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Coventry and Warwickshire
Health and Care Partnership

People Board Workforce Dashboard

Issued February 2022

Highlights	Issues
NHS Trusts	
Substantive Staff- In year increase of 0.67% (122.42FTE) **Medical & Dental** - Overall in-year increase in Medical & Dental workforce by 2.20% - 43.73 FTE. 1.36% consultant growth GEH,SWFT & UHCW show increases in Consultant staff.	SWFT continue to show an in-year decrease in substantive staff and had the highest reduction in non-medical non-clinical substantive staff of 9.70% CWPT recorded an in-year reduction in medical & dental staff.
Nursing& Midwifery - In-year growth in Registered Nursing staff by 3.53% a growth of 192.17FTE. UHCW recorded in month increase in substantive Nursing staff, and reduction in vacancies. Adult Nursing staff had an overall in-year growth of 5.20% Nursing Vacancies now @ 769.37FTE GEH &UHCW recorded in-month reduction in Nursing staff vacancies.	All Trusts except UHCW recorded an in-month decrease in Substantive Nursing. An increase in Nursing vacancies for CWPT, GEH & SWFT. Overall Nursing vacancies increased to 769.37FTE from a previous low of 679.68FTE. Adult nursing vacancies increased from previous month low of 431.67FTE to a high of 447.86FTE
AHP- Overall in year growth of 1.47% (20.59FTE) In-month increase in AHP staff for UHCW	AHP vacancies have gone up from a previous 87.56FTE to a high of 129.09 notably within CWPT with SWFT almost doubling vacancies for Diagnostics from previous month. Overall in-month reduction in AHP substantive staff across all other trusts except for UHCW.
Healthcare Assistants- CWPT maintains an in-year increase in substantive HCA staff (2.96%) while GEH shows stable in-month growth.	Overall in-year reduction of HCA @ 4.65%- high reduction within SWFT @ 10.48%. Vacancies increased to 301.36FTE form a previous month low of 230.35FTE.
Absence	12 month rolling sickness Absence continues increase across NHS providers. Staff rolling turnover has been rising across all Trusts since M6 ranging between 10.02 to 15.78%
Adult Social Care workforce	
	Vacancy rate increased to 9.4% across West Midlands in December compared to 9.1% in November
Primary Care	
Overall increase in workforce compared to previous month An in-year increase in; Admin staff by 3.5%	Continued In-year reduction noted for; GPs (excl Registrars) reduced by 1.8%. Nursing staff decreased by 1.3%

NHS Trust Turnover and Sickness Absence

KPI Measure		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9
All Sickness Absence Rate - 12 month rolling %	CWPT	5.27%	5.28%	5.30%	5.41%	5.58%	5.71%	5.88%	6.04%	6.19%
	GEH	4.96%	4.80%	4.72%	4.73%	4.76%	4.79%	4.82%	4.83%	4.93%
	SWFT	4.39%	4.43%	4.41%	4.56%	4.67%	4.75%	4.93%	4.97%	
	UHCW	4.41%	4.67%	4.94%	5.73%	5.91%	5.85%	6.10%	5.96%	6.55%
All Staff Turnover - 12 month rolling rate %	CWPT	9.25%	9.27%	9.28%	10.11%	10.65%	11.09%	11.61%	11.99%	12.36%
	GEH	10.26%	10.97%	10.94%	10.58%	10.42%	10.18%	10.62%	12.47%	12.64%
	SWFT	11.57%	11.80%	12.39%	13.24%	14.07%	14.18%	14.35%	15.13%	15.78%
	UHCW	11.35%	11.57%	12.19%	10.93%	10.14%	10.02%	10.42%	10.94%	11.18%

Data is 12 month rolling turnover and rolling absence data including the covid impact of suppressed turnover and increased absence.
As of the 25th of January daily sickness absence across the NHS system providers was recorded at 7.1%, of which covid related absence was recorded @ 2.6% from a previous high peak of 5.4% on the 5th of January.
Note these are daily reported rates so cannot be mapped to the absence % information.
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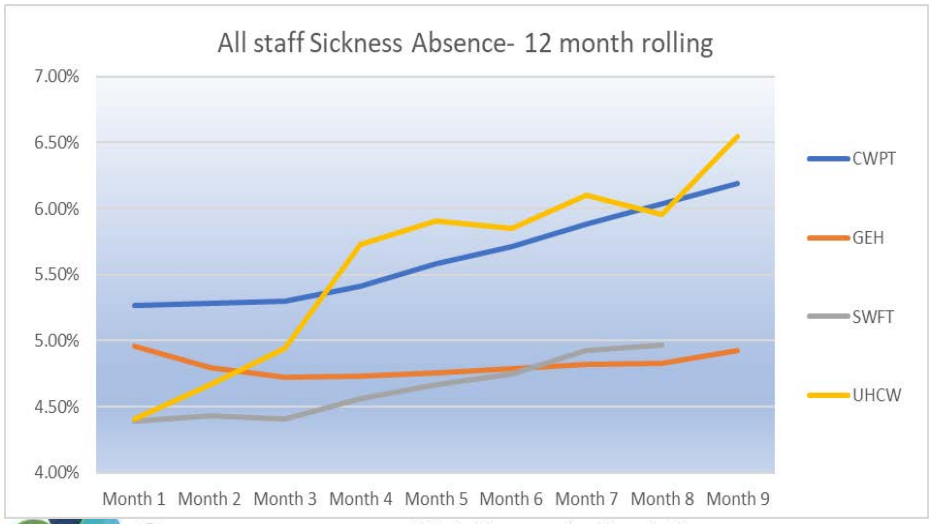
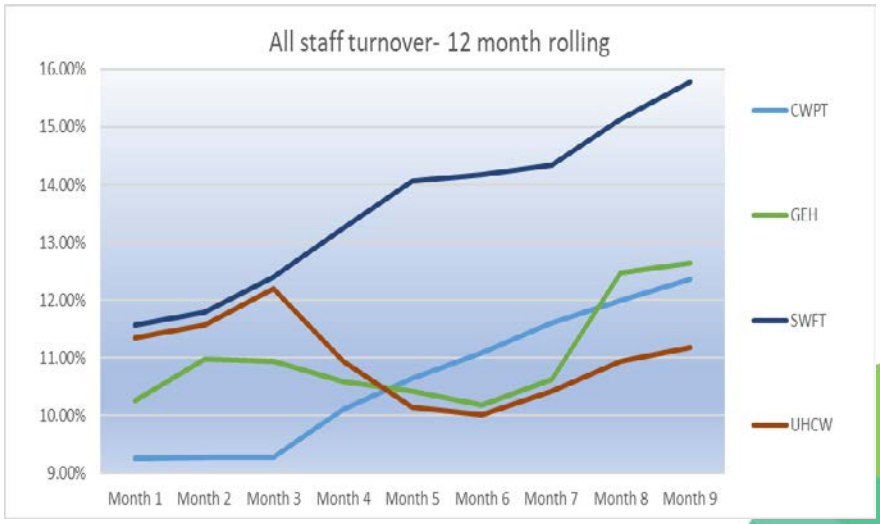




Coventry and Warwickshire
Health and Care Partnership

NHS Trust Substantive staff WTE and growth

Substantive Staff Summary WTE		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	In Yr Change	% Change
Total medical and dental substantive staff	CWPT	195.99	182.26	185.02	184.36	213.19	192.79	190.09	188.06	180.96	-15.03	-7.67%
	GEH	268.57	268.82	267.24	267.34	268.00	279.39	287.64	291.39	283.95	15.38	5.73%
	SWFT	415.33	413.87	414.64	411.71	401.36	412.52	414.39	414.07	418.28	2.95	0.71%
	UHCW	1111.92	1118.95	1121.67	1110.85	1166.37	1173.72	1167.55	1158.75	1152.35	40.43	3.64%
Totals		**1991.81**	**1983.90**	**1988.57**	**1974.26**	**2048.92**	**2058.42**	**2059.67**	**2052.27**	**2035.54**	**43.73**	**2.20%**
Total non medical - clinical substantive staff	CWPT	2398.49	2416.52	2406.72	2409.73	2416.30	2450.00	2488.03	2484.62	2445.04	46.55	1.94%
	GEH	1522.62	1554.29	1565.20	1563.47	1580.50	1589.64	1559.13	1576.86	1558.55	35.93	2.36%
	SWFT	2864.59	2834.27	2839.02	2827.10	2813.80	2808.94	2838.80	2845.37	2837.12	-27.47	-0.96%
	UHCW	6358.07	6371.49	6376.42	6347.71	6390.61	6373.23	6373.32	6414.13	6449.13	91.06	1.43%
Totals		**13143.77**	**13176.57**	**13187.36**	**13148.01**	**13201.21**	**13221.81**	**13259.28**	**13320.98**	**13289.84**	**146.07**	**1.11%**
Total non medical - non-clinical substantive staff	CWPT	950.39	976.42	981.67	990.04	991.65	997.02	999.18	1002.54	1010.54	60.15	6.33%
	GEH	501.50	492.31	468.51	472.15	480.00	487.53	501.81	494.28	454.18	-47.32	-9.44%
	SWFT	1062.38	1067.75	1050.40	1045.47	1049.52	1060.43	1067.36	1060.29	959.36	-103.02	-9.70%
	UHCW	692.24	684.15	683.53	682.09	686.91	722.76	723.39	731.89	716.50	24.26	3.50%
Totals		**3206.51**	**3220.63**	**3184.11**	**3189.75**	**3208.08**	**3267.74**	**3291.74**	**3289.00**	**3140.58**	**-65.93**	**-2.06%**
Total WTE substantive staff	CWPT	3545.87	3576.20	3574.41	3585.13	3622.14	3640.81	3678.30	3676.22	3637.54	91.67	2.59%
	GEH	2292.69	2315.42	2300.96	2302.96	2328.50	2356.56	2348.58	2362.53	2296.68	3.99	0.17%
	SWFT	4349.46	4323.97	4312.14	4292.36	4272.76	4289.97	4326.63	4325.81	4220.84	-128.62	-2.96%
	UHCW	8184.11	8200.47	8203.65	8165.68	8269.81	8293.63	8285.85	8326.36	8339.49	155.38	1.90%
Substantive Totals		**18372.13**	**18416.06**	**18391.16**	**18346.13**	**18493.21**	**18580.97**	**18639.36**	**18690.92**	**18494.55**	**122.42**	**0.67%**

- An in year overall increase in Substantive staff by 0.67%. CWPT continues to record the highest in year increase in substantive staff, currently @ 2.59%- despite a decrease in Medical staff.
- Medical & dental staff has the highest in-year increase (2.20%) notably within GEH recording the highest in-year increase of 5.73%
- An overall decline of substantive staff within SWFT mostly among non-medical clinical Non-Clinical staff (9.70%)

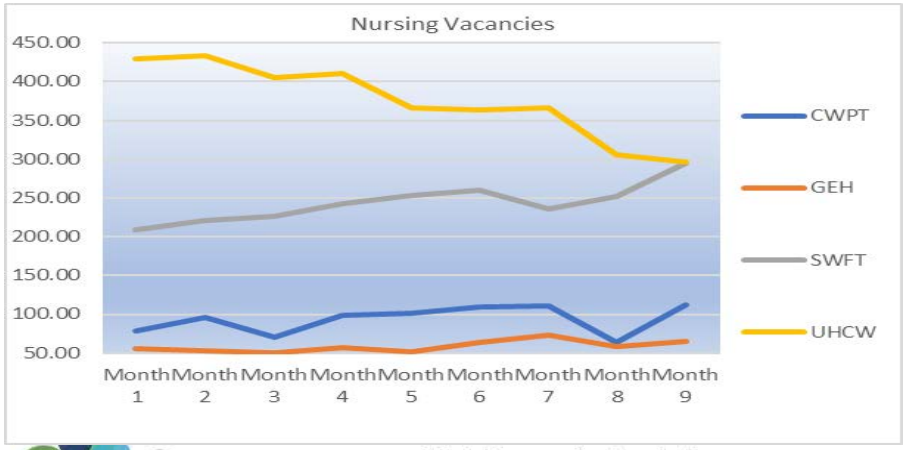
NHS Trust Nursing Substantive Staff & Vacancies by role

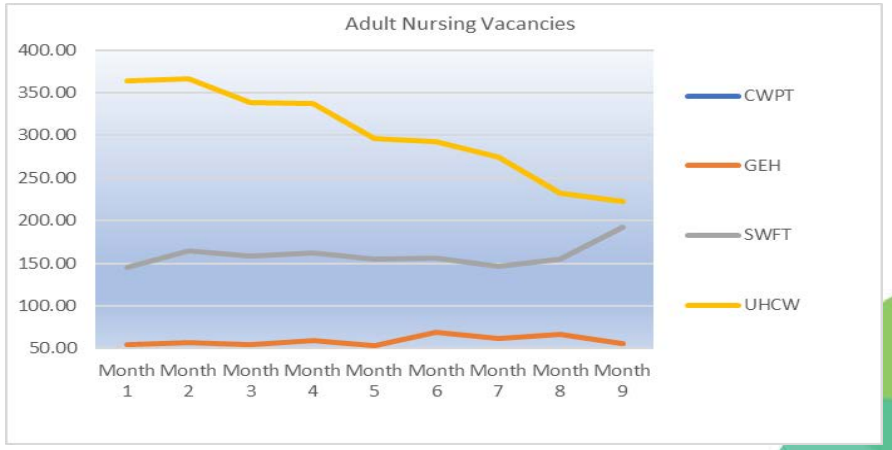
In year growth (3.53%) for Registered Nursing staff. Of which Adult Nursing staff have an overall in year increase of 5.20%.

