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Schedule	Wednesday 21 May 2025, 1:30 PM — 4:00 PM BST
Venue	Stockingford Community Centre, Haunchwood Road, Nuneaton. CV10 8DY - free parking available on site
Description	<p>If you are a member of the public or press and would like to attend a Board meeting taking place in person, could you please email icb.governance@nhs.net advising of this so that we can monitor attendance, and please include the following details in your email: date of the meeting, first name and surname, email address, your organisation or group name if attending on behalf of them, and any accessibility requirements (e.g. large print format materials, mobility considerations, etc).</p>
Notes for Participants	<p>This business meeting is held in public for the purpose of transparency. Questions from members of the public are permitted where they both relate to agenda items and are submitted by midday the day before the meeting via the link found at https://www.happyhealthylives.uk/integrated-care-board/about-us/icb-board-meetings/</p> <p>For easy navigation throughout the meeting pack, please click on the thumbnail icon in the top left-hand corner of the screen (3 horizontal lines with 3 dots on the left), then select the relevant item and click on the paper you wish to view. This will save you having to scroll through the pack.</p> <p>Integrated Health and Care Delivery Plan (IHCDP) Priorities:</p> <ol style="list-style-type: none">1 - Prioritising prevention and improving future health outcomes through tackling health outcomes2 - Improving Access to health and care services and increasing trust and confidence3 -Tackling immediate system pressures and improving resilience
Organiser	Carolyn Bennett

Agenda

1:30 PM	1. STANDING ITEMS		
1:30 PM	1.1. Welcome and Apologies For Information - Presented by Danielle Oum		
1:31 PM	1.2. Confirmation of Quoracy For Information - Presented by Danielle Oum	 1.2 - ICB Quoracy Sheet.docx	1
1:32 PM	1.3. Declarations of Interest For Assurance - Presented by Danielle Oum	 1.3 - CW-ICB Declarations of Interest Statement.docx  Register of Interests Board (In Public) 21 May 2025 - Updated 13May2025.pdf	2 3
1:33 PM	1.4. Minutes of the meetings held on 19 March 2025 For Approval - Presented by Danielle Oum	 DRAFT ICB Minutes 19 March 2025 FV.docx	7
1:34 PM	1.5. Matters Arising/Action Log For Discussion - Presented by Danielle Oum	 1.5 - CWICB Action Log.pdf	21
1:36 PM	2. ICB Chair's Report For Information - Presented by Danielle Oum	 Chairs Report for 21 May 2025.docx	22
1:38 PM	3. ICB Chief Executive Officer's Report For Information - Presented by Philip Johns	 250515 Chief Executive Officer Report - May 2025 v3.docx	25

1:43 PM	<p>4. Citizen's Story - The importance of enabling integration - [IHCDP Priorities 1+2] For Discussion - Presented by Philip Johns</p> <p> Integration Story May Board.docx</p>	29
<hr/>		
1:58 PM	<p>5. Reports from Committees held since the last Board meeting - 11 March and 23 April Audit, 21 March Extraordinary and 17 April Coventry Care Collaborative, 24 March Extraordinary Warwickshire Care Collaborative, 8 April Quality, Safety and Experience, 2 April and 7 May Finance and Performance, 7 April People and ICB People and 20 March and 11 April West Midlands Joint Committee report For Approval and Assurance - Presented by Pamela Bradbury, Kevin Davis, Chris Hurst, Philip Johns, Dr Sukhi Dhesi and Harry Hayer</p> <p> Summary of Committee reports to Board.docx</p> <p> Report to Board - Audit Committee 11 March 2025.docx</p> <p> Report to Board - Audit Committee 23 April.docx</p> <p> Board Report from Cov Care Collab Committee 21 Mar 2025.docx</p> <p> Board Report from Cov Care Collab Committee 17 Apr 2025.docx</p> <p> Board Report from Extraordinary WCCCommittee 24 Mar 2025 Final.docx</p> <p> QSEC Board Report Final 8 4 25 V4.docx</p> <p> FandP report to Board 2 April 2025 Public.docx</p> <p> FandP report to Board 7 May 2025 FV.docx</p> <p> CW-ICB Committee Report to Board PCSystem 7 April 2025v4.docx</p> <p> People Committee ICB Report to Board April 2025v4.docx</p> <p> 250514 Summary of West Midlands Joint Committee for Specialised Services meetings on 20 March and 11 April 2025 - vF.docx</p>	<p>33</p> <p>37</p> <p>43</p> <p>49</p> <p>50</p> <p>53</p> <p>55</p> <p>61</p> <p>67</p> <p>74</p> <p>77</p> <p>80</p>
<hr/>		

2:06 PM	6. Responding to national challenges whilst delivering for the Coventry and Warwickshire population - Update on ICB Transition - [IHCDP Priorities 1+2+3] For Endorsement - Presented by Philip Johns and Rachael Danter		
	 250513 Update to Board on ICB transition options - May 2025 v3.docx		82
	 ICB Board - National Challenges and how the ICB responds- May 2025 v1.docx		86
2:11 PM	7. Update on Care Collaborative Approach - [IHCDP Priorities 1+2+3] Presented by Rachael Danter, Laura Nelson and Ali Cartwright		
	 Update on Care Collaborative Approach.docx		92
2:19 PM	8. ICB Prioritisation Framework Update - [IHCDP Priorities 1+2+3] For Information - Presented by Rachael Danter		
	 ICB Board - Prioritisation Framework - May 2025 v1.2.docx		102
2:37 PM	9. Board and Committee Governance - [IHCDP Priority 2] For Approval - Presented by Mark Gwynne		
	 Board and Committee Governance - May 2025.docx		110
	 Board and Committee Governance - May 2025 App 1 F&P System ToR.docx		120
	 Board and Committee Governance - May 2025 App 2 ICB F&P ToR.docx		136
	 Board and Committee Governance - May 2025 App 3 Transition ToR.docx		153
2:47 PM	10. Future Commissioning of CAMHS (Child and Adolescent Mental Health Services) - [IHCDP Priorities 1+2] For Approval - Presented by Dr Imogen Staveley		
	 CAMHS commissioning Board paper May 2025 vF final (002).pdf		165

2:57 PM	11. Integrated Provider Performance Report - [IHCDP Priorities 1+2+3] For Assurance - Presented by Rachael Danter, Felicity Davies, Madi Parmar and Jamie Soden	 Integrated Provider Performance Report May 2025 v1.2.docx	173
3:11 PM	12. Finance Update - overview, recovering and savings programme - [IHCDP Priorities 2+3] For Discussion - Presented by Madi Parmar	 Board Finance Update May2025.docx	200
3:21 PM	13. Procurement of All Age Mental Health, Learning Disabilities and Autism Individual Packages of Care - [IHCDP Priority 3] For Approval - Presented by Dr Imogen Staveley	 ICB Board Procurement Paper All Age MHL & Autism POC May 2025.docx	207
3:26 PM	14. Independent Mental Health Homicide Review into the tragedies in Nottingham (SPOC task 56940) - [IHCDP Priorities 1+2] For Assurance - Presented by Mr Viral Kantaria	 Intensive outreach ICB Board Paper May25FINAL2.docx	215
3:31 PM	15. Questions from members of the public For Discussion - Presented by Danielle Oum		
3:35 PM	16. Feedback from Behaviours Guardian For Discussion - Presented by Andy Hardy	 Integrated Care Board Behavioural Principles V3.pdf	224
3:38 PM	17. Any Other Business Presented by Danielle Oum		

18. DATE OF NEXT MEETING - Wednesday 16 July 2025 - 13.30-
16.00 - face to face - venue tbc asap

INTEGRATED CARE BOARD

Quoracy

Members

- Chair – Danielle Oum
- Chief Executive Officer – Phil Johns
- Three Partner member(s) NHS and Foundation Trusts, one of whom will have the knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness:
 - Glen Burley, Andy Hardy, Melanie Coombes
- Two Partner member(s) Primary Medical Services – Dr Sukhi Dhesi and Dr Terry Eaton
- Two Partner member(s) Local Authorities – Becky Hale and Pete Fahy
- Five non-executive Members – Kevin Davis, Harry Hayer, Pamela Bradbury, Steve Rimell, Chris Hurst
- Chief Finance Officer – Madi Parmar
- Chief Medical Officer – Dr Imogen Staveley
- Chief Nursing Officer – Ellie Monkhouse
- Chief Transformation Officer – Rachael Danter

Quorum

The quorum of the Board is a minimum of nine members. This must include at least:

- a) Either the Chief Executive Officer or the Chief Finance Officer
- b) Either the Chief Medical Officer or the Chief Nursing Officer
- c) At least one Independent Member
- d) At least one Partner Member.

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

If any member of the Board 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, they shall no longer count towards the quorum.

If the Board is not quorate then the meeting may proceed if those attending agree, but no decision may be taken, or the meeting may be postponed at the discretion of the Chair.

Declarations of Interest

*Under the Health and Care Act 2022, there is a legal obligation to manage conflicts of interest appropriately. **Where possible, any conflict of interest should be declared to the Chair of the meeting as soon as it is identified in advance of the meeting.** Where this is not possible, it is essential that at the beginning of the meeting a declaration is made if anyone has any conflict of interest to declare in relation to the business to be transacted at the meeting. An interest relevant to the business of the meeting should be declared whether or not the interest has previously been declared.*

Type of Interest	Description
Financial Interests	<p>This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could include being:</p> <ul style="list-style-type: none"> • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (of more than 5% of the issued shares), partner or owner of a private or not for profit company, business or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A consultant for a provider; • In secondary employment; • In receipt of a grant from a provider; • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	<p>This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may include situations where the individual is:</p> <ul style="list-style-type: none"> • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for the CQC or NICE; • A medical researcher.
Non-Financial Personal Interests	<p>This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:</p> <ul style="list-style-type: none"> • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • A member of a political party; • Suffering from a particular condition requiring individually funded treatment; • A financial advisor.
Indirect Interests	<p>This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). This should include:</p> <ul style="list-style-type: none"> • Spouse / partner; • Close relative e.g., parent, [grandparent], child, [grandchild] or sibling; • Close friend; • Business partner.

NHS Coventry and Warwickshire Integrated Care Board - Register of Interests for Board (In Public) 21 May 2025

Title	First Name	Surname	Current position(s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest - (Name of the organisation and nature of business)	Type of Interest				Date of Interest	
					Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect	From	To
Members										
Ms	Pamela	Bradbury	Non-Executive Member, CWICB	Daughter is Head of Operational Transformation and Improvement, British Pregnancy Advisory Service				✓	May-2025	Current
Mr	Adam	Carson	Managing Director, South Warwickshire University NHS Foundation Trust	1. Voting Board Director, South Warwickshire University NHS Foundation Trust	✓				Apr-2024	Current
Mr	Adam	Carson	Managing Director, South Warwickshire University NHS Foundation Trust	2. Partner is Journalist for ITV Central				✓	Sep-2005	Current
Ms	Melanie	Coombes	Chief Executive, Coventry and Warwickshire Partnership Trust	1. Chair, Mental Health Digital Health Forum		✓			Jul-2022	Current
Ms	Melanie	Coombes	Chief Executive, Coventry and Warwickshire Partnership Trust	2. Board Member, Mental Health Confederation National Board		✓			Jul-2022	Current
Ms	Rachael	Danter	Chief Transformation Officer and Deputy Chief Executive Officer, CWICB	1. Nephew-in-law works in Transformation Team at the Coventry and Warwickshire ICB				✓	Sep-2022	Current
Ms	Rachael	Danter	Chief Transformation Officer and Deputy Chief Executive Officer, CWICB	2. Son works for the Kenilworth MP Jeremy Wright				✓	Apr-2025	Current
Mr	Kevin	Davis	Non-Executive Member, CWICB	Director, Ladder for Greater Birmingham, Apprenticeship Foundation		✓			Apr-2022	Current
Dr	Sukhdeep	Dhesi	Practice Partner Member	1. GP Partner, Croft Medical Centre, Leamington Spa	✓				Mar-2008	Current
Dr	Sukhdeep	Dhesi	Practice Partner Member	2. Croft Medical Centre is a Member of South Warwickshire GP Federation	✓				Mar-2015	Current
Dr	Sukhdeep	Dhesi	Practice Partner Member	3. Director, Dhesi Medical Ltd	✓				Oct-2015	Current
Dr	Sukhdeep	Dhesi	Practice Partner Member	4. Husband is a Dental Surgeon				✓	Jul-2006	Current
Dr	Sukhdeep	Dhesi	Practice Partner Member	5. Brother-in-Law is Chief Information Officer, McKesson UK.				✓	Apr-2018	Current
Dr	Sukhdeep	Dhesi	Practice Partner Member	6. The Chief Medical Officer for the Coventry and Warwickshire ICB is the wife of my business partner at Croft Medical Centre (To be removed in Nov 2025)				✓	Jul-2022	May-2025
Dr	Sukhdeep	Dhesi	Practice Partner Member	7. Trustee on the Board of Coventry, Warwickshire and Worcestershire MIND		✓			Oct-2024	Current
Dr	Sukhdeep	Dhesi	Practice Partner Member	8. GP providing Out of Hours service for the Practice Plus Group Provider	✓				Dec-2022	Current
Dr	Sukhdeep	Dhesi	Practice Partner Member	9. Clinical Director, Leamington South Primary Care Network (To be removed in Oct 2025)	✓				Apr-2023	Apr-2025
Dr	Sukhdeep	Dhesi	Practice Partner Member	10. Colleague is Business Partner at Croft Medical Centre and Chair of Warwickshire Local Medical Committee				✓	Sep-2021	Current
Dr	Sukhdeep	Dhesi	Practice Partner Member	11. Mid 5 GP Ambassador for the Training Hub	✓				Apr-2025	Current
Dr	Sukhdeep	Dhesi	Practice Partner Member	12. Practice in Coventry (tbc)	tbc	tbc	tbc	tbc	tbc	tbc
Dr	Terry	Eaton	Partner Member, Primary Medical Services	1. Member, Coventry Local Medical Committee		✓			Dec-2022	Current
Dr	Terry	Eaton	Partner Member, Primary Medical Services	2. Daughter works as a GP receptionist with Coventry and Warwickshire Partnership NHS Foundation Trust				✓	Feb-2024	Current
Mr	Pete	Fahy	Director of Adult Social Care and Housing (Coventry City Council), Chair of Coventry Care Collaborative	Nil						Current

Ms	Danielle	Oum	Chair, CWICB	1. Member, Vice-Chancellor's Health Advisory Board, Coventry University		✓			Mar-2023	Current
Ms	Danielle	Oum	Chair, CWICB	2. Director, Mostly Moseley Properties Ltd	✓				May-2022	Current
Ms	Danielle	Oum	Chair, CWICB	3. Chair of Aquarius and Board Member of Waythrough, charitable services to people with issues related to drugs, alcohol and gambling.	✓				May-2023	Current
Ms	Danielle	Oum	Chair, CWICB	4. Board Member, Fusion21 Ltd, social value procurement	✓				Dec-2023	Current
Ms	Danielle	Oum	Chair, CWICB	5. Chair, Tuntum Housing Association	✓				Sep-2024	Current
Ms	Madi	Parmar	Chief Finance Officer, CWICB	1. Healthcare Financial Management Association Member and Advisory Committees' contributor: Payment Systems and Specialised Services Group and ICB Chief Finance Officer Group		✓			Jan-1998	Current
Ms	Madi	Parmar	Chief Finance Officer, CWICB	2. Fellow Member, Chartered Institute of Public Finance Accountants (FCIPFA)		✓			Sep-1994	Current
Ms	Madi	Parmar	Chief Finance Officer, CWICB	3. Husband employed by West Midlands Combined Authority as Senior Solicitor Note:				✓	Oct-2024	Current
Ms	Madi	Parmar	Chief Finance Officer, CWICB	4. Chair of National Healthcare Financial Management Association's ICB Chief Finance Officer Committee		✓			Sep-2024	Current
Dr	Imogen	Staveley	Chief Medical Officer, CWICB	1. Locum GP in Coventry and Warwickshire	✓				Sep-2024	Current
Dr	Imogen	Staveley	Chief Medical Officer, CWICB	2. GP Appraiser, North Central and North East London	✓				Dec-2015	Current
Title	First Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Date of Interest	
					Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect	From	To
Attendees										
Dr	Shade	Agboola	Director of Public Health, Warwickshire County Council	Non-Executive Director, DHU Healthcare (not-for-profit community interest company)	✓				Aug-2022	Current
Mr	Chris	Bain	Chief Executive Healthwatch Warwickshire	1. Trustee at Equalities and Inclusion Partnership		✓			Jan-2019	Current
Mr	Chris	Bain	Chief Executive Healthwatch Warwickshire	2. Trustee at Independent Advocacy Alliance		✓			Jan-2020	Current
Ms	Alison	Cartwright	Chief Integration Officer, CWICB	Shareholder of Applied Geology (can undertake site/ground investigations for NHS organisations)	✓				May-2013	Current
Ms	Felicity	Davies	Chief People Officer, CWICB	Nil						Current
Dr	Allison	Duggal	Director of Public Health, Coventry City Council	1. Leader with both Girl Guiding and Scouts			✓		Aug-2023	Current
Dr	Allison	Duggal	Director of Public Health, Coventry City Council	2. Member, Association of Directors of Public Health and a Fellow of the Faculty of Public Health		✓			Aug-2023	Current
Dr	Allison	Duggal	Director of Public Health, Coventry City Council	3. Partner is employed by Atkins (SNC-Lavalin) and is involved in work on highways and rail infrastructure, sometimes leading on bids for work with local authorities and NHS				✓	Aug-2023	Current
Mr	Mark	Gwynne	Interim Director of Corporate Governance, CWICB	Nil						Current
Ms	Ruth	Light	Chief Officer, Healthwatch Coventry	Nil						Current
Ms	Laura	Nelson	Chief Integration Officer, CWICB	Personal relationship with Director within University Hospitals Coventry and Warwickshire NHS Trust				✓	Jun-2020	Current
Ms	Sue	Ogle	Chief Executive Officer, Voluntary Action Coventry	Nil						Current
Mr	Eddie	Olla	Chief Digital and Information Officer, CWICB	Member of Shuri Network Steering Group. The Shuri Network is the first NHS and care network of women from minority ethnic groups in digital health.			✓		Apr-2023	Current

Ms	Karen	Winchcombe	Chief Executive, Warwickshire Community and Voluntary Action	Funding to Community And Voluntary Action from Coventry and Warwickshire Integrated Care Board	✓				Sep-2022	Current
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Unconfirmed Minutes of the Coventry and Warwickshire Integrated Care Board Meeting

Held on Wednesday 19 March 2025 at 13.30-15:45, at Coventry Rugby Club, Coventry

Members		
Prof Danielle Oum	Chair, Coventry and Warwickshire Integrated Care Board (CWICB)	DO
Ms Pamela Bradbury	Deputy Chair, CWICB	PB
Mr Kevin Davis	Non-Executive Member, CWICB	KD
Mr Chris Hurst	Non-Executive Member, CWICB	CH
Mr Steve Rimell	Non-Executive Member, CWICB	SR
Mr Harry Hayer	Non-Executive Member, CWICB	HH
Dr Angela Brady	Outgoing Chief Medical Officer, CWICB	AB
Dr Imogen Staveley	Incoming Chief Medical Officer, CWICB	IS
Ms Rachael Danter	Chief Transformation Officer and Deputy CEO, CWICB	RD
Mr Phil Johns	Chief Executive Officer, (CEO) CWICB	PJ
Ms Madi Parmar	Chief Finance Officer, CWICB	MP
Ms Becky Hale	Partner Member, Local Authority	BH
Mr Pete Fahy	Partner Member, Local Authority	PF
Dr Sukhi Dhesi	Partner Member, Primary medical Services	SD
Dr Terry Eaton	Partner Member, Primary Medical Services	TE
Ms Su Rollason for Prof Andy Hardy	Partner Member, NHS and Foundation Trusts	SR

Ms Melanie Coombes	Partner Member, NHS and Foundation Trusts	MC
Ms Ellie Monkhouse	Chief Nursing Officer, CWICB	EM
In Attendance:		
Ms Felicity Davies	Chief People Officer, CWICB	FD
Mr Mark Gwynne	Director of Corporate Governance, CWICB	MG
Ms Rose Uwins	Head of Communications and Public Affairs, CWICB	RU
Mr Rory Kirk	Chief of Staff to CWICB CEO	RK
Ms Amy Danahay	Programme Manager, CWICB	AD
Dr Allison Duggal	Director of Public Health, Coventry	AD
Mr Chris Bain	Chief Executive, Healthwatch Warwickshire	CB
Ms Fiona Garrigan	Chief Officer, Healthwatch Coventry	FG
Carolyn Bennett	Business Support Coordinator, CWICB (Minute Taker)	CBe
Apologies:	Mr Glen Burley, Partner Member, NHS and Foundation Trusts	GB

Item No:		Action
1.	Standing Items:	
1.1	<p>Welcome and Apologies</p> <p>Ms Oum welcomed everyone to the meeting and apologies were noted as above. Ms Oum advised attendees the meeting was being held in public rather than a public meeting and that the meeting was being recorded for the purposes of writing minutes, after which the recording would be deleted.</p> <p>Ms Oum advised there had been opportunity for anyone to ask questions about items on the agenda and that opportunity closed at midday the previous day as per the procedures in place.</p>	
1.2	<p>Confirmation of Quoracy</p> <p>The meeting was confirmed as quorate.</p>	

1.3	<p>Declarations of Interest</p> <p>No further declarations of interest were made beyond those already reported on the Declarations of Interest Log.</p> <p>Members were reminded of the need to declare their interest in any items requiring a decision so that their interest could be considered and appropriately managed.</p>	
2.	<p>South Warwickshire Community Hospital Rehabilitation Bed Consultation Decision Making Business Case</p> <p>Ms Oum introduced the item and Mr Gwynne read out the one question that had been received from Mr Alasdair Elliott, Chair of the Beds4Badger Group.</p> <p><i>‘Despite the narrow focus of the Consultation on the specific location of a number of ‘Community Rehabilitation’ beds, the feedback has clearly demonstrated the strength of feeling from the local Shipston on Stour Valley community to move towards our original vision of local, integrated, health and care services. In particular, a number of written responses have emphasised the wish to see the NHS and the local community work together to develop such services in what our MP has described as a ‘neighbourhood services model and team’. In the light of these responses, would the ICB please consider an amended wording for recommendation 3 to strengthen the commitment to this? In addition to the current wording, we would suggest adding something like:</i></p> <p><i>The ICB Board also asks SWFT to work with the local community and General Practices to develop a ‘neighbourhood services model’ with a specific focus on agreed priorities such as care for frail older people, dementia care, and end of life care.’</i></p> <p>Ms Oum thanked Mr Elliott for his detailed question which made an important point about the ongoing conversation, dialogue and communication with the community.</p> <p>Ms Nelson advised the ICB commissioned services based on the needs of the population. The feedback gained throughout the consultation period had been reviewed and relevant pieces of work had already commenced in response to the feedback. Engagement had taken place with the local community however further engagement was planned over the next six months. The ICB was committed to a collaborative governance structure.</p> <p>Ms Nelson summarised the purpose of the paper and the ask of the Board which was to review the recommendations, supporting evidence and consultation feedback in order to decide on the future permanent location of the 35 community rehabilitation beds. From a financial, workforce, access to beds and consultation outcomes point of view, option B was the preferred option.</p>	

In response to the concerns raised in the consultation about access to the consultation process, Ms Uwins pointed out there had been numerous online and offline events, with good engagement from those in attendance, as well as coverage in the local newspapers. Engagement work had also taken place with Healthwatch. Regarding accessibility, the older population had been very well represented at the various events and work had taken place using numerous different specialists, including a presentation at Warwickshire County Council's Health Overview and Scrutiny Committee, to ensure that as many appropriate people as possible were reached.

