- OPAT virtual ward at GEH commenced
- Pilot for WMAS clinical navigators to commence in south
- Ongoing exploration of hotel care scheme
- Review of pathway 1&2 provision
- ECIST support
- National support UHCW
- Twice weekly regional review
- Realtime view of delays per organisation, pathway, and lead for discharge

3. Further work

- Discharge pathways mapping
- Missed opportunities audit
- Prehospital pathway workstream
- Review the Directory Of Service (DOS)
- Nursing home support
- Paramedic visiting service
- Risk appetite discussion supported by NHSEI

4. Current Performance

The data below highlights the current position and the performance trend since measurement commenced:



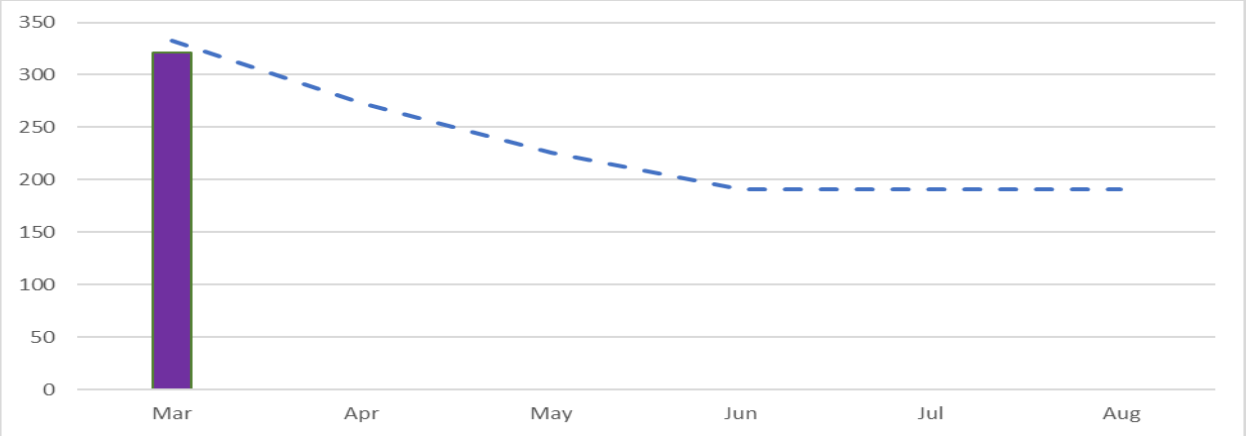
Small incremental improvements are being felt across the system, daily monitoring is in place to ensure traction on actions

5. Trajectory for recovery

The ambition is to recover as quickly as possible during the next 4 months and embed new ways of working to ensure the system, as a whole, is more resilient for next winter.

The charts below set out that trajectory.

End month Profile	Mar	Apr	May	Jun	Jul	Aug
Patients with a Right to Reside - Midnight a.m.	1230	1290	1337	1372	1372	1372
Patients with no Right to Reside - Midnight a.m.	519	459	412	377	374	374
Patient not dscharged - Midnight p.m.	333	273	226	191	191	191
In month Monitoring	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Patients with a Right to Reside - Midnight a.m.	1149					
Patients with no Right to Reside - Midnight a.m.	535					
Patient not dscharged - Midnight p.m.	321					
Variance	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Patients with a Right to Reside - Midnight a.m.	-81					
Patients with no Right to Reside - Midnight a.m.	16					
Patient not dscharged - Midnight p.m.	-12					



Monitoring will continue through the governance arrangements already identified

Risks in achieving the target

Over the last quarter, the impact of Covid in terms of managing/cohorting patients and staff isolation, the increase in urgent care demand and the reduction in Care Home and Domiciliary Care capacity have all impacted on the system's ability to meet the trajectory set. Organisations also recognise there are internal process issues (as outlined in the NHSEI intensive discharge review) which have also affected their ability to discharge patients as quickly as they could. Many of these issues are now abating or being addressed and as such these risks are being mitigated/reduced.

However, the removal of the national Hospital Discharge Grant (HDG) at the end of March poses significant risk to future flow and safe discharge. Many of schemes that have been put in place in response to COVID will no longer be funded and ceasing those schemes could have an impact on timely discharge. The full extent of this is being explored with a full review of discharge to assess (D2A) and other schemes commenced. Other schemes, such as 7-day integrated discharge teams, seem to have yielded very little gain to date and these will all be considered as part of the review.

As well as assessing the HDG, a review of the Better Care Funds is being undertaken. This will not have any immediate impact as the commissioning round has already taken place. However, it will provide the opportunity to reassess how we might utilise the money next winter and beyond. This approach is supported by NHSEI.

By solely concentrating on discharges, the system recognises that this will not address all the issues the system is experiencing. Recent audits have demonstrated that by preventing unnecessary admissions or A&E attendances and creating alternatives to A&E significantly reduces the numbers of occupied bed days. This subsequently supports better flow by preventing unnecessary admissions due to factors such as staff fatigue, overwhelmed departments, late decision making and lack of knowledge of alternatives to A&E.

Unfortunately, the current pressures have also meant that most of the capacity for Same Day Emergency Care (SDEC) and Decisions Units is being utilised as part of the bed base. This results in no facility being available for streaming and admission prevention with admission becoming the only option.

The system needs to reignite the risk appetite discussion as quickly as possible to develop its thinking regarding how risk is effectively managed across the system and more importantly where the greatest risks lie, which could be at the 'front door.' Use of technology such as the SHREWD system is being explored which enables systems to have a real time view of where the waiting times are especially in relation to category 2 ambulance waits. This will enable an informed, real time discussion as to where the greatest clinical risks lie but there will need to be a cultural shift within organisations across the system to enable this discussion to happen.