Vacancies remain relatively high@ 769.37 with Adult nursing vacancies recorded @ 447.86FTE. CWPT & SWFT recorded notably increase in vacancies.

Substantive Staff Summary WTE		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Change in Year	% Change
Registered nursing, midwifery and health visiting staff	CWPT	921.89	915.75	906.11	902.67	905.84	904.40	902.78	921.70	916.11	-5.78	-0.63%
	GEH	677.64	675.69	676.10	672.56	682.52	677.59	690.66	691.65	685.09	7.45	1.10%
	SWFT	1390.09	1385.59	1392.43	1376.20	1361.85	1359.94	1376.85	1382.06	1376.51	-13.58	-0.98%
	UHCW	2448.74	2454.55	2483.66	2496.48	2537.55	2549.17	2562.97	2611.97	2652.82	204.08	8.33%
Substantive Nursing Totals		**5438.36**	**5431.58**	**5458.30**	**5447.91**	**5487.76**	**5491.10**	**5533.26**	**5607.38**	**5630.53**	**192.17**	**3.53%**
of which Adult Nurses	CWPT	160.15	161.12	158.79	156.20	158.76	154.20	154.25	156.43	158.28	-1.87	-1.17%
	GEH	543.56	545.02	542.80	542.41	547.96	542.10	551.25	550.09	544.24	0.68	0.12%
	SWFT	616.34	603.97	611.79	609.02	610.70	614.79	623.51	625.63	624.83	8.49	1.38%
	UHCW	2035.91	2043.75	2072.54	2091.35	2127.58	2140.14	2157.77	2189.53	2203.00	167.09	8.21%
Substantive Adult Nurses Totals		**3355.96**	**3353.86**	**3385.92**	**3398.98**	**3445.00**	**3451.23**	**3486.78**	**3521.68**	**3530.35**	**174.39**	**5.20%**

Vacancies		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Change in Year	% Change
Registered Nursing, Midwifery and Health Visiting Staff Vacancy WTE	CWPT	78.23	96.50	70.27	98.55	100.92	109.03	110.65	64.13	112.32	34.09	43.58%
	GEH	55.21	53.35	50.29	56.77	51.09	63.80	73.24	58.17	65.68	10.47	18.97%
	SWFT	208.58	220.69	225.95	242.78	252.73	259.99	235.46	251.74	294.72	86.14	41.30%
	UHCW	429.61	434.14	405.17	410.99	365.93	363.22	366.25	305.64	296.65	-132.96	-30.95%
Totals		**771.63**	**804.68**	**751.68**	**809.09**	**770.67**	**796.04**	**785.60**	**679.68**	**769.37**	**-2.26**	**-0.29%**
Of which Adult Nurses	CWPT	-8.55	-13.98	-29.84	-10.94	-13.86	-14.52	-9.11	-22.07	-22.92	-14.37	0.00%
	GEH	55.25	56.95	54.91	59.23	53.93	69.62	62.30	67.09	55.51	0.26	0.48%
	SWFT	145.48	164.40	158.14	161.71	154.83	156.42	146.71	154.90	192.13	46.65	32.07%
	UHCW	363.61	366.89	338.10	337.99	296.85	293.19	274.33	231.75	223.14	-140.47	-38.63%
Totals		**555.79**	**574.26**	**521.31**	**547.99**	**491.75**	**504.71**	**474.23**	**431.67**	**447.86**	**-107.93**	**-19.42%**





Coventry and Warwickshire
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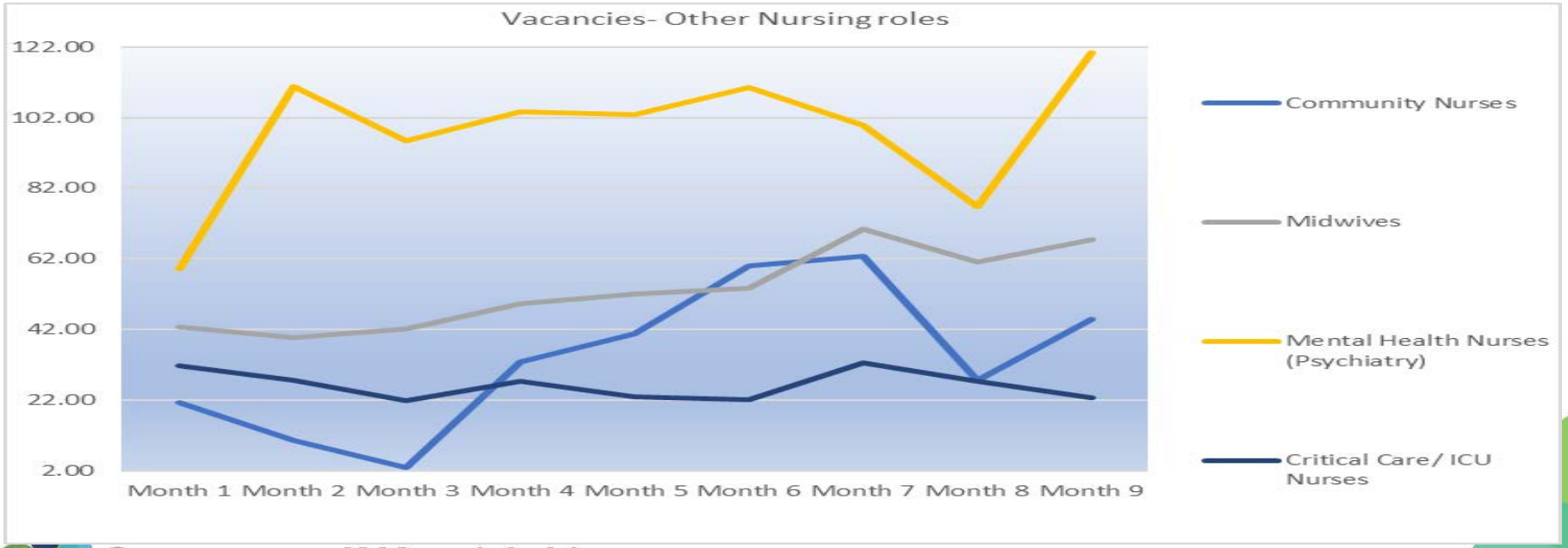
NHS Trust other Qualified Nursing Vacancies by role

Vacancies		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Change in Year
Community Nurses	CWPT	3.04	3.04	-14.87	6.92	6.68	20.08	28.06	-6.65	5.76	2.72
	GEH	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.02	0.00	-0.20
	SWFT	20.65	9.34	19.90	29.27	38.26	44.19	38.43	39.30	45.23	24.58
	UHCW	-2.64	-2.04	-2.44	-3.44	-4.29	-4.39	-3.99	-4.99	-5.99	-3.35
Totals: *Community Nurses*		**21.25**	**10.54**	**2.79**	**32.95**	**40.85**	**60.08**	**62.70**	**27.68**	**45.00**	**23.75**
Midwives	CWPT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GEH	-5.22	-10.44	-9.62	-6.86	-6.50	-8.24	-12.07	-12.07	-9.26	-4.04
	SWFT	15.64	15.93	17.76	17.49	19.12	20.88	19.54	14.63	16.83	1.19
	UHCW	32.30	34.09	34.05	38.72	39.41	41.04	62.98	58.52	59.84	27.54
Totals: *Midwives*		**42.72**	**39.58**	**42.19**	**49.35**	**52.03**	**53.68**	**70.45**	**61.08**	**67.41**	**24.69**
Mental Health Nurses *(Psychiatry)*	CWPT	60.72	112.51	96.98	105.41	104.56	112.29	101.37	78.47	121.19	60.47
	GEH	-1.00	-1.00	-1.00	-1.00	-1.00	-1.00	-1.00	-1.00	0.00	1.00
	SWFT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	UHCW	-0.64	-0.64	-0.64	-0.64	-0.64	-0.64	-0.64	-0.64	-0.64	0.00
Totals: Mental Health Nurses		**59.08**	**110.87**	**95.34**	**103.77**	**102.92**	**110.65**	**99.73**	**76.83**	**120.55**	**61.47**
Critical Care/ ICU Nurses	CWPT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GEH	0.00	0.00	2.06	6.32	6.30	5.76	5.80	5.80	5.80	5.80
	SWFT	10.24	10.63	9.43	9.67	10.36	11.07	13.25	11.91	11.82	1.58
	UHCW	21.36	17.06	10.23	11.31	6.37	5.21	13.64	9.61	5.00	-16.36
Totals: *Critical Care/ICU Nurses*		**31.60**	**27.69**	**21.72**	**27.30**	**23.03**	**22.04**	**32.69**	**27.32**	**22.62**	**-8.98**



NHS Trust Medical & AHP Staff & Vacancies by role

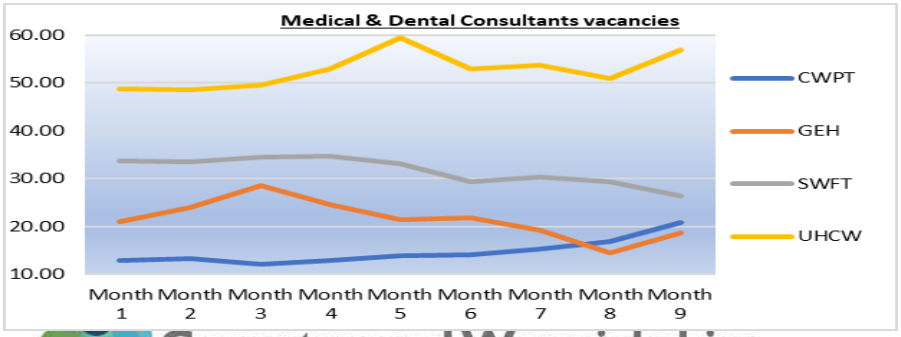
Overall in-year increase in AHP staff by 1.47% with GEH recording the highest in year increase in AHP staff of 6.30%.

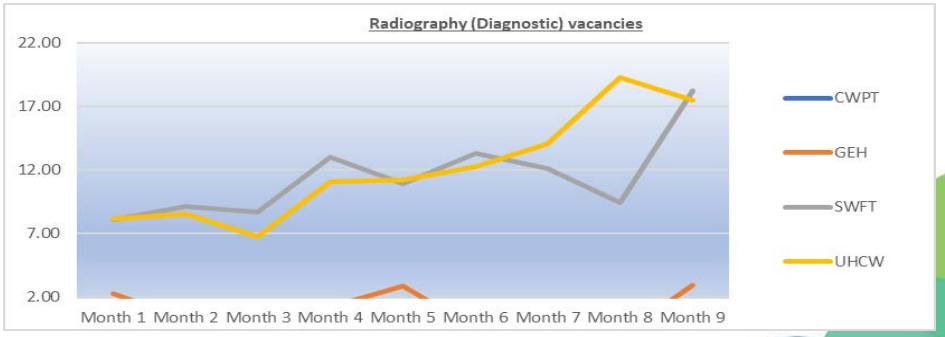
Overall In-year increase in AHP vacancies mostly remaining high within CWPT & SWFT.

Overall in year increase in Consultant staff. In month increase in Consultant vacancies to 122.99FTE.