Ms Nelson confirmed that having checked a significant number of years' worth of records, 85% of the people that had used the previous beds in Shipston were not from the Shipston area but from areas such as Warwick, Leamington Spa and Stratford upon Avon. Ms Monkhouse advised that no concerns or issues had been raised regarding safety or quality in the recommendations proposed and that good processes and procedures appeared to be in place.

Ms Nelson reported that while modelling work was under way, both population and housing development growth had been considered and that a huge piece of transformation work had been carried out. Data for the future was still being reviewed and there was close engagement with Warwickshire County Council. Ms Nelson had been very assured by the work carried out.

Regarding clinical engagement, Dr Brady stated that originally, discussion had taken place with clinicians at SWFT (South Warwickshire University NHS Foundation Trust) however, good, independent advice had also since been obtained from the West Midlands Clinical Senate via consultation. This was undertaken to ensure best practice and the most clinically appropriate ways of working would result. Work with other groups covered quality and safety aspects. All confirmed the recommendations proposed gave the best direction of travel. Subsequent engagement with provider clinicians also agreed with the direction of travel. Dr Brady was supportive of option B.

Mr Hayer complimented the amount of engagement carried and in response to his question about whether there would be any material or negative impact on any demographic, Ms Danahay noted that age was a consideration and this had been reviewed, however transport was already in place. Ongoing monitoring and regular equality impact assessments had been factored into the work to be carried out.

Ms Davies questioned the amber coloured needs in option A regarding workforce to which Ms Nelson replied that due to the rural location there were some challenges.

Mr Rimell had been struck by the strength of response from the local community through the public engagement but was satisfied with the responses given and felt the substance was sound.

Ms Nelson reported that a programme of work had been developed to run more events, one being a stakeholder event and that further resources were available

for communities to access. There was a need to continue to educate the population therefore lots of work was ongoing. There was a large mix of people in the Warwickshire area and there was value in carrying out the public consultation with learning still being gained.

Mr Rimell noted that although options A and B were both viable, it appeared that option B would be the most suitable option particularly given the current, very challenging, economic environment.

Ms Hale stated the report was really clear and there had been full discussion at various relevant meetings. Recommendation three needed to be strengthened and option B remained the strongest. More work was needed to move forward with the wider development.

Mr Johns noted this was a piece of work around Warwickshire but wondered if the same should be done for Coventry City and Warwickshire north as there were no community led bases there.

Ms Nelson agreed to take away the above point to pick up with her counterpart and pointed out that a key piece of work had already started with the Care Collaborative Committees on population health needs. Ms Nelson also confirmed patient outcomes had continued to be monitored during the current temporary arrangements.

Ms Oum read out each of the recommendations in the report and the following responses were obtained.

The ICB Board members:

- **Recommendation 1: Consultation Process**

Confirmed that they were assured that the ICB had met its statutory duties in ensuring that an effective and robust public consultation process had been undertaken and that this consultation would inform the decisions made.

- **Recommendation 2: Geographical distribution of 35 community rehabilitation beds**

Considered the full findings of the consultation feedback, the information contained in the DMBC and selected Option B, which detailed the permanent location of the 35 community hospital rehabilitation beds, providing the necessary approval to proceed with implementation:

Option B:

- The beds remain in their current locations as follows:
 - The original 16 community rehabilitation beds, temporarily moved from the Ellen Badger Hospital in January 2022 due to construction works at the hospital site, are permanently

LN

	<p>relocated to Champion Ward, Leamington Spa Rehabilitation Hospital.</p> <ul style="list-style-type: none"> - 19 community rehabilitation beds remain at the Nicol Ward, Stratford-upon-Avon Hospital. <p>• Recommendation 3: Community Engagement</p> <p>Supported a whole system approach to engagement with the communities, prioritising rural communities initially, aligned with the Neighbourhood Health Guidelines 2025/26, using Shipston and surrounding areas as a blueprint for future ICS engagement.</p> <p>Ms Oum thanked everyone involved for the work undertaken, including members of the public, and committed to the ICB working to address the needs of rural communities.</p> <p>The meeting paused for five minutes and the four members of public present left.</p>	
3.	<p>Minutes of the meetings held on 15 January 2025</p> <p>The minutes of the last meeting were approved as a true and accurate record.</p>	
4.	<p>Matters Arising/Action Log</p> <p>There were no matters arising from the minutes and no outstanding actions for discussion.</p>	
5.	<p>Chair's Report</p> <p>Ms Oum took the paper as read and noted this was a challenging time. A staff away day had taken place on Monday 17 March and Ms Oum was very proud of the way the ICB and its staff had conducted itself and for the constructive questions asked.</p>	
6.	<p>Chief Executive Officer's Report</p> <p>Mr Johns presented his report which had been written in a very busy week after the announcements the previous week that NHSE would be abolished and that ICB running costs were to be reduced by 50%. Mr Johns noted the position was currently very fluid position and that the position about providers was presently unclear.</p> <p>The staff away day had gone as well as it could and Mr Johns thanked colleagues for their participation and cooperation.</p> <p>Mr Johns had attended a meeting of West Midlands ICBs and Ms Danter was carrying out a piece of work on what strategic commissioning might look like going forwards. The approach regarding staffing and recruitment was being reviewed and further communication would follow.</p>	

There was a need to manage the transformation and to continue to deliver the four aims of ICB, which would now be doubly challenging. Board members and staff would be kept as informed as possible.

Mr Johns stated there was still a desire to get the next plan signed off as soon as possible although it was currently unknown as to what could be planned as opposed to what the ICB would be told to plan. Whatever it was, Mr Johns said the ICB will need to make it work and the same would go for System partners. The ICB was in a good position to move forwards already having the Care Collaborative Committees in place, however there were significant levels of concern amongst staff.

Regarding type one attendance figures having gone up for Urgent and Emergency Care (UEC), Mr Johns confirmed there was nothing systemic taking place however there had been a flu peak. Ms Danter added differential growth had been spotted at SWFT however this was due to out of area work and differences in population growth.

Mr Rimell recognised the very challenging times and pointed out there was a need for colleagues to raise risks and concerns. Service outcomes were bound to be affected and there was a need to maintain the right culture as the situation developed.

Ms Bradbury highlighted that the Care Collaboratives were still in their infancy and a review of the maturity matrix was taking place this week. The Collaboratives were not in any solid position and there would be a need to put some support into these to move forwards.

Mr Johns indicated there was a need to see what was in the NHS 10 year plan.

On Dr Dhesi asking how the ICB was communicating with providers regarding announcements, Mr Johns advised that when more was known, and what the impact might be, the ICB would think about what needed to go out and in what format.

Ms Coombes pointed out that all partners were in the same position. The Coventry and Warwickshire Partnership NHS Trust (CWPT) had a number of patients worrying thinking the NHS was closing therefore they put something on their website. There was a need to think about consistent messaging and what the ICB would want in case there was an opportunity to influence relevant bodies.

Mr Fahy reminded all that the ICB was a partnership, and that how everyone supported each other was critical. The Coventry City Council would support however it could, with messaging for example, and recommended that to avoid people creating rumours, everyone should act like partners.

Ms Hale agreed and suggested opportunities in the situation should be sought to develop the desired collaboration.



	<p>Ms Oum thanked Mr Fahy and Ms Hale for their support and agreed that how everyone worked together to manage the best outcomes for the population and colleagues was paramount.</p> <p>Mr Hurst added that whatever plan came out was likely to fit well with where the ICB was. There was a need to manage the long term as well as now and strength in the partnership would be valuable so all must work together. Mr Hurst felt the ICB was in a good position to seize opportunities and that it should take some comfort from that.</p> <p>Ms Oum thanked all for their really useful contributions.</p> <p>Mr Bain highlighted that the outcomes on patients would be the concern of Healthwatch and agreed that messaging would be important. Mr Bain wondered how the changes would work with the other things going on in Government such as social services, etc.</p> <p>Mr Johns agreed this was a valid point and there was a need to think about how Coventry and Warwickshire would fit in with the local government. There was a need to have a clear view.</p> <p>Mr Fahy noted there would be a need to manage the difficult points and all organisations were not in lock step or within the same timetables.</p> <p>Dr Brady pointed out there could be strength in the Integrated Care Partnership (ICP) and this could be really important.</p> <p>Dr Oum requested members looked out for further communication.</p>	
7.	<p>Welcome and thanks</p> <p>Ms Oum introduced and welcomed Dr Staveley to members who had recently joined the ICB as the new Chief Medical Officer.</p> <p>Ms Oum also gave thanks to Dr Brady and Mr Rimell, both of whom would be leaving the ICB at the end of March.</p>	
8.	<p>Patient Story – Louis’s Story</p> <p>Ms Uwins summarised Louis’s story which was about the experience he had endured during his prostate cancer diagnosis and the difficult challenges he had faced along his journey.</p> <p>Dr Staveley explained that diagnosis was about shared decision making with patients. The prostate specific antigen (PSA) test was not a screening test and it was not without risk of harm. Safer testing methods and MRI (magnetic resonance imaging) scanning were now available and the ‘worry’ was being analysed. There was a need to ensure patients were as informed as possible and that an informed decision could be made.</p>	

	<p>Dr Brady highlighted there was strength in the ICB's inequalities work and recommended focus on this area of work continued.</p> <p>Dr Duggal reported changes were starting to be seen but there was still some work to be done. Dr Dhesi added there was a need to take patients on a journey. There were problems with some healthcare professionals and there was a need to ensure best practice was being followed.</p> <p>Ms Rollason asked how learning was shared across organisations to which Ms Danter replied this was through the System and Regional Cancer Board for cancer and through the Elective Care Board for other areas.</p> <p>Ms Coombes questioned how improvements could be made, how issues were linked and if people in clinical areas were aware.</p> <p>It was agreed that Ms Danter and Ms Coombes would take away the above concerns and report back in due course.</p> <p>Thanks were given to Louis for sharing his story.</p> <p>Board members:</p> <ul style="list-style-type: none"> • Noted for information, the contents of the report. 	RD/MC
9.	<p>Coventry and Warwickshire Integrated Health and Care Delivery Plan – 2025 Review and Refresh Approach</p> <p>Ms Danter took the 'light touch' paper as read and pointed out there was a requirement to issue the plan. The paper gave a review of the work completed to date and Ms Danter summarised the contents.</p> <p>Board members:</p> <ul style="list-style-type: none"> • APPROVED the Coventry and Warwickshire Integrated Health and Care Delivery Plan Review approach for 2025/26. 	
10.	<p>Prioritisation Framework</p> <p>Ms Danter explained that a number of pieces of work were being undertaken and that since November, these were being pulled together. The timeframe was challenging, however, it had been agreed through the SSPG (System, Strategy and Planning Group) to develop a commissioning tool and work on this continued. The tool identified seven areas and there were four areas to be scored against. The purpose of the tool was to decide on one of the outcomes.</p> <p>Ms Danter talked through the slides presented which showed the process to be followed. Mr Johns advised some decisions needed to be made now and Ms Oum added there was a desire to test the tool.</p>	

Ms Danter explained there were 12-15 items now that could be pushed through the model. The next step was to present the 12 items to the 1 April 2025 Executive Team meeting, take them through a committee and then to the Board.

Ms Rollason noted the categories had been developed through weightings and there was a need to test the tool in order to review the outcomes. The impact would need to be tested.

Mr Rimell felt the process was mechanistic and there was a need to be more fluid about some parts.

Ms Coombes stated it was not possible to see how the unintended consequences on different services would be checked. There had already been some decommissioning and engagement from the beginning was critical.

Ms Danter advised the unintended consequences would be part of the review and were included on the template. Services coming to a natural end had been chosen for testing.

Ms Rollason felt it was a good starting point and wondered how nuances would be picked up. There was a large concern about what constituted value.

Ms Danter was keen to ensure there were sufficient decision points.

Ms Duggal had spoken to Mr Johns about the tool and advised the Public Health were supportive of it. There was NICE (National Institute for Health and Care) guidance on pathways but there was some concern regarding pace. Some information was within NHSE and there was a need to be mindful of that given the recent announcements. Ms Duggal asked how reviews would be undertaken and should this take place every six months or so.

Ms Danter advised the latter was still being considered.

Mr Johns said the ICB would get some things wrong and people would lobby: the ICB would not be able to protect the things it wanted to if it did not make decisions.

ICB Board members:

- **NOTED** the contents of the report.

11.

Procurement Report

Ms Parmar summarised the three recommendations listed within the report.

ICB Board members:

- **Approved** the three procurement recommendations listed for:



	<ul style="list-style-type: none">- elective service contracts- primary care clinical foundation systems- GP out of hours	
12.	<p>Integrated Provider Performance Report</p> <p>Ms Danter pointed out this was a time of peak activity from an urgent care point of view and summarised the key points within the report. Work was under way with Trusts to reduce waiting times and some breaches had been due to clinical complexities. Work had commenced on starting to monitor community waits. Ms Oum noted a detailed discussion had taken place at the last Finance and Performance Committee meeting on performance.</p> <p>Ms Parmar summarised the financial report and stated teams were working hard with System partners. Support was being provided by the regional team and the ICB was on track to meet its statutory duties. There was now a capped position for elective and the ICB was on track to over perform in this area. This was a risk to manage with partners. Regarding efficiency, the ICB was on track to deliver £125m or slightly over.</p> <p>In relation to planning, the ICB had to submit a draft System plan as at the end of February and a final submission was due on 27 March. An extraordinary Finance and Performance Committee meeting had been arranged for 26 March to which Board members had been invited. A more detailed plan would be available at that meeting. A very difficult and challenging allocation had been given for this year with a challenging plan to deliver.</p> <p>Ms Davies reported that the substantive workforce had increased with reduced agency and bank work. Some ambitious targets had been set by NHSE. Sickness was a concern at 5.73% and this was off track and higher than the regional target. Ways of reducing sickness levels were being sought. The growth in clinical roles was being managed and work continued with the People Plan delivery. Delivery of some inclusive recruitment training had also taken place. Ms Davies summarised the remainder of the report and indicated that the staff survey results had now been published following their embargo. A deep dive into the results would be taken to the April People Committee meeting.</p> <p>Ms Monkhouse reported the ICB was currently in a good place from a quality point of view and gave a summary of the report.</p> <p>Dr Brady indicated a number of metrics had been added to the report and gave a brief summary.</p> <p>Ms Oum thanked colleagues for all of their work over the challenging period and she also thanked System partners.</p> <p>ICB Board members:</p>	



	<ul style="list-style-type: none"> • Noted the contents of the report for assurance and noted the actions to improve performance and quality as required. • Noted the financial position and actions being undertaken to mitigate the current forecast deficit and risks. • Noted the risks around workforce which were resulting in sickness and higher turnover. 	
13.	<p>Board Assurance Framework (BAF)</p> <p>Mr Gwynne presented the report and advised that each risk had a nominated lead. The current BAF had seven open risks with six rated as extreme and no scores had been changed over the past year. There was a requirement to present the BAF to the Board and the final report would be presented in May. The paper set out some considerations to be made and a number of emerging risks. The revised BAF would be developed over next few weeks.</p> <p>Ms Oum highlighted that the ICB was working in a high risk environment and that it was right to be looking at the BAF. The BAF had been discussed at a recent Executive Team and Non-Executive Member meeting.</p> <p>ICB Board members:</p> <ul style="list-style-type: none"> • NOTED the approach set out for improvement of Risk Management; • DISCUSSED the current BAF and initial considerations for inclusion in the revised BAF; and • APPROVE the timeline for refresh of the BAF. 	
14.	<p>Reports from Committees held since the last Board meeting</p> <p><u>8 January 2025 People Committee</u> – noted for information.</p> <p><u>8 January 2025 People Committee</u> – noted for information.</p> <p><u>14 January 2025 Audit Committee:</u></p> <p>Board members APPROVED the Emergency Preparedness, Resilience and Response (EPRR) annual report including NHSE confirmed assessment (core standards) and delegation of submission to the AEO (accountable emergency officer) and ENDORSED the report in line with the NHSE requirements to publicly state the organisation’s readiness and preparedness activities in the format of an annual report.</p> <p>Board members APPROVED the following policies for a period of 3 years following a review by the Policy Advisory Group: Incident Reporting Policy; Unreasonable and Persistent Behaviour Management Policy; Access to Health Records Policy; and Subject Access Requests Policy.</p> <p>Board members APPROVED the cancellation of disputed IPoC (individual packages of care) invoices (£255k).</p> <p><u>28 January 2025 Quality, Safety and Experience Committee</u> – noted for information.</p>	

5 February Finance and Performance (F&P) Committee – noted for information.

5 March 2025 F&P Committee:

Board members **APPROVED** the amendment to the BCF (Better Care Fund) for Coventry City Council and signed off the Section 75s for the BCF with both Local Authorities.

Procurement:

- Board members **APPROVED** the enactment of the one-year contract extensions for the period 1st April 2025 to 31st March 2026, to Circle Health Group and Nuffield Warwickshire for elective services.
- Board members **APPROVED** the Direct Contract Awards for Emis, Docman and DXS, known as general practice clinical foundation systems.
- Board members **APPROVED** a Direct Award (subject to Direct Award Process C documentation being approved by the Procurement Panel) a two-year contract from 1 July 2025 to 30 June 2027 at an annual value of £7.2m.

12 February 2025 Warwickshire Care Collaborative Committee – Board members noted the Committee had:

- endorsed the request for the proposed integrated approach to planning and reviewing schemes funded by the Better Care Fund.
- approved an extension of the current GP Out of Hours contract subject to further discussions with Rugby Place.
- noted that mobilisation of the Community Integrator Contract was being managed through the development of the three agreed areas.

20 February 2025 Coventry Care Collaborative Committee – Board members noted that the Committee had:

- approved the commissioning plans and timelines proposed for the IUC (integrated urgent care) programme and the Procurement Panel to direct award to extend current GP Out of Hours services delivered by Practice Plus Group (PPG) for a maximum of 2 years, with the appropriate Provider Selection Regime (PSR) process applied being given.

15.

Delegation of acute specialised services and mental health, learning disability and autism (MHLDA) services from NHS England

Ms Parmar summarised the report indicating that the governance of the additional services would be the same as others. Ms Parmar was in support of the delegation but drew attention to the details noted in the implications section of the report. Mr Hurst added that the ask had been to the Audit Committee which was in favour of approval.

Ms Parmar confirmed there would be some opportunities with the delegation and that Mr Johns attended the meetings hosted by BSOL (Birmingham and Solihull) ICB where matters were being discussed. Various pieces of work were ongoing and Committee approval was required. Conversations were taking

	<p>place amongst Chief Medical Officers and within mental health and there was a need to understand the impact.</p> <p>ICB Board members:</p> <ul style="list-style-type: none"> - APPROVED the delegation to the ICB of the additional acute and MHLDA specialised services to the ICB from April 2025. 	
16.	<p>Questions from members of the public</p> <p>No further questions had been received.</p>	
17.	<p>Feedback from Behaviours Guardian</p> <p>Ms Monkhouse provided positive feedback on the behaviour of members.</p>	
18.	<p>Any Other Business</p> <p>No other business was raised.</p>	

DRAFT

ACTION SCHEDULE - COVENTRY AND WARWICKSHIRE INTEGRATED CARE BOARD

Updated 12.5.2025

114	19/03/2025	4.1	South Warwickshire Community Hospital Rehabilitation Bed Consultation Decision Making Business Case	Ms Nelson to speak to her counterpart within Coventry regarding community led bases to see if similar work was required there.	Ms Nelson	May-25	Complete	Discussions have started in Warwickshire in relation to the current bed position across all discharge pathways. Alongside this, an ICB led proposed strategic priorities for community bed-based care has initiated which will be system wide. Discussions between Coventry and Warwickshire in relation to community based services continue through close collaboration between Chief Integration Officers alongside relevant forums with all partners involved.
115	19/03/2025	5	Citizen's Voice	Ms Danter and Ms Coombes to consider learning from Patient Voice story re prostate cancer.	Ms Danter/Ms Coombes	May-25	Complete	This has been picked up by the System Cancer team.

Chair's Report

1. Setting the conditions for delivering the 10 year plan

For my first Board report of the new financial year I wanted to start by looking at how far the Integrated Care System, under the guidance of the Integrated Care Board, has come since its inception in June 2023.