Conclusion

Flow through organisations is complex and concentrating on one single element will never bring sustainable improvement. The system and organisations are clear what actions are required and although progress has been slower than expected, some progress is being made. All the actions set out in the report need to continue and transformation across the whole UEC pathway is required by all partner organisations.

Normally, the numbers of delayed discharges naturally improve after the end of April; however, it is fair to say that the NHS is not in normal times. It is therefore critical that collaborative engagement across the system in the UEC transformation program continues to deliver the desired changes that will enable recovery of the elective position and provide a more sustainable position for winter 22/23. Planning for next winter has already begun with a review of what has gone well and what hasn't. A discussion regarding the development of system schemes not just organisational schemes and what will be embedded now as business as usual is also required to support a different approach to next winter.

Recommendations

The board are asked to receive the report and note the actions to date.
To embrace and support the risk appetite discussion and its conclusions
To support and engage in the review of the BCFs and discharge schemes
To support and work collaboratively in the transformation of urgent and emergency care including the alternatives to A&E and system wide schemes.

End of Report

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

Contribution to meeting the aims of the ICS:

- Improving outcomes in population health and healthcare: Aligns to system planning and operational guidance
- Tackling unequal outcomes, experience and access: N/A
- Enhancing Productivity and value for money: providing update and assurance regarding financial performance and planning
- Supporting the broader social and economic development of C&W: N/A

Contribution to meeting the priorities of the ICB:

Accelerate preventative programmes and activities that target those at greatest risk, eg.pre-rehabilitation, mental health programmes
Work together, as partners, at system and Place to identify and address health inequalities and variations in health and care provision
Protect the most vulnerable, ensuring inclusivity runs through everything we do
Focus our delivery on Place-based care, supported by strong, well developed PCNs
Successfully manage urgent emergency care (UEC), particularly winter pressures (including Flu) alongside managing any further Covid-19 surges (continuing Covid-19 vaccination and mass testing)
Restore elective care to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics
Care for and develop our workforce ensuring they continue to have the resilience and support to deliver the best care to our patients and communities particularly our BAME employees
Maximise all enablers that support us deliver our Five-Year Plan commitments eg. digitally enabled care, our estate and flexible working
'Live within our means' and become financially sustainable

This paper relates to the ICB priority of to *'Live within our means' and become financially sustainable'* as follows:-

- In-year Forecasting achievement of capital plan;
- In-year potential revenue forecast deficit to be confirmed following SWFT discussion with NHSE/I concerning the change in accounting rules concerning the capitalisation of Digital expenditure.

- Significant efficiency challenge for 22/23.
- Elective Recovery Fund (both capital and revenue) available into 22/23. A balanced financial plan will be dependent on:
  - Managing emergency growth within existing resources.
  - Continued strong (relative) performance across Elective recovery.
  - Robust efficiency programmes at organisational, Place and System level.
  - Withdrawal of COVID related costs as COVID funding reduces.
  - An affordable capital plan that is within the System allocation and supports the process of elective recovery.

Recommendation:

Members are requested to **NOTE FOR INFORMATION**.
Members are requested to **DISCUSS**:

- Challenging 2022/23 efficiency requirement
- Support of 2022/23 pragmatic approach to contract setting described in the paper
- Capital allocation versus the inherent demand for capital issue

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

System Financial Update to NHS ICS Board

1. Executive Summary

1.1 This paper follows on from the financial update paper from last month in terms of the H2 financial position and also picks up a number of current pertinent issues. Specifically the paper will cover:

- Year-end forecasts for revenue and capital
- 2022/23 System Planning Updates for revenue and capital

1.2 The report providing update and assurance regarding financial performance and planning. It specifically relates to the ICB priority of to *'Live within our means and become financially sustainable'*.

2. H2 System Finance Forecast

2.1 The system has reviewed its Risk Assessed Forecast Outturn for Best, Likely and Worst case outturns (summarised in the table below) in line with significant scrutiny from both Regional and National Teams. Our worst case scenario (£8.3m deficit) was driven by a desire to continue to push elective activity where possible recognising that this may come at a premium. Our best case scenario (£2.5m surplus) is driven by winter pressures that stop elective activity and reduce some of the elective spending (recognising that the ERF underwrite means we keep the income).

2.2 However, the RAFOT has deteriorated as SWFT have an issue regarding the change in accounting rules concerning the capitalisation of Digital expenditure – they are currently in dialogue with NHSE/I and will confirm their forecasts following these discussions. Their current expectation is an adverse impact of £3.5m, which is reflected in all the RAFOT scenarios.

Cov & Warks ICS RAFOT	Best £000s	Likely £000s	Worst £000s
	2,501	-3,299	-8,273

2.3 The key material risk that the System organisations need to manage within their H2 position is the extent to which we are achieving our position through non recurrent means and the potential drop off of income support in future years.

2.4 The M10 Provider capital forecast is outlined in the table below:

Provider	CDEL Plan YTD £000s	CDEL Actual YTD £000s	CDEL Variance YTD £000s	CDEL Plan FYE £000s	CDEL FOT £000s	CDEL Variance FYE £000s	% spend YTD Actual	% spend FOT M11-12
CWPT	8,569	776	7,793	11,179	7,074	4,105	11.0%	89.0%
GEH	6,349	5,120	1,229	6,600	12,046	-5,446	42.5%	57.5%
UHCW	40,465	28,818	11,647	56,998	56,998	0	50.6%	49.4%
SWFT	8,880	8,860	20	11,463	12,193	-730	72.7%	27.3%
Totals	64,263	43,574	20,689	86,240	88,311	-2,071	49.3%	50.7%

2.5 The system is anticipating achieving its capital forecast and is working actively to manage the spend for year-end. NB: additional capital funding MoUs have been agreed that will address the FOT adverse variance in the above table.