Substantive Staff Summary WTE		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Change in Year	% Change
Registered allied health professionals	CWPT	253.00	256.10	251.21	255.27	258.19	258.92	257.11	259.39	242.95	-10.05	-3.97%
	GEH	106.81	110.94	110.48	109.48	105.48	114.27	114.09	112.54	113.54	6.73	6.30%
	SWFT	439.30	421.46	436.18	430.43	438.41	442.60	450.31	445.73	442.05	2.75	0.63%
	UHCW	605.44	602.82	604.09	600.63	598.55	600.02	605.36	603.07	626.60	21.16	3.49%
Totals: AHPs		1404.55	1391.32	1401.96	1395.81	1400.63	1415.81	1426.87	1420.73	1425.14	20.59	1.47%
Consultants (including Directors of Public Health)	CWPT	77.15	76.93	77.81	78.15	77.15	77.41	76.31	76.12	75.97	-1.18	-1.53%
	GEH	98.79	98.79	98.15	98.15	98.00	100.87	100.32	106.07	101.82	3.04	3.07%
	SWFT	179.41	180.14	179.21	179.01	180.61	184.42	183.17	184.12	186.86	7.45	4.15%
	UHCW	477.13	477.14	477.08	477.18	472.32	478.53	480.14	482.78	479.13	2.00	0.42%
Totals: Consultants		832.48	833.00	832.25	832.49	828.08	841.23	839.94	849.09	843.78	11.30	1.36%

Vacancies		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Change in Year	% Change
Registered AHP	CWPT	18.46	40.72	39.62	45.42	47.38	34.93	36.92	15.19	71.58	53.12	287.76%
	GEH	-3.96	-8.96	-5.11	-3.95	-4.00	-5.75	-9.80	-5.75	-9.46	-5.50	138.89%
	SWFT	20.89	65.45	40.67	31.33	24.00	52.30	26.09	39.09	43.34	22.45	107.47%
	UHCW	29.87	30.15	28.88	38.76	51.10	50.43	36.74	39.03	23.63	-6.24	-20.89%
Totals: AHPs		**65.26**	**127.36**	**104.06**	**111.56**	**118.48**	**131.91**	**89.95**	**87.56**	**129.09**	**63.83**	**97.81%**
of which Radiography (Diagnostic)	CWPT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
	GEH	2.29	0.29	-0.71	1.29	2.89	-0.44	-0.84	-0.94	2.94	0.65	28.20%
	SWFT	8.07	9.12	8.70	13.02	10.96	13.33	12.11	9.42	18.25	10.18	126.15%
	UHCW	8.15	8.58	6.77	11.05	11.24	12.26	14.02	19.28	17.49	9.34	114.60%
Totals:: Radiography (Diagnostic)		**18.51**	**17.99**	**14.76**	**25.36**	**25.09**	**25.15**	**25.29**	**27.76**	**38.68**	**20.17**	**108.9%**
Medical/Dental Consultant Vacancy WTE	CWPT	12.91	13.37	12.15	12.91	13.91	14.16	15.26	16.82	20.83	7.92	61.35%
	GEH	21.04	24.04	28.65	24.62	21.51	21.95	19.26	14.51	18.76	-2.28	-10.82%
	SWFT	33.72	33.59	34.52	34.72	33.12	29.31	30.36	29.41	26.37	-7.35	-21.80%
	UHCW	48.84	48.63	49.69	52.90	59.58	52.98	53.71	50.92	57.03	8.19	16.77%
Totals: Consultants		**116.51**	**119.63**	**125.01**	**125.15**	**128.12**	**118.40**	**118.59**	**111.66**	**122.99**	**6.49**	**5.57%**





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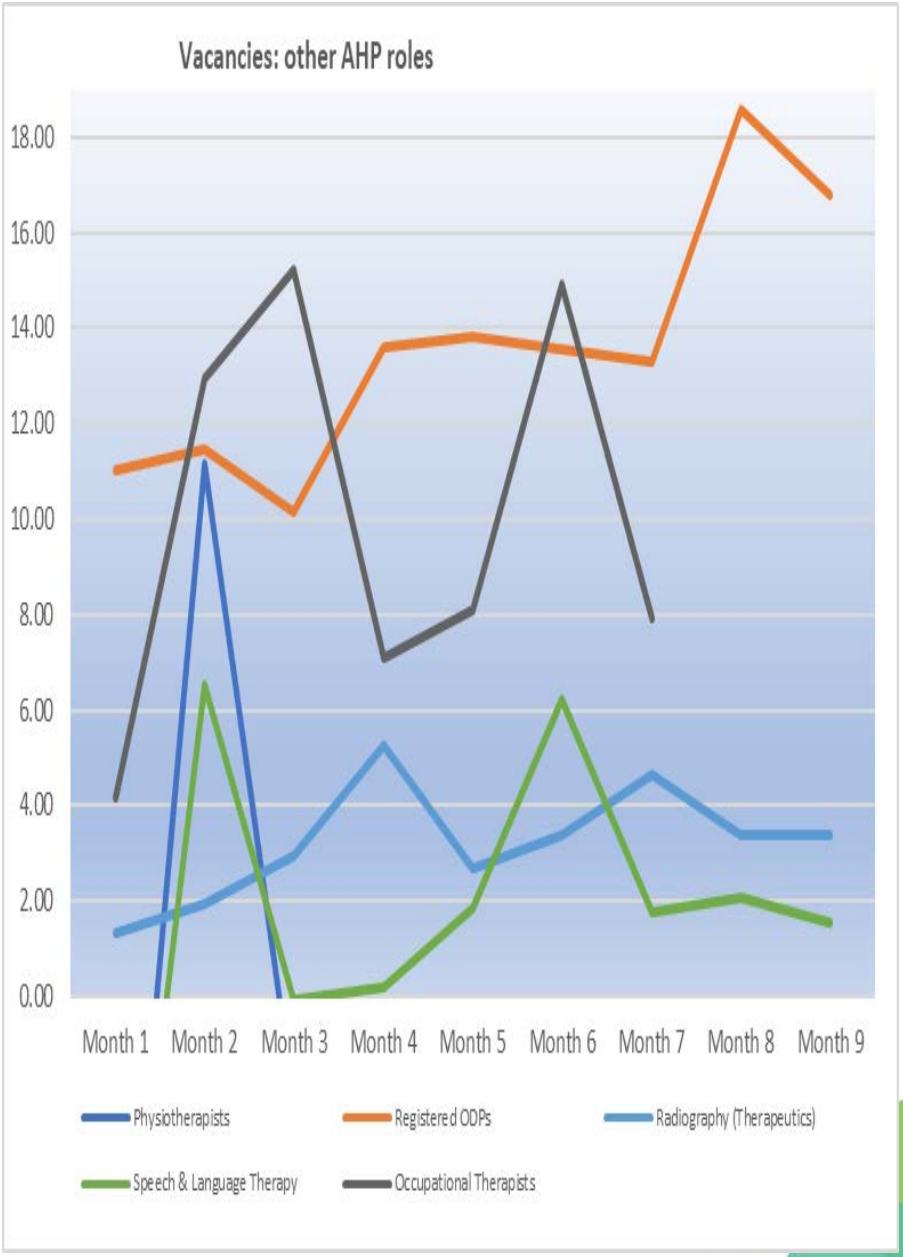
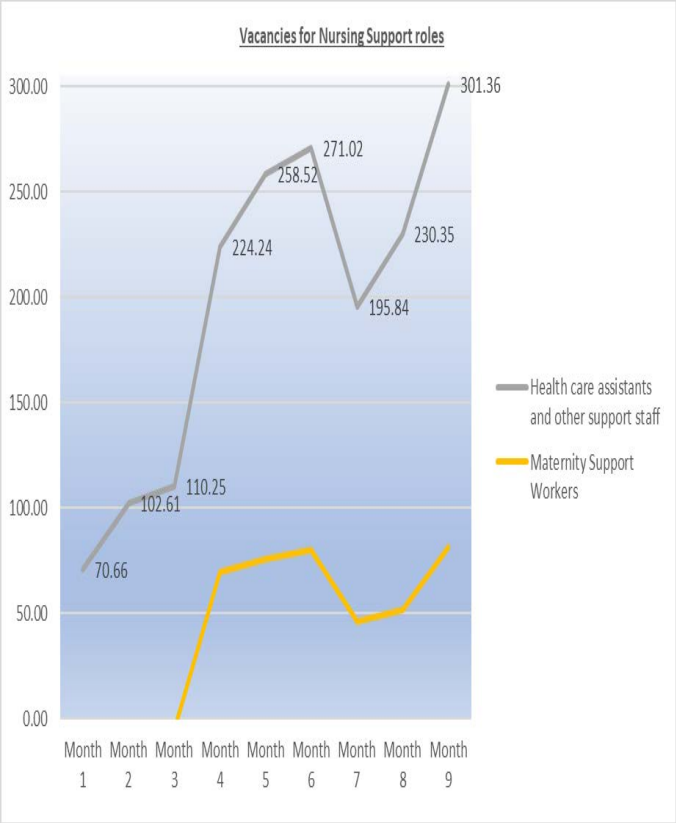
NHS Trust other AHP Vacancies by role

Vacancies		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9
Physiotherapists	CWPT	-2.54	-1.34	-0.40	-2.00	-1.92	-1.92	-2.01	-3.57	12.39
	GEH	-7.48	-7.48	-5.82	-5.82	-3.10	-7.76	-6.24	-6.24	-6.64
	SWFT	2.04	22.07	6.87	2.23	-4.65	-0.67	6.59	8.82	10.33
	UHCW	-1.59	-2.10	-2.80	-3.81	-6.26	-8.30	-16.29	-16.55	-34.83
Totals: Physiotherapists		**-9.57**	**11.15**	**-2.15**	**-9.40**	**-15.93**	**-18.65**	**-17.95**	**-17.54**	**-18.75**
Occupational Therapists	CWPT	0.51	9.98	11.27	12.61	11.62	10.81	12.58	21.40	24.19
	GEH	1.22	-1.78	-1.98	-1.98	-0.90	-0.98	-1.78	-1.27	-3.28
	SWFT	0.63	3.53	6.28	-3.17	-5.14	2.84	-2.59	0.98	1.30
	UHCW	1.80	1.20	-0.36	-0.37	2.53	2.22	-0.30	2.30	3.30
Totals: Occ Therapists		**4.16**	**12.93**	**15.21**	**7.09**	**8.11**	**14.89**	**7.91**	**23.41**	**25.51**
Registered ODPs	CWPT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GEH	2.88	2.88	3.39	2.55	2.60	1.28	-0.72	-0.72	-0.70
	SWFT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	UHCW	8.15	8.58	6.77	11.05	11.24	12.26	14.02	19.28	17.49
Totals: ODPs		**11.03**	**11.46**	**10.16**	**13.60**	**13.84**	**13.54**	**13.30**	**18.56**	**16.79**
Radiography (Therapeutics)	CWPT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GEH	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	SWFT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	UHCW	1.33	1.93	2.93	5.25	2.67	3.38	4.65	3.38	3.38
Totals: Radiography (Therapetics)		**1.33**	**1.93**	**2.93**	**5.25**	**2.67**	**3.38**	**4.65**	**3.38**	**3.38**
Speech & Language Therapy	CWPT	-3.10	3.78	-2.78	-2.98	-2.98	-1.92	-1.79	-2.42	-2.42
	GEH	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	SWFT	-5.07	3.40	3.39	2.87	4.49	7.81	4.59	5.49	5.05
	UHCW	-0.67	-0.67	-0.67	0.33	0.33	0.33	-1.01	-1.01	-1.07
Totals: S&LT		**-8.84**	**6.51**	**-0.06**	**0.22**	**1.84**	**6.22**	**1.79**	**2.06**	**1.56**



NHS Trust Support to Nursing Staff & Vacancies by role

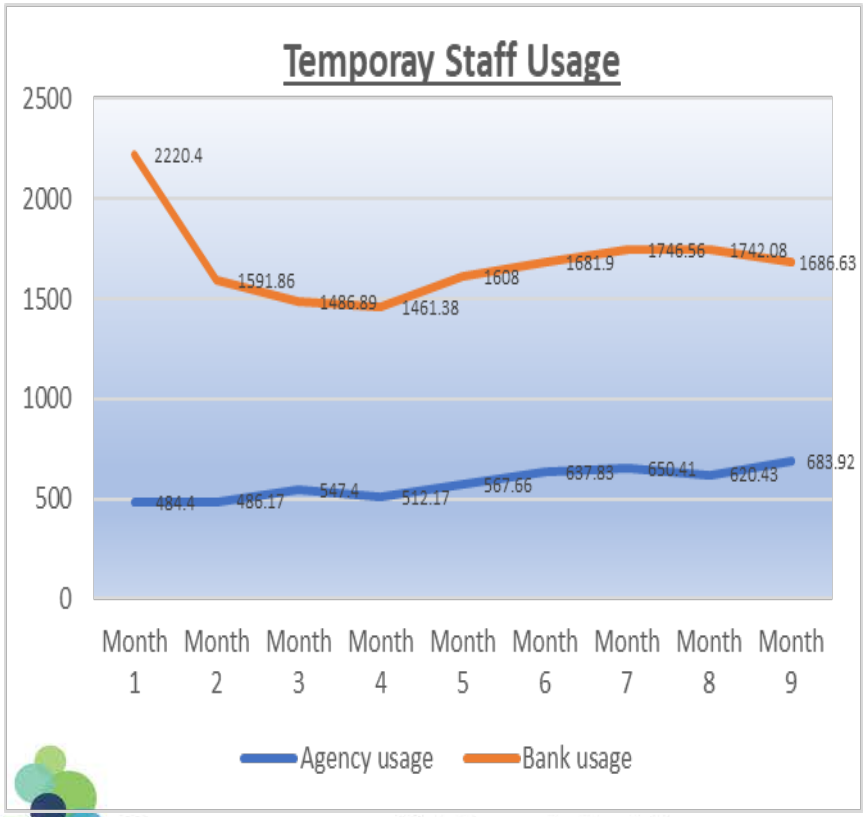
- Continued in-year decrease in substantive HCA staff, only CWPT maintains an increase.
- A continued increase in HCA vacancies to 301.36FTE except for GEH who show an in-month decrease from 53.36FTE to 46.36FTE



Staff Category		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9
Nursing Associates	CWPT	19.80	18.80	18.80	18.80	17.80	23.60	23.68	23.48	23.60
	GEH	7.76	7.76	7.76	7.76	7.76	8.68	9.68	9.68	9.68
	SWFT	26.72	27.72	27.72	27.72	27.72	27.72	27.72	27.72	27.72
	UHCW	20.81	20.61	21.15	22.09	20.97	19.97	19.65	27.83	27.83
Totals		**75.09**	**74.89**	**75.43**	**76.37**	**74.25**	**79.97**	**80.73**	**88.71**	**88.83**
Trainee Nursing Associates	CWPT	27.00	27.00	27.00	27.00	27.00	30.00	33.00	42.00	42.00
	GEH	15.00	15.00	15.00	15.00	15.00	15.00	15.00	15.00	15.00
	SWFT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	UHCW	19.00	19.00	19.00	18.00	16.00	12.00	12.00	10.00	10.00
Totals		**61.00**	**61.00**	**61.00**	**60.00**	**58.00**	**57.00**	**60.00**	**67.00**	**67.00**
Health care assistants and other support staff (Nursing)	CWPT	667.58	682.00	685.35	688.39	694.57	699.27	728.83	700.12	687.36
	GEH	292.14	288.49	288.91	284.37	285.54	278.13	279.10	281.90	281.90
	SWFT	612.58	606.53	559.77	569.28	558.68	550.64	547.46	548.31	548.36
	UHCW	1284.01	1277.87	1260.62	1233.14	1220.08	1221.91	1256.41	1232.89	1205.75
Totals		**2856.31**	**2854.89**	**2794.65**	**2775.18**	**2758.87**	**2749.95**	**2811.80**	**2763.22**	**2723.37**
Maternity Support Workers	CWPT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GEH	24.43	25.43	26.03	26.03	24.73	24.13	24.15	21.73	21.73
	SWFT	19.45	20.96	18.77	18.55	19.49	19.52	19.29	18.39	18.02
	UHCW	76.87	76.99	74.92	71.69	71.24	71.81	73.88	74.43	71.40
Totals		**120.75**	**123.38**	**119.72**	**116.27**	**115.46**	**115.46**	**117.32**	**114.55**	**111.15**

NHS Trusts Temporary Staff usage

- Temporary staff usage remains high across Trusts. Increase in use of Agency staff while Bank usage appears to dip.