The role of our ICB has been to lead on how we reimagine the system, setting the conditions in which everyone can best work together to improve care, promoting collaborative working and removing silos and barriers between organisations. This strategic approach to commissioning and willingness to move decision making closer to the frontline and to the patients and residents it serves has put Coventry and Warwickshire in a good position for the future. The 10 Year Plan, now due for release in June, will outline the need for the NHS to deliver the “three shifts” – treatment to prevention, analogue to digital and hospital to community, and I am confident that the significant work and investment the ICB has undertaken in reconfiguring the system prepares us well for this task.

All of the activities of the ICB in transforming the system have been integral to this goal. At this month's Board, you will hear more about that development of the Collaborative structure and the benefits we are starting to see across all of the different Collaboratives we have in place. This is particularly demonstrated in our Citizen's Story this month, which features not one but two stories which show how devolving care closer to the communities who receive it and working together has led to targeted and successful interventions which have improved lives and access. We have further set the conditions for many more stories like this in the future through our Community Integrator contracts, an innovative new way of commissioning which supports our acute providers to set their own agendas locally, taking responsibility for planning and delivering community services in Coventry and Warwickshire. The value of these contracts is approximately £100m over 10 years and they are aimed at empowering local providers and communities to come together to deliver a set of shared outcomes, removing silo working, unnecessary duplication and driving integration across primary, community, acute, social care and voluntarily sector services. These contracts have been in place for just over a year and, although change and innovation takes time, these stories clearly show the value of what we can achieve as a system when we work together.

As the NHS is going through another significant phase of transformation, it will be vital that we build on what is working and go further and faster in delivering change. While we are still working through the details of our approach to the new changes, I am adamant that, as leaders in Coventry and Warwickshire, we continue to focus on the reason that we are here and to continue to deliver

our vision of helping people to start well, live well and age well, to promote independence and put people at the heart of everything we do.

2. Development of the Voluntary, Community, Faith and Social Enterprise Sector

Another key part of the transformation of the NHS over the past few years has been the recognition of the importance of the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector in improving health and wellbeing. The sector reaches people and communities which the statutory organisations can't and I have long been a champion of the importance of their role in tackling health inequalities, supporting prevention and reaching people and communities often missed by traditional services and pathways to health and social care services. As part of the wider development of the Collaboratives the ICB has supported the development of a sector led VCFSE Collaborative, providing the sector with a voice and influence in the development and delivery of services, as well as forming an integral part of our People and Communities Strategy.

Our VCFSE Collaborative is holding their first Assembly, their first official annual event to bring the sector together with organisations from across the Integrated Care System to discuss and share ideas on how we can engage and work together to help reduce health inequality. The Assembly this year is particularly keen to hear the voices of smaller community organisations and groups so they are empowered to help shape the future of the Collaborative and the ICS's relationship with the sector.

The Assembly takes place on May 22nd and you can register for tickets here - [ICS VCFSE Collaborative Assembly for Coventry and Warwickshire Tickets, Thu, May 22, 2025 at 9:30 AM | Eventbrite](#)

3. Temporary support for Finance and Performance Committee

Following the departure of Steve Rimell, and in light of the changes currently happening across the NHS, we have taken the decision to not replace his role for the time being.

In order to continue to support our committees, Paul Taylor, currently a Non-Executive Director at Birmingham and Solihull Integrated Care Board, will be supporting us as Interim Chair of the Finance and Performance Committee. He will not be taking on the wider non-executive director role, but as an experienced finance professional with many years of experience in the NHS, we are grateful for his insight and support for this vital committee.

Meetings / Points of Note:

Date	Details
20 March	Non-Executive Director Forum
24-Mar	Coventry Health and Well-being Board meeting
25-Mar	NHS Confed ICB Chairs Network
01-Apr	Meeting: Healthwatch Coventry and Danielle Oum
02-Apr	ICB Leads focus group HMICFRS
11-Apr	NHS Confed - ICB Chairs Network Meeting
16-Apr	Virtual Meeting: Mayor's Health Equity Advisory Council
24-Apr	NHS Confed - ICB Chairs Network Meeting
6 May	West Midlands Mental Health Commission - Community of Practice
14 May	Keynote announced: Integrated Care Delivery Forum - Spring 2025
15 May	Meeting with Herefordshire & Worcestershire ICB chair and CEO

Chief Executive Officer Report, 21 May 2025

1. NHS reform and next steps for Coventry and Warwickshire ICB

The past two months since our last Board meeting have seen the picture around the role of Integrated Care Boards (ICBs) across England continue to evolve. Since the government's announcement in March that all ICBs must reduce their running costs by 50%, driven in part by challenging public finances and the impact of any NHS deficit upon the same, we've gained more clarity on what this means for Coventry and Warwickshire.

NHS England has been working to define the reductions expected for each ICB, acknowledging that across ICBs, there is significant variety in size, scale and financial positions. As an ICB, our current spend per head on staffing is among the lowest in the country – 8th out of 42 – reflecting our previous efforts to find savings and run an efficient and lean organisation. This means that the impact of the 50% headline reduction is less severe: we need to find savings of 34%.

While lower than the savings expected of some ICBs, this still represents a huge reduction which will inevitably impact our staff, our work and our partners.


To find the mandated cost savings while maintaining service delivery for our communities, many smaller ICBs across England will 'cluster' together to deliver shared functions. Since March, my colleagues and I have been working closely with our peers at the other five West Midlands ICBs to shape and agree how this will work. Working with independent consultants Pricewaterhouse Cooper (PwC), we have looked at a range of options, including coming together as a single ICB for the West Midlands, clustering into a footprint to align with the West Midlands Combined Authority, and partnering with Herefordshire and Worcestershire as a neighbour ICB. A recommendation reflecting this work and recent discussions with our partners and Board members is contained later in these papers.

I recognise that this is an uncertain and worrying time for staff. My priority continues to be providing clarity for our staff as soon as possible and I remain committed to sharing news as early as I can.

I would again ask our system partners to be mindful of the impact on both our ICB as an organisation, and the personal impact on individual colleagues.

2. The future role of the ICB as a strategic commissioner

ICBs are now shifting to the role of 'strategic commissioners', shifting to a focus on population health using their roles as healthcare purchasers and contract-holders to drive better outcomes. While this shift is not new to Coventry and Warwickshire, it has been accelerated following the government's announcements on NHS reform.



Through its model ICB – the ‘blueprint’ for which was published at the beginning of May – NHS England is now setting out the future roles and responsibilities of ICBs and what their role as strategic commissioners will look like. This is aimed at providing more consistency and to better enable the ICB’s strategic objectives of shifting care out of hospital and into the community and working in a more integrated way.

The Secretary of State has tasked ICBs to be ‘pioneers of reform’ through strategic commissioning. This means that an ICB is not just there to purchase care from providers, but use its commissioning and purchasing function to drive reform, act as guardian of public money, and champion patient and population interest. As a strategic commissioner, ICBs will focus on understanding the health of their populations and then paying for the best healthcare options or services and resources to deliver the population health outcomes it wants to achieve.

Organisational roles are changing across the NHS landscape. National policy and strategy will be set by a consolidated Department of Health and Social Care (DHSC) and NHS England, while regional teams will be more explicitly responsible for provider (and ICB) performance. This means operational, day to day performance management and assurance will move away from ICBs. Other specific functions, including strategic workforce planning, will shift away from ICBs to regional teams, while some responsibilities will shift down to providers – including digital, pathway and service development, and sustainability.


While there are significant challenges posed by the ongoing work to restructure ICBs and the wider NHS, it also brings opportunities. Driving better outcomes and delivering better services for populations, and tackling health inequalities at a system level, is what ICBs were set up to do. This new approach enables us to strip back functions that are better done elsewhere to focus on delivering transformational benefits for our populations. By focusing our efforts and building on our progress to shift local decision making closer to local people and building a population health management approach at the ICB level, we can really add value for our communities. As an ICB and wider NHS region, we are working through what these changes mean for us and our partners. As always, our priority is to ensure that we are continuing to provide high quality and effective services for our communities.

3. Continuing to deliver for Coventry and Warwickshire

Despite the challenges of the ongoing NHS reform, our focus remains on how we can best deliver for people and communities in Coventry and Warwickshire. Our staff, alongside colleagues in our partner organisations, are working hard to maintain good services and improve outcomes and experiences for patients and service users within a very pressured financial and operating context.

As an ICB and system, we are focussing on the core elements of our strategy for 2025-26:

1. tackling elective waiting lists and reducing pressure on acute providers;

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2. shifting decisions closer to communities through our Care Collaboratives and Community Integrator model, including continuing to develop integrated neighbourhood teams to support and treat people in the community;
 3. improving outcomes for children and young people, including reducing waiting lists for paediatric care and ADHD (attention deficit hyperactivity disorder);
 4. focusing on prevention rather than treatment, taking a population health management approach to focus on high impact areas like cardiovascular and respiratory illness; and
 5. improving mental health support, including developing a neighbourhood model for mental health care and improving access for children and young people and support in schools.

2025-26 will be a year of transition for us as we shift to a more strategic role, but it will take us closer to where we know we need to be.

4. Urgent and Emergency Care (UEC)

In March we continued to see positive performance in terms of average Category 2 ambulance response times, which at 22 minutes and 5 seconds was below the 30-minute expectation for the third successive month. We also saw a small improvement in ambulance handovers, with 73.1% completed within 30 minutes compared to 72.7% in February.

A&E performance saw some improvement in March, reaching 70.2%, however this remains below the regional and national averages.


Further detail is included in the Integrated Provider Performance report and for discussion in the main agenda.

5. The launch of the Arden Health Partnership

I'm delighted that the Arden Health Partnership officially launched on Wednesday 14 May. The partnership will build on the collaboration already happening across the area and support a collective approach to improving health outcomes for communities in Coventry, Warwickshire and the wider region. The partnership will focus on tackling entrenched health inequalities and developing preventative and integrated care models, using shared data, training and digital innovation to address rising demand for services including mental health.

The Partnership brings the ICB together with:

- The University of Warwick and Coventry University
- University Hospitals Coventry and Warwickshire NHS Trust
- South Warwickshire University NHS Foundation Trust and George Eliot Hospital NHS Trust – The Foundation Group

- 
- Coventry and Warwickshire Partnership NHS Trust
 - Health Innovation West Midlands

By sharing expertise, intelligence and skills across academic and NHS partners – as well as drawing on the expertise of wider partners like local government, industry and the third sector – we can build on our existing partnership working and work on prevention and health inequalities to deliver real positive change for our communities.

End of report

Report To and Date:	NHS Coventry and Warwickshire Integrated Care Board – 21 May 2025
Report Title:	Citizen’s Story – The Importance of enabling Integration
Report From:	Phil Johns, Chief Executive Officer, CWICB
Author:	Rose Uwins, Head of Communications and Public Affairs, CWICB
Previous Considerations and Engagement:	N/A
Purpose:	For Discussion

Achievement of the following ICP Priorities and Focus Areas is supported:

Priorities	<input checked="" type="checkbox"/> 1 - Prioritising prevention and improving future health outcomes through tackling health outcomes	<input checked="" type="checkbox"/> 2 - Improving Access to health and care services and increasing trust and confidence	<input type="checkbox"/> 3 -Tackling immediate system pressures and improving resilience
	<input checked="" type="checkbox"/> 1 - Reducing health inequalities	<input type="checkbox"/> 4- Enabling personalised care	<input type="checkbox"/> 8 - Supporting people at home
Focus Areas	<input checked="" type="checkbox"/> 2- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities	<input checked="" type="checkbox"/> 5 - Improving access to services especially primary care	<input type="checkbox"/> 9 - Developing and investing in our workforce, culture and clinical and professional leadership
	<input type="checkbox"/> 3- Enabling the best start in life for children and young people	<input type="checkbox"/> 6- Engaging and involving our people, communities and stakeholders	
		<input checked="" type="checkbox"/> 7 - Making services more effective through greater collaboration and integration	

Executive Summary and Key Points:

- Since its inception in June 2022, Coventry and Warwickshire ICB has been setting the conditions through which our System can move care and decision making closer to people.
- By working differently – together – we’re preparing our System for the future: moving care closer to communities, focusing on prevention, and making better use of technology.

- Through our Collaborative structures, Places and Community Integrator contracts, we have removed the barriers and silos which so often get in the way of collaborative working and created the conditions in both Coventry and Warwickshire for success.
- Our two stories for this month demonstrate the power of working together across organisational boundaries.

Improving Lives Patient Story - Christine and Zena

- The Improving Lives programme is part of the Coventry Place work that brings together partners across the city including NHS Trusts, Coventry City Council, Coventry and Warwickshire Integrated Care Service (ICS) and Coventry and Warwickshire NHS Partnership Trust (CWPT) to transform Coventry's services for older people so they can lead independent lives in good health. The partner organisations focus on improving outcomes for people who may need extra help from the hospital, community services or adult social care. To find out more, see [Improving Lives Programme - University Hospitals Coventry & Warwickshire](#)
- Zena had a fall in her house and ended up in hospital for two months. Christine, Zena's daughter, shares that Zena received physio while she was in hospital to help with her recovery and when it was time for Zena to go home, the health care team spoke to them both through the service that was available to support Zena. Once she left hospital, Zena had an assessment and was told that she would be able to receive physio for as long as needed as long-term care.
- Speaking about the support Zena received, Christine said that they both felt thoroughly supported by the health and care team, and they built a positive relationship with them. Christine said that the staff worked with Zena to tailor the physio exercises to suit Zena and she was very pleased when Zena was able to make her a cup of coffee on her own for the first time in years, and return back to her beloved Bingo following the support given.

Community Recovery Service Patient Story – Barrie

- The Community Recovery Service (CRS) is a short-term service that provides additional support to patients to return home confidently following hospital admission. CRS works with patients to support their recovery through home care and therapy services. Funded by the NHS and Warwickshire County Council, the care and therapy offered to patients is tailored to their individual needs and is offered for up to six weeks. To find out more, see [Community Recovery Service \(CRS\) :: South Warwickshire University NHS Foundation Trust](#)
- The Community Recovery Service (CRS) helps patients recover at home after being in hospital for a long time. The service offers support for patients for up to six weeks, four times a day and can help patients with getting washed and dressed and conducting

day to day care activities as well as physio and palliative care to ensure patients are safe and can remain at home.

- Barrie was unwell for a long period of time and after returning home, he had a fall and ended up back in hospital. Once he was ready to go home, he was then supported by the Community Recovery Service.
- Adam, from the CRS team, is shown in the case study taking Barrie through his daily exercises to aid his recovery at home. This includes performing leg movements and supporting Barrie while he uses a walker.
- Speaking about the support he is given; Barrie says how he gets around well, and he uses the walls and doors as support when he needs to. Talking about his goals for progress, Barrie shares that before being ill, he used to go on a weekly 5 to 8 mile walk with a group of friends and his long-term aim is to get back to doing it. He said that he is very happy to be doing the exercises to help improve his knee after his fall.

Recommendation:

Members are requested to:

- **NOTE FOR INFORMATION** the contents of the report.

Implications

Conflicts of Interest:	None.
Financial and Workforce:	The two patient stories demonstrate the power of integration and working together in supporting people to recover more quickly, improving outcomes and ultimately reducing the cost pressures on the NHS
Performance:	Through working together we can reduce duplication, improving productivity and performance
Quality and Safety:	None

Inclusion

<p>Has an equality impact assessment been undertaken? (delete as appropriate) An EQIA is required for new services or changes to service delivery. For more information the EQIA Policy and Tool can be found here.</p>	<p>Yes (attached or hyperlinked)</p>		<p>No (state why in the row below)</p>		<p>Not applicable (state why in the row below)</p>	(✓)
This is not a new service or change to service delivery.						
<p>Has a Health Equity Assessment Tool (HEAT) been completed? HEAT may be used for new, changing or existing services and processes.</p>	<p>Yes (attached or hyperlinked)</p>		<p>No (state why in the row below)</p>		<p>Not applicable</p>	(✓)

More information can be found here .								(state why in the row below)
This is not a new service or change to service delivery.								
Engagement								
Patient and Public Engagement:		N/A						
Clinical and Professional Engagement:		The structure of our System brings together our workforce, both clinical and managerial to work together for the benefit of our patients						
Risk								
Risk:		N/A						

Report To and Date:	CWICB - 21 May 2025
Report Title:	Summary of Escalations/Highlights to the Board from Committee Reports

Report from the 11 March 2025 Audit Committee meeting	
Chair – Chris Hurst	
Item or issue	Purpose for escalation/highlight
n/a	
Items referred to the Board for Approval	
Review of the ICBs Standing Financial Instructions (SFIs) and Delegated Financial Limits – the Board is recommended to APPROVE the amendment to the Delegated Limits as above (delegated decisions to Care Collaboratives for new funding) to ensure continued effective operational financial controls are in place.	
Delegation of acute specialised services and mental health, learning disability, and autism (MHLDA) services from NHS England – the Board is recommended to APPROVE the delegation of the additional acute and MHLDA specialised services from April 2025 to the ICB.	
Update of the Sanctions and Redress Policy – the Board is recommended to APPROVE the adoption of the updated Sanctions and Redress Policy included in appendix 1 of the report sent to the Audit Committee meeting (minor changes such as job titles and the addition of an Equality Impact Assessment).	

Report from the 23 April 2025 Audit Committee meeting	
Chair – Chris Hurst	
Item or issue	Purpose for escalation/highlight
AI Usage Policy	Suggestion for the Board to allocate time to consider the role of the AI policy document and look at examples of how AI was already being used and proposed to be used by the ICB.
Annual Accounts Report – Month 12	APPROVAL GIVEN in respect of the ICB Annual Accounts for submission to NHSE.
Impact of Changes of the wider NHS	Board recommended to consider the risks identified by the Audit Committee and to agree how they will be monitored by the Board and its sub-committees during the transition period.
Items referred to the Board for Approval	
n/a	

Report from 21 March 2025 Extraordinary Coventry Care Collaborative Committee meeting

Chair – Kevin Davis

Item or issue	Purpose for escalation/highlight
n/a	
Items referred to the Board for Approval	
n/a	

Report from the 17 April 2025 Coventry Care Collaborative Committee meeting

Chair – Kevin Davis

Item or issue	Purpose for escalation/highlight
n/a	
Items referred to the Board for Approval	
n/a	

Report from the 24 March 2025 Extraordinary Warwickshire Care Collaborative Committee meeting

Chair – Pamela Bradbury

Item or issue	Purpose for escalation/highlight
Nil	
Items referred to the Board for Approval	
Nil	

Report from the 14 May 2025 Warwickshire Care Collaborative Committee meeting

Chair – Pamela Bradbury (verbal)

Item or issue	Purpose for escalation/highlight
tbc	
Items referred to the Board for Approval	
tbc	

Report from the 8 April 2025 Quality, Safety and Experience Committee meeting

Chair – Pamela Bradbury

Item or issue	Purpose for escalation/highlight
n/a	
Items referred to the Board for Approval	
n/a	

Report from the 2 April 2025 Finance and Performance Committee meeting

Deputy Chair – Dr Sukhi Dhesi

Item or issue	Purpose for escalation/highlight
n/a	
Items referred to the Board for Approval	
n/a	

Report from the 7 May 2025 Finance and Performance Committee meeting

Presented by Danielle Oum

Item or issue	Purpose for escalation/highlight
2025/26 Financial Planning Submission Update	The committee noted the unprecedented levels of efficiency required to achieve the System break even plan of 2025-26 and committed to seek assurance of progress through monitoring monthly System expenditure.
Items referred to the Board for Approval	
n/a	

Report from the 7 April 2025 People (System) Committee meeting

Chair – Harry Hayer

Item or issue	Purpose for escalation/highlight
n/a	
Items referred to the Board for Approval	
n/a	

Report from the 7 April 2025 ICB People Committee meeting	
Chair – Harry Hayer	
Item or issue	Purpose for escalation/highlight
n/a	
Items referred to the Board for Approval	
n/a	

Audit Committee Report for the meeting held on 11 March 2025		
Key Information		
Committee Chair: Chris Hurst	Committee Executive Lead: Madi Parmar	Date of Next Meeting: 23 April 2025
Quoracy met?	Yes	
Purpose of the report	For ASSURANCE in respect of the key decisions/issues raised at the 11 March 2025 Audit Committee meeting For APPROVAL of the recommendations set out within this report.	
Recommendation	Members are requested to be ASSURED in respect of the matters set out within this report. Members are requested to APPROVE the recommendations set out within this report.	