3. 2022/23 System Financial Planning – Revenue

3.1 The Finance Advisory Board (FAB) has signed off the System 2022/23 Planning Timetable (**Appendix 1**). This contains key checkpoints both internally and with NHSE/I prior to submitting the Draft and Final Finance Plan.

3.2 The revenue allocation methodology is fundamentally the H2 envelope doubled as the baseline. The following are principles that FAB is looking to agree and that NHSE/I have feedback is in line with other systems:

- a principle that as organisations lived within the H2 funding in 2021/22 they can agree the same for 2022/23, as issues such as inter provider and cost pressure issues were effectively covered off. NB: organisations still to sign off final allocation values; there has been an ask to re-open discussions around the start point baselines which is ongoing.
- We anticipate some relatively minor 'below the line' adjustments where services will change in 2022/23 (e.g. MSK and Stroke).
- Efficiency remains a key challenge that requires close scrutiny - in addition to the 1.1% tariff productivity requirement, there is also the:
    - Convergence adjustment towards fair share allocations (£8.3m) – to both reduce overall resource consumption to Spending Review 2021 funded levels and move ICBs towards a fair share funding distribution.
    - Covid allocation for 2022/23 will be reduced by £44.2m from £77.6m to £33.4m.
    - with a significant amount of the 21/22 efficiencies only being achieved non-recurrently (c. £37m of the total programme), this will add to the challenge of planning a break-even position for 2022/23.
- One final adjustment that FAB is considering is to top slice growth to create an investment reserve, for example to use to support Place initiatives. The value of this is still under consideration.

3.3 The above approach should enable the System to model a baseline plan that will equate to the 2020/21 activity. The System is then receiving a further c. £35m ERF to increase current activity levels to 104% of 2019/20 levels of value-based activity and deliver 10% more elective activity than before the pandemic. The two activity targets should align – i.e. 104% level of value-based activity should result in 110% of 2019/20 elective activity. This is currently being worked through by the System organisations.

4. System Planning – Capital

4.1 The System has received its multi-year capital allocations (**Appendix 2**), which is intended to increase clarity and certainty. NHSE/I have confirmed these are unlikely to change, despite still being classified as draft. Specifically for 2022/23:

- The system provider allocation is £39.4m compared to £47.1m 2021/22 allocation.
- There are additional capital allocations for Diagnostics (£9.4m) and Technical Funding (£6.9m) increases the allocation to £54.9m
- This rises further to £56.6m as the Primary Care Operational Capital allocation has now been included in this envelope total.
- Additionally, there is still £133m of Elective Recovery / Targeted Investment Fund Regional capital to be allocated, for which the System has recently submitted initial bids of c. £43m.

4.2 Due to this change in approach it is difficult to assess our 2022/23 offer against 2021/22. However, the overall 2022/23 allocation has increased from 2021/22. NB: a key concern is the reduction in Provider Totals for 2023/24 and 2024/25 allocations reduced by £4.7m to a £34.7m allocation (**Appendix 2**).

4.3 Currently FAB are reviewing the fairest way on how the allocation should be split across providers (aim to agree on Friday 4 March 2022). This needs to be balanced against the commitments and 'must do' business as usual capital schemes for 2022/23.

4.4 The initial review showed a tension as the capital allocation was insufficient to cover the capital demand for such schemes. This analysis is being validated and refined, with other possible phasing and capital routes being considered.

4.5 A balanced financial plan will necessitate:

- Managing emergency growth within existing resources.
- Continued strong (relative) performance across Elective recovery.
- Robust efficiency programmes at organisational, Place and System level.
- Withdrawal of COVID related costs as COVID funding reduces.
- An affordable capital plan that is within the System allocation and supports the process of elective recovery.

Recommendation

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

- Challenging 2022/23 efficiency requirement
- Support of 2022/23 pragmatic approach to contract setting described in the paper
- Capital allocation versus the inherent demand for capital issue