		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9
Agency	CWPT	134.37	135.65	150.58	163.33	155.67	159.3	144.62	154.57	165.96
	GEH	61.55	48.72	98.66	84.59	76.35	93.43	118.28	107.96	100.15
	SWFT	106.34	110.34	107.35	141.16	133.76	155.47	173.49	143.12	143.56
	UHCW	182.14	191.46	190.81	207.68	201.88	229.63	214.02	214.78	274.25
	Total Agency usage	**484.4**	**486.17**	**547.4**	**512.17**	**567.66**	**637.83**	**650.41**	**620.43**	**683.92**
Bank	CWPT	464.1	488.42	481.44	508.82	410.01	502.32	512.46	491.48	532.42
	GEH	278.86	197.56	211.21	261.7	234.19	234.37	235.56	269.55	236.74
	SWFT	379.91	325.36	294.33	353.29	359.97	336.36	375.05	377.56	339.7
	UHCW	1097.53	580.52	499.91	599.27	603.83	608.85	623.49	603.49	577.77
	Total Bank usage	**2220.4**	**1591.86**	**1486.89**	**1461.38**	**1608**	**1681.9**	**1746.56**	**1742.08**	**1686.63**

Coventry and Warwickshire
Health and Care Partnership

Adult Social Care Workforce across Coventry & Warwickshire

Source: Skills for care Annual data collection

Back to map | Key findings | Employment overview | Recruitment and retention | Demographics | Pay | Qualifications and training

You are viewing data for **Coventry and Warwickshire**

Demographics

Download PowerPoint

Use the drop down menus to filter the information shown on this dashboard

Select a sector: All sectors
Select a service: All services
Select a job role: All job roles

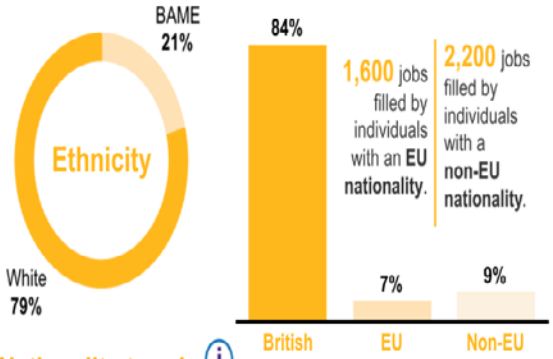
Base jobs: 23,500

Gender

85% of the workforce were **female.**

15% of the workforce were **male.**

Ethnicity and nationality

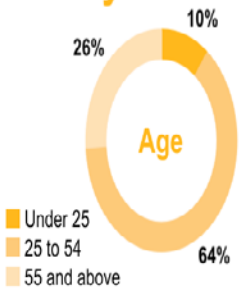


1,600 jobs filled by individuals with an **EU nationality.**

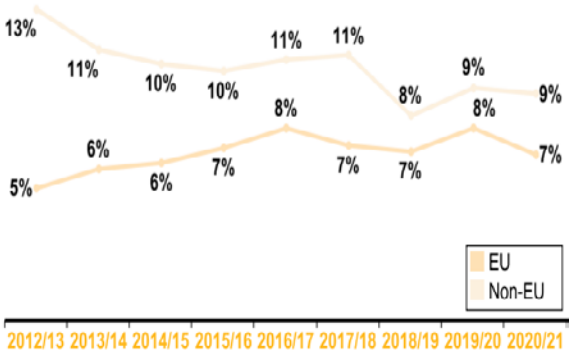
2,200 jobs filled by individuals with a **non-EU nationality.**

Age

The average **age** was **44 years old**



Nationality trends



Back to map | Key findings | Employment overview | Recruitment and retention | Demographics | Pay | Qualifications and training

You are viewing data for **Coventry and Warwickshire**

Recruitment and retention

Download PowerPoint

Use the drop down menus to filter the information shown on this dashboard

Select a sector: All sectors
Select a service: All services
Select a job role: All job roles

Base jobs: 23,500

5.5% vacancy rate (or 1,300 vacancies) in 2020/21

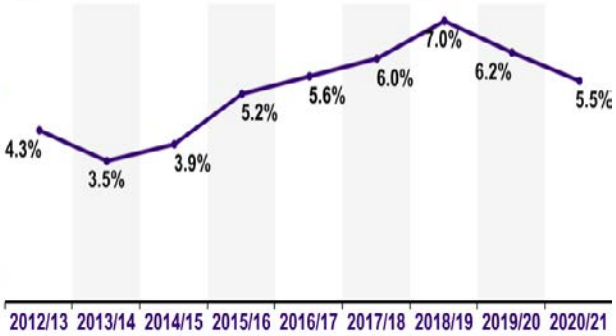
33.7% turnover rate (or 7,500 leavers) in 2020/21

61% of **recruitment** is from **within adult social care**

9.9 average **sickness days** taken in 2020/21

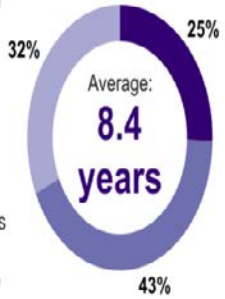
Vacancy rates

Select an option: (•) Vacancy rates ( ) Turnover rates



Experience in sector

Select a view: (•) Experience in sector ( ) Experience in role



Key:
- Less than 3 years
- 3 to 9 years
- 10 years or more

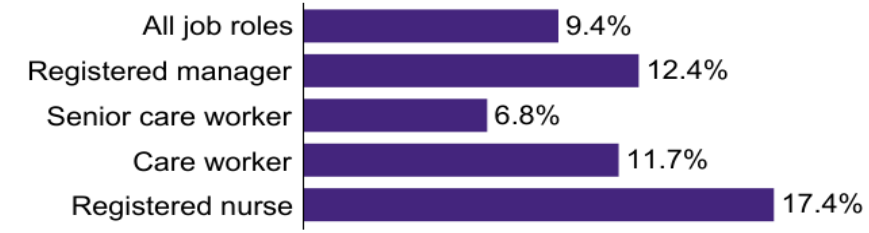
Coventry and Warwickshire Health and Care Partnership

Recruitment and retention - Vacancies: Comparisons between March 2021 and December 2021

Vacancy rate of providers since March 2021

Select a view:
- (●) Current vacancy rate
- ( ) Percentage point change

Current vacancy rate



Select a view:
- (●) Region
- ( ) Service type

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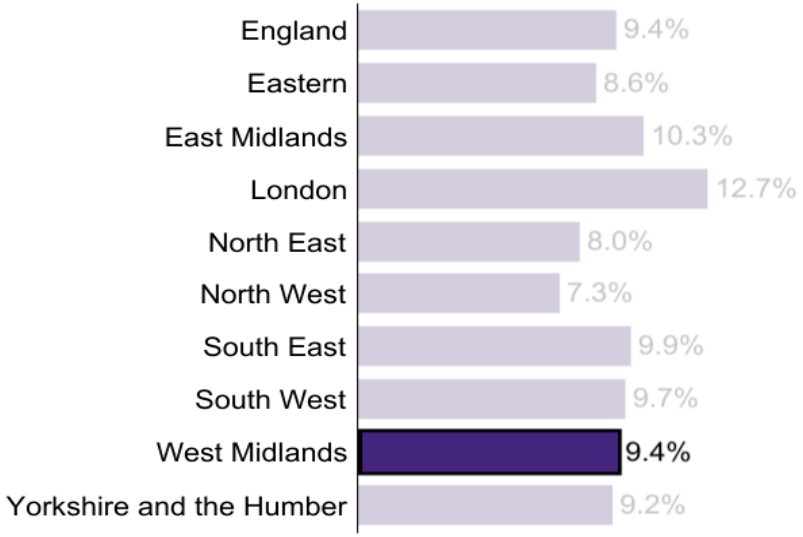
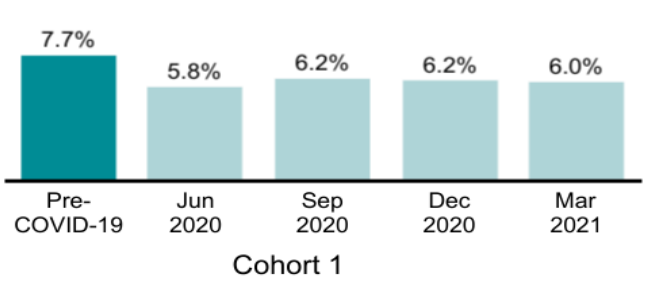
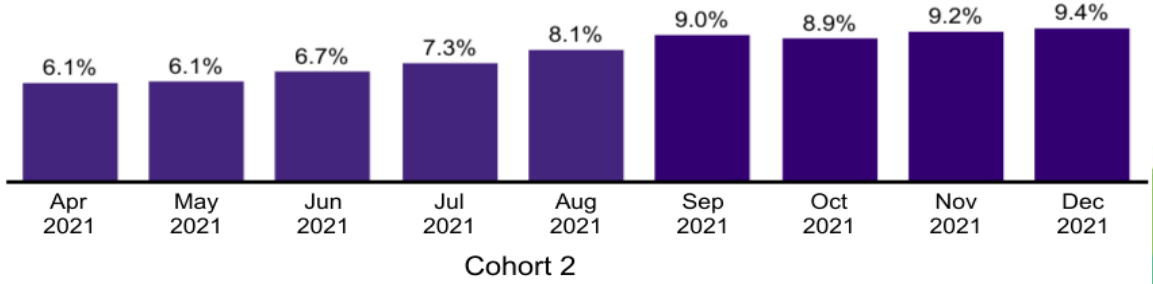
Current vacancy rate



Vacancy rate trend

Select a service
All services





Coventry and Warwickshire
Health and Care Partnership

GP Workforce Dashboard

Age Profiling

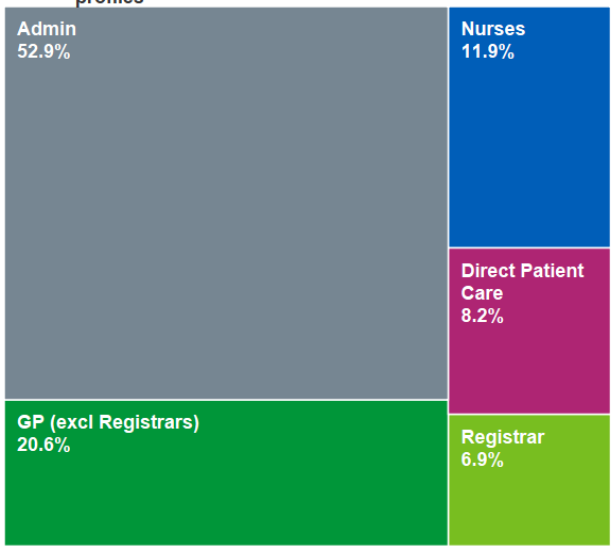
Health Education England

Clear All

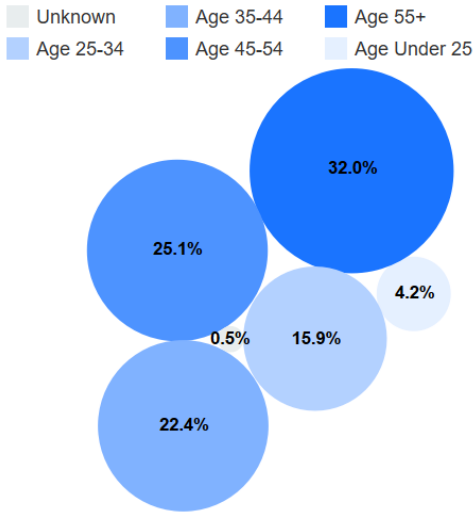
Region Name	ICS Name	CCG Name	Census Date	Select FTE or Head Count
Midlands	Coventry and Warwickshire	All	30/11/2021	Head Count