Key highlights of discussions and decisions held during the meeting:		
Agenda item description & key discussion points	Assurance achieved and sources/gaps in assurance and action agreed	Highlight to reports front sheet? Please state Yes or No (all boxes to be completed by Lead Exec then reviewed by Chair before report is returned to Committee Administrator)
<p>Chair's Update</p> <p>The ICB Board's Development Session on 19 February on Risk in Governance had been very useful and productive.</p> <p>It was noted there was a system wide Non-Executive Directors' Forum on 20 March 2025. The session would focus on finance and discuss roles of partner Audit Committees and governance overall.</p>	NOTED	No
<p>ICS Shared Electronic Patient Record (EPR) Governance Update</p> <p>An update on the progress made in implementing a governance framework designed to manage ICS-wide risks associated with the Electronic Patient Record (EPR) system was provided.</p> <p>The Terms of Reference for the Single Instance EPR Strategic Oversight Group were shared.</p>	ASSURANCE ACHIEVED regarding the progress of the ICS-wide EPR governance approach for managing system-wide EPR risks.	No



<p>Currently, each Trust has an EPR Project Board and Programme Board which was governed by its Trust Board in association with its own governance and the Oversight Group was providing a central functionality for sharing learning, risks, etc.</p> <p>The Coventry and Warwickshire Partnership NHS Trust (CWPT) was currently out to procurement for a separate mental health specific EPR and therefore not part of the single instance that was being used across the ICS.</p> <p>Finances and benefits realisation were discussed along with the need for regular assurance to relevant Committees.</p>		
<p>Internal Audit Progress Reports</p> <p>Internal Audit had finalised four reviews and completed fieldwork on Sickness Absence Management and Post Payment Verification (PPV).</p> <p>An extra review of the Board Assurance Framework (BAF) would be undertaken due to limited assurance. It had been agreed to put this in place of the financial monitoring audit. The oversight framework had been updated as the ICB was now in level two.</p>	<p>ASSURANCE ACHIEVED in respect of progress against the internal audit plan delivery and in actioning internal audit recommendations.</p>	<p>No</p>
<p>Internal Audit Plan 25/26</p> <p>Following discussion with Directors and Non-Executive Members regarding the 25/26 Plan, Care Collaboratives were identified as a possible system focus audit.</p> <p>Children’s Complex Care Packages and Health Inequalities were included as new areas for assurance.</p> <p>Priorities were discussed and it was noted that workforce was included in all plans for Providers and the ICB. Due to having a smaller workforce, it was agreed no audit was required for 25/26 and this would resume in 26/27.</p> <p>Members were asked to approve the Service Charter presented.</p>	<p>APPROVED whilst noting any amendments that are required.</p>	<p>No</p>
<p>Financial Ledger Final Report</p> <p>Two low risk recommendations had been made and actioned.</p>	<p>ASSURANCE ACHIEVED in respect of the financial ledger controls in place.</p>	<p>No</p>
<p>Payroll (Client End Controls) Final Report</p> <p>Two low level recommendations had been raised and implemented.</p>	<p>ASSURANCE ACHIEVED in respect of the Payroll Client End Controls in place.</p>	<p>No</p>

<p>Fit and Proper Persons Test (FPPT) Final Report</p> <p>Two low level recommendations had been raised and implemented.</p>	<p>ASSURANCE ACHIEVED in respect of the FPPT processes in place.</p>	<p>No</p>
<p>Policy for ICB Co-pilot role out</p> <p>The Committee was asked to assess, review and comment on the proposals made as guard rails would need to be put in place to pull together some thinking around governance, compliance and risk management. This was to avoid people leaking data potentially or innovatively having access to sensitive data and information.</p> <p>It was recognised that changes would need to be made to the associated Information Governance Policy and Records Management Policy in due course.</p> <p>Guidance was currently being produced by the Department of Health and NHS England but local AI (artificial intelligence) policy guidelines would also be required.</p> <p>The policy had been approved by the Policy Advisory Group (PAG) and was subject to any views expressed and ready for consideration and approval by the Audit Committee at a later date.</p>	<p>ACTION AGREED for Committee members to review and comment on the paper by 28 March 2025 and feedback comments or concerns to Mr Olla. ACTION AGREED that the policy would come back to the next Audit Committee for approval.</p>	<p>No</p>
<p>Interim Board Assurance Framework (BAF) Final Report</p> <p>The report had been delayed due to ICB staffing issues and it was noted the report provided limited assurance overall.</p> <p>Two medium level recommendations and one low risk recommendation had been raised and these were being addressed by the Director of Corporate Governance.</p> <p>A revised BAF was scheduled to be taken to the ICB Board in March 2025 combined with a revised Risk Policy to gain additional assurance.</p> <p>External Audit advised they would reflect on the Internal Audit report and it was likely further conversations would be required to understand some of the evidence throughout the year as they would have to form their own assessment on the impact on value for money for this year.</p> <p>External Audit acknowledged there were promising conversations regarding what was being done to action some of the findings going forwards.</p> <p>The frequency of reporting, importance of regular monitoring, handling of different forms of risks and assurance required was discussed.</p>	<p>ASSURANCE ACHIEVED in respect of the actions identified to address concerns with the BAF.</p>	<p>No</p>

<p>External Audit - Audit Planning Report Year ending 31 March 2025</p> <p>Planning materiality had been based at 2% of the forecasted total expenditure and the performance materiality at 75% of the planning materiality.</p> <p>Materiality would be revisited when the draft set of financial statements were received at year end.</p> <p>Three risks and areas of audit focus were identified as:</p> <ul style="list-style-type: none"> • Misstatement due to fraud and error. • Risk of fraud in expenditure recognition and focusing on understatement of expenditure. • Remuneration report disclosures specialised commissioning services this year. <p>A new area of delegated specialised commissioning services had arisen this year and there were no new revenue streams or significant accruals or other estimates associated with this new area of expenditure.</p> <p>Value for Money detailed planning was ongoing and no significant weaknesses in arrangements had been identified to date, however the outcome of the BAF could affect this.</p> <p>Assurance discussions were ongoing regarding BSoL (Birmingham and Solihull ICB) hosting the specialised services.</p>	<p>NOTED</p>	<p>No</p>
<p>Risk Management Report</p> <p>No new risks had been added but the risk around People Planning Implementation had been split to make it specific in terms of what was being considered.</p> <p>Two risk ratings had gone down and there had been no increase in risk ratings.</p> <p>A discussion about the role of the Audit Committee in relation to the risk register took place and it was agreed the Committee had two responsibilities:</p> <ul style="list-style-type: none"> • To form a view through continuous assessment about whether the committee scrutiny arrangements were effective. • To be in the best position to see if there were any gaps or overlaps across the committee assurances. <p>It was agreed in future the Corporate Governance Team would make things more explicit about which committees were looking at which risks.</p>	<p>ASSURANCE ACHIEVED in respect of the report and revised approach to embedding risk management.</p>	<p>No</p>



<p>Q3 Quarterly Governance Report</p> <p>It was confirmed that future reports would be more focussed providing headlines and assurance of some of the highlights that needed flagging and how to find out more about any of the areas the Committee was addressing.</p>	<p>ASSURANCE ACHIEVED in the arrangements for managing matters relating to governance.</p>	<p>No</p>												
<p>Financial Account Report - Month 10</p> <p>Committee members were requested to approve the cancellation of £322k Individual Packages of Care (IPoC) invoices from the system.</p> <p>The invoices related to duplicate charges where the ICB had already paid the invoice via a payment schedule, but the provider had also submitted an invoice, or where the rate had not been agreed by the ICB.</p>	<p>NOTED the report for assurance.</p> <p>APPROVED cancellation of IPoC invoices to the value of £322k.</p>	<p>No</p>												
<p>Review of the ICBs Standing Financial Instructions (SFIs) and Delegated Financial Limits</p> <p>The review of the SFIs showed there were no amendments required.</p> <p>There was one recommendation within the Delegated Financial Limits which set out delegated decisions to Care Collaboratives for new funding. This was not included in the scheme of delegation and was for existing services within the existing budget set out.</p> <table border="1" data-bbox="130 1312 979 1536"> <thead> <tr> <th>REF</th> <th></th> <th>DELEGATED TO</th> <th>FINANCIAL LIMIT (excluding VAT)</th> </tr> </thead> <tbody> <tr> <td>13</td> <td colspan="3">BUSINESS CASE (CASE FOR CHANGE)</td> </tr> <tr> <td>a</td> <td>Delegated authority to approve business cases for re-procurement of existing services within existing budget envelope. (Approval limits are annual values)</td> <td>Accountable Officer/Chief Executive and Chief Finance Officer (acting jointly) or the relevant Care Collaborative Committee for in-scope services</td> <td>Unlimited - CFO to report list of such cases approved to Finance & Performance Committee or the relevant Care Collaborative Committee</td> </tr> </tbody> </table>	REF		DELEGATED TO	FINANCIAL LIMIT (excluding VAT)	13	BUSINESS CASE (CASE FOR CHANGE)			a	Delegated authority to approve business cases for re-procurement of existing services within existing budget envelope. (Approval limits are annual values)	Accountable Officer/Chief Executive and Chief Finance Officer (acting jointly) or the relevant Care Collaborative Committee for in-scope services	Unlimited - CFO to report list of such cases approved to Finance & Performance Committee or the relevant Care Collaborative Committee	<p>NOTED no changes were recommended to the Standing Financial Instructions and APPROVED the recommendation to the ICB Board to amend the Delegated Financial Limits to ensure continued effective operational financial controls were in place.</p>	<p>Yes</p>
REF		DELEGATED TO	FINANCIAL LIMIT (excluding VAT)											
13	BUSINESS CASE (CASE FOR CHANGE)													
a	Delegated authority to approve business cases for re-procurement of existing services within existing budget envelope. (Approval limits are annual values)	Accountable Officer/Chief Executive and Chief Finance Officer (acting jointly) or the relevant Care Collaborative Committee for in-scope services	Unlimited - CFO to report list of such cases approved to Finance & Performance Committee or the relevant Care Collaborative Committee											
<p>Delegation of acute specialised services and mental health, learning disability, and autism (MHLDA) services from NHS England</p> <p>Committee members were asked to sign off the scope of services and increased value in terms of existing services.</p> <p>All decisions went through the West Midlands Joint Chief Executives Committee and subsequent meetings that sat beneath this, all of which were attended by Coventry and Warwickshire ICB representatives.</p> <p>Work was ongoing in terms of due diligence around budgets and clinical risk.</p>	<p>ASSURANCE ACHIEVED that the ICB's current governance arrangements allowed for the delegation of the additional acute and MHLDA specialised services.</p> <p>APPROVED THE RECOMMENDATION TO THE BOARD that it approved the delegation to the ICB</p>	<p>Yes</p>												

	of the additional acute and MHLDA specialised services from April 2025.	
<p>Update of the Sanctions and Redress Policy</p> <p>The Sanctions and Redress Policy had not been reviewed since December 2021 and had now been updated to reflect some minor changes, such as the removal of individuals' names and instead using job titles, and the addition of an Equality Impact Assessment.</p>	RECOMMENDED to the ICB Board adoption of the updated Sanctions and Redress Policy included in Appendix 1 of the report sent to the meeting.	Yes
<p>Counter Fraud Progress Report</p> <p>Counter Fraud were comfortable in relation to the assessment that they were working diligently through to make sure the score overall was green.</p> <p>Counter Fraud were also comfortable with the amber score on risk assessment and overall moving forward on strengthening green scoring that had been achieved the previous year.</p>	ASSURANCE ACHIEVED in respect of progress against the counter fraud plan delivery.	No
<p>2025/26 Counter Fraud, Bribery and Corruption Work Plan</p> <p>Counter Fraud were working in conjunction with internal audit colleagues to ensure work was not duplicated.</p> <p>High risk National Fraud initiative data matches were looked at every year and mandate fraud was in the plan for next year.</p>	APPROVAL GIVEN in respect of the Internal Audit Plan for 25/26 whilst noting any amendments that may be required.	No

Items for escalation:		
Item or issue	Purpose for escalation	Escalated to
n/a		

<p>Items referred to the Board for Approval</p> <p>Board members are RECOMMENDED to APPROVE the changes to Delegated Financial Limits to the ICB Board to ensure continued effective operational financial controls are in place.</p> <p>Board members are RECOMMENDED to APPROVE the delegation to the ICB of the additional acute and MHLDA specialised services from April 2025.</p> <p>Board members are RECOMMENDED to adopt the updated Sanctions and Redress Policy included in Appendix 1 of the report sent to the Audit Committee meeting.</p>

Audit Committee Report for the meeting held on 23 April 2025		
Key Information		
Committee Chair: Chris Hurst	Committee Executive Lead: Madi Parmar	Date of Next Meeting: 16 June 2025
Quoracy met?	Yes	
Purpose of the report	For ASSURANCE in respect of the key decisions/issues raised at the 23 April 2025 Audit Committee meeting For APPROVAL of the recommendations set out within this report.	
Recommendation	Members are requested to be ASSURED in respect of the matters set out within this report. Members are requested to APPROVE the recommendations set out within this report.	

Key highlights of discussions and decisions held during the meeting:		
Agenda item description & key discussion points	Assurance achieved and sources/gaps in assurance and action agreed	Highlight to reports front sheet? Please state Yes or No (all boxes to be completed by Lead Exec then reviewed by Chair before report is returned to Committee Administrator)
Chair's Update An update was presented on strengthening assurances received through the Finance and Performance Committee, including how partner assurances feed into the Committee's oversight. The need for executive and non-executive teams to remain focused on their business amidst the NHS reorganisation was emphasised.	NOTED	No
Artificial Intelligence (AI) Usage Policy An Artificial Intelligence (AI) strategy policy was presented for approval. It was suggested the policy should clearly state key messages for staff, such as the appropriate use of AI tools and ensuring data safety.	APPROVED the policy, noting the emerging nature of AI which would mean frequent review of this policy to ensure it remained current. NOTED the Records Management Policy	No

<p>Adding a policy statement on how the ICB would handle documents that had clearly been produced using AI tools and whether as an organisation this was acceptable or not was also suggested.</p> <p>It was confirmed a mandatory training programme would be delivered by a national training programme for AI, which would be utilised to ensure staff were adequately trained in using AI tools.</p> <p>Following the discussion, the Chair suggested it may be helpful for the Board to allocate time at a future session to consider the future role, value and scope of AI, looking at practical examples of how AI was already being used by the ICB. The Chair agreed to discuss this proposal with the ICB Chair and Chief Executive.</p>	<p>and the Information Risk Policy would also require review with the introduction of AI.</p>	<p>Yes</p>
<p>Collaborative Development Programme report</p> <p>A Care Collaborative Maturity Matrix had been implemented to monitor progress across five core domains. Assessment results indicated early-stage maturity, with most responses across both geographies rated as "Emerging" or "Developing". Key development areas included financial arrangements, workforce, and service delivery, with no domains assessed as "Thriving".</p> <p>NHS Elect had delivered targeted development sessions in March 2025, validating self-assessment findings and supported skill development in collaborative working and conflict resolution. Further sessions were scheduled throughout the year, alongside a Capsticks-led workshop on the Provider Selection Regime.</p> <p>Progress continued across other Collaboratives, including Acute, Mental Health, Learning Disabilities and Autism (LDA) and Primary Care, with specific advancements noted in oncology, pathology, elective productivity, and primary care strategy development.</p>	<p>NOTED</p>	<p>No</p>
<p>Internal Audit Progress Report</p> <p>Internal Audit had received new audit requests for business continuity and continuing healthcare complaint payments.</p> <p>Most reviews were now complete with the exception of Safeguarding which would be completed soon.</p> <p>A draft report had been issued on Post Payment Verification (PPV).</p> <p>Members noted it had been a successful year and congratulated internal audit and members of the ICB on completing the reviews.</p>	<p>ASSURANCE ACHIEVED in respect of respect of progress against the internal audit plan delivery. Further, members were assured that good progress had been made in actioning internal audit recommendations.</p>	<p>No</p>

<p>Draft Interim Head of Internal Audit Opinion March 2025</p> <p>Internal Audit advised significant assurance would be provided overall.</p>	<p>ASSURANCE RECEIVED in respect of progress against the Head of Internal Audit Opinion.</p>	<p>No</p>
<p>Sickness Absence Management Final Report</p> <p>The Human Resources team had highlighted the importance of meaningful discussions taking place during return-to-work interviews.</p> <p>The review highlighted there were cases where staff were not moved to formal sickness monitoring but did not state why. It was agreed that managers would be reminded to add to the document the reason why they were not moving staff on to that trigger.</p> <p>Internal Audit noted support services were offered to employees with stress, anxiety or depression.</p>	<p>ASSURANCE ACHIEVED in respect of the Sickness Absence Management Controls in place.</p>	<p>No</p>
<p>Delegated Primary Care Functions Follow Up Final Report</p> <p>Internal Audit advised four actions had been recommended to address the gaps in control and compliance and it was noted that the ICB had taken action to address all required actions.</p>	<p>ASSURANCE ACHIEVED that recommendations contained in the Delegated Primary Care Functions internal audit report had now been actioned.</p>	<p>No</p>
<p>Board Assurance Framework (BAF) Year End Final Report</p> <p>Internal Audit had noted the progress made since February and the need for further embedding of actions and assurances.</p> <p>The Risk Policy had been updated and excellent work completed by the Governance Team to act on the interim report.</p> <p>External Audit would discuss the report and advise if it needed reporting as a significant weakness in arrangements.</p>	<p>ASSURANCE ACHIEVED in respect of the progress made with the BAF following the interim report.</p>	<p>No</p>
<p>Crime and Security Management Annual Work Plan 2025/26</p> <p>Internal Audit presented the report which outlined the following proposed areas of priority activity:</p> <ul style="list-style-type: none"> • Core Activities • Violence, Prevention and Reduction (VPR) Standard • NHS Best Practice 	<p>APPROVAL GIVEN in respect of the Crime and Security Management Annual Work Plan 2025/26.</p>	<p>No</p>

<p>Risk Management Report</p> <p>The report provided an overview of the current position and next steps to continue to embed risk management in the organisation and refresh the BAF.</p>	<p>ASSURANCE ACHIEVED in respect of the Risk Management Report and revised approach to embedding risk management.</p>	<p>No</p>
<p>Draft Annual Report and Accounts</p> <p>The draft Annual Report and Accounts would be submitted to NHS England (NHSE) on 25 April 2025 for feedback and to assure them of the progress that had been made ahead of the final submission on 23 June 2025.</p> <p>The introduction section would include the context of change in landscape.</p>	<p>ASSURANCE RECEIVED in respect of progress made to the ICB's draft Annual Report.</p>	
<p>Financial Account Report – Month 12</p> <p>The report summarised the ICB's fully completed achievements.</p>	<p>NOTED</p>	<p>No</p>
<p>Annual Accounts Report – Month 12</p> <p>It was noted this was the ICB's third year as an organisation but also its third year of meeting its financial duties and it would not be carrying forward any historic debt repayments into 2025/26.</p> <p>It was confirmed there had been no changes in terms of how the accounts had been prepared and there was consistency between the years.</p>	<p>APPROVAL GIVEN in respect of the ICB Annual Accounts for submission to NHSE.</p>	<p>Yes</p>
<p>Impact of Changes of the wider NHS</p> <p>A presentation was shared on the changing NHS landscape and the potential impact on the ICB in light of the Government's recent announcement on the abolition of NHSE and up to 50% cuts in ICB infrastructure costs, publishing a new 10 year plan and shifts to digital, left shift and transformation.</p> <p>The importance of maintaining focus on core objectives and ensuring a smooth transition was highlighted and emphasis was placed on the need for the ICB Board to consider risks related to capacity, focus, system cohesion, financial management, governance and transition.</p> <p>PricewaterhouseCoopers (PWC) had been commissioned jointly by the Chief Executives of all the West Midlands Chief Executive Officers to undertake an options appraisal in terms of how organisations might cluster to inform the future direction of travel.</p>	<p>NOTED ACTION AGREED Board recommended to consider the risks identified by the Audit Committee and to agree how they will be monitored by the Board and its sub-committees during the transition period.</p>	<p>Yes</p>

<p>The ICB had been developing its allocative strategy with considerable engagement over the last two years and an updated paper would be shared at the June Finance and Performance Committee meeting.</p> <p>There was a role for the Audit Committee in looking at the assurance of how it safely transitioned and a wider role for all of the committees of the Board to maintain oversight of their statutory functions.</p> <p>In the course of the discussion, the Chair drew out five potential risks facing the system and ICB during the transition period:</p> <ol style="list-style-type: none"> 1) Inadequate ICB staff resources – loss of capacity and capability vs increased workload in the run up to the transition 2) Drift of focus (due to externally driven demands) 3) Partners begin to drift apart, under pressure 4) Amplification of risks to financial delivery, and 5) Compromised governance (e.g., short-circuiting of established processes, ambiguity regarding accountabilities, and or unmapped decision making). 6) Smooth and Safe Transition <p>The chair proposed that it would be helpful for the ICB Board to reflect on these risks to consider how they may be mitigated and to confirm the responsibilities of the individual sub-committees for monitoring each risk domain.</p>		
<p>Update of Travel and Expenses Policy</p> <p>The Travel and Expenses Policy had been reviewed and updated in relation to a change in process for employees to claim eye sight test and corrective lenses reimbursement and in preparation for the implementation of a new finance system in October.</p>	<p>APPROVAL GIVEN to the amendment of the policy.</p>	<p>No</p>
<p>Governance Policies: Information Security, Data Encryption and Email Usage</p> <p>The report summarised changes to the Information Security, Data Encryption and Email Usage policies and advised there were no significant changes to the policies.</p>	<p>APPROVAL GIVEN to the following policies with maximum review periods of:</p> <p>Information Security Policy - 3 years Data Encryption Policy – 3 years Email Usage Policy – 18 months</p>	<p>No</p>

	The withdrawal of the Home and Teleworking Policy.	
Mental Health Investment Standard Audit Progress An update was provided on the Mental Health Investment Standard (MHIS) Audit progress. A full detailed report would be shared at the next meeting.	NOTED	No

Items for escalation/highlight:		
Item or issue	Purpose for escalation	Escalated to
AI Usage Policy	Suggestion for the Board to allocate time to consider the role of the AI policy document and look at examples of how AI was already being used and proposed to be used by the ICB.	ICB Board
Annual Accounts Report – Month 12	APPROVAL GIVEN in respect of the ICB Annual Accounts for submission to NHSE.	ICB Board
Impact of Changes of the wider NHS	Board recommended to consider the risks identified by the Audit Committee and to agree how they will be monitored by the Board and its sub-committees during the transition period.	ICB Board

Items referred to the Board for Approval
n/a

Extraordinary Coventry Care Collaborative Committee Report of the meeting held on 21 March 2025		
Key Information		
Committee Chair: Kevin Davis	Committee Executive Lead: Ali Cartwright	Date of Next Meeting: 17 April 2025
Quoracy met?	Yes	
Purpose of the report	For ASSURANCE in respect of key decisions taken/issues raised at the 21 March 2025 Extraordinary Coventry Care Collaborative Committee meeting.	
Recommendation	Members are requested to be ASSURED in respect of the matters set out within this report.	

Key highlights of discussions and decisions held during the meeting:			
Agenda item description & key discussion points	Assurance achieved and sources / Gaps in assurance and action agreed	Item to be added to summary cover sheet? (Exec Lead/ Chair to state Yes or No please in each box.)	
Extraordinary Meeting 21 March 2025 Better Care Fund Planning Submission Report A request for approval of the Better Care Fund (BCF) planning documents on behalf of the Integrated Care Board (ICB) was made, with sign-off by the Health and Wellbeing Board and submission to NHS England Regional Team by 31 March 2025. It was agreed that additions to the planning document should be made to include responses to requests for further details related to adding dates for targets and an improved explanation of pathway two usage, and to highlight what Improving Lives achieved by the end of 2024-25 and what it would achieve in 2025-26.	APPROVED subject to responding to further information requested by NHS England.	No	
Items for escalation:			
Item or issue	Purpose for escalation	Escalated to	
n/a			

Items referred to the Board for Approval
N/A

Coventry Care Collaborative Committee Report of the meeting held on 17 April 2025		
Key Information		
Committee Chair: Kevin Davis	Committee Executive Lead: Ali Cartwright	Date of Next Meeting: 19 June 2025
Quoracy met?	Yes	
Purpose of the report	For ASSURANCE in respect of key decisions taken/issues raised at the 17 April 2025 Coventry Care Collaborative Committee meeting.	
Recommendation	Members are requested to be ASSURED in respect of the matters set out within this report.	