Appendix 1: 2022/23 System Planning Timetable

Date	Description	Finance Lead
19/01/22	**Technical planning guidance issued**	**NHSE/I**
20/01/22	Technical planning guidance circulated to the System	AF
W/C 17/01/22	**Templates issued: Functional finance templates (system and provider) and related technical guidance FAQs issues: Finance, Activity, Performance and Workforce - Head of System Financial Planning (HoSFP) to distribute**	**AF**
25/01/22	High level System response to NHSE/I regarding initial views on draft 2022/23 allocations	AS
28/01/22	Interim Finance Advisory Board (FAB): review System Capital envelopes for next 3 years and agree forward planning actions	AS
04/02/22	FAB agreement on process for System capital allocation and base assumptions concerning 22/23 activity modelling	AS
07/02/22	Technical Finance Group to develop and report back on FAB planning actions on a weekly basis	AF
07/02/22	Weekly System Contracting Group commences - tasked to ensure consistency, agree principles and avoid duplication to support the contracting process.	AF
Pre 28/02/22	Detailed review of technical guidance / funding envelopes and consolidated System communication responses with NHSE/I.	AS
W/C 28/02/22	**System and organisational templates issued and collection portal open for activity, performance and workforce.**	**NHSE/I**
W/C 21/02/22	System Finance Lead (SFL) / HoSFP Confirm and Challenge (C&C) meetings with each System organisation to review draft revenue and capital plans.	AS
25/02/22	Interim Finance Advisory Board (FAB): review System Capital schemes for ERF / TIF, Diagnostics and Technology bids	AS
COB 02/03/22	Agreed C&C actions completed draft plans updated and shared with HoSFP	All /AF
04/03/22	First cut of activity plans shared with Steve Jarman-Davies (as per e-mail 23-02-22)	SJD
04/03/22	FAB discussion regarding template issues and to agree System activity and Workforce approach	AS
06/03/22	Consolidated System Activity plans to be shared with System Leads (as per e-mail 23-02-22)	SJD
07/03/22	Technical Finance Group Meeting (TFG) to agree System Activity and Workforce approach	AF
W/C 07/03/22	SFL / HoSFP Draft Plan Review Meeting with NHSE/I Regional Team	AS
11/03/22	Draft Plan review and FAB sign off	AS
15/03/22	HoSFP to submit Draft System Financial Plan narrative to HFL for review	AF
TBC	PEG Draft Plan Review / Sign off (Extra-ordinary PEG meeting required)	AS
W/C 14/03/22	FAB / PEG paper outlining draft Finance Plan submission approach / issues / further actions	AS
17/03/22	**Draft Plans – finance (system and provider), activity & performance, workforce, narrative submissions (noon deadline)**	**AS / AF**
25/03/22	Interim FAB to update / sign off inter-system contracts	AS
18-30/3/22	Final discussions to ensure contracts agreed / signed off by 31 March.	All
31/03/22	**Inter-System contracts agreed and signed in line with guidance**	**AS**
W/C 11/04/22	SFL / HoSFP C&C meetings with each System organisation to review final revenue and capital plans	AS
18/04/22	TFG to review System Activity and Workforce alignment	AF
20/04/22	Agreed C&C actions completed draft plans updated and shared with HoSFP	All /AF
22/04/22	Final Plan review and FAB sign off	AS
W/C 25/04/22	SFL / HoSFP Final Plan Review Meeting with NHSE/I Regional Team	AS
26/04/22	HoSFP to submit Final System Financial Plan narrative to HFL for review	AF
TBC	PEG Final Plan Review / Sign off (Extra-ordinary PEG meeting required)	AS
28/04/22	**Final plans - finance (system and provider), activity & performance, workforce, narrative, draft MH workforce submissions (noon deadline)**	**AS / AF**
09/05/22	PEG paper outlining final system financial plan submitted for PEG on 16 May	AS
23/06/22	**Final MH workforce submission**	**CH**

2022

Appendix 2: System Multi-Year Allocations

	Total Provider Operational Capital Allocation £'000	22/23 Primary Care Operational Capital Allocation £'000	Total 22/23 System Operational Allocation £'000	Elective Recovery/ Targeted Investment Fund £'000	Endoscopy £'000	Community Diagnostic Centres £'000	Total Diagnostics £'000	Levelling up digital Maturity £'000	Front Line Digitisation £'000	Critical Sybersecurity infrastructure Risks £'000	Total Tech Funding £'000	Total System Capital £'000
22/23	39,434	1,723	41,157		190	9,250	9,440	3,555	2,250	178	5,983	**56,580**
23/24	34,737	1,728	36,465		540	3,580	4,120				-	**40,585**
24/25	34,737	1,733	36,470		280	3,580	3,860				-	**40,330**

For 2022/23, the NHS capital allocation split into three categories:
1. System-level allocation (£4.0bn) – to cover day-to-day operational investments, typically self-financed by organisations or financed by DHSC through business loans or system capital support PDC (previously known as emergency capital PDC). In 2021/22 this was £3.9bn.
2. Nationally allocated funds (£1.1bn) – to cover nationally strategic projects already announced and in development or construction – e.g. hospital upgrades ('STP schemes') and new hospitals. In 2021/22 this was £1.2bn.
3. Other national capital investment (£2.7bn) – including national programmes such as elective recovery, diagnostics and national technology funding and the mental health dormitory programme. In 2021/22 this was £1.7bn.

Report Title:	ICS Digital Transformation Strategy Update
Report From:	Adrian Stokes, Interim Chief Finance Officer, CCG
Author:	Simon Jones, Acting Chief Digital Information Officer, C&W ICS Alec Price-Forbes, Chief Clinical Information Officer, C&W ICS
Previous Considerations and Engagement:	Partnership Executive Committee - 20th December 2021
Purpose:	For information and agreement of immediate resource requirements as the strategy developments

Contribution to meeting the aims of the ICS:

ICS Digital Transformation Strategy sets out how we will transform and support people to live well, as well as enabling the radical redesign needed for more proactive, seamless and person-centric care enabled by digital transformation. Digital transformation is seen as the key enabler to meet objectives referenced in NHSEI ICS Design Framework: better health for everyone, better care for all and efficient use of NHS resources, and the four fundamental objectives for ICS:

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

Contribution to meeting the priorities of the ICB:

Preventative programme - digital capabilities outlined in this transformation strategy are fundamental to accelerating preventative programmes that target those at greatest risk
Work together - capabilities outlined in this transformation strategy will allow partners, system and place to identify and address health inequalities and variation in health and care provision
Protect the most vulnerable - inclusivity runs as a theme throughout the ICS Digital Transformation Strategy
Place-based care - this strategy supports a focus on our delivery of place based care
Urgent emergency care (UEC) - the digital capabilities outlined in this strategy allow us to better support UEC considerations
Elective care - digital capabilities outlined in this strategy will allow us to move to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics
Workforce - digital enablers will ensure workforce have resilience and support to deliver the best care to our patients and communities
Maximise enablers - this strategy is fundamental to support five-year plan commitment around digitally enabled care, flexible working and estate reform
'Live within our means' digital transformation is the mechanism to allow us to become financially sustainable through redesigned care pathways and new ways of working