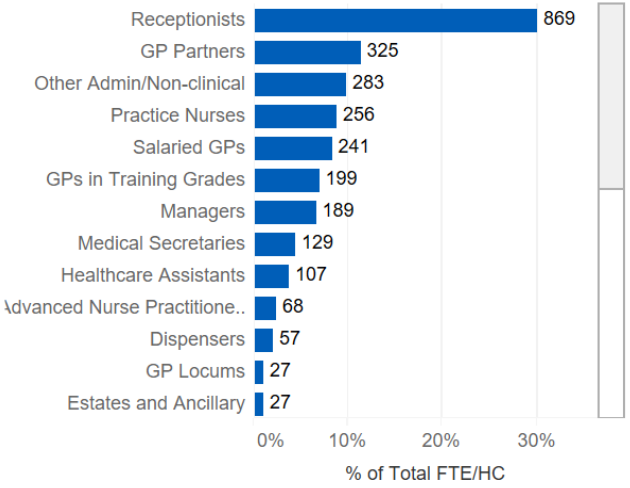
This analysis does not inlcude FTE nor headcount estimates

Click on a chart segment to drill down to age profiles



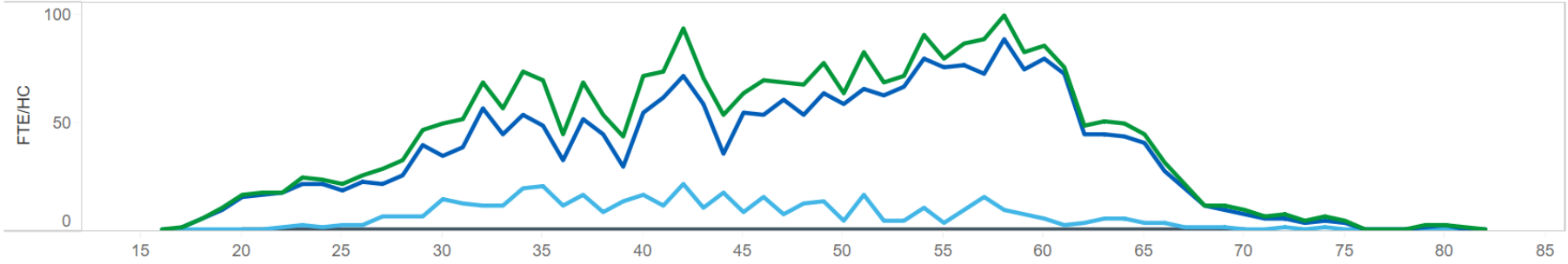
Click on a bubble to drill down to job role





Head Count by Age and Gender

Show Total
Yes



Coventry and Warwickshire
Health and Care Partnership

GP Workforce Dashboard

Percentage of staff type

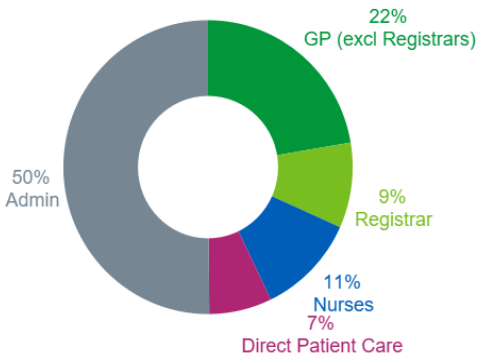
Health Education England

Clear All

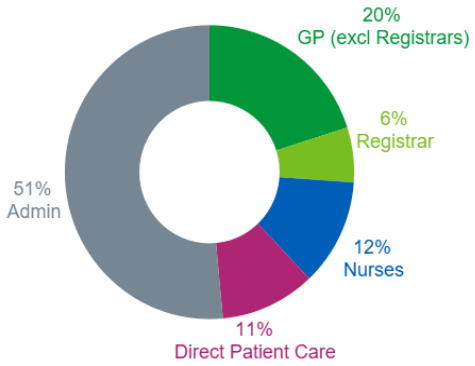
Region Name	ICS Name	CCG Name	Census Date
Midlands	Coventry and Warwickshire	All	30/11/2021

GP (excl Registrars)	Registrar	Nurses	Direct Patient Care	Admin	Grand Total
464	195	232	146	1,041	2,077

% of staff type in 30/11/2021



% of staff type in NHS England



Variance between March 2021 and November 2021

Compare from March 2021

Compare to November 2021

Coventry and Warwickshire Health and Care Partnership

Dashboard Data sources

NHSEI Monthly Provider Workforce Returns as @ 31st of December 2021 (Month 9)

Primary care data is sourced from HEE, Midlands Workforce Observatory data for 30 November 2021

Social Care data is sourced from Skills for Care.

Workstream	Quarter 3	Quarter 4
	Complete	**In Progress**
Governance	1. Confirm to NHSEI the composition of the ICB Board 2. Draft Constitutions and standing orders submitted to NHSEI for consideration 3. Establish the process to identify and escalate risks 4. Deferred approach to Due diligence in closure of CCG approved 5. Constitution workshops held - postponed until Q1	1. Finalise governance handbook 2. Submit ICS NHS Body Constitution for approval 3. Due Diligence 'sit rep' prepared for April Audit Committee Support Chair with the development of a ICB Board member induction process 4. Agree engagement activities with Non-Executives and system partners about ICB committee membership in setting up sub-committees 5. Revised system risk register and ICB Risk policy 6. establishment of a system risk group preparation of new ICB board members induction • ICP establishment action and engagement plan developed • Development of a system EPRR framework
Quality	1. Undertake work on the development and implementation of a quality improvement dashboard 2. Share best practices for identifying quality risks across the system • First workshop held with excellent reception and appetite 3. Ongoing Quality Framework presented to ICB Shadow Board for feedback to support further development 4. Undertook System Risk Register workshop 5. Continued development and socialisation of the Quality Strategy	1. Evidence and Expectations framework and support paper in development for NHSE/I 2. Discuss and implement the National Guidance on System Quality Groups (National Quality Boards) ToR with the SQG (System Quality Group) 3. Continue development of the Primary Care Quality Assurance Framework (QAF) 4. Continue to develop the Quality Strategy: • SQG review - March • Further development to align with the Core 20 + 5 and ICS priorities – May/June
Finance	1. Develop an ICS financial framework and approach 2. Collective agreement of system finances, funding gaps and opportunities 3. Agree the prioritisation framework and define and share efficiency programme opportunities 4. Support with the appointment of ICS financial leadership	1. Due diligence undertaken 2. Ensure that financial systems are ready for go live 3. Undertake efficiency planning for 2022/23 4. Develop the ICS assurance framework 5. Develop risk sharing agreements 6. Develop financial arrangements at Place

Digital	1. Digital Transformation Strategy - "Develop" phase 2. Integrated Care Record - satisfy requirements for Minimum Viable Solution 1 (MVS1) 3. Remote Monitoring - deployment to care homes and identified population cohorts 4. Population Health - establish strategic plans: management and technical capabilities and resource model to support PHM 5. Citizen Portal - procurement and deployment of technical solutions at SWFT and CWPT 6. Electronic Patient Record - planning for deployment activities	1. Digital Transformation Strategy - "Engage" phase 2. Undertake reviews on data, intelligence and insight sharing 3. Baselines: Financial Investment Model, Resource Model, Infrastructure Assessment 4. Integrated Care Record - plan to implement MVS2 capabilities 5. Remote Monitoring - scale and integrate to wider virtual health and care initiatives 6. Population Health - expand management capability (PDP Module C) to Coventry and South Warwickshire 7. Citizen Portal - consolidation and integration (UHCW and NHSapp) 8. Electronic Patient Record - establish resourcing to support implementation 9. Establish plans for cross-system intelligence function
People/OD	1. Phil Johns is confirmed as the interim designate CEO 2. Agreed staff transfer process 3. Working with partners to develop the People Board 4. Consultation for exec roles completed	1. Completed NED recruitment 2. Currently recruiting mandated board roles 3. Agreed the staff transfer process prior to consultation starting in April 4. Currently commissioning/scoping of the OD activity to underpin the strategy 5. Working with partners to develop the People Board
Communications & Engagement	1. Ongoing development an approach for VCSE representation in system governance (vision and mission statement agreed) 2. Work with partners / Healthwatch to develop our principles of engagement as an ICS/ICB (vision and mission statement agreed) 3. Development on approach for embedding patient insight into governance at neighbourhood, place, and system level (action plan agreed)	1. Ongoing development of ICS narrative 2. Ongoing engagement on principles and strategy for engagement 3. Ongoing development of final strategy for ICB/ICS engagement 4. Tender for VCSE Alliance development piece
Estates	1. Undertake a pilot at two sites to begin to identify potential opportunities aligned to under-utilised space and new ways of working • The pilot ran with two sites at GEH with their back-office function in Lewes House and Audiology at SWFT. These are now complete, and findings are included in the new estates	1. Ensure that estates facilitates agreed ways of working • As part of our development of an estates delivery plan planned for 6th April. This session will allow all parties of the ICS to consider the priorities of strategy and agree key workstreams, shared best practice and key stakeholders to take these priorities forward. Alignment of estates programme wider than capital planning is a key area of focus and should include; agile

	strategy that was circulated to stakeholders at the beginning of February. 2. Collate and review each organisation's current estates development plans Create a 5-year estates programme plan • This work is still on-going. The short, medium and long-term priorities have been identified in the estates strategy and there is a time out session planned for the 6th April to establish plans on how these will be delivered.	working impact, change in operational delivery, use of 'digital first' impact, sustainability impact and financial opportunities. 2. Use the estates programme plan to inform the 5 year capital plan • The capital planning process has now been established and quarterly reviews of schemes is now taking place with the support from AAP 3. Establish plans to achieve a sizeable reduction in the ICS' carbon footprint • This will be addressed at the time out session planned for the 6th April and also alongside the ICS sustainability strategy due to be completed by end March 2022. 4. Transfer properties from the CCG to the ICS Body • This work is on-going due to the ICS extension and will align to the contractual and legal requirements. 5. Create plans to achieve a greater efficiency of the ICS estate • ICS strategy has been shared with all parties and feedback sessions have been held to allow co-ordination and changes to be made collectively. The time out session planned for 6th April will allow all system partners to feed into the estates delivery programme for the next 5 years aligning delivery to each providers ambition.
Clinical and Professional Leadership	1. Design early draft CPL model including Organogram and narrative that demonstrates coverage of the 5 guiding principles in national guidance 2. Cooperative collaboration undertaken with the Quality team aligned to interdependencies and governance structures 3. Allied Health Professional lead assigned to support transitional redesign and ensure wider involvement 4. Ongoing work with the Chief Medical Officers across the system, considering the formation of a clinical executive	1. Review clinical and professional leadership at all governance levels • Statutory ICS Clinical roles advertised, closing date reached. • ICB interface with Clinical Executive (multi professional senior clinical leadership) scoping underway • Place based Clinical leadership governance mapping in development but continuing to deliver. • AHP and Pharmacy System networks shared their structures and governance at System Clinical Forum Feb 2022 • General Practice system wide development of governance "from practice, through place to board" being led by the GP Clinical Advisory Group. 2. Review interdependencies within the CMO portfolio that may impact CPL i.e., Digital strategy, workforce

		3. Create CPL design paper looking at the direction of travel including a review and expansion of the CPL transition plan submitted to NHSE/I and the ICB • This will form one of the two evidence and expectations documents to be submitted to NHSE/I for review 4. Continue to deliver clinical priorities
Assurance	1. Engage, co-design future assurance framework with Care Collaboratives including principles for assurance, and phased performance assurance approach to incorporate outcomes. Initial workshop held in February 2022 to commence discussions. 2. Co-design the assurance metrics and create consolidated reporting for all system forums 3. Agree SRM oversight arrangements for 2022-23 4. Develop interim shadow oversight arrangements proposal for Care Collaborative level for 2022/23	1. Finalise Care Collaborative Assurance Framework, agreeing the MOU and terms of reference. (Shadow form commences 1st July 2022) 2. Support Care Collaborative and place leads to implement performance reporting for phase 1. 3. Develop Care Collaborative Readiness to operate process, and assurance gateways. 4. Support and oversee Care Collaborative Development Plans
Care Collaboratives (CCs)	1. Develop a MoU with system 2. Jointly agree place plans 3. Co-design place development with VCS, service users and PCNs 4. Assess capabilities at place and identify gaps	1. Agree indicative Place budgets for 2022/23 2. Agree the reporting and oversight for key forums

Enc L **Draft subject to the passage of the Health and Care Bill through Parliament**

Coventry and Warwickshire Integrated Care Board

CONSTITUTION

Text in green indicates a clause which is optional, or which requires local completion. Supporting notes will explain more about what is required and may also provide examples that could be suitable
Text in purple is where there have been local additions - first submitted version
Text in blue is where there have been local additions - second submitted version
Text in red are amends following NHSE feedback, further local engagement and in light of version 1.4 of Model and Notes – third submitted version
Text in amber is where there have been local amendments following third submission to NHSE

Draft subject to the passage of the Health and Care Bill through Parliament

CONTENTS

1. Introduction

1.1 Foreword

1.1.1 NHSE has set out the following as the four core purposes of ICSs:

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

1.1.2 The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

1.2 Name

1.2.1 The name of this Integrated Care Board is Coventry and Warwickshire Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is coterminous with the area covered by Coventry City Council and Warwickshire County Council.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).[5]

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the

requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This constitution is published at [TO BE ADDED].