Key highlights of discussions and decisions held during the meeting:		
Agenda item description & key discussion points	Assurance achieved and sources / Gaps in assurance and action agreed	Item to be added to summary cover sheet? (Exec Lead/ Chair to state Yes or No please in each box.)
Effective Management of In-Scope Risks No additions to the risk register had been reported, but monitoring continued in the Coventry Forum alongside the potential for collating risk activity and mitigating risk between organisations.	NOTED.	No
Collaborative Development Development sessions for Collaboratives had been scheduled.	NOTED.	No
Coventry Improvement Approach An outline of benefits of partnership working between primary and secondary care to develop improvements in care pathways was noted. A Kaizen (continuous improvement) approach was to be applied and initial focus would be improvement of clinical correspondence for proof of concept for upscaling.	APPROVED.	No

<p>Community Integrator Transformation Programme</p> <p>The lead provider University Hospital Coventry & Warwickshire (UHCW) was currently in a diagnostics phase which was due to complete in May 2025. Importance had been placed on a neighbourhood teams focus, data, voluntary sector involvement, and joined up working to push boundaries to deliver the right care.</p>	NOTED.	No
<p>Integrated Urgent and Emergency Care Commissioning Approach</p> <p>Outputs from the current patient and market engagement phase were to inform a future procurement process. Running alongside this was a programme of work to identify opportunities for 'quick wins'.</p>	NOTED.	No
<p>Winter Schemes 2025/26</p> <p>The allocation for 2025/26 had been agreed at system level for primary care and mental health schemes. Remaining funding would be split across Coventry and Warwickshire Collaboratives with host providers to sign off schemes. Agreed schemes would be monitored for impact.</p>	NOTED.	No
<p>Coventry Care Collaborative Forum update</p> <p>Discussions since the last meeting included winter funding allocations and scheme proposals, Coventry Improvement Approach, a proposed Virtual Care Strategy, Homeless and Rough Sleeper guidance and strategy, and a 'No Wrong Doors for Carers' initiative.</p>	NOTED.	No
<p>Performance Report</p> <p>Data provided noted challenged A&E performance, ambulance handover delays, and flow pressures and for assurance that the System had improvement actions and associated trajectories in place for areas of challenged performance. Community waiting times data was now also included.</p>	ASSURANCE ACHIEVED.	No
<p>Quality Report</p> <p>Members were assured that the necessary quality processes were in place in organisations and across the system to effectively mitigate, manage and where necessary, escalate quality concerns to the committee for in scope services; current challenges remained for community care provider staffing (international recruitment). In response to requests, an action was agreed to include in future reports relevant areas of</p>	<p>ASSURANCE ACHIEVED.</p> <p>Action agreed: Patient experience compliance to be discussed in the System Quality Group and future quality reports to be reformatted to include relevant information relating</p>	No

overlap with other committees such as patient experience and workforce wellbeing.	to patient experience and workforce wellbeing.	
Finance Report Consideration of how to further breakdown costs of block contracts were to be undertaken in the financial year 2025/26 to help inform future commissioning decisions.	NOTED.	No
Continuing Healthcare (CHC) Assurance Report It was noted that CHC service and Fast Track referrals/acceptances now met the national key performance indicator target of 90%. All CHC reviews last year were completed; complaints, disputes and appeals remained low; risks remained regarding overspend in staffing issues (agency spend) and legal fees.	NOTED.	No
Items for escalation:		
Item or issue	Purpose for escalation	Escalated to
n/a		

Items referred to the Board for Approval
N/A

Extraordinary Warwickshire Care Collaborative Committee Report of the meeting held on 24 March 2025		
Key Information		
Committee Chair: Pamela Bradbury	Committee Executive Lead: Laura Nelson	Date of Next Meeting: 14 May 2025
Quoracy met?	Yes	
Purpose of the report	For ASSURANCE in respect of key decisions taken/issues raised at the 24 March 2025 Extraordinary Warwickshire Care Collaborative Committee meeting.	
Recommendation	Members are requested to NOTE the content of the report and be ASSURED in respect of the matters set out within this report.	

Key highlights of discussions and decisions held during the meeting:		
Agenda item description & key discussion points	Assurance achieved and sources / Gaps in assurance and action agreed	Item to be added to summary cover sheet? (Exec Lead/ Chair to state Yes or No please in each box.)
<p>Better Care Fund and System Planning 2025/26</p> <p>A request for approval of the Better Care Fund (BCF) planning documents (including the financial values), on behalf of the Integrated Care Board (ICB) was made, with sign-off by the Health and Wellbeing Board and submission to NHS England Regional Team by 31 March 2025. It was noted this was a rollover year with no material changes.</p>	APPROVED	No
<p>Community Recovery Service Model Options for 2025/26</p> <p>Members were requested to consider the two Community Recovery Service (CRS) delivery models from April 2025 onwards, aimed at deciding which model to implement. Members acknowledged the only option of additional money, that may be required in year to safeguard SWFT (South Warwickshire University NHS Foundation Trust), as the budget holder for CRS, would be via further discussion around the winter funding allocation. Members noted the financial contributions confirmed from the Integrated Care</p>	Additional work and SWFT Board will progress CRS discussion further. Outcome will be updated at May Committee meeting, due to Committee unable to make decision on behalf of other organisations linked to the transfer.	No

Board (ICB) and the Warwickshire County Council (WCC) through the Better Care Fund (BCF) 2025/6.			
Items for escalation:			
Item or issue	Purpose for escalation	Escalated to	
N/A			

Items referred to the Board for Approval
N/A

Quality, Safety and Experience Committee (QSEC) Report for the meeting held on 8 April 2025

Key Information

Committee Chair: Pamela Bradbury	Committee Executive Lead: Ellie Monkhouse	Date of Next Meeting 10 June 2025
Quoracy met?	Yes	
Purpose of the report	For ASSURANCE in respect of key decisions/issues raised at the 8 April 2025 meeting of the Quality, Safety and Experience Committee	
Recommendation	Members are requested to be ASSURED in respect of the matters set out within this report.	

Key highlights of discussions and decisions held during the meeting:

Agenda item description and key discussion points	Assurance achieved and sources/gaps in assurance and action/s agreed	Highlight to reports front sheet? Please state Yes or No (all boxes to be completed by Lead Exec then reviewed by Chair before report is returned to Committee Administrator.)
<p>Effective Management of In-Scope Risk Report</p> <p>The QSEC is responsible for overseeing seven risks of which one was rated as extreme and six were rated as high.</p> <ul style="list-style-type: none"> - Q/001 Reducing reliance on inpatient care for patients who are autistic or have a learning disability (previously Transforming Care - It was reported that the System had met the trajectory target for adults and exceeded the trajectory target for children for 2024/25. This was the first time as a System this had been achieved. - Q/037 Home Office Overseas Sponsorship Scheme Home Office Overseas Sponsorship Scheme – It was reported that a new scheme will come into effect that will provide additional assurance. There are concerns that the new scheme may 	<p>ASSURANCE ACHIEVED for the Risk Management Report and NOTED the outcomes of the Risk Management Framework.</p>	<p>No</p>

<p>provide additional challenges to providers particularly staffing issues. The CWICB team and the local authority are working together to look at the implications.</p>		
<p>Quality Surveillance and Performance Report</p> <p>There were two quality concerns that were on enhanced surveillance as outlined below. Each concern was subject to robust oversight and monitoring via a quality improvement group (QIG) or through a relevant Board to oversee and drive quality improvements.</p> <ul style="list-style-type: none"> - Primary Care - Paediatric Audiology – The 30 remaining case records under review had been completed by 31 March 2025. Work was now continuing with the South Warwickshire University NHS Foundation Trust (SWFT) to ensure all patients would be on a treatment pathway by September 2025. <p>NHS England had launched the Patient and Carer Race Equality Framework (PCREF), for all NHS mental health trusts and mental health service providers to embed across England. This was a new mandatory framework for Trusts and providers. The Coventry and Warwickshire Partnership Trust (CWPT) had allocated a Senior Responsible Officer (SRO) and work was being overseen by the Chief Medical Officer at CWPT. It was a key component of the quality improvement plans within CWPT.</p> <p>Following a Care Quality Commission (CQC) visit to SWFT at the end of March 2025, a warning notice 29A had been issued. This was in relation to the number of paediatric trained nurses in the emergency department and the incorrect usage of the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLs) on medical wards. SWFT had been given until the end of April 2025 to update the action plan.</p>	<p>ASSURANCE ACHIEVED in respect of the effectiveness of quality monitoring and oversight processes in place to support robust quality and patient safety oversight within our system.</p>	<p>No</p>
<p>Population Health Inequalities and Prevention (PHIP) Report</p> <p>The key areas to note included:</p> <ul style="list-style-type: none"> - The report updated the Committee on discussions regarding PHIP governance and made a proposal regarding future 	<p>NOTED the contents of the report.</p> <p>ASSURANCE ACHIEVED in respect of the work and proposed future governance of the PHIP Programme.</p>	<p>No</p>

<p>reporting arrangements, suggesting routine reporting to the Care Collaborative Committees for an initial 6-month period, along with further scoping work with key stakeholders to map out a direction of travel for PHIP governance.</p> <ul style="list-style-type: none"> - The report also shared details of progress with the System Prevention Framework and the creation of a Prevention Network. - It was agreed that further discussion was required in relation to the proposal regarding future reporting arrangements for PHIP. 	<p>ACTIONS AGREED:</p> <p>The Director of Corporate Governance agreed to confirm if the Executive Team was a decision making forum.</p> <p>The Chief Medical Officer agreed to discuss the prospect of moving PHIP reports to the Collaboratives further with the Chairs of the Collaboratives and provide a further update to QSEC members.</p>	
<p>Special Educational Needs and Disabilities (SEND) Oversight and Assurance Report</p> <p>The ICB had several statutory responsibilities described within the code of practice broadly assigned to three categories.</p> <ul style="list-style-type: none"> - to jointly commission services for SEND - to mobilise services to provide advice to contribute to an education, health and care needs assessment (EHCNA) within 6 weeks. - deliver provision stated in section G of an Education, Health and Care Plan (EHCP). <p>Significant work continued in preparation for the SEND inspections expected for Coventry and Warwickshire.</p> <p>A risk in relation to capacity within the ICB team due to the pause for recruitment was highlighted.</p>	<p>ASSURANCE ACHIEVED in relation to the statutory duties of the ICB for SEND. However, it should be noted that there are ongoing concerns and work required to ensure that joint commissioning activities are achieved across the SEND provision.</p>	No
<p>Local Maternity and Neonatal Transformation Assurance Report</p> <p>The latest statistics were presented and a number of recommendations and actions were being followed through.</p> <p>An emerging risk was noted in relation to funding and support around transformation; the budget was less than previous years.</p>	<p>SIGNIFICANT ASSURANCE ACHIEVED in respect of the progress against the Three-Year Maternity and Neonatal Delivery Plan and Saving Babies Lives Care Bundle v3 (SBLCBv3).</p>	No
<p>Review of Intervention and Assertive Community Mental Health Team Treatment and Maturity Index Self-Assessment</p>	<p>ASSURANCE ACHIEVED that the NHS England ask to review and update action plans following receipt of the independent report</p>	No

<p>Following on from the action plan presented to QSEC in November 2024, the NHS England independent review identified a number of key recommendations and systems were asked to ensure these were being sufficiently addressed within their action plans with additional inclusions required where necessary.</p> <p>These included:</p> <ul style="list-style-type: none"> - personalised assessment of risk across community and inpatient teams, - joint, discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies), - multi-agency working and information sharing, - working closely with families, - eliminating Out of Area Placements in line with ICB 3-year plans. <p>The current action plan had been updated to include the five areas above.</p> <p>The updated action plan would be presented to the ICB Board and the CWPT Board.</p>	<p>recommendations had been completed.</p> <p>AGREED ACTION:</p> <p>The Director of Commissioning agreed to include data and numbers in the updated Review of Intervention and Assertive Community Mental Health Team Treatment and Maturity Index Self-Assessment to go to the ICB and CWPT Board meetings.</p>	
<p>Coventry and Warwickshire Children and Adolescent Mental Health Service (CAMHS) Local Transformation Plan (LTP) 2025/2027</p> <p>The refreshed LTP 2025-27 specifically adopted a programme approach to enable the management of delivery, provide a grip on key risks, issues and this provided assurance to the QSEC.</p> <p>The deliberate two year Plan sat within a revised governance programme and programme management would be overseen by a Programme Delivery Group which would report into the CAMHS Strategic Board.</p> <p>The key elements of the Plan were provided along with the six priorities and it was noted that details of the required funding and resources would be presented to the Committee at a later date.</p>	<p>ENDORSED the refreshed Coventry and Warwickshire CAMHS Local Transformation Plan 2025-27 subject to approval by Warwickshire County Council and Coventry City Council.</p> <p>ASSURANCE ACHIEVED about the oversight in place to maintain safety of children and young people within the system-wide Children and Adolescents Mental Health Services.</p>	No
<p>Emergency Attention Deficit Hyperactivity Disorder (ADHD) Policy for People Under 25 years</p> <p>They key areas to note included:</p>	<p>NOTED the risks associated with the adoption of the temporary emergency policy and that, whilst some risks would be incurred in its adoption, the aim was to reduce the net risk to the System</p>	No

<p>- Due to a rise in referrals for diagnosis and to reduce the differences in waiting times for adults and children, members were advised that a temporary, one year, emergency policy had been developed which prioritised new referrals for children and adults aged under 25. A full policy was also being developed and the temporary policy would allow savings to be made along with other benefits.</p> <p>The Finance and Performance Committee had approved the policy and a Quality Impact Assessment had been completed.</p>	<p>by prioritising children and young people.</p> <p>NOTED the work programme to develop an ADHD Transformation Plan and programme to address the wider issues and risks within ADHD.</p>	
<p>Items for Information</p>		
<p>Warwickshire County Council Director of Public Health Annual Report</p> <p>The report was noted for information.</p>	<p>NOTED</p>	<p>No</p>
<p>Coventry and Warwickshire Health Protection Strategy</p> <p>The report was noted for information.</p>	<p>NOTED</p>	<p>No</p>
<p>Coventry and Warwickshire Safeguarding Assurance Report</p> <p>The report was noted for information.</p>	<p>NOTED</p>	<p>No</p>
<p>Coventry and Warwickshire Children in Care Assurance Report</p> <p>The report was noted for information.</p>	<p>NOTED</p>	<p>No</p>
<p>Primary Care Highlight report January and February 2025</p> <p>The reports were noted for information.</p>	<p>NOTED</p>	<p>No</p>
<p>Clinical Executive Group Flash Report November 2024 and January 2025</p> <p>The reports were noted for information.</p>	<p>NOTED</p>	<p>No</p>
<p>System Quality Group Flash Report</p> <p>The report was noted for information.</p>	<p>NOTED</p>	<p>No</p>

<p>Coventry and Warwickshire System Research and Development Stakeholder and Committee Activity Report</p> <p>The report was noted for information.</p>	<p>NOTED</p>	<p>No</p>
<p>Update for QSEC Actions</p> <p>The report was noted for information.</p>	<p>NOTED</p>	<p>No</p>
<p>University Hospitals Coventry and Warwickshire NHS Trust – Quality Account 2024/25 (Virtual Item)</p> <p>Committee members were asked to approve the ICB statement in relation to the UHCW Quality Account 2024/25.</p>	<p>APPROVED</p>	<p>No</p>

<p>Items for escalation to Board:</p>		
<p>Item or issue</p>	<p>Purpose for escalation</p>	<p>Escalated to</p>
<p>None</p>		

<p>Items referred to the Board</p>
<p>N/A</p>

Finance and Performance Committee Report for the meeting held on 2 April 2025		
Key Information		
Committee Chair: Dr Sukhi Dhesi	Committee Executive Lead: Madi Parmar	Date of Next Meeting: 7 May 2025
Quoracy met?	Yes	
Purpose of the report	For ASSURANCE in respect of key decisions/issues raised at the 2 April 2025 Finance and Performance (F+P) Committee meeting.	
Recommendation	Members are requested to be ASSURED in respect of the matters set out within this report.	

Key highlights of discussions and decisions held during the meeting:		
Agenda item description & key discussion points	Assurance achieved and sources / Gaps in assurance and action agreed	Highlight to reports front sheet? Please state Yes or No (all boxes to be completed by Lead Exec then reviewed by Chair before report is returned to Committee Administrator).
Finance Report M11 <ul style="list-style-type: none"> - The ICB had agreed a position of £14.4m deficit. Funding would be received for this deficit which would result in a technical break-even position for the year. - The importance of working with System partners to remove recurrent costs, particularly in workforce, was agreed. 	NOTED.	No
ICB Resource Allocation Model <ul style="list-style-type: none"> - The aim of this model was to allocate resources between the two geographical Care Collaboratives based on health inequalities. - The model would be used during 2025/26 for shadow reporting and resource allocation. - This was an excellent piece of work carried out by the team and represented a multidisciplinary effort to develop a method 	NOTED.	No

<p>that was more informed and sensitive to the local population.</p> <ul style="list-style-type: none"> - A future update on the shadow reporting would come to the Committee to provide understanding of the potential impact of adopting the new method. 		
<p>Risk Management Report – Effective Management of In-Scope Risks and Board Assurance Framework</p> <ul style="list-style-type: none"> - There were twenty-eight open risks, eight rated extreme and twenty rated high. The Finance and Performance Committee was responsible for the oversight of fourteen risks, six rated extreme and eight rated high. - Work continued on the Risk Register to differentiate between ICB organisational risks and wider system risks. 	ASSURANCE ACHIEVED.	No
<p>Continuing Healthcare and Section 117 Assurance Update</p> <ul style="list-style-type: none"> - The ICB was anticipating an overspend this year by £1.3m, due mainly to an increase in costs over the last quarter where mental health, learning disability and autism packages had contributed significantly. - Staffing costs had been under constant review and overspend had been reduced significantly. Agency usage had reduced. - The ICB hit national Key Performance Indicators in terms of performance with over 90% of people receiving a decision within 28 days of referral and there had been an improvement in the rate of acceptance for fast-track referrals. 	NOTED.	No
<p>Performance and Assurance Report</p> <ul style="list-style-type: none"> - Responsibility for urgent and emergency care metrics now sat with the Care Collaborative Committees. - The overall Refer to Treatment (RTT) waiting list fell in January but had grown by 12.1% since the end of April 2024. - There was an increase in the waiting list at University Hospital Coventry and Warwickshire due to issues experienced with the implementation of the new Electronic Patient Record (EPR) system. 	ASSURANCE ACHIEVED.	No

<ul style="list-style-type: none"> - Faster diagnosis standard performance fell in January and was now below the 77% national expectation. Improvement plans and recovery trajectories were in place for problematic specialties and progress updates were provided fortnightly at the System Oversight Group. - NHSE had just published the new NHS Performance Assessment Framework for 2025/26. NHSE planned to consult on this in quarter one and having removed all of the targets except four, NHSE had now reintroduced another eighty targets. An update would be provided at the next Committee. 		
<p>Primary Care Group Highlight Report The Committee was assured by the contents of the report.</p>	ASSURANCE ACHIEVED.	No
<p>Highlight Reports:</p> <p>Finance Advisory Board (FAB)</p> <ul style="list-style-type: none"> - The Committee noted for information the contents of this report. <p>System Prioritisation Panel</p> <ul style="list-style-type: none"> - The Committee noted for information the contents of this report. <p>Procurement and Patient Choice Panel</p> <ul style="list-style-type: none"> - The Committee noted for information the contents of this report. 	NOTED.	No
<p>CWICB Clinical Commissioning Policies The following policies were approved:</p> <ul style="list-style-type: none"> • Policy for Snoring surgery (in the absence of obstructive sleep apnoea) • Policy for Arthroscopic Shoulder Decompression for Subacromial Pain • Policy for Arthroscopy of Knee Joint (Diagnostic and Therapeutic) 	APPROVAL GIVEN.	No

<p>Emergency ADHD Policy</p> <ul style="list-style-type: none"> - Approval of this temporary policy was agreed. It had been put in place to provide time for the full policy to be developed. - The aim was to address the growth in referrals and improve access for children and young people (CYP). The policy included a commitment to repurpose savings to support CYP services and remove exclusions based on concurrent mental health or learning disabilities. - Further updates would be made and presented at the next Committee. - The policy was supported by contract management as it enabled an accreditation process to be used for providers to ensure they meet quality standards. 	<p>APPROVAL ACHIEVED.</p>	<p>No</p>
<p>Procurement Report</p> <p>Five procurement recommendations were put to the Committee for approval:</p> <ul style="list-style-type: none"> - The enactment of the one-year contract extension for the period 1st April 2025 to 31st March 2026, to Coventry and Warwickshire Integrated Primary Care for these services under the Public Contracts Regulations (PCR). - The ICB being party to the Ramsay (The) Cherwell, subject to communication from the Lead Commissioner, for the period 1st April 2025 to 31st March 2026, for elective services. - Contract awards under Provider Selection Regime (PSR) direct award process A for the period 1st April 2025 to 31st March 2026, to all General Practices within Coventry and Warwickshire. - The direct award under PSR Direct Award Process C of a contract to Myton Hospice for a one-year period 1st April 2025 at a cost of £2,010,383. - A contract award under PSR Direct Award Process C to the Coventry and Rugby GP Alliance for the provision of the services outlined about, for a 1-year contract from 1st April 2025 to 31st March 2026, with an annual budget of £1,377,534. 	<p>APPROVAL GIVEN.</p>	<p>No</p>

<p>General Practice Estates Planning – Eastern Green Locality</p> <ul style="list-style-type: none"> - Presented for approval for: <ul style="list-style-type: none"> • The support for the retention of the ‘on-site’ option (land and capital contributions) noting that the ICB would also continue to assess ‘off-site’ options, alongside the reserved ‘on-site’ option, to enable the ICB to manage risk and respond to a changing population and associated healthcare needs. • Confirmation to be given in writing to Coventry City Council that at this point in the planning process, the ‘on-site’ option (in line with the S106 agreement for OUT/2018/3225), is retained, meaning that the land and ‘on-site’ capital contributions would be reserved for primary care and healthcare purposes. 	<p>APPROVAL GIVEN.</p>	<p>No</p>
<p>Decommissioning Policy</p> <ul style="list-style-type: none"> - Committee members were asked to approve the Policy for a further year to support the difficult decisions being made to achieve savings and to enable the Committee to be assured that the process followed was that previously approved by the F+P Committee and by the ICB Board. - Following the first tranche of reviews of services for possible decommissioning/ reduction carried out by the Senior Leadership Team (SLT) and the Executive Team, agreement was sought and given for future decisions made by the SLT and Executive Team to be agreed by members of the Finance and Performance Committee by email to enable a speedy process. 	<p>APPROVAL GIVEN. AGREEMENT PROVIDED.</p>	<p>No No</p>

<p>Items for escalation:</p>		
Item or issue	Purpose for escalation	Escalated to
<p>Nil</p>		

<p>Items referred to the Board for Approval</p>
<p>None</p>

Finance and Performance Committee Report for the meeting held on 7 May 2025		
Key Information		
Committee Chair: Paul Taylor	Committee Executive Lead: Madi Parmar	Date of Next Meeting: 4 June 2025
Quoracy met?	Yes	
Purpose of the report	For ASSURANCE in respect of key decisions/issues raised at the 7 May 2025 Finance and Performance (F+P) Committee meeting. For APPROVAL of the recommendations set out within this report.	
Recommendation	Members are requested to be ASSURED in respect of the matters set out within this report. Members are requested to APPROVE the recommendations set out in this report.	