Recommendation:

Members are requested to

- Members are requested to ENDORSE the approach to the development of the ICS Digital Transformation Strategy

Implications							
Conflicts of Interest:	No conflicts of interested noted at this time						
Financial and Workforce:	There are financial and workforce implications in this report						
Performance:	The ICS Digital Strategy support a series of performance outcomes identified in the benefits of the wider strategy						
Quality and Safety:	Quality and Safety need to be worked through in strategic planning stage						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	**Has an equality impact assessment been undertaken?** *(Delete as appropriate)*	**Yes** (attached or hyperlinked)		**No**		**N/A**	✓
Patient and Public Engagement:	Public engagement had been part of the development of this strategy.						
Clinical and Professional Engagement:	Clinical colleagues were engaged with designing the ICS Digital Transformation Strategy. The engagement included stakeholder focus groups.						
Risk and Assurance:	If inadequate level of resource (finance and workforce) are not agreed to support this, there is a risk to project quality, cost and timescale. Full details will be included on the Corporate Risk Register.						

1. Executive Summary

1.1 The purpose of this paper is to provide an update on the progress on the development of the C&W ICS Digital Transformation Strategy.

1.2 The NHS's health and care services are dependent on people, processes, data and technology. Many of these IT systems are outdated and inefficient. The Department of Health & Social Care (the Department) and NHS England & NHS Improvement (NHSE&I) believe that digital transformation is essential to re-imagining how we deliver these new ways of working.

1.3 The strategy outlines how we can use digital and data to reimagine how care is delivered to make health and care services more sustainable and to address rising demand, support health and care services to be tailored to individual care needs, understand and address access and inequality disparities, and deploy resources to provide preventative services to support people to stay healthy.

2. National Context

2.1 The pandemic enabled us to achieve a level of digital transformation, in some areas, that might have otherwise taken several years. This was for collaboration and coordination purposes (e.g. Teams) as well as for direct care (e.g. remote video consultations). As we move into the recovery period, it is critical that we build on the progress we've made and ensure that all health and care providers have a strong foundation in digital practice.

2.2 The NHS Long Term Plan sets the ambition and direction of travel for health and care services to better support the needs of their local populations, served through greater collaboration between health and care partner organisations within the Integrated Care Systems (ICS).

2.3 The DHSC White Paper describes ICSs as an opportunity to deliver the best possible care for people, creating partnerships across the NHS and local government to address the complex health challenges experienced by society. **Digital transformation is essential to the achievement of the ICS core objectives:**

- Improving population health and healthcare
- Tackling unequal outcomes and access
- Enhancing productivity and value for money
- Helping the NHS support broader social and economic development

2.4 The ICS Design framework references standards and requirements for digital and data, centred on NHSX's What Good Looks Like framework, to accelerate digital and data transformation and have smart digital and data foundations in place from April 2022.

3. ICS Digital Transformation Strategy

3.1 The vision for ICS Digital Transformation Strategy is to "enable people across Coventry and Warwickshire to "start well, live well and age well, promote independence, and put people at the heart of everything we do."

3.2 Digital transformation is using digital and data capabilities to reimagine health and care delivery to improve our population's wellness.

3.3 The ICS Digital Transformation Strategy has been developed around citizen journeys or use cases to identify the digital and data capabilities required to address population needs and operate in an integrated way, by applying an enterprise-wide approach to the strategy.

4. Our Approach

4.1 In September 21, Coventry and Warwickshire ICS (C&W ICS) secured funding from NHSx to commission a consulting partner, Deloitte, to coordinate the development of our own Strategy. **C&W ICS is the first across the NHS to have developed a Digital Transformation Strategy**

4.2 The intent was to create an optional 'blueprint' guide that could be used to support the remaining 41 Integrated Care Systems (ICS) to develop their own strategies, to deliver ambitions around digital and data transformation for their respective systems. The blueprints would be shared with other ICS areas to ensure that the standards contained within the 'What Good Looks Like' (WGLL) Framework are used to accelerate digital and data transformation. The WGLL framework has 7 success measures:

- **Well led** - proposed ICS governance to align all organisations' digital and data strategies, programmes, procurements, services, etc.
- **Ensure smart foundations** - cross-organisation investment in modern infrastructure to retire unsupported systems
- **Safe practice** - established processes to manage digital assurances at ICS-level
- **Support people** - created a digital first approach and share innovative improvement ideas from frontline health and care staff
- **Empower citizen** - developed a ICS-wide strategy for citizen engagement and citizen-facing digital services led by and co-designed with citizens
- **Improve care** - ICS-wide approach for data and digital solutions to redesign care pathways to give the right care in the most appropriate setting
- **Healthy populations** - Delivery of an ICS-wide intelligence platform with fully linked, longitudinal data-sets to support population health management

4.3 It is recognised that digital, workforce and estates strategies are enablers of a wider clinical strategy. There is a need to ensure digital transformation strategy is iterative to ensure it continues to address our evolving strategic requirements (clinical, workforce and estates) and ensure close alignment with cross cutting initiatives such as population health management, elective recovery, diagnostics and health inequalities.

5. Governance and Leadership

5.1 Glen Burley is identified as the Executive sponsor for the strategy. ICS senior executives / Integrated Care Board have been briefed in the development process to secure ownership and support for the sign-off and approval of the final strategy (expected July 2022).

5.2 A working group of clinical and digital leads from all the ICS and partner organisations (e.g. CIOs, CCIOs, CDIOs) was established and responsible for developing and then socialising the strategy with respective partner organisations for buy-in and alignment. Relevant ICS digital, data and strategy boards were engaged to obtain regular feedback throughout the development process and to ensure alignment of the strategy with wider programmes of work.