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) Adult safeguarding and carers (the Care Act 2014)
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000).
g) Provisions of the Civil Contingencies Act 2004

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under—

a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z43 (duty to have regard to effect of decisions)
e) section 14Z44 (public involvement and consultation),
f) sections 223GB to 223N (financial duties), and
g) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z58 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing,

or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z59).

1.5 Status of this Constitution

1.5.1 The ICB was established on [date] by [*name and reference of establishment order*], which made provision for its constitution by reference to this document.

1.5.2 This constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

1.5.3 Changes to this constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this constitution may be varied in accordance with the procedure set out in this paragraph. The constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure[6] and that application is approved; and

b) where NHS England varies the constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the constitution is as follows:[7]

a) The Chief Executive Officer or the Chair may periodically propose amendments to the constitution which shall be considered and approved by the Board. Approval by the Board will be in accordance with the arrangements for decision making as set out in 4.9 of the Standing Orders.

b) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a constitution:

a) Standing orders– which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the constitution but are required to be published.

a) The Scheme of Reservation and Delegation (SoRD)[8]– sets out those decisions that are reserved to the Board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the constitution. The SoRD identifies where, or to whom functions and decisions have been delegated to.

b) The Functions and Decision Map (FDM)- a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) The Standing Financial Instructions (SFIs) – which set out the arrangements for managing the ICB's financial affairs.

d) The ICB Governance Handbook– which includes:

- Terms of reference for all committees and sub-committees of the Board that exercise ICB functions.
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- The SoRD.
- The SFIs.
- The FDM.
- Key policy documents listed in 1.7.3(e) below.

e) Key policy documents - including:

- Standards of Business Conduct Policy
- Conflicts of interest Policy and Procedures

- Citizens and Community Engagement Strategy
- Inequalities Strategy

Composition of The Board of the ICB

2.1 Background

2.1.1 This part of the constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website [add link].[14]

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this constitution as "the Board" and members of the ICB are referred to as "Board Members") consists of:

a) a Chair
b) a Chief Executive Officer
c) at least three Ordinary members.

2.1.4 The membership of the ICB (the Board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy[17], requires the ICB to appoint the following additional Ordinary Members:

a) three executive members, namely:
   - ~~Director of Finance~~Chief Finance Officer
   - ~~Medical Director~~ Chief Medical Officer
   - ~~Director of Nursing~~ Chief Nursing Officer
b) At least two[18] independent non-executive members.

2.1.6 The Ordinary[15] Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are identified and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.1.1 The ICB has 7[16] Partner Members

a) Three Partner Members - NHS Trusts and Foundation Trusts
b) Two Partner Members – Providers of Primary Medical Services
c) Two Partner Member(s) - Local Authorities

2.1.2 The ICB has also appointed the following further Ordinary Members to the Board[19]

a) Up to five independent non-executive members.

2.1.3 The Board is therefore composed of the following members:

a) Chair
b) Chief Executive Officer
c) Three Partner member(s) NHS and Foundation Trusts
d) Two Partner member(s) Primary Medical Services
e) Two Partner member(s) Local Authorities
f) Up to five non-executive members
~~g)~~ ~~Director of Finance~~ Chief Finance Officer
~~h)~~ ~~Medical Director~~ Chief Medical Officer
i) ~~Director of Nursing~~ Chief Nursing Officer

2.2 Regular Participants and Observers at Board Meetings[20]

2.2.1 The Board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

~~2.2.2~~ Participants[21] will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote. [22] Specified Participants are:

a) ~~A~~ Healthwatch representative(s)
b) The Directors of Public Health for Coventry and Warwickshire
c) Other Directors of the ICB

2.2.3 Observers[23] will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.2.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the Board passes a resolution to exclude the public as per the Standing Orders.

3 Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"[24]
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership[25]

3.2.1 A Member of Parliament.

3.2.2 A person whose involvement with the private healthcare sector or otherwise could reasonably be deemed to risk undermining the independence of the NHS.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—

a) in the United Kingdom of any offence, or
b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,

c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties;

3.2.7 A health care professional (within the meaning of section 14N of the 2006 Act) or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—
a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to—
a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under—
a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair[26]

3.3.1 The ICB Chair[27] is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 The first term of office for the Chair will be up to a maximum of three years. Subsequent terms will be three years. The total number of terms a Chair may serve is three[28] terms.

3.4 Chief Executive Officer

3.4.1 The Chief Executive Officer will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.[29]

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England[30]

3.4.3 The Chief Executive Officer must fulfil the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act

3.4.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role

3.5 Partner Member(s) - NHS Trusts and Foundation Trusts[32]

3.5.1 These Partner Members are jointly nominated by the Partners which provide services within the ICB area and are of a *description to be inserted in accordance with the regulations*[33]:

a) Coventry and Warwickshire Partnership NHS Trust
b) George Eliot Hospital NHS Trust
c) University Hospitals Coventry and Warwickshire NHS Trust
d) South Warwickshire NHS Foundation Trust

e) West Midlands Ambulance Trust (to be confirmed meets 10% income threshold)

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an Executive Director of one of the NHS Trusts or FTs within the ICB's area[34]
b) Specify any other criteria as may be set out in any NHS England guidance
c) Specify any other criteria agreed locally by the ICB

3.5.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Add any exclusion criteria set out in NHS E guidance
c) Add any locally determined exclusion criteria

3.5.4 These Members will be appointed by[35] the appointment panel subject to the approval of the Chair. A formal interview process can be established at the Chair's discretion.

3.5.5 The appointment process will be as follows[36]:

a) A panel appointed by the Board of the Integrated Care Board will oversee the appointment. It will include at least one Board Member and will be supported by suitably qualified and experienced advisors. The appointment panel will draft a role outline at the point of recruitment setting out the requirements of the role.
b) NHS Trusts and NHS Foundation Trusts listed at 3.5.1 are to jointly nominate the proposed members for which there are vacancies.
c) The appointment panel will circulate the list of nominations to the NHS Trusts and NHS Foundation Trusts eligible to nominate (listed at 3.5.1) for the purpose of confirming the accuracy of the list.
d) Using a minimum of a paper-based screen, the appointment panel will assess the suitability of nominated members against the role outline and the eligibility and disqualification criteria set out at 3.1, 3.2, 3.5.2 and 3.5.3 in order to select a preferred candidate(s) which will be presented to the ICB Chair.
e) Appointments are subject to the approval of the ICB Chair. An interview process can be established at their discretion.

3.5.6 The term of office[37] for these Members will be three years and the total number of terms they may serve is unlimited.

3.6 Partner Members - Providers of Primary Medical Services.

3.6.1 These Partner Members are jointly nominated by providers of primary medical services for the purposes of the health service within the integrated care board's area, and (ii) are *description to be inserted in accordance with the regulations*]. [109]

3.6.2 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Specify any other criteria set out by NHS England's guidance
b) Specify any other criteria agreed locally by the ICB[38]

3.6.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Add any criteria set out in NHS E guidance
c) Add any locally determined criteria

3.6.4 These members will be appointed by[39] the appointment panel subject to the approval of the Chair

3.6.5 The appointment process will be as follows[40]:

a) A panel appointed by the Board of the Integrated Care Board will oversee the appointment. It will include at least one Board Member and will be supported by suitably qualified and experienced advisors. The appointment panel will draft a role outline at the point of recruitment which will set out the requirements of the role.
b) Those eligible to nominate, listed at 3.6.1 are invited to submit one nomination each to the appointment panel, regardless of the number of vacancies.
c) The appointment panel will circulate the list of nominations to those eligible to nominate (listed at 3.6.1) for the purpose of confirming the accuracy of the list.
d) The appointment panel will notify those who have been nominated of their nomination and inform them of the requirement that they obtain five written endorcements from those eligible to nominate.
e) The appointment panel will circulate the list of nominations who have provided the required number of written endorcements from those eligible to nominate (listed at 3.6.1) for the purpose of confirming the accuracy of the list.
f) Using a minimum of a paper-based screen, the appointment panel will assess the suitability of nominated members against the role outline and the eligibility and disqualification criteria set out at 3.1, 3.2, 3.6.2 and 3.6.3 in order to select a preferred candidate(s) which will be presented to the ICB Chair.
g) Appointments are subject to the approval of the ICB Chair. An interview process can be established at their discretion.

3.6.6 The term of office[41] for this Partner Member will be three years and the total number of terms they may service is unlimited.

3.7 Partner Member(s) - Local Authorities

3.7.1 These Partner Members are jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Coventry City Council
b) Warwickshire County Council

3.7.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1
b) Specify any other criteria set out by NHS England's guidance

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Add any criteria set out in NHS E guidance]

3.7.4 This member will be appointed by[42] the appointment panel subject to the approval of the Chair

3.7.5 The appointment process will be as follows[43]:

a) A panel appointed by the Board of the Integrated Care Board will oversee the appointment. It will include at least one Board Member and will be supported by suitably qualified and experienced advisors. The appointment panel will draft a role outline at the point of recruitment setting out the requirements of the role.
b) The Local Authorities listed at 3.7.1 are invited to submit one nomination each to the appointment panel, regardless of the number of vacancies.
c) The appointment panel will circulate the list of nominations to the Local Authorities eligible to nominate (listed at 3.7.1) for the purpose of confirming the accuracy of the list.
d) Using a minimum of a paper-based screen, the appointment panel will assess the suitability of nominations against the role outline and the eligibility and disqualification criteria set out at 3.1, 3.2, 3.7.2 and 3.7.3 in order to select a preferred candidate(s) which will be presented to the ICB Chair.
e) Appointments are subject to the approval of the ICB Chair. An interview process can be established at their discretion.

3.7.6 The term of office[44] for this Partner Member will be 3 years and the total number of terms they may service is unlimited terms.

3.8 Chief Medical ~~Director~~ Officer[45]

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner with the regulatory body (GMC)
c) Specify any other criteria set out by NHS England's guidance

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Add any criteria set out in NHS E guidance

3.8.3 This member will be appointed by[47] an appointment panel following a competitive process and will be subject to the approval of the Chair.

3.9 ~~Director of Nursing~~ Chief Nursing Officer[48]

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse and hold registration with the NMC
c) Specify any other criteria set out by NHS England's guidance

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Add any criteria set out in NHS E guidance

3.9.3 This member will be appointed by[50] an appointment panel following a competitive process and will be subject to the approval of the Chair.

3.10 ~~Director of Finance~~ Chief Finance Officer[51]

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Qualified accountant with full membership of one of the five accountancy institute members of the Consultative Committee of Accountancy Bodies or the Chartered Institute of Management Accountants
c) Specify any other criteria set out by NHS England's guidance

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) [Add any criteria set out in NHS E guidance]

3.10.3 This member will be appointed by[53] an appointment panel following a competitive process and will be subject to the approval of the Chair

3.11 Independent Non-Executive Members[55]

3.11.1 The ICB will appoint up to five independent Non-Executive Members, one of whom will be appointed as the Deputy Chair by the Chair.

3.11.2 These members will be appointed by[56] an appointment panel subject to the approval of the Chair.

3.11.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Not be employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICS area
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee
e) The remaining will have specific knowledge, skills and experience that enables them to express an informed view and effectively discharge the functions of the ICB
f) Have a strong interest in the area served by the ICS
g) Specify any other criteria set out by NHS England's guidance

3.11.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area
c) They hold substantial conflicts of interests that would interfere with their ability to be independent and offer an impartial perspective
d) add any criteria set out in NHS E guidance

3.11.5 The term of office for an independent non-executive member will be three years and the total number of terms an individual may serve is three[58] terms after which they will no longer be eligible for re-appointment.

3.11.6 Initial appointments may be for a shorter period[59] in order to avoid all non-executive members retiring at once. Thereafter, new appointees will

ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

3.11.7 Subject to[60] a satisfactory appraisal, the Chair may approve the re-appointment of an independent non-executive member up to the maximum number of terms permitted for their role.

3.12 Board Members: Removal from Office.

3.12.1 Arrangements for the removal from office of Board members by the Chair is subject to the term of appointment, and application of the relevant ICB policies and procedures.

3.12.2 With the exception of the Chair, Board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this constitution, regulations or guidance
b) If they fail to attend a minimum of 75% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) Are deemed to have failed to uphold the Nolan Principles of Public Life
f) Are subject to disciplinary proceedings by a regulator or professional body.

3.12.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.2 apply.

3.12.4 Executive Directors (including the Chief Executive Officer) will cease to be Board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.12.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.12.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a. terminate the appointment of the ICB's Chief Executive Officer; and

b. direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.13 Terms of Appointment of Board Members

3.13.1 With the exception of the Chair and Non-executive members, arrangements for remuneration[63] and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB website and any guidance issued by NHS England or other relevant body. Remuneration for the Chair will be set by NHS England. Remuneration for non-executive members will be set by a Non Executive Remuneration Panel [63].

3.13.2 Other terms of appointment will be determined by the Remuneration Committee.

3.13.3 Terms of appointment of the Chair will be determined by NHS England.

3.14 Specific arrangements for appointment of Ordinary Members made at establishment[110]

3.14.1 Individuals may be identified as "designate ordinary members" prior to the ICB being established.

3.14.2 Relevant nomination procedures for partner members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5-3.7 and the nominating organisations (as set out in clauses 3.5-3.7) have confirmed their nominations following the Health and Care Bill receiving Royal Assent

3.14.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate ordinary members should follow, as far as possible, the processes set out in section 3.5-3.11 of this constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.14.4 On the day of establishment, a committee consisting of the Chair, Chief Executive Officer will appoint the ordinary members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

3.14.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial ordinary members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.11.