Key highlights of discussions and decisions held during the meeting:		
Agenda item description & key discussion points	Assurance achieved and sources / Gaps in assurance and action agreed	Highlight to reports front sheet? Please state Yes or No (all boxes to be completed by Lead Exec then reviewed by Chair before report is returned to Committee Administrator).
ICS SECTION		
<p>2025/26 Financial Planning Submission Update</p> <p>The System position for 2024/25 was that all providers had hit their control totals with some deficits being offset by some surplus's. The overall position was that the ICS had, for the third year running, hit its financial target and this was a major achievement.</p> <p>The financial planning update that the system submitted a break even plan, but one which</p>	NOTED.	No

<p>required delivery of a challenging 6.1% efficiency target.</p> <p>There were risks to system plans and there was a need to stay on trajectory for the second half of the year. Progress was being made on recurrent savings.</p> <p>The planned significant workforce reductions and efficiency levels were discussed, with a focus on reducing agency and bank staffing costs and making unprecedented levels of efficiency savings.</p> <p>All providers had transacted in their workforce plans their corporate services cost reductions and work continued around some concerns in this area.</p> <p>Exploration at system level was under way to seek interventions that could be put in place to reduce sickness absence and learning was being shared.</p> <p>The ICB Senior Leadership Team (SLT) was running a prioritisation process for decision-making and plans were afoot to implement a System Financial Recovery Board with terms of reference being finalised. It was agreed that this work would be shared with providers once plans were further developed</p> <p>Risks around workforce management were discussed along with the need to work as a System and to ensure staff wellbeing was well supported.</p> <p>Decommissioning work was ongoing and it was agreed more visibility of the processes being followed throughout the System would be helpful. Triaging was under way and aligned stakeholder engagement would follow.</p> <p>It was agreed a System 'Spending Profile' would be included in financial reporting in future to allow the committee to judge on a monthly basis how well spending restrictions were being delivered.</p>		
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<p>2025/26 Operational Planning Update</p> <p>Activity and performance trajectories were shared which provided an overview of the performance plan, including revised trajectories for A&E and mental health services.</p> <p>Challenges in achieving targets for cancer, elective activity, and urgent care were highlighted.</p> <p>The final activity plan had been submitted on the 30 April.</p> <p>It was noted that overall, it was going to be a challenging year in hitting performance targets, particularly with a planned reduction in workforce and functions transferring out between the ICB, providers and the region.</p> <p>The Oversight and Assessment Framework was expected imminently and this would bring some scrutiny on organisations across the System however this would encourage organisations to drive delivery in the first quarter to create a stable platform ahead of winter.</p> <p>The increase in waiting times for head and neck cancer had raised concerns alongside a few other areas such as pathology, dermatology and neurology and work was ongoing to review these. Also, individual organisations were reviewing their own statistics regarding access to pathways.</p> <p>The fortnightly Strategic Oversight Group held organisations mutually to account, and it was working through challenges to drive performance. Outcomes and discussions from this forum would be shared with the F&P Committee.</p> <p>Work was also ongoing regarding analysing access to urgent dental care figures.</p>	<p>NOTED.</p>	<p>No</p>
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<p>Update on Collaboratives</p> <p>An update was provided on the progress and development of the six Care Collaboratives.</p> <p>A Care Collaborative Maturity Matrix had been implemented to monitor progress across five core domains.</p> <p>Assessment results indicated early-stage maturity, with most responses across both geographics rated as "Emerging" or "Developing". Key development areas included financial arrangements, workforce, and service delivery, with no domains assessed as "Thriving".</p> <p>Collaborative capacity and capability issues were discussed.</p> <p>It was noted a Voluntary Community and Social Enterprise sector Collaborative was due to be launched on 22 May.</p> <p>Work on delegated budgets through a lead provider was planned and all agreed the ICB was in a good place to progress and following the right direction of travel.</p>	<p>NOTED.</p>	<p>No</p>
<p>Update on ICB Reconfiguration</p> <p>Ongoing work related to the ICB reconfiguration was discussed including mapping functions and achieving a 34% running cost target.</p> <p>It was noted the ICB would submit its plan on how it would achieve the savings to NHS England at the end of May.</p> <p>The ICB was working with other West Midlands ICBs to look at sharing the work being undertaken on functions mapping. To support this work, ICBs had commissioned PricewaterhouseCoopers to pull together an options appraisal which would be presented back to Chief Executives and to ICB Boards around the 12 May. Chief Executive Officers were currently meeting fortnightly.</p>	<p>NOTED.</p>	<p>No</p>

ICB SECTION		
<p>Month 12 Finance Report</p> <p>The month 12 ICB finance report was presented which highlighted a £4.7 million surplus for the ICB.</p> <p>There was a risk around ERF (elective recovery fund) going into 2025/26 regarding recovery of underperformance.</p> <p>There had been a reduction in agency spend in some areas and this was planned to continue.</p> <p>Recruitment was frozen and following extensive external review, there was confidence that there would be no audit risk that should materialise.</p>	<p>NOTED for information the year end draft financial position (unaudited) for the ICS.</p> <p>NOTED for information the ICS efficiency challenge and the impact to the underlying position.</p> <p>NOTED for information that agency controls continue to be under review.</p> <p>NOTED for information that pay and WTE (whole time equivalent) analysis continued.</p>	<p>No</p>
<p>Mental Health Investment Standard (MHIS)</p> <p>The Mental Health Investment Standard plan was discussed for 2025/26, and endorsement was sought for the proposed investments.</p> <p>It was agreed further work on analysing outcomes would take place.</p> <p>It was confirmed that all service development funding had been committed and the mental health standard was on track to be met.</p>	<p>APPROVED the 25/26 MHIS investment plans.</p> <p>APPROVED the proposals for the MH Section 75 expenditure.</p> <p>NOTED the reporting and monitoring requirements.</p>	<p>No</p>
<p>Performance and Assurance Report</p> <p>The committee noted the key challenges outlined in the report and referred to the report for the associated mitigating actions.</p> <p>It was noted that the recording issues regarding severe mental health checks had now been overcome.</p>	<p>NOTED the contents of the report and ASSURANCE ACHIEVED as to actions to improve performance as required.</p>	<p>No</p>
<p>Procurement of All Age Mental Health, Learning Disabilities and Autism Individual Packages of Care</p> <p>A market engagement process had been concluded and an outline of the process that was undertaken, together with the response and</p>	<p>RECOMMENDATION to the ICB Board for this item to be presented as a separate agenda item.</p>	<p>Yes</p>

<p>outcomes received, were summarised in the full report.</p> <p>A five year contract was being proposed with an option for a five year extension. It was proposed the tender would be issued in July with the contract being awarded in January 2026 and the service starting in April 2026.</p> <p>It was confirmed that more than one credible provider seemed willing to submit a tender and so the risks of a single tender proposal were small.</p> <p>The outcome from the market engagement supported the ICB in making an informed decision on the next stage of the procurement process.</p>		
<p>Terms of Reference Review for 2025/26</p> <p>Proposed changes to committee terms of reference were presented, including splitting the F+P committee into separate two committees, one with a system focus and the other with an ICB focus.</p>	<p>DISCUSSED the proposals to inform changes to the Terms of Reference for 2025/26 for inclusion in the governance report to Board for its approval.</p>	<p>No</p>
<p>Annual Effectiveness Review 2024/25</p> <p>The committee effectiveness review was discussed, and the need for timely submission of meeting papers was highlighted. Good committee attendance was noted.</p>	<p>DISCUSSED the results of the effectiveness review and considered any learning and development to support effectiveness.</p>	<p>No</p>
<p>CWICB Clinical Commissioning Policies</p> <p>The following policies were submitted for approval:</p> <ul style="list-style-type: none"> • Policy for Carpal Tunnel Syndrome release • Policy for Tonsillectomy/ Adenotonsillectomy 	<p>APPROVAL GIVEN for adoption by the ICB Board of the two policies listed.</p>	<p>No</p>
<p>Procurement - Provider Selection Regime (PSR) Update</p> <p>Assurance was provided on the provider selection regime, noting the need to publish contract awards annually and that one or two numbers would be corrected before the annual</p>	<p>ASSURED ACHIEVED that the ICB was discharging its responsibilities for the procurement of clinical services in accordance with the Provider Selection Regime (PSR) regulations and guidance.</p>	<p>No</p>

report was published. It was also noted that the PSR work had added time-consuming for the Finance and Procurement team.		
<p>Highlight Reports</p> <p>Finance Advisory Board (FAB) Primary Care Group Highlight Report Procurement and Patient Choice Panel</p> <p>The Committee noted the contents and were assured by the reports.</p>	ASSURANCE ACHIEVED	No

Items for escalation:		
Item or issue	Purpose for escalation	Escalated to
2025/26 Financial Planning Submission Update	The committee noted the unprecedented levels of efficiency required to achieve the System break even plan of 2025-26 and committed to seek assurance of progress through monitoring monthly System expenditure.	The Board

Items referred to the Board for Approval
n/a – see separate agenda item for the All Age Mental Health, Learning Disabilities and Autism Individual Packages of Care procurement item.

People Committee Report for the meeting held on 7 April 2025		
Key Information		
Committee Chair: Chris Hurst	Committee Executive Lead: Felicity Davies	Date of Next Meeting: 30 June 2025
Quoracy met?	Yes	
Purpose of the report	For ASSURANCE in respect of key decisions/issues raised at the 7 April 2025 People Committee (System) meeting.	
Recommendation	Members are requested to be ASSURED in respect of the matters set out within this report.	

Key highlights of discussions and decisions held during the meeting:		
Agenda item description & key discussion points	Assurance achieved and sources / Gaps in assurance and action agreed	Item to be added to summary cover sheet? (Exec Lead/ Chair to state Yes or No please in each box.)
Equality, Diversity, Inclusion and Belonging Deep Dive (EDIB) Committee were presented with the EDIB strategic approach with emphasis placed on the importance for an inclusive environment and to address any disparities within the system-wide approach. An EDIB dashboard has been created to monitor progress.	Committee members APPROVED the EDIB report.	No
Effective Management of In-scope Risks (covering BAF and CRR) The ICB had entered a period of change following the recent announcements related to the re-organisation of the NHS	Committee Members received ASSURANCE for the Risk report and noted the outcomes for the Board Assurance Framework.	No

<p>so some of the risks may need to be reviewed in light of the announcements. There is a Directorate and Programme risk register which feeds into the corporate risk register and BAF which have all recently been reviewed by the Directorate.</p>		
<p>One People Plan Progress Report</p> <p>The One People Plan progress is an update on performance against the People Plan. The key points raised were that there was good progress being made on the Employability Academy, the attraction and future skills and work was currently starting on the health and wellbeing and workforce plans. There had been a pause on the retention work while awaiting the staff survey results.</p> <p>A new dashboard had been produced for the Committee; there were still some challenges around EDI, sickness absence and turnover and delivery of the workforce plan. There had been some positives in the Employability Academy from the data and nurse vacancies, around framework usage and agency usage.</p> <p>It was agreed to ensure volunteers and work experience was incorporated in the Plan to attract people into NHS careers and support was offered to give some input in these specialised areas.</p>	<p>Committee Members received ASSURANCE for the One People Plan.</p>	<p>No</p>
<p>Workforce Innovation Progress Update – Workforce Plan Update</p> <p>The Workforce Plan was a core component of the annual operational planning submission. There was still some further work required on the workforce plan, and there would be a re-submission on 24 April 2025.</p> <p>There was a need in the ICB to provide robust support and challenge to providers to deliver the workforce plan as the ICB moved into 2025/6. The support of the</p>	<p>Committee Members were ASSURED that the overall numbers within the workforce plan had been robustly challenged and were supported by delivery plans.</p> <p>Committee Members NOTED that there may be a requirement for a further submission on 24 April 2025 subject to NHSE confirmation.</p>	<p>No</p>

<p>NEMs (Non-Executive Members) at their organisational committees would be appreciated. It was noted that UHCW (University Hospitals Coventry and Warwickshire) were currently doing a rapid process improvement work stream on variable pay including temporary staffing so it would be interesting to see the outcome of this process; other authorities had completed a similar process.</p>		
<p>Staff Survey results</p> <p>The key points on the Staff Survey results included that there had been slight improvements across the Trusts. The response rates had improved from 44.96% to 55.61%. There had been a big improvement from the ICB and George Eliot hospital (GEH) Trusts. South Warwickshire Foundation Trust (SWFT) and the ICB were best in some of the themes both locally and nationally. It was also noted that GEH and SWFT were above average compared with benchmarks, however, there had been a slight reduction in the scores for diversity and inclusion.</p> <p>All Providers had reported back to their Boards and were working on their individual action plans. As noted previously, retention work had been paused.</p>	<p>Committee Members received ASSURANCE for the Staff Survey results.</p>	<p>No</p>

<p>Items for escalation:</p>		
Item or issue	Purpose for escalation	Escalated to
n/a		

<p>Items referred to the Board for Approval</p>
<p>n/a</p>

People Committee Report for the meeting held on 7 April 2025		
Key Information		
Committee Chair: Chris Hurst	Committee Executive Lead: Felicity Davies	Date of Next Meeting: 30 June 2025
Quoracy met?	Yes	
Purpose of the report	For ASSURANCE in respect of key decisions/issues raised at the 7 April 2025 People Committee meeting.	
Recommendation	Members are requested to be ASSURED in respect of the matters set out within this report.	

Key highlights of discussions and decisions held during the meeting:		
Agenda item description & key discussion points	Assurance achieved and sources / Gaps in assurance and action agreed	Item to be added to summary cover sheet? (Exec Lead/ Chair to state Yes or No please in each box.)
<p>People Plan Update</p> <p>Committee members noted that due to the impact of recent ICB announcements, there may be a need to pause some activities within the Human Resources team to allow them to support any organisational changes. Also, the recent staff away day was repurposed due to the announcements.</p> <p>The culture change programme had been approved to start in April 2025.</p> <p>A significant improvement in every single People Promise theme had been noted in the staff survey results, which showed the ICB culture change journey and something to be proud of.</p> <p>A new wellbeing framework had been developed and an update on the launch of the expectations of people managers framework was provided.</p>	<p>ASSURANCE ACHIEVED regarding the progress made towards delivery of the Our People Our Purpose Plan for 24/25 and the impact the recent announcements will have on the delivery of the 25/26 plan.</p>	<p>No</p>

<p>ICB – Health and Safety Incidents and Delivery Reports</p> <p>The Health and Safety Annual Report presented noted the low rate of incidents with only one slip, trip, and fall in four years and no RIDDOR incidents.</p> <p>An increase in the number of first aiders, fire marshals, and DSE (display screen equipment) assessors was noted, with a compliance rate of 92% for health and safety training.</p> <p>The revised changes to the Health and Safety policy and Smoke-Free policy were to reflect legislative changes.</p>	<p>ASSURANCE ACHIEVED that the health and safety agenda continued to be met, awareness had been raised regarding incident reporting.</p> <p>ENDORSED the Health and Safety and Smoking policies.</p>	<p>No</p>
<p>Annual Staff Survey Report</p> <p>The Staff Survey had produced positive results. An increase in staff survey response rates to 76.6%, compared to a benchmark average of 74%, was noted along with positive increases in the Workforce disability equality standards and Workforce Race Equality standards.</p> <p>The CWICB was the best in the Midlands for two themes, reflecting the engagement and efforts of all colleagues.</p>	<p>ASSURANCE ACHIEVED regarding the staff survey results.</p>	<p>No</p>
<p>Equality Delivery Report (EDS)</p> <p>The EDS report highlighted the improvements in scores and the need to focus on making further improvements.</p> <p>An action plan had been developed linked to the wider Equality Diversity Inclusion action plan, to address the improvements needed across all three EDS themes.</p>	<p>APPROVAL given for the Equality Delivery System report to be published on the CWICB website.</p>	<p>No</p>

<p>HR Policies</p> <p>Committee members approved the policies presented which did not include any fundamental changes. This included new polices for Sexual Misconduct and an Inclusive Recruitment policy which replaced the Reduction and Induction policy.</p>	<p>APPROVAL was given to the HR Policies presented.</p>	<p>No</p>
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<p>Items for escalation:</p>		
Item or issue	Purpose for escalation	Escalated to
n/a		

<p>Items referred to the Board for Approval</p>
<p>n/a</p>

Report To and Date:	NHS Coventry and Warwickshire Integrated Care Board, 21 May 2025
Report Title:	Summary of West Midlands Joint Committee for Specialised Services meetings on 20 March and 11 April 2025
Report From:	Phil Johns, Chief Executive Officer, CWICB
Author:	Rory Kirk, Chief of Staff to the CEO, CWICB
Previous Considerations and Engagement:	N/A
Purpose:	For Information

Executive Summary and Key Points:

- The West Midlands Joint Committee for Specialised Services held two meetings on 20 March 2025 and 11 April 2025.
- This report provides a combined summary highlighting the progress and key discussions from both meetings.

Recommendation:

Members are requested to:

- note the updates from the West Midlands Joint Committee Specialised Services meetings held on 20 March 2025 and 11 April 2025.

1. Introduction

The West Midlands Joint Committee for Specialised Services held two meetings on 20 March 2025 and 11 April 2025. These meetings focused on the delegation process, financial planning, specialised commissioning, and addressing fragile services. This report provides a combined summary highlighting the progress and key discussions from both meetings.

2. Key discussions and progress

- 2.1 The Interim Regional Director of Specialised Commissioning at NHS England provided an update at both meetings. This included an update on the formal delegation process and update on the establishment of the Mental Health group expected in May.
- 2.2 The committee also discussed other specialised commissioning services including positive progress on the high-cost drugs incentive scheme, the specialised services approach around fragile services and mutual aid for oral-maxillofacial services.

- 2.3 The Senior Programme Manager for Specialised Networks in the Midlands Region presented the Neonatal Capacity Plan, recommending not to trigger major service changes at this stage and focus on mitigations. This includes an increase in capacity in Birmingham and local suggestions around how we coordinate areas such as training and transfers which will be picked up by the Local Maternity and Neonates network. The committee agreed on the plan and the need for further work to detail the capacity changes.
- 2.4 The Director of Commissioning Finance for the Midlands Region, led discussions on financial plans for 2025-26, noting the forecast for activity growth was around 8%. Options to consider by ICB were:
- Reserve resources to fund at 8.1%
 - Assume financial cap of 5% (£7.5m) and reserve resources to this level which was recommended by Chief Finance Officers.
 - Assume financial cap at 2024/25 outturn with management of growth through productivity assumptions and use of marginal cost analysis

It was agreed, for planning purposes, to accept the recommendation of the finance group.

3. Recommendation

- 3.1 The Board is recommended to note the updates from the West Midlands Joint Committee Specialised Services meetings held on 20 March 2025 and 11 April 2025.

Report To and Date:	NHS Coventry and Warwickshire Integrated Care Board – 21 May 2025
Report Title:	Update on ICB transition
Report From:	Phil Johns Chief Executive Officer, CWICB
Author:	Rory Kirk Chief of Staff to the CEO, CWICB
Previous Considerations and Engagement:	Board Development Sessions – 16 April and 7 May
Purpose:	For Endorsement

Executive Summary and Key Points:

- To achieve running cost saving targets, Coventry and Warwickshire ICB is exploring ‘clustering’ with other West Midlands ICBs – either a West Midlands Combined Authority footprint with BSOL and Black Country, or a smaller cluster with Herefordshire and Worcestershire.
- Evidence reviewed against seven criteria does not clearly point to either option, however in terms of pace of delivery and the reduction in running costs to recycle into front line services the smaller cluster option would present less complexity.
- At a development session on 7 May, while the board expressed a preference to align with the West Midlands Combined Authority footprint, the Board also accepted a cluster with Herefordshire and Worcestershire could be the best immediate term route to achieving our running cost reduction targets.

Recommendation:

Board members are asked to:

- **ENDORSE** the creation of an ICB cluster with Herefordshire and Worcestershire ICB.
- **DELEGATE** approval of relevant NHS England submissions to the Transition Committee.