6. Capabilities

6.1 To achieve the ICS's Digital Transformation aspirations, a series of digital and data capabilities have been proposed. The ICS will need to implement and adopt in order to achieve the future vision of care, as defined by the citizen journeys and underpinned by Advanced Analytics, Data inter-operability and technical infrastructure enablers:

- **Citizen and Patient Portal -** Citizen/Patient empowerment and activation provided by a single digital point of access to their health and care records and personalised resources and self-serve support, system-wide appointment management, and virtual communication with health and care teams
- **Integrated Care Record** - the integration of records from primary care, secondary care, mental health, community and social care, ambulance and NHS 111 into a structured, but **read-only** view, for health and care professionals, launched from their own organisational systems
- **Virtual Health and Care** - digitised support and virtual interactions between and amongst health and care professionals, citizens, and patients. Remote monitoring and virtual wards, outside of physical health and care settings, using physiological data and citizen-reported metrics
- **Digital Workforce Tools** - agile working, collaboration, training, people management, and self-serve access capabilities, including enhanced staff recruitment and retention and improved staff well-being, engagement and development across the employee lifecycle
- **Population Health Management Platform** - an intelligence platform with data aggregation and analytical capabilities fed by a rich, linked dataset across care settings. This will detail the health and wellbeing of our population, to predict and prevent those at risk of developing avoidable illness. It will support our overall population health management approach, as well as providing insights to close care gaps for existing cohorts of patients
- **Electronic Health & Care Record** - clinical Information system with **read and write, real-time access** to citizen and patient level data – the consolidated system of record. This will provide seamless information access across the ICS, improve quality of care and outcomes and provide a rich repository of standardised data to enable advanced analytics, population health management, and research

7. Digital Investment

7.1 Cost estimates create understanding of financial and funding implications (both capital and revenue) of strategy delivery, support business case development, prioritise investments and validate the strategy's scope, roadmap and key activities:

- Estimated current ICS digital spend (2%)
- Total proposed investment = 4% (£150m over 3 years)
- Expected benefits - estimated £240m (based on ROI of 1.6 taken from national and international experience of digital transformation in health and care)

7.2 Key finance risks to consider are:

1. **Funding Models** - NHS have traditionally relied primarily on capital allocations to fund IT/Digital transformational initiatives. The move to Cloud and "as a service" links digital more to revenue funding in line with accounting guidance / capital resource limits and prioritisation at ICS and provider level.
2. **Funding Availability** - expected gap in funding availability from the NHSE/I to meet the objectives set out in ICS the Digital Transformation Strategy

Programme	FY22/23 – 24/25							
	Capital				Revenue			
	22/23	23/24	24/25	Total	22/23	23/24	24/25	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Population Health Management Platform	0.0	0.1	0.0	**0.1**	1.4	2.1	1.7	**5.2**
Integrated Care Record	0.0	0.0	0.0	**0.0**	0.9	1.2	1.1	**3.2**
Electronic Health & Care Record SWFT/GEH EPR	0.0	0.0	0.0	**0.0**	8.0	11.1	7.7	**26.8**
Electronic Health & Care Record UHCW EPR	9.3	6.8	0.0	**16.1**	0.6	6.0	7.2	**13.8**
Virtual Health and Care	0.0	4.8	4.8	**9.6**	0.0	0.0	0.0	**0.0**
*Integrated Citizen Portal**	1.7	0.0	0.0	**1.7**	0.0	1.8	3.7	**5.5**
*Advanced Analytics**	0.4	0.4	0.5	**1.3**	0.0	0.5	0.8	**1.3**
*Infrastructure and Technical Capabilities**	1.6	4.0	3.9	**9.5**	0.0	0.0	0.0	**0.0**
*Digital Workforce and Enablers**	2.7	3.7	0.0	**6.4**	2.3	4.3	5.0	**11.6**
TOTAL	15.6	19.8	9.2	44.7	13.1	27.0	27.3	67.5

** These programmes are not yet defined and the costs are informed by rough order of magnitude estimates.*

8. Further Activities

8.1 **Strategy Refinement** - NHSx provided C&W ICS with £250k capital to resource additional baselining work:

- **Finance -** we are required to submit digital investment plans for 22/23 by the end of March 22 and overall 3 year digital investment plans by July 22
- **Resources -** refine the resource capability and capacity model to describe how digital roles will work at a) assurance b) coordination c) delivery levels in the strategy
- **Governance** - we are reviewing and agreeing structures required to deliver the strategy

8.2 **Core Digital Team** - NHSE have provided £820k revenue for ICS to resource a 'core digital team' to support planning and implementation of digital transformation plans. Allocation will be assessed within the future ICB structure discussions through CCG Exec team.