4 Arrangements for the Exercise of our Functions.

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 [64]The ICB has adopted a Code of Conduct for staff and will maintain and promote effective 'whistleblowing' procedures to ensure that concerned staff have a safe and confidential means through which their concerns can be voiced. A copy of this Code of Conduct is detailed within the ICB's Dignity at Work policy and will be available on the ICB's website. Alternatively, interested persons will be able to obtain a hard copy upon application to the ICB's headquarters.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care
c) comply with directions issued by NHS England;
d) have regard to statutory guidance including that issued by NHS England; and
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(e) above, documenting them as necessary in this constitution, its governance handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees
b) a committee or sub-committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the

functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full on the ICB website.

4.4.2 Only the Board may agree the SoRD and amendments to the SoRD may only be approved by the Board

4.4.3 The SoRD sets out:

a) those functions that are reserved to the board;
b) those functions that have been delegated to an individual or to committees and sub committees;
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published [INSERT web address]

4.5.3 The map includes:

a) Key functions reserved to the Board of the ICB
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS

foundation trust, local authority, combined authority or any other prescribed body;

d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees[65]

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference and membership agreed by the Board[66]. All terms of reference are published in the Governance Handbook.

4.6.4 The Board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:

a) Submit regular decision or assurance reports to the board
b) Committee Chair to attend Board meetings
c) Comply with internal audit findings and Committee effectiveness reviews
d) Comply with any other reporting requirements set out in the Committee Terms of Reference

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees are required to act in accordance with this constitution, including the standing orders as well as the SFIs and any other relevant ICB policy.

4.6.7 The following committees will be maintained:

a) **Audit Committee[68]:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by an independent non-executive member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee**[69]**:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by an independent non-executive member other than the Chair or the Chair of Audit Committee.

4.6.8 The terms of reference for each of the above committees are published in the governance handbook[70].

4.6.9 The Board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published[71] in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 The ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation[72]. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the Board.

4.7.4 The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published within the Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions[73]

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the Board.

5.1.3 A full copy of the Standing Orders[74] is included in Appendix 2 and form part of this constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs published within the Governance Handbook.

6 Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest[75]

[DN: subject to change in line with NHS England guidance[76]]

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published within the Governance Handbook on the ICB website.[77]

6.1.3 All Board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest Policy and the Standards of Business Conduct Policy[78].

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian[79]. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;

d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles[80]

6.2.1 In discharging its functions the ICB will abide by the following principles:

a) Decision-making must be concerned with meeting the statutory duties of ICB at all times, including the four aims. Any individual involved in decisions relating to ICB functions must be acting clearly in the interests of the ICB and of the public, rather than furthering direct or indirect financial, personal, professional or organisational interests.
b) ICBs have been created to give statutory NHS providers, local authority and primary medical services (general practice) nominees a role in decision-making. Any individuals undertaking ICB roles or duties will be expected to act in accordance with the first principle, and it should not be assumed that an individual is personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations.
c) There should be a clear distinction between those whose input informs decisions, including shaping the ICB's understanding of how best to meet patients' needs and deliver care for their populations, and those who are taking decisions.
d) The personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision taking need to be declared, recorded and managed appropriately in accordance with ICB policy.
e) Actions to mitigate Conflicts of Interests should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible.
f) Where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should recuse themselves from the process.
g) The way conflicts of interest are declared and managed should contribute to a culture of transparency about how decisions are made.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers[81] of the interests of:

a) Members of the ICB
b) Members of the Board's committees and sub-committees
c) Its employees

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website.[82].

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests[83] (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB;
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
c) comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring Accountability and Transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.

7.2 Principles[84]

7.2.1 In discharging our functions the ICB will abide by the following principles:

a) The ICB is committed to working transparently and openly.
b) The ICB's constitution and standing orders are consistent with this principle and are published on the ICB website and available for review at an ICB Office.
c) Section 7 of the constitution sets out how the ICB will hold regular public meetings, advertised in advance with publicly available agenda and papers. The public will have the opportunity to ask questions at the meetings and minutes will be published in a timely manner.
d) Section 5 of the constitution sets out the ICB's approach to decision-making.
e) The ICB will provide regular and accessible updates on its vision, plans and progress against priorities through public meetings and other means of communication, including its website.
f) The ICB will adhere to the constitution in making its decisions. Any perceived conflicts of interest will be addressed according to section 6.
g) Board members must act in line with the Nolan principles.
h) The ICB will publish an Engagement Strategy which will confirm how the ICB will involve and engage with the public. set out its approach to transparency in greater detail within its Engagement Strategy.

7.3 Meetings and publications

7.3.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 information will be provided to NHS England as required.

7.3.7 The constitution and governance handbook will be published as well as other key documents including but not limited to:

- Conflicts of interest Policy and Procedures
- Registers of interests[85]
- The Scheme of Reservation and Delegation (SORD)
- Prime Financial Policies
- Standing Financial Instructions (SFIs)
- Functions and Decisions Map
- Standards of Business Conduct Policy
- Citizens and Community Engagement Strategy
- Inequalities Strategy

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- section 14Z34 (improvement in quality of services),
- section 14Z35 (reducing inequalities),
- section 14Z43 (have regard to effect of decisions)
- section 14Z44 (public involvement and consultation), and
- sections 223H and 223J (financial duties).

And

a) proposed steps to implement the ICP Strategy and Coventry Health and Wellbeing Board and Warwickshire Health and Wellbeing Board's local health and wellbeing strategies.[86]

7.4 Scrutiny and Decision Making

7.4.1 At least three independent non-executive members will be appointed to the board including the Chair; and all of the board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:
a) Add local arrangements to describe[87].

7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year and in particular how it has discharged its duties under sections
a) 14Z34 (improvement in quality of services),
b) 14Z35 (reducing inequalities),
c) 14z43 (have regard to the effect of decisions)
d) 14Z44 (public involvement and consultation), and

7.5.2 The annual report will also review the extent to which the ICB has exercised its functions in accordance with the plans published under section
a) 14Z50 (Integrated Care System plan), and
b) 14Z54 (capital resource use plan), and

7.5.3 Review any steps the board has taken to implement any joint health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees.

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The Board has established a Remuneration Committee[88] which is chaired by a Non-Executive member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the Board. No employees may be a member of the Remuneration Committee but the Board ensures that the Remuneration Committee has access to appropriate advice by

a) enabling the Chair of the Committee to invite individuals such as the Chief Executive Officer, ~~Director of Finance~~ Chief Finance Officer, HR Advisor and external advisors to attend all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote.

8.1.4 The Board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published within the Governance Handbook.

8.1.6 The duties of the Remuneration Committee include[89]:

a) Setting the ICB pay policy and standard terms and conditions including adoption of any pay frameworks for all employees including senior managers/directors (including board members) ~~and non-executive directors~~ who are not being paid under a national pay framework
b) Oversight of executive board member performance
c) Any other locally assigned duties

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z44(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the Integrated Care Board
b) the development and consideration of proposals by the ICB
c) for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and
d) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z52 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) In line with the arrangements set out in the Communication and Engagement Strategy.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities[90].

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is working.
d) Build relationships with excluded groups – especially those affected by inequalities.
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.
g) Use community development approaches that empower people and communities, making connections to social action.
h) Use co-production, insight and engagement to achieve accountable health and care services.
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 In addition the ICB has agreed the principles set out in the Communication and Engagement Strategy. [91]

9.1.5 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.6 These arrangements, include[92]:

a) The arrangements set out in the Communication and Engagement Strategy.[93]

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB Board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this constitution
Committee	A committee created and appointed by the ICB Board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships (known in the Coventry and Warwickshire system as Care Collaboratives) are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive Officer plus other members. All other members of the Board are referred to as Ordinary Members.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Consultative forum	A collaborative forum to inform and align decisions by relevant statutory bodies, such as the ICB or local authorities, in an advisory role. In this arrangement, the

	decisions of statutory bodies should be informed by the consultative forum.
Individual executives or staff	Statutory bodies may agree to delegate functions to individual members of staff to exercise delegated functions, and they may convene a committee to support them, with membership that includes representatives from other organisations.

Appendix 2: Standing Orders

1. Introduction[94]

1.1. These Standing Orders have been drawn up to regulate the proceedings of Coventry and Warwickshire Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution[95].

2. Amendment and review

2.1. The Standing Orders are effective from add date. [96]

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per [refer to the clause number in the constitution for making amendments].

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB constitution and will not be implemented until the constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These standing orders apply to all meetings of the Board, including its committees and sub-committees unless otherwise stated. All references to Board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the Board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Director of Corporate Affairs, will provide a settled view which shall be final.

3.5. All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive Officer as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the

circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings[97]

4.1.1. Meetings of the Board of the ICB shall be held at regular intervals[98] at such times and places[99] as the ICB may determine.

4.1.2. In normal circumstances, each member of the Board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two[100] days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3. A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4. The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2. Chair of a meeting

4.2.1. The Chair of the ICB shall preside over meetings of the Board.

4.2.2. If the Chair is absent, or is disqualified from participating by a conflict of interest, the Deputy Chair of the ICB will preside. [101]

4.2.3. The Board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3. Agenda, supporting papers and business to be transacted

4.3.1. The agenda for each meeting will be drawn up and agreed by the Chair[102] of the meeting.

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least 14 calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the Board at least seven calendar days before the meeting.

4.3.3. Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at insert weblink.

4.4. Petitions

4.4.1. Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board in accordance with the ICB policy as published in the Governance Handbook.

4.5. Nominated Deputies[103]

4.5.1. With the permission of the person presiding over the meeting, the Executive Members and the Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. The deputy may speak and vote on their behalf.

4.5.2. The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6. Virtual attendance at meetings[104]

4.6.1. The Board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7. Quorum[105]

4.7.1. The quorum for meetings of the Board will be 50% of members, including:

a) Either the Chief Executive Officer or the ~~Director of Finance~~ Chief Finance Officer

~~b)~~ Either the ~~Medical Director~~Chief Mecial Officer or the ~~Director of Nursing~~ Chief Nursing Officer

c) At least one independent member

d) At least one Partner Member

4.7.2. For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.7.3. For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8. Vacancies

4.8.1. In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

- Where possible and appropriate to do so, a nominated temporary deputy for the vacant role will be confirmed by the Chair
- Where it is not possible to identify a deputy, the Chair will be required to identify an alternative member of the Board to enable a quorum to be determined. In doing so the Chair will need to ensure that a diverse and balanced representation of views will be maintained in the given circumstances.
- The rationale for and use of this alternative quorum will be recorded in the minutes of the meeting.

4.9. Decision making

4.9.1. The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2. Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required.

The process for voting, which should be considered a last resort, is set out below:

a) All members of the Board who are present at the meeting will be eligible to cast one vote each.
b) Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers[107] (as detailed within paragraph 5.6. of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3. If consensus cannot be reached, the Chair may make decisions on behalf of the board where there is disagreement. Where necessary boards may draw on third party support such as peer review or mediation by NHS England and NHS Improvement.

Urgent decisions

4.9.4. In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible the following will apply.

4.9.5. The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive Officer (or relevant lead director in the case of committees)[108] subject to every effort having made to consult with as many members as possible in the given circumstances.

4.9.6. The exercise of such powers shall be reported to the next meeting of the Board for formal ratification and the Audit Committee for oversight.

4.10. Minutes

4.10.1. The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2. The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3. No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4. Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11. Admission of public and the press

4.11.1. In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the Board and all meetings of committees which are comprised of entirely board members or all board members at which public functions are exercised will be open to the public, except where a resolution is agreed to exclude the public in accordance with clause 7.3.1 of the Constitution.

4.11.2. The Board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3. The person presiding over the meeting shall give such directions as he/she/they thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Governing Body's business shall be conducted without interruption and disruption.

4.11.4. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting suppress or prevent disorderly conduct or behaviour.

4.11.5. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Board.

5. Suspension of Standing Orders

5.1. In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members, one of whom should be an independent non-executive member.

5.2. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents.