1. Introduction

- 1.1 The government has announced significant and rapid changes to the way the NHS in England is led and managed, including significant running cost reductions for both NHS England and Integrated Care Boards (ICBs) – with a 34% reduction mandated for Coventry and Warwickshire ICB by the end of 2025. The scale of these reforms will mean that ICBs within the West Midlands will need to cluster together to provide joint services and find cost savings.
- 1.2 Since the announcement of these reforms, West Midlands ICB CEOs have been working closely to provide clarity for providers, staff and communities. The options being explored include one single ICB for the West Midlands (consolidating 6 separate ICBs), two ICBs (made up of groups of three current ICBs), or three ICBs (made up of two current ICBs).
- 1.3 The six West Midlands ICBs have agreed on a set of 7 criteria to assess options against. While work is being done collectively across the six ICBs to take a collective view, in Coventry and Warwickshire we have carried out an internal analysis to assess the best options for our patients and communities. This analysis has been shared with Board members at development sessions on 16 April and 7 May and is summarised here.

2. The options for 'clustering'

- 2.1 For Coventry and Warwickshire, the primary options being considered for 'clustering' with other West Midlands ICBs are:
 - Joining a single ICB for the West Midlands, consolidating all 6 ICBs;
 - Clustering with Birmingham and Solihull ICB (BSOL) and Black Country ICB to align with the West Midlands Combined Authority (WMCA) footprint; and
 - Clustering with Herefordshire and Worcestershire ICB (HW) as a close neighbour.
- 2.2 A single West Midlands ICB would be significantly larger in population terms than those currently served across the region. At nearly 7 million people, this would represent a significant and complex merger process, and take the ICB away from its populations and is therefore considered a less feasible and desirable option when considering the immediate term goal of reducing ICB running costs. The decision was therefore between the larger WMCA cluster of three ICBs, or smaller pairing with Herefordshire and Worcestershire.

3. The assessment criteria

- 3.1 There are seven criteria that the six West Midlands ICBs are collectively and individually assessing against to inform their decisions:

- a. **Patient flows:** in terms of both acute and GP patient flows, Coventry and Warwickshire is very self-contained and the data is not significant or systemic enough to clearly define the future footprint.
- b. **Financial affordability and sustainability:** in terms of running cost reductions, Coventry and Warwickshire is fairly close to BSOL and Black Country, but closer to H&W in terms of required efficiencies. H&W's distance from target in terms of funding allocations presents some longer-term risk for Coventry and Warwickshire.
- c. **Population sizes:** both the single WM ICB option and the WMCA cluster with BSOL and Black Country would dramatically increase population size (at 6.67 million and 4.91 million respectively), while a cluster with H&W would be more manageable at 1.95 million.
- d. **Population characteristics:** Coventry and Warwickshire has similarities with BSOL and the Black Country, but the other WMCA ICBs are significantly more deprived. C&W has similarities with all West Midlands ICBs but is most similar to the 'shire' ICBs of H&W, Shropshire, Telford and Wrekin (STW) and Staffordshire and Stoke-on-Trent (SSOT).
- e. **Operating models around place, localities and providers:** Coventry is a member of the West Midlands Combined Authority, however Warwickshire is not – meaning the case for Coventry and Warwickshire joining a WMCA footprint is less clear. In terms of place-based partnerships, Coventry is in a similar place in its journey as the other ICBs.
- f. **Deliverability:** a cluster with H&W is the most manageable and feasible in terms of total population (1.95m) – retaining economies of scale while not going 'too big'. Larger clusters would bring significantly more complexity. However, Coventry and Warwickshire's relative self-sufficiency in terms of service provision and patient flows means that it could reasonably cluster with most other WM ICBs without additional complexities.

4. Summary conclusion

- 4.1 In general, the available evidence against the seven criteria does not clearly point to either option, although suggests slightly more similarity and a lower level of complexity in terms of clustering with H&W.
- 4.2 Recognising the rapid pace of change, the Board has been updated at two recent development sessions: 16 April and 7 May. At the session on 7 May, Board members were presented with evidence and analysis against the seven criteria as summarised above.
- 4.3 Board members reflected on the available options. While there was a clear preference to cluster with Birmingham and Solihull ICB and Black Country ICB to align with the West Midlands Combined Authority footprint, both this option and a cluster with Herefordshire and Worcestershire ICB were acceptable and the Board recognised that the immediate priority for ICBs is to find running cost savings at pace. A cluster with Herefordshire and Worcestershire is therefore recommended as the best route to meet this objective within the deadline of Q3 in 2025-26.
- 4.4 PWC were commissioned as independent consultants to assess evidence and options for clustering. On Monday, 12 May 2025, they set out their recommendations to CEOs that the six

ICBs should cluster into three pairs: Coventry and Warwickshire with Herefordshire and Worcestershire, Birmingham and Solihull with the Black Country, and Shropshire, Telford and Wrekin with Staffordshire and Stoke-on-Trent. This recommendation reflected the available evidence and relative self-sufficiency of the majority of ICBs (aside from the more significant flows between BSOL and Black Country).

- 4.5 For now, Coventry and Warwickshire's partnership with Herefordshire and Worcestershire is an interim arrangement aimed at sharing services, functions and resources to reduce running costs while maintaining service delivery for our communities. This arrangement will be kept under review, and a potential partnership on the West Midlands Combined Authority footprint may be explored in future.
- 4.6 Coventry and Warwickshire ICB (like all West Midlands ICBs) is establishing a Transition Committee as a formal committee of the Board to oversee the transition and approve submission of relevant documents and plans in line with the final decision on future clusters, then oversee changes and transfers of functions and cost savings. The Board is asked to delegate authority to the Transition Committee for sign-off of any required submission to NHS England, with progress to be reported by the Committee to the Integrated Care Board.

5. Recommendations

5.1 Board members are asked to:

- **ENDORSE** the creation of an ICB cluster with Herefordshire and Worcestershire ICB.
- **DELEGATE** approval of relevant NHS England submissions to the Transition Committee.

End of Report

Report To and Date:	NHS Coventry and Warwickshire Integrated Care Board, 21 May 2025
Report Title:	Responding to national challenges whilst delivering for the Coventry and Warwickshire population
Report From:	Rachael Danter Chief Transformation Officer and Deputy Chief Executive Officer, Coventry and Warwickshire ICB
Author:	Rachael Danter Chief Transformation Officer and Deputy Chief Executive Officer, Coventry and Warwickshire ICB
Previous Considerations and Engagement:	Not applicable
Purpose:	For Information

Contribution to meeting the aims of the ICS:			
Priorities	<input checked="" type="checkbox"/> 1 - Prioritising prevention and improving future health outcomes through tackling health outcomes	<input checked="" type="checkbox"/> 2 - Improving Access to health and care services and increasing trust and confidence	<input checked="" type="checkbox"/> 3 - Tackling immediate system pressures and improving resilience
Focus Areas	<input checked="" type="checkbox"/> 1 - Reducing health inequalities	<input checked="" type="checkbox"/> 4- Enabling personalised care	<input checked="" type="checkbox"/> 7 - Making services more effective through greater collaboration and integration
	<input checked="" type="checkbox"/> 2- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities	<input checked="" type="checkbox"/> 5 - Improving access to services especially primary care	<input checked="" type="checkbox"/> 8 - Supporting people at home

Key Points:
<ul style="list-style-type: none"> • The national policy landscape is shifting rapidly, the planned abolition of NHS England in its current form, and reallocation of functions across each level of the NHS marks more than a structural shift - it redefines how we will approach commissioning, accountability, and leadership at all levels. • NHS England has set clear expectations: ICBs must reduce running costs by 50% nationally (with a 34% target at Coventry and Warwickshire level) by Q3 2025/26, while safeguarding key functions and ensuring investment is directed toward what truly matters. • Now is the moment for ICBs to fully step into their role as strategic commissioners, embedding a whole-system mindset and creating the conditions for deep collaboration across the system - enabling us to leverage reform effectively, navigate the evolving NHS landscape and deliver better outcomes for the population. • The Model ICB Blueprint outlines how ICBs will transition into a more focused, strategic role by defining which core functions will be retained and strengthened, which capabilities must be developed, and which activities should be transferred to regional teams or provider organisations over time. • This will allow ICBs to concentrate on their core strategic responsibilities, including strategic planning and purchasing, population health management, market shaping, outcome monitoring, and system

assurance, ensuring they are positioned to lead system-wide transformation and deliver long-term improvements in health outcomes and value.

- Coventry and Warwickshire (C&W) ICB has already laid much of the groundwork needed to transition into a more strategic commissioning role. However, it should be noted that there are still areas for development in most of the identified Model ICB functions and activities. However, the progress to date and our stipulated direction of travel highlights a strong synergy with the expectations of a Model ICB and mature Strategic Commissioner.

Recommendation:

Members are asked to **NOTE** the contents of this report **for information**.

Implications						
Conflicts of Interest:	No conflicts identified					
Financial and Workforce:	This transition work programme will look to deliver the required reduction of £10.3m ICB running and programme cost savings target					
Performance:	Quality, safety, and performance standards will form part of the regular reporting relating to the transition to the new future state.					
Quality and Safety:						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	Has an equality impact assessment been undertaken? (Delete as appropriate)	Yes (attached or hyperlinked)		No	N/A	✓
Patient and Public Engagement:	Staff and stakeholder engagement will form part of the collective system transition work programme.					
Clinical and Professional Engagement:						
Risk and Assurance:	<p>There are a number of risks associated with these changes.</p> <ul style="list-style-type: none"> • Firstly, any reorganisation is a distraction from delivering the 25/26 system plan. • Secondly, reducing the headcount of the ICB will reduce its ability to deliver all of the functions required, particularly ahead of legislative change. • Thirdly, some of the skills and expertise identified in the Model ICB Blueprint are not apparent in the current ICB. Therefore, there will need to be a period of education, training and repurposing of roles to ensure the ICB is able to operate as a mature Strategic Commissioner. 					

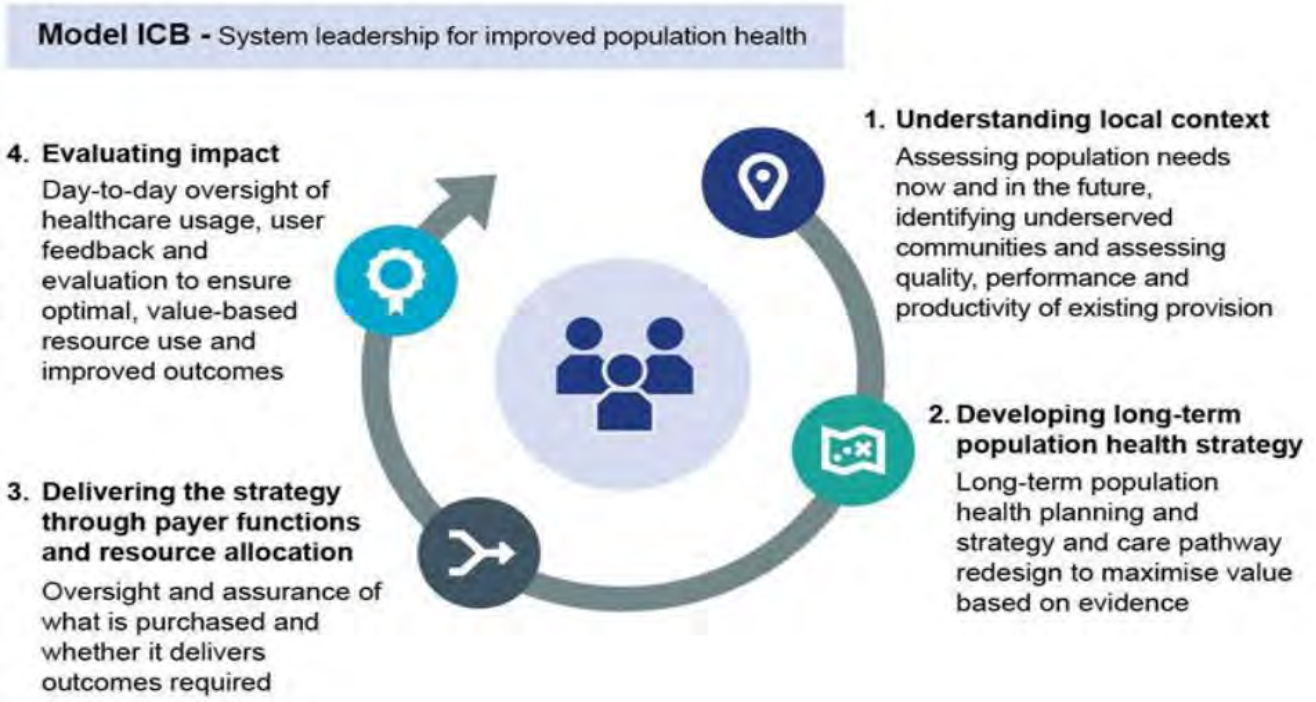
1. Background and Context

- 1.1 We are at a defining moment in the evolution of our health and care system. The national policy landscape is shifting rapidly, the planned abolition of NHS England in its current form, and reallocation of functions across each level of the NHS marks more than a structural shift - it redefines how we will approach commissioning, accountability, and leadership at a National, Regional, Local ICB and Provider level. With publication of the Model ICB Blueprint, the direction is clear: strategic commissioning will sit at the heart of the 10 -Year Health Plan.
- 1.2 For too long, commissioning has been tied to transactional contracting and provider performance management - measuring volume over value, but this model no longer fits the needs of a complex, interconnected system. Instead, the system is moving toward a model where integration, innovation, prevention, and shared outcomes guide decisions. The upcoming NHS 10-Year Health Plan and the national Model ICB Blueprint set the direction for the system: leaner, more focused ICBs that concentrate on what truly matters - population health, health equity, and system-wide transformation.
- 1.3 NHS England has set clear expectations: ICBs must reduce running costs by 50% nationally (with a 34% target at Coventry and Warwickshire level) by Q3 2025/26, while safeguarding key functions and ensuring investment is directed toward what truly matters. This is not necessarily about doing less; it is about doing what matters - differently. This makes the shift to strategic commissioning not only more urgent but also more complex.
- 1.4 To meet this challenge, we must act swiftly and decisively, reshaping our organisations, sharpening our focus on core strategic purposes, and building the capabilities required to lead reform. Now is the moment for ICBs to fully step into their role as strategic commissioners, embedding a whole-system mindset and creating the conditions for deep collaboration across the system - enabling us to leverage reform effectively, navigate the evolving NHS landscape and deliver better outcomes for the population.

2. Future role of the ICB

- 2.1 Integrated Care Boards (ICBs) were established in July 2022 with statutory responsibility for planning and arranging health services, overseeing NHS service performance, and providing system leadership across their local areas. In addition to these commissioning functions, they were tasked with delivery roles such as emergency planning, safeguarding, and NHS Continuing Healthcare assessments.
- 2.2 ICBs were launched in the wake of COVID-19, amidst rising demand and deepening financial pressures. In this environment, operational firefighting has too often taken priority over system transformation and value-based commissioning - consequently there has been varying interpretations of the ICB role. Some ICBs have focused on addressing social determinants of health; others on improving provider collaboration; and still others on supporting provider financial and operational performance. This diversity, combined with ongoing pressures to maintain financial balance, has often limited the ability of ICBs to deliver against the four integrated care system (ICS) objectives, with resources continuing to flow disproportionately to acute hospital providers.

- 2.3 To clarify and strengthen the role of ICBs, the Darzi review and the NHS Model ICB Blueprint outline the need for a renewed focus on strategic commissioning - placing as much emphasis on long-term strategy and outcomes as on performance oversight. This includes rebuilding skills and capabilities to commission care wisely, enabling ICBs to act as genuine system leaders.
- 2.4 To deliver their purpose ICBs will need to focus on the following:



- 2.5 To navigate the transition to Strategic Commissioning effectively, it will be essential to identify and eliminate duplication, particularly in functions which are already effectively managed at the Provider and/or Regional Team level. This streamlining creates both the space and the mandate for ICBs to assume their roles as strategic commissioners and system convenors, focusing on population health, prevention, integration, and value.
- 2.6 The Model ICB Blueprint outlines how ICBs will transition into a more focused, strategic role by defining which core functions will be retained and strengthened, which capabilities must be developed, and which activities should be transferred to regional teams or provider organisations over time. To achieve this, ICBs will need to delegate many operational and transactional commissioning activities - such as workforce planning, primary care transformation, pathway development, digital leadership, and provider performance oversight - to other parts of the system. This will allow ICBs to concentrate on their core strategic responsibilities, including strategic planning and purchasing, population health management, market shaping, outcome monitoring, and system assurance, ensuring they are positioned to lead system-wide transformation and deliver long-term improvements in health outcomes and value.
- 2.7 The ICB will undertake a redesign of our own organisation to align with the future model. This includes reducing headcount and board size as per the Blueprint's guidance, realigning executive

portfolios toward population health and strategic commissioning, and identifying staff for voluntary redundancy or redeployment (aligned to national guidance on fair process). A dedicated Transition Committee (with executive and non-executive members) will be formed to oversee this change, manage risks and report progress as well as be assured that day-to-day system delivery continues in line with the agreed plan. The ICB will also need to map out which commissioning activities will transfer to regional teams or providers and ensure these are transferred in a safe and planned way.

3. Laying the foundations of our future state as a Strategic Commissioner.

- 3.1 Coventry and Warwickshire (C&W) ICB has already laid much of the groundwork needed to transition into a more strategic commissioning role. Over recent years, we have deliberately developed a commissioning infrastructure built on the principle of subsidiarity, ensuring that decisions are made as close to local communities as possible and aligned to local priorities.
- 3.2 Our Care Collaboratives (defined nationally as place-based partnerships) covering Coventry and the three Warwickshire areas - are well positioned to evolve into Accountable Care Organisations (ACOs) of the future. While their current scope focuses on Urgent and Emergency Care, Continuing Healthcare (CHC), Community Services, and the Better Care Fund, there is a clear opportunity over time to expand their role further to adopting an per capita budget approach.
- 3.3 With a robust development plan already in place to strengthen Care Collaborative capacity and capability, and with established provider collaboratives across acute, mental health/learning disabilities and autism (LD&A) and primary care, as well as the newly established Voluntary Community Faith and Social Enterprise Collaborative, the C&W ICB is well positioned to lead the next phase of our strategic commissioning and system transformation journey.
- 3.4 Significant work has been undertaken in laying the foundations for a well-informed population health strategy. Our dynamic PHM platform enables us to use real-time data and intelligence to develop a deep understanding of the needs of our local population and how these are likely to change over time. Work is already underway in our place-based partnerships to segment the population and stratify health risks, particularly for those cohorts of patients driving the greatest demand/cost and work has begun to disaggregate health data to surface inequalities.
- 3.5 Negotiating and managing outcome-based contracts is not new to the ICB and these have been in place since 2018, with the latest examples being the recently commissioned Community Integrator contracts. Work has recently been undertaken to better define the long-term outcomes for the contract, which will measure the health impact for the services commissioned as well as highlight the return on investment which will inform future commissioning decisions.
- 3.6 The ICB has worked closely with partners to develop a valued-based Prioritisation Framework which meets the core purpose of an ICB and ensures a consistent, evidence-based approach to resource allocation across Coventry and Warwickshire. The outcomes of the process inform allocation of resources to maximise improved health and access to high quality care, shifting focus from institutions to population outcomes, and targeting health inequalities by improving equity of access, experience, return on investment and outcomes. This along with the work commenced on allocative funding for the geographic Care Collaboratives demonstrates our role in developing system strategy and market shaping and management, recognising there is further to go.

- 3.7 Working alongside the Local Authorities and the newly established VCFSE Collaborative our approach to user feedback, co-design and engagement continues to evolve. These mechanisms provide routes of contact and engagement with the associated organisations across the system and provide vital links to our communities. The next steps are to develop an approach to ensure user feedback mechanisms are embedded in our commissioning activities to co-design and influence how resource is allocated and evaluated.

4. Conclusion

- 4.1 Although the ICB has made good progress in developing some of the skills and expertise to operate as a Strategic Commissioner, it should be noted that there are still areas for development in most of the identified Model ICB functions and activities. However, the progress to date and our stipulated direction of travel highlights a strong synergy with the expectations of a Model ICB and mature Strategic Commissioner.

5. Recommendation

Members are asked to **NOTE** the contents of this report **for information**.

END OF REPORT

Report To and Date:	Integrated Care Board, 21 May 2025
Report Title:	Update on Care Collaborative Approach
Report From:	Rachael Danter Chief Transformation Officer and Deputy Chief Executive Officer, Coventry and Warwickshire ICB
Author:	Rebecca Chislett, Director of Integration and Planning, Coventry and Warwickshire ICB
Previous Considerations and Engagement:	Not applicable
Purpose:	For Information

Contribution to meeting the aims of the ICS:

Priorities	<input checked="" type="checkbox"/> 1 - Prioritising prevention and improving future health outcomes through tackling health outcomes	<input checked="" type="checkbox"/> 2 - Improving Access to health and care services and increasing trust and confidence	<input checked="" type="checkbox"/> 3 - Tackling immediate system pressures and improving resilience
	<input checked="" type="checkbox"/> 1 - Reducing health inequalities	<input checked="" type="checkbox"/> 4- Enabling personalised care	<input checked="" type="checkbox"/> 7 - Making services more effective through greater collaboration and integration
Focus Areas	<input checked="" type="checkbox"/> 2- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities	<input checked="" type="checkbox"/> 5 - Improving access to services especially primary care	<input checked="" type="checkbox"/> 8 - Supporting people at home

Key Points:

- **Strategic Alignment with National Policy:** Coventry and Warwickshire ICB is well positioned to deliver the ambitions of the NHS Model ICB Blueprint, having already developed a devolved commissioning model rooted in subsidiarity, enabling localised, needs-led decision-making.
- **Care Collaboratives as Vehicles for Transformation:** Two Geographic Care Collaboratives now operate as formal ICB sub-committees of the Board, holding delegated authority for commissioning key services. They are supported by Collaborative Forums to co-design care models and deliver system transformation aligned to neighbourhood needs.
- **Development Programme and Maturity Assessment:** A comprehensive development programme is underway, supported by a Care Collaborative Maturity Matrix. Initial self-assessments show most areas are at the 'Emerging' or 'Developing' stage, with targeted development sessions scheduled throughout 2025 to strengthen leadership, financial governance, and partnership working.
- **Integrated Commissioning Priorities:** Current collaborative priorities include building Integrated Neighbourhood Teams, enhancing urgent and emergency care coordination, preparing for winter resilience, improving long-term condition management, and redesigning non-emergency patient transport services.
- **System-wide Collaborative Infrastructure:** The wider collaborative framework includes established Acute, Mental Health, Learning Disability and Autism (LDA), and Primary Care

(PCC), Voluntary, Community, Faith, and Social Enterprise (VCFSE) Collaboratives, each progressing aligned strategies, governance models, and service redesign efforts to support the future accountable care model for the system.