10 Next Steps

Digital Strategy Milestones	Approval Group
Development Period: Sep 21 - Dec 21 (complete)	**Partnership Executive Group:** 20th December 2021 (complete)
Engagement Period: Jan 22 - May 22 This includes detailed work around baselines including: Financial Investment Model, Resource Model and Infrastructure.	**Shadow ICB Board (update):** 16th March **CCG Executive:** March 22 (Resource Approval) **Financial Advisory Board:** April 22 (Investment Model)
Approval Period: May 22 - June 22	**Organisational Boards (approval)** **Exec Board PEG - recommendation to ICB):** July 22 **ICB Board (approval):** July 22 **NHSE/I (approval):** July 22
Strategic Plan Period: July 22 - Dec 22	**Digital Transformation Board**
Implementation Period: Jan 23 - onwards	**Digital Programme Groups**

Recommendation

- Members are requested to ENDORSE the approach to the development of the ICS Digital Transformation Strategy

END OF REPORT

Report Title:	Transition to Integrated Care System (ICS) – Progress Update March 2022
Report From:	Rachael Danter Chief System Transformation Officer
Author:	Hayley Allison Head of Transition
Previous Considerations and Engagement:	Paper has been presented to the System Strategy and Planning Group (SSPG) on 7th March 2022
Purpose:	For information

Contribution to meeting the aims of the ICS:

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

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

Contribution to meeting the priorities of the ICB:

This programme of work supports all of the ICB priorities:
Accelerate preventative programmes and activities that target those at greatest risk, eg. pre-rehabilitation, mental health programmes
Work together, as partners, at system and Place to identify and address health inequalities and variations in health and care provision
Protect the most vulnerable, ensuring inclusivity runs through everything we do
Focus our delivery on Place-based care, supported by strong, well developed PCNs
Successfully manage urgent emergency care (UEC), particularly winter pressures (including Flu) alongside managing any further Covid-19 surges (continuing Covid-19 vaccination and mass testing)
Restore elective care to 'better than' pre-Covid levels, with particular focus on long waiters, cancer and diagnostics
Care for and develop our workforce ensuring they continue to have the resilience and support to deliver the best care to our patients and communities particularly our BAME employees
Maximise all enablers that support us deliver our Five-Year Plan commitments eg. digitally enabled care, our estate and flexible working
'Live within our means' and become financially sustainable

Recommendation:

Members are requested to

- **NOTE THE CONTENTS OF THE PAPER FOR INFORMATION**

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

Transition to Integrated Care System (ICS) – Progress Update March 2022

1. Key Points and Purpose

1.1. The purpose of this report is to update the shadow NHS Integrated Care System (ICS) Board regarding the work undertaken through the system-wide Transition Forum. As the Board will be aware, the transition into a full ICS was a statutory requirement to be completed by the 30th of March 2022 ready for go live on the 1st of April 2022 but in December it was announced that this would be delayed until 1st July 2022.

1.2. The revised timeline for establishment of ICS was issued by NHSE/I in January (see further information pack), some of the milestones have moved and this has been reflected within our workstream plans.

1.3. Our workstream infrastructure with named SROs for each area continues to work well and has a detailed plan to deliver the necessary activities and provide evidence and assurance of our ability to operate against the core requirements of an ICS. The workstream leads continue to work together to identify and resolve any interdependencies between the areas of work. The transition team continue to support leads to identify and develop evidence to support our readiness to operate.

1.4. As part of the NHSE/I assurance process, there is a requirement for us to submit assessments against the Readiness to Operate framework and a refreshed SDP. We have made two submissions to date in October and December 2021, both of which our overall feedback was positive. Our next submission of the Readiness to Operate is required by 31st March 2022, along with our evidence to date, and a refreshed System Development Plan.

1.5. The workstream deliverables and progress in quarter 3 and quarter 4 in-progress is summarised in the further information pack

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

2. Next Steps

The continued development and delivery of the workstream plans will be overseen and supported by the Transition team. Preparation for the 31st March ROS and refreshed SDP submission is underway and will be shared retrospectively at the April meeting of the ICB.

3. Recommendation

1) to NOTE the progress made to date
2) to NOTE the 31st March 2022 submission to NHSE/I
3) to NOTE that there are no red or amber risks identified at this stage

Report Title:	Constitution and Scheme of Reservation and Delegation (SORD)
Report From:	Philip Johns, Chief Executive Officer Designate ICB, Accountable Officer Coventry and Warwickshire CCG
Author:	Claire Jones Corporate Governance Manager, Coventry and Warwickshire Clinical Commissioning Group
Previous Considerations and Engagement:	Constitution: Coventry and Warwickshire Integrated Care Board (Shadow), 15 September 21, 13 October 21, 10 November 21, 26 January 22 Health Watch of Coventry and Warwickshire: 3 December, 11 and 18 February 2022 SORD - Good Governance Institute 2 March 2022
Purpose:	For consideration and endorsement

Contribution to meeting the aims of the ICS:

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

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

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

Ensuring that the ICB is accountable and demonstrates transparency to local people and stakeholders is critical to its success and the key arrangements and principles of how the ICB will ensure accountability and transparency in its work are set out in the Constitution. The SORD sets out the functions (powers and duties) of the ICB and identifies the relevant organisation or committee for decision making and oversight, ensuring clear responsibilities and transparent accountability in the delivery of the ICB's statutory functions and the four aims. As the system develops, decision making and oversight of ICB functions will be delegated from the ICB to the component parts of the system, such as to partners closest to users of services, which will support the aim of tackling unequal outcomes, experience and access.

Contribution to meeting the priorities of the ICB:

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

provides clear governance and leadership arrangements that enable the effective setting, delivery and monitoring of the ICB's strategic priorities.

The SORD captures the arrangements for delegating the Powers and Duties of the ICB so that responsibilities, decisions and oversight arrangements can be held at the most appropriate level of the ICB or within the wider ICS to effectively achieve the ICB priorities.

Recommendation:

Members are requested to:

- CONSIDER the content of this latest draft of the Constitution and provide feedback;
- CONSIDER the content of this first draft of the SORD and provide feedback;
- ENDORSE the plan set out in 2.6 for the engagement and endorsement of the draft Constitution and the SORD.

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

1. Executive Summary

1.1 On its first day of establishment the Integrated Care Board's (ICB) Board (the 'Board') is required to approve its Constitution and Scheme of Reservation and Delegation (SORD).