6.1 The ICB will use a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

a) the Chief Executive Officer
b) the Chair
c) the ~~Director of Finance~~Chief Finance Officer

6.2 The following individuals are authorised to execute a document on behalf of the group by their signature:

a) the Chief Executive Officer
b) the Chair
c) the ~~Director of Finance~~Chief Finance Officer

Coventry and Warwickshire Integrated Care Board – DRAFT Scheme of Reservation and Delegation

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Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
REGULATION AND CONTROL				
Constitution 1.6	Consider and approve applications to NHS England on changes to the Constitution including the Standing Orders.	✓		
Constitution Standing Order 3.6	Ratifying or agreeing a course of action in respect of non-compliance with the Standing Orders	✓		
Constitution 4.6	Establish and approve terms of reference and membership for ICB Committees.	✓		
Constitution 1.7.3	Approve the ICB scheme of reservation and delegation.	✓		
N/A	Exercise or delegate those functions of the ICB which have not been retained as reserved by the ICB Board or delegated to its Committees and sub-committees or delegated to named other individuals as set out in this document.			Chief Executive
Constitution 3.12	Removal of Board Members.			Chair
Constitution 5.2	Approving Standing Financial Instructions.	✓		
Constitution 4.7.3	Approve delegation arrangements under section 65Z5 of the 2006 Act.	✓		
Constitution Standing Order 4.2.3	Appoint a Chair to all committees and sub-committees.	✓		
Constitution Standing Order 4.9.6	Ratify the exercise of those powers reserved or delegated to the Board by the Chair in the case of urgent decisions and extraordinary circumstances.	✓		
Constitution Standing Order 4.11.1	Agree resolutions to exclude the public where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons.	✓		
Constitution Standing Order 4.6.7, Function 57	Arranging appropriate internal and external audit.		Audit and Governance Committee	
Constitution 3.13.1 and 3.13.2, Function 51	Agree arrangements for remuneration, any allowances and other terms of appointment for Board Members excluding Non-Executive Members and Chair.		Remuneration Committee	

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
Constitution 3.5.5, 3.6.5, 3.7.5, 3.8.3, 3.9.3, 3.10.3, 3.11.2, Function 52 and 53	Oversee the appointment process for the Partner Members (NHS Trusts and Foundation Trusts, Providers of Primary Medical Services and Local Authorities), Medical Director, Director of Nursing, Director of Finance and Non-Executive Members.		Remuneration Committee	
Constitution 8.1.6, Function 52 and 53	Setting the ICB pay policy and standard terms and conditions including adoption of any pay frameworks for all employees including senior managers/directors (including board members) who are not being paid under a national pay framework.		Remuneration Committee	
Constitution 8.1.6	Oversight of executive board member performance		Remuneration Committee	
Constitution 3.5.6, 3.6.6, 3.7.6	Approval of the appointment of the Board Members.			Chair
Constitution 3.13.1	Remuneration for Non-Executive Members.		Non-Executive Remuneration Panel	
Constitution 6.1.6	Act as the Conflicts of Interest Guardian.			Chair of Audit and Governance
STRATEGIC PLANNING				
Function 1 and 2	Consult on Commissioning Plan.	✓		
Function 4	Prepare a Joint Strategic Needs Assessment along with the local authority.		Delegated to Local Authorities' Health and Wellbeing Boards	
Function 5	Prepare a Joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment.		Delegated to Local Authorities' Health and Wellbeing Boards	
Function 6	Ensuring due regard to ICP Strategy.	✓		
OPERATIONAL COMMISSIONING				
Function 10	Enter into agreements, acquire and dispose of property and accept gifts (including property on trust).		Finance and Performance Committee	
Function 13	Refer a dispute concerning an NHS contract to the Secretary of State.	✓		
Function 15	Agreeing to make facilities available to providers or eligible voluntary organisations.		Audit and Governance Committee	
Function 16	Power to make grants.		Finance and Performance	

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
			Committee	
Function 17	Supply of goods and services by CCGs to local authorities.		Audit and Governance Committee	
Function 18	Making payments towards expenditure incurred by local authorities on social care functions.		Finance and Performance Committee	
Function 19	Making payments toward expenditure incurred by a voluntary organisation.		Finance and Performance Committee	
Function 20	Authorise payments to providers.		Finance and Performance Committee	
PERSONALISED COMMISSIONING - CONTINUING HEALTH CARE, FUNDED NURSING CARE AND PERSONAL HEALTH BUDGETS				
Function 22-24 and 26	Oversight of quality of Personalised Commissioning.		Quality Committee	
Function 25	Nominate members for Independent Review panels.			Director of Nursing
Function 22, 28, 30 and 31	Oversight of costs of NHS continuing healthcare, funded nursing care, PHB and direct payments.		Finance and Performance Committee	
Function 32	Oversight of after-care services.		Integrated Commissioning Committee	
PATIENT RIGHTS AND NHS CONSTITUTION - CHOICE, WAITING TIMES AND INDIVIDUAL FUNDING REQUESTS				
Function 35 and 36	Oversight of duty to offer a choice of health service provider and to publicise and promote information about patient choice.		Integrated Commissioning Committee	
Function 37, 39 and 41	Oversight of maximum waiting times standard, including cancer waiting time standards.		Finance and Performance Committee	
Function 38, 40	Oversight of arrangements on duty to offer an alternative provider.		Finance and Performance Committee	
Function 42	Approve or reject individual requests for funding.		Individual Funding Request Panel	
Function 42	Approve or reject individual requests for funding when a request for review is made following the initial Individual Funding Request Panel decision. (Panel will review the process that the IFR Panel followed rather than the decision that was reached.)		Individual Funding Request Review Panel	
PUBLIC INVOLVEMENT AND OVERVIEW & SCRUTINY				
Function 43	Oversight of arrangements for public involvement and consultation.		Audit and Governance Committee	
EMERGENCIES				
Function 45	Oversight of the role of the ICB in respect of emergencies.		Audit and Governance Committee	
CORPORATE				
Function 49	Oversight of arrangements for the management of conflicts of interest.		Audit and Governance Committee	

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
Function 54 and 55	Approval of the annual report and accounts.	✓		
Function 54 and 55	Approving a timetable for producing the annual report and accounts???		Audit and Governance Committee	
Function 56	Oversight of the application of the seal.			
CONSTITUTIONAL ARRANGEMENTS				
Function 58-67	Ensuring the Constitution meets the requirements of Schedule 1A, the new Schedule 1B and the new schedule 14Z29 of the NHS 2006 Act.	✓	*Recommendation from Audit and Governance Committee*	
Constitution 1.6, Function 67	Consider and approve applications to NHS England on changes to the Constitution including the Standing Orders.	✓		
Constitution Standing Order 3.6	Ratifying or agreeing a course of action in respect of non-compliance with the Standing Orders.	✓		
Constitution 4.6	Establish and approve terms of reference and membership for ICB Committees.	✓		
Constitution 1.7.3	Approve the ICB scheme of reservation and delegation.	✓		
PERFORMANCE ASSESSMENT AND OVERSIGHT BY NHS ENGLAND				
Function 70 and 71	Oversight of the duty to provide documents, information and explanations to NHS England as requested for the purposes of its performance functions.	✓	Relevant committee as required	
Function 72	Oversight of the duty to co-operate with NHS England and other ICBs where the ICB is subject to related directions from NHS England.	✓	Relevant committee as required	
Function	Oversight of arrangements between the ICB and NHS bodies and local authorities.	✓		
Function 74, 75 and 78	Approval and oversight of the exercising of: • NHS England functions including those jointly exercised with NHSE England • functions jointly with other ICBs • ICB functions by, or jointly with, NHS England.	✓		
Function 76	Approval and oversight of pooled funds.	✓		
Function 77 and 79	Approval and oversight of joint exercise of functions with combined authorities and with Local Health Boards.	✓		
Function 80	Approval and oversight of arrangements with the Secretary of State in respect of the exercise of public health functions.	✓		
Function 81	Power to agree arrangements for support with the Secretary of State.	✓		
Function 82	CCG power to apply to become a Care Trust.	✓		

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
FINANCE				
Function 83	Oversight of the duty to comply with NHS England direction in respect of spending allotted monies and paying monies arising from disposals or valuations to NHS England.		Finance and Performance Committee	
Function 84	Oversight of the duty to use monies designated for integration for that purpose (the Better Care Fund).		Finance and Performance Committee	
Function 85	Oversight of the duty to comply with financial requirements set by NHS England directions in respect of ICB and system expenditure.		Finance and Performance Committee	
Function 86	Oversight of duties to comply with revenue and capital resource limits and financial objectives set by NHS England in respect of the ICB and system.		Finance and Performance Committee	
Function 87	Oversight of duty to publish details of how it has spent quality payments from NHS England.		Finance and Performance Committee	
Function 88	Oversight of compliance with restrictions on the use of support monies and other support resources provided by NHS England.		Finance and Performance Committee	
Function 89 and 90	Power to recover charges owed to an NHS body as a civil debt and to recover any reduction, remission or repayment which was not due to a person as a civil debt.	✓	*Recommendation from Audit and Governance Committee*	
Function 91	Power to raise additional income.	✓		
Function 92	Power to undertake fundraising.		Audit and Governance Committee	
Function 93	Power to invest in companies.	✓	*Recommendation from Audit and Governance Committee*	
Function 94	Power to enter into externally financed development agreements.	✓	*Recommendation from Audit and Governance Committee*	
Function 95	Oversight of duty to provide financial information to NHS England.		Finance and Performance Committee	
Function 96	Oversight of duty to provide information to the Secretary of State.	✓	Relevant committee as per request	
Function 97	Oversight of duty to assist with fraud investigations.		Audit and Governance Committee	
Function 98	Power to disclose information related to its functions to third parties in prescribed circumstances.		Audit and Governance Committee	
GENERAL DUTIES				
Function 99	Oversight of duty to promote the NHS Constitution.		Audit and Governance Committee	
Function 101	Oversight of duty as to improvement in quality of services.		Integrated Commissioning Committee	
Function 102	Oversight of duty in relation to assisting and supporting NHS England to discharge duty in relation to quality of primary medical services.		Integrated Commissioning Committee	

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
Function 103	Oversight of duty as to reducing inequalities.	✓	Inequalities sub-Committee and all other Committees and sub-Committees	
Function 104	Oversight of duty to promote involvement of each patient.		Audit and Governance Committee	
Function 105	Oversight of duty as to patient choice.		Integrated Commissioning Committee	
Function 106	Oversight of duty to obtain appropriate advice.		Audit and Governance Committee	
Function 108	Oversight of duty in respect of research.		Finance and Performance Committee	
Function 109	Oversight of duty to promote education and training.		Finance and Performance Committee	
Function 110	Oversight of duty to promote integration.	✓		
Function 111	Oversight of duty to have regard to guidance on commissioning published by NHS England.		Integrated Commissioning Committee	
Function 112	Oversight of duty to make available facilities to university medical or dental schools for the purposes of clinical teaching and research.		Finance and Performance Committee	
Function 113	Oversight of duty to make arrangements to ensure functions are discharged having regard to need to safeguard and promote the welfare of children.		Quality Committee	
Function 128	Oversight of joint commissioning arrangements.		Integrated Commissioning Committee	
Function 132-135	Oversight of general requirements for local audit, including procedure for appointment, requirement to have auditor panel, and the functions of the auditor panel.		Audit and Governance Committee	
Function 136	Oversight of arrangements for publicity for public interest reports.		Audit and Governance Committee	
Function 137	Oversight of the audit or examination of English NHS charity accounts.		Audit and Governance Committee	
Function 138	Oversight of the Public Sector Equality Duty.	✓	*Recommendation from Audit and Governance Committee*	
Function 139	Oversight of provision of relevant services for adults with autistic spectrum conditions.		Integrated Commissioning Committee	
Function 140 and 141	Oversight of supply of information to local authorities regarding individuals' participation in education or training and individuals' need for educational support services.		People Committee	
Function 144 and 45	Oversight of arrangements, including local arrangements, to safeguard and promote welfare of children.		Quality Committee	
Function 146	Oversight of the combining of safeguarding partner areas and		Quality Committee	

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
	delegating functions.			
Function 147	Oversight of the combining of child death review partner areas and delegating functions.		Quality Committee	
Function 149	Oversight of the establishment and conduct of reviews under the Domestic Violence, Crime and Victims Act.		Quality Committee	
Function 150	Oversight of the arrangements for assessing risks posed by certain offenders.		Quality Committee	
Function 151	Power to enter into agreements for the purpose of furthering sustainable development of countries other than the UK or improving the welfare of their populations.	✓		
Function 152	Oversight of arrangements related to the Freedom of Information Act.		Audit and Governance Committee	
Function 153	Oversight of consideration of The Mayor's health inequalities strategy	✓		
Function 154	Oversight of duty related to authorities responsible for crime and disorder strategies.		Integrated Commissioning Committee	
Function 155	Oversight of duty to collaborate with provision of youth justice services.		Integrated Commissioning Committee	
Function 156	Oversight of duty to collaborate in the establishment of youth offending teams.		Integrated Commissioning Committee	
Function 157	Oversight of duty to cooperate with Youth Justice Board.		Integrated Commissioning Committee	
Function 158	Oversight of duty to act in accordance with guidance as set out in Crime and Disorder Act.		Integrated Commissioning Committee	
Function 159	Oversight of duty of certain bodies to help local authority as set out in Education Act.		Integrated Commissioning Committee	
Function 160	Oversight of duty of Local Health Board or NHS trust to notify parent as set out in Education Act.		Integrated Commissioning Committee	
Function 161	Oversight of co-operation between ICB and other authorities as set out in Children Act.		Quality Committee	
Function 162	Oversight of ICB's co-operation in respect of Local authorities' duty to investigate.		Quality Committee	
Function 163	Oversight of duty Children accommodated by health authorities and local education authorities.		Quality Committee	
Function 164	Oversight of duty in relation to persons discharged from hospital.		Quality Committee	
Function 165	Oversight of duty in relation to information as to hospitals as set out in Mental Health Act.		Quality Committee	
Function 166	Oversight of duty in relation to After-care as set out in Mental Health Act.		Quality Committee	

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
Function 167	Oversight of arrangements of notification of hospitals having arrangements for special cases.		Quality Committee	
Function 168	Oversight of duty to co-operate with Commissioner as set out in Domestic Abuse Act.		Quality Committee	