1.2 To support the creation of these key documents NHS England (NHSE) has issued a Model Constitution, which it periodically revises to reflect changes in the Health and Care Bill and feedback from systems, and a list of current CCG statutory functions (duties and powers) that will be conferred on ICBs, subject to relevant legislation being passed. Coventry and Warwickshire ICB's Constitution and SORD have been developed using these guiding documents.

2. Constitution

2.1 A draft of the Constitution was circulated to Members of Coventry and Warwickshires' NHS Integrated Care System Body on 18 February 2022 ahead of its submission to NHSE on 25 February 2022. The draft was also shared with representatives from the Local Medical Committees and the two local Healthwatch organisations. Feedback received on the draft was incorporated into the version submitted to NHSE on 25 February.

2.2 Subsequent amendments have been made to:

- two of the Executive Director job titles to reflect the title of the posts advertised;
- the sections concerned with locally agreed eligibility and exclusion criteria and/or the appointment and nomination process for the Partner Member roles for NHS Trusts and Foundation Trusts (3.5.2, 3.5.3, 3.5.5) and Providers of Primary Medical Services (3.6.2, 3.6.3, 3.6.5) and Local Authorities (3.7.5).

2.3 Members are invited to share any feedback they may have on the current draft.

2.4 Further work is scheduled as follows:

- finalise the Foreword (1.1);
- include the local arrangements to describe how the ICB will comply with requirements of the NHS Provider Selection Regime (7.4.3) – pending release of national guidance;
- add any additional locally assigned duties of the Remuneration Committee (8.1.7);
- provide dates, establishment order name and reference, weblinks and final clause numbers;
- check final numbering, references and formatting.

2.5 In addition to the work identified in 2.4, further amendments will have to be made in response to the two further versions of the Model Constitution NHSEI plans to release (11 March and 13 May). It should be noted that the release of a number of recent NHSEI key documents for ICB Establishment, such as the current Model

Constitution, has been delayed and therefore, it is possible that these release dates may not be adhered to.

2.6 Taking account of NHSEI's release and submission deadlines and the mandated nature of any changes made by revisions to the Model it is proposed that Members consider the following plan for endorsement of drafts:

16 March	Members provide feedback on the current draft* or endorse if no feedback is given. *This draft does not include the revisions mandated by the mid-March release of the Model Constitution.
17-23 March	NHSEI mandated revisions are incorporated and if feedback was received from 16 March meeting this is considered and the draft amended accordingly.
24-30 March	A revised draft is reviewed and signed-off by ICB Chair Designate and CCG's Accountable Officer.
31 March	Draft is submitted to meet NHSE's deadline.
4-22 April	Where possible the draft is amended to reflect further work identified in 2.4 above.
25 April	Draft is circulated to designate Members of the Board, the Local Medical Committees and the two local Healthwatch organisations to ensure there is opportunity to feedback on the changes made.
4-11 May	Any feedback received is considered and the draft amended accordingly.
18 May	Members of the Board provide feedback on the draft* or endorse if no feedback received. * This draft will not include the revisions mandated by the mid-May release of the Model Constitution.
14-18 May	NHSE mandated revisions are incorporated into draft.
18-19 May	If feedback was received from 18 May meeting this is considered and the draft amended accordingly.
19 May	A revised draft is reviewed and signed-off by Chair Designate and CCG's Accountable Officer.
20 May	Draft is submitted to meet NHSE's deadline.

3. Scheme of Reservation and Delegation

3.1 In respect of the ICB's functions, the default arrangement is that these are exercised by the Board unless they are delegated; however, it should be noted that the Board, regardless of any delegation arrangements it has made, remains legally accountable for the exercise of its duties and powers.

3.2 The SORD, which the Board will be required to approve, lists all functions of the ICB (including those that have been delegated to the ICB by other bodies, eg NHSE's

functions relating to the commissioning of primary medical services) and clearly identifies which the Board has:

- reserved to itself;
- delegated to individuals (Board members or employees);
- delegated to committees and sub-committees of the organisation that have been established by the Board;
- delegated to other statutory bodies using the Boards legal to delegate functions to another organisation or to a joint committee with another organisation.

3.3 The first version of the Board approved SORD will represent the starting position as of 1 July 2022. As the system evolves and changes are proposed to which functions are reserved and which delegated the SORD will be updated to reflect this and approval from the Board, which cannot be delegated, will be sought.

3.4 A first draft has been produced and shared with the Good Governance Institute (GGI), and is enclosed for consideration. The next stages of development ahead of 31 March submission to NHSE are to:

- address feedback from this Body;
- address feedback from the GGI;
- rationalise/conflate descriptions where appropriate;
- engage with the CCG's senior leaders to confirm assumptions regarding functions reserved and delegated (and where delegated to).

3.5 In respect of endorsing the SORD it is proposed that Members approve the use of the same plan to endorse the Constitution identified in 2.6 above. It should be noted that whilst it is not anticipated that NHSE's planned revisions to the Model Constitution will impact on the content of the SORD should this prove to be the case the plan would allow for this.

Conclusion

The Constitution is well-developed at this stage albeit that further work is scheduled as identified in paragraphs 2.4 and 2.5 above. The version of the SORD presented provides a secure base from which the ICB can ensure its functions are met as of 1 July 2022. The SORD in particular will need to be reviewed regularly following the establishment of the ICB to reflect the changing position as the system develops.

Recommendation

Members are requested to:

- CONSIDER the content of this latest draft of the Constitution and provide feedback;
- CONSIDER the content of this first draft of the SORD and provide feedback;
- ENDORSE the plan set out in 2.6 for the engagement and endorsement of the draft Constitution and the SORD.

End of Report

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

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