Recommendation:

Members are asked to **NOTE** the contents of this report **for information.**

Implications

Conflicts of Interest:	No conflicts identified					
Financial and Workforce:	None for this report					
Performance:	n/a for this report					
Quality and Safety:						
Inclusion: The EQIA tool can be found in the EQIA policy here.]	Has an equality impact assessment been undertaken? (Delete as appropriate)	Yes (attached or hyperlinked)		No	N/A	✓
Patient and Public Engagement:	Stakeholder – including Patient, Public and Clinical and Professional engagement forms a key part of the decision-making process incorporated into the relevant collaborative model.					
Clinical and Professional Engagement:						
Risk and Assurance:	No risks identified.					

1. Background and Context

- 1.1 The NHS Model ICB Blueprint sets out a vision for Integrated Care Boards to operate as lean, strategic commissioners focused on improving population health outcomes and reducing inequalities. ICBs are expected to retain key functions such as population health management, market-shaping, strategic purchasing, and system assurance, while delegating operational and transactional commissioning activities to provider organisations, and local system partners.
- 1.2 Coventry and Warwickshire (C&W) ICB is strongly positioned to fulfil this national ambition, having already developed and implemented plans to transition toward a commissioning infrastructure founded on the principle of subsidiarity. This model empowers local decision-making, ensuring that commissioning is informed by and responsive to the specific needs of local communities.
- 1.3 In November 2022, the C&W system agreed a Target Operating Model which established a collaborative-led structure, including two Geographical Care Collaboratives, a Primary Care Collaborative, an Acute Provider Collaborative, a Mental Health Collaborative, and a Learning Disability and Autism (LDA) Collaborative.
- 1.4 In June 2024, the two Geographic Care Collaboratives—covering Coventry and the three Warwickshire footprints were formally established as committees of the ICB Board. Operating as sub-committees of the ICB Board, these Collaboratives include cross-sector representation from providers, local authorities, clinicians, and the voluntary sector. They hold delegated commissioning budgets and decision-making authority for key service areas including Urgent and Emergency Care, Community Services, Continuing Healthcare (CHC), and the Better Care Fund (BCF).
- 1.5 In effect, these Care Collaboratives form the foundation of future Accountable Care Organisation (ACO) models for Coventry and Warwickshire. Through a Host or Lead Provider arrangement, they are positioned to assume more advanced responsibilities, such as managing a per capita budget, delivering coordinated care across entire pathways, and integrating local providers to deliver seamless, person-centred services.
- 1.6 The Care Collaboratives are supported by well-established Provider Collaboratives in Acute, Mental Health, Learning Disability and Autism, and Primary Care, which enable delivery at scale and across organisational boundaries.
- 1.7 The ICB has a clear development plan in place to build on these strong collaborative foundations. This includes strengthening collaborative capability, maturing governance and accountability structures, and preparing for further delegation of commissioning functions in line with national reforms. As a result, C&W ICB is well positioned to lead the next phase of strategic commissioning and system transformation.

2. Care Collaboratives

- 2.1 Care Collaboratives bring together Place partnerships of health and social care at a geographical footprint; empowering local leaders, who know their communities and local services, to shape, inform, and ultimately make commissioning and delivery decisions to drive greater collaboration and integration in respect of the planning and provision of services to best meet the needs of the citizens of Coventry and/or Warwickshire.

Connecting with their local communities Care Collaboratives will support the design and delivery of integrated pathways and services to ensure that outcomes are improved, and health inequalities reduced for the local populations.

2.2 There are two Care Collaboratives across Coventry and Warwickshire – one for Coventry and one for Warwickshire. Each Care Collaborative Committee operates as a formal sub-committee of the ICB Board with delegated authority for commissioning decisions. These Committees are supported by Collaborative Forums, which act as the ‘engine room’ for transformation—bringing together a wider range of stakeholders to co-design care models, develop innovative delivery proposals, and work in partnership with the three Place-Based Partnerships to make recommendations that drive local service improvement.



2.3 The key areas of focus include:

- **Community Integrator:** Supporting Lead Providers to establish Integrated Neighbourhood Teams, with a focus on developing robust Population Health Management capabilities. This work aims to design and deliver services tailored to local needs at the neighbourhood level.
- **Integrated Urgent and Emergency Care (iUEC):** Advancing integration of urgent care pathways across health and care settings, with a particular emphasis on coordination between primary care, community services, and acute providers.
- **Winter Resilience:** Prioritising and coordinating winter pressure schemes to ensure system preparedness. This includes fostering collaborative, cross-sector responses to demand surges during winter months.
- **Long-Term Conditions:** Enhancing community-based care and proactive management models for people living with long-term conditions, aligned with national ambitions to reduce hospital admissions and improve quality of life.
- **Patient Transport Services Commissioning:** Reviewing and refining local commissioning arrangements to ensure timely, equitable, and efficient non-emergency transport services, particularly for vulnerable populations.

Care Collaborative Development Programme

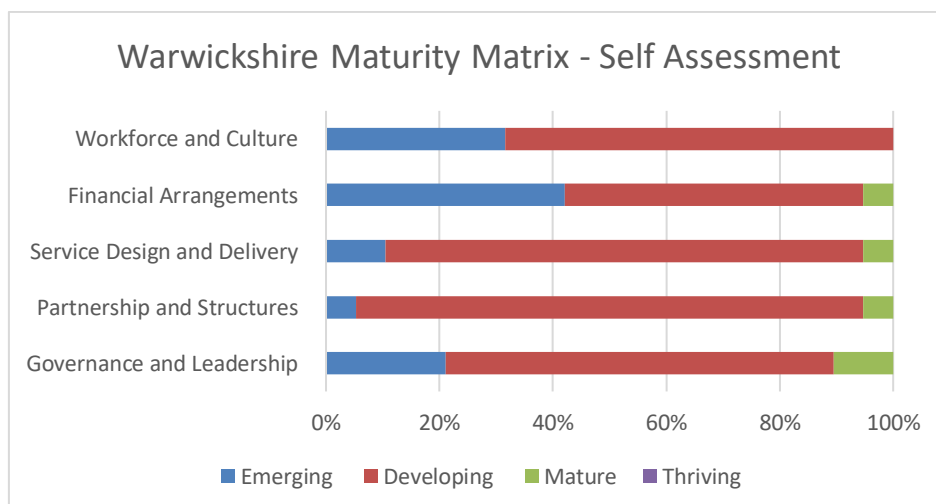
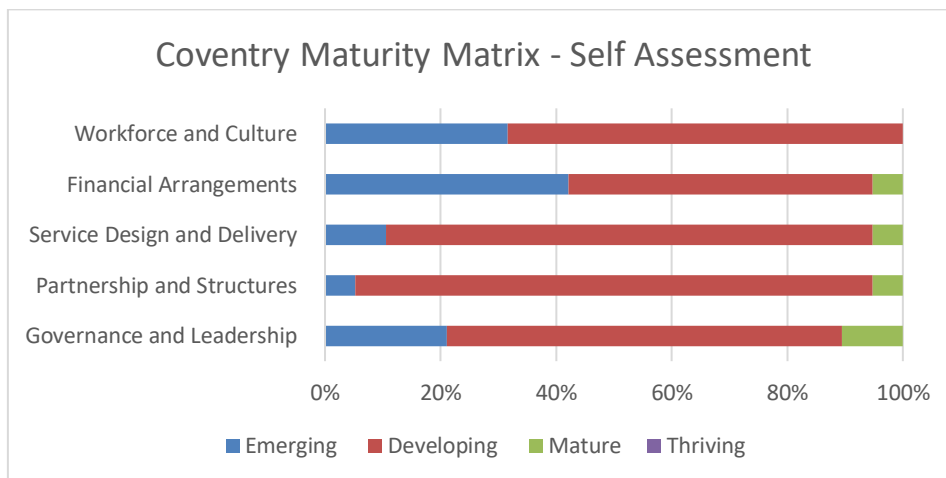
2.4 Care Collaborative development continues to be a strategic priority for the ICB. As the system progresses towards the delegation of more commissioning responsibilities to local footprints, the development of strong and robust partnerships with appropriate commissioning capability and capacity will be essential to us delivering our goals.

2.5 Strengthening the capability of Care Collaboratives in areas such as finance, leadership, and service planning is key to enabling them to take on expanded delegated functions. This includes preparing for a shift of transactional functions and tactical commissioning outward to Host providers and partners, allowing the ICB to focus on system leadership, strategic commissioning, and population health outcomes.

2.6 To support this development journey, we have a robust development programme. A maturity matrix has been designed to monitor and track the progress of Care Collaboratives over time. The maturity matrix has is provided in full in appendix 1, and encompasses five core domains:

- Governance and Leadership
- Partnership Structures
- Service Design and Delivery
- Financial Arrangements
- Workforce and Culture

- 2.7 All Care Collaboratives members (forum and committee) were invited to undertake a self-assessment against these domains, rating their current maturity as either Emerging, Developing, Mature, or Thriving. The assessment was designed to support local reflection and inform tailored development activity.
- 2.8 Coventry achieved a 58% completion rate, with 19 out of 33 members submitting a self-assessment. This represents an encouraging level of engagement. In contrast, Warwickshire recorded a lower response rate, with only 16 out of 50 members completing the assessment, equating to a 32% uptake. This comparatively low level of participation in Warwickshire is disappointing and presents a challenge in terms of fully understanding the maturity position and identifying consistent development needs across the footprint.
- 2.9 Despite the variation in uptake, the overall percentage-based maturity profiles between the two geographies are closely aligned, as demonstrated in the charts below:



- 2.10 The analysis indicates that both Coventry and Warwickshire scored predominantly in the "Emerging" and "Developing" categories, reflecting the early phase of collaborative maturity. This outcome is consistent with expectations at this stage of development. A breakdown by domain highlights that:
- Governance and Leadership and Partnership Structures in both areas are largely assessed as "Developing", suggesting early progress in shaping collaborative oversight and decision-making arrangements.
 - Financial Arrangements was commonly rated as "Emerging", indicating this as a key area requiring additional focus and support to strengthen commissioning infrastructure. This also needs to be considered in the wider System and National financial context.
 - Service Design and Delivery and Workforce and Culture assessments are primarily within the "Emerging" and "Developing" range, consistent with the current stage of evolution of the collaboratives.
 - Notably, Warwickshire showed slightly higher levels of "Developing" scores in Service Design and Governance, while Coventry had marginally higher proportions of "Emerging" responses in Financial Arrangements and Workforce. Neither geography reported any domain as "Thriving", which underscores the shared recognition that substantial development remains ahead.
- 2.11 NHS Elect facilitated development sessions for both Care Collaboratives in March 2025. These sessions served to validate the outputs of the self-assessment process, identify key areas for improvement, and agree future development priorities. In addition, the sessions provided a valuable opportunity for partners to come together and build skills in collaborative working—specifically focusing on the development of robust, deliverable proposals and effective strategies for managing conflicts in decision-making. Feedback from both sessions was positive, with high levels of attendance and strong engagement from participants.
- 2.12 Recommendations arising from these sessions are currently being incorporated into the ways of working and future work programmes of the Forum and Committees. Further development sessions are scheduled for June, September, and December 2025, and will be tailored to reflect the outputs and themes identified from the self-assessment process and earlier development activity.
- 2.13 In addition, a dedicated development session hosted by Capsticks will take place later in the year. This will focus on the Provider Selection Regime (PSR), with the aim of ensuring that Care Collaborative members and host organisations are fully informed of their responsibilities and requirements under the updated procurement regime.

3. Acute Collaborative

- 3.1 The objectives of the Acute Provider Collaborative (APC) focus on reducing variations in quality, efficiency, and access, while addressing unequal experiences and outcomes. APC have identified the following priorities based on the areas where there is greatest opportunities to work together across the three Acute trusts to improve delivery. A brief update against each priority is detailed below:
- **Oncology Network:** The oncology network triumvirate leadership team has now been appointed. Inaugural meeting held 9th April 2025. Initial programme of work under development with a view to what can be delivered in first six months. The oncology network seeks to develop

a single service model underpinned by tri-party partnership agreement, single governance, shared accountability and shared resources.

- **Urology Network:** The Urology Area Network (UAN) met 28th March, work continues focused on improvements in prostate cancer care, acute kidney stones pathway and sustainable workforce.
- **Pathology Network:** Review of current services complete. Proposals for a sustainable pathology offer currently being socialised, with sign off amongst the three Trusts due by end of May.
- **Stroke:** Quality review complete, incorporating outcomes against business case. Next steps and improvement plan to be agreed early May 2025.
- **Interhospital transfer:** Work on-going to understand issues and risk against timely inter-hospital transfers for stroke, cardiology and neuro-surgery.
- **Elective Productivity:** New priority for APC as agreed at February 2025 formal meeting. Programme plan under development.

4. Mental Health Collaborative and Learning Disability and Autism (LDA) Collaborative

4.1 The Mental Health Collaborative and LDA Collaboratives are two separate Collaboratives:

- The Mental Health Collaborative brings together experts by experience, alongside representatives of key partner organisations including commissioners, providers and other local stakeholder bodies. The purpose of the Mental Health Collaborative is to improve the mental health and wellbeing of children, young people and adults by working together at scale.
- The LDA Collaborative is to provide a space to have joint and collective oversight, responsibility and decision making relating to achieving our shared system objectives for autistic people and people with a learning disability. The LDA Collaborative oversees the work of the LDA Operational Steering Group, LDA Health Inequalities Steering Group, Autism Partnership Board and the Working in Partnership Learning Disabilities Group.

4.2 In line with the national direction of travel for ICBs to delegate operational and transactional commissioning activities to provider organisations, and learning from other further advanced systems in the West Midlands where such arrangements have already been in place since 2022, the ICB's will look to follow the direction of travel for Coventry and Warwickshire Partnership NHS Trust (CWPT) to formally become Lead Provider through delegation of a tactical commissioning for all-age mental health services. This is intended to commence with adult mental health services and then incorporate child and adolescent mental health services (CAMHS). A new high-level contract between the ICB and CWPT will support these arrangements, based on a new system all-age mental health strategy.

4.3 A review is underway led by the Chief Integration Officer for Mental Health, Learning Disabilities and Autism to evaluate the role and purpose of the Mental Health and LDA Collaboratives. This strategic assessment will inform the development of a roadmap for their future within the system commissioning and delivery architecture.

4.4 Further work to develop relevant governance and supporting architecture arrangements will draw on existing learning from within Coventry and Warwickshire, the Midlands and across England.

5. Primary Care Collaborative

- 5.1 The Primary Care Collaborative (PCC) has been operational since September 2022 and has a membership made up of clinicians and managers from Practices, PCNs and at scale Providers working as the expert reference group for primary care within the system. The initial focus has been on developing a strong and unified voice for General Practice to support, develop and strengthen General Practice services and their offer to the system. In parallel regular meetings take place with pharmacy, optometry, and dental providers and a joint provider collaborative forum has been set up in early 2025.
- 5.2 The recent areas of focus include the development of the Primary Care Strategy, which was clinically led and included a thorough engagement with Primary Care stakeholders, the strategy is now being finalised. This has been signed off by the ICB Board and was published in March 2025. This will shortly be followed by more detailed Primary Care People and Information technology strategies to enable successful delivery.
- 5.3 In March PCC had a development session facilitated by NHS Elect around the implementation of the Primary Care Strategy. Discussion areas included:
- Key objectives in the strategy and clarification of outstanding questions about the published document
 - Key risks to implementation
 - Key risks of not delivering
 - Management/Mitigation of risk
 - How to support a high accountability climate within the PCC group
 - Proposed future state for PCC – key opportunities, the power of an effective GP Collaborative, understanding the importance of all levels of scale (practice, PCN, Place, System) and the role/need for GP providers at those scales, GP provider ambition.

6. VCFSE Collaborative

- 6.1 As set out in NHSE's Design framework and within "ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector". ICBs are expected to have developed a formal agreement for engaging and embedding the VCFSE (Voluntary, Community, Faith and Social Enterprise) sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector.
- 6.2 The VCFSE Collaborative was organically developed by the sector with support from the ICB with the intention to:
- Provide the ICS with a **single route of contact and engagement** with the sector across the system and links to communities, reducing risk of duplication and conflict of interest
 - Compliment and **join up with the wider ICS structure** across Geographical Care Collaboratives and at Place in both Coventry and Warwickshire
 - Facilitate an **equitable and fair process** for the whole sector to gain access to funding and opportunities to integrate and participate in collaborative working, encouraging and enabling the sector to operate in a coordinated way

- Enable the VCFSE in CW to have a **representative voice at system and collaborative** level – both as a provider and as a link to local communities
- Better positions the VCFSE sector within the ICS to enable it to **contribute to the design and delivery of integrated care**

6.3 In its first year the VCFSE Collaborative has focused on ensuring its structure is representative of the sector, growing its reference group and supporting involvement of the sector in decision-making through Collaborative members participating in the geographical Care Collaboratives. Recognising the dual role which the sector plays in our health economy, there are representatives for the sector as providers of services, as well as the sector as links to seldom heard and underserved communities.

6.4 In 2025/26 the focus of the VCFSE Collaborative is to grow its membership with a focus on smaller, grassroots organisations to enable their representation in our structures. The first Assembly of the VCFSE Collaborative, bringing together the Sector with statutory health and care organisations is scheduled for May 22nd 2025, to explore the role of the Collaborative in service design and development, focusing on the work already in train on prevention. Supporting the representation of the sector across our collaborative structures, the Collaborative are also working on a Memorandum of Understanding to guide the relationship between the sector and statutory organisations of the ICS, building on best practice approaches from other areas.

7. Recommendations

7.1 Members are requested to note the contents of the report for information.

End of Report

Appendix 1: Care Collaborative Maturity Matrix

Dimension	Emerging	Developing	Mature	Thriving
1. Governance & Leadership	<ul style="list-style-type: none"> Informal leadership roles. Limited shared decision-making. Minimal alignment with strategic priorities. 	<ul style="list-style-type: none"> Established leadership group with defined roles. Some shared governance arrangements. Joint vision or strategy developed. 	<ul style="list-style-type: none"> Formal governance structure in place. Strong alignment with ICS/organisational priorities. Regular joint decision-making and accountability. 	<ul style="list-style-type: none"> Integrated leadership and governance across partners. High trust, shared ownership of outcomes. Proactive joint strategic planning and decision-making.
2. Partnership Structures	<ul style="list-style-type: none"> Partnership structures are ad hoc and task-specific. Limited collaboration mechanisms. Little/no public engagement. 	<ul style="list-style-type: none"> Partnership structures are formalised (e.g., working groups, steering committees). Shared forums for discussion and problem-solving. Some public engagement. 	<ul style="list-style-type: none"> Integrated committees or boards in place. Effective collaboration mechanisms established (e.g., shared platforms, integrated workstreams). Effective patient engagement 	<ul style="list-style-type: none"> Co-designed and co-led structures that span organisations. Seamless communication and collaboration. Clear accountability and shared outcomes. Co-designed with the public.
3. Service Design & Delivery	<ul style="list-style-type: none"> Services are designed & delivered independently by each organisation. Limited data-sharing and joint planning. 	<ul style="list-style-type: none"> Some services are designed and delivered collaboratively (e.g., joint initiatives). Beginning to share data and plan jointly. 	<ul style="list-style-type: none"> Integrated service models (e.g., joint care pathways, shared data systems). Evidence of improved patient outcomes. 	<ul style="list-style-type: none"> Fully integrated services with shared performance metrics and outcomes. High patient satisfaction and outcomes across the partnership.
4. Financial Arrangements	<ul style="list-style-type: none"> Separate budgets and financial planning processes. Minimal pooling or shared resources. Organisations struggle to stay within financial budgets. 	<ul style="list-style-type: none"> Some shared funding or pooled budgets for joint initiatives. Financial risks and benefits are partially shared. Organisations stay within financial budgets. 	<ul style="list-style-type: none"> Pooled budgets and shared financial planning across multiple areas. Transparent financial governance in place. 	<ul style="list-style-type: none"> Fully integrated financial model with shared budgets and risk management. Financial sustainability and alignment with strategic objectives.
5. Workforce & Culture	<ul style="list-style-type: none"> Independent workforce planning. Limited joint training or cultural alignment. 	<ul style="list-style-type: none"> Some joint workforce planning and development activities. Beginning to build a shared culture and values. 	<ul style="list-style-type: none"> Joint workforce strategies in place. Shared learning and development programs. Strong culture of collaboration and respect. 	<ul style="list-style-type: none"> Fully integrated workforce planning. Shared culture, values, and identity. High levels of staff engagement and retention across the partnership

Report To and Date:	Coventry and Warwickshire Integrated Care Board, 21 May 2025
Report Title:	ICB Prioritisation Framework update
Report From:	Rachael Danter Chief Transformation Officer and Deputy Chief Executive Officer, Coventry and Warwickshire ICB
Author:	Rebecca Chislett, Director of Integration and Planning, Coventry and Warwickshire ICB
Previous Considerations and Engagement:	Not applicable
Purpose:	For Information

Contribution to meeting the aims of the ICS:			
Priorities	<input checked="" type="checkbox"/> 1 - Prioritising prevention and improving future health outcomes through tackling health outcomes	<input checked="" type="checkbox"/> 2 - Improving Access to health and care services and increasing trust and confidence	<input checked="" type="checkbox"/> 3 -Tackling immediate system pressures and improving resilience
Focus Areas	<input checked="" type="checkbox"/> 1 - Reducing health inequalities	<input checked="" type="checkbox"/> 4- Enabling personalised care	<input checked="" type="checkbox"/> 7 - Making services more effective through greater collaboration and integration
	<input checked="" type="checkbox"/> 2- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities	<input checked="" type="checkbox"/> 5 - Improving access to services especially primary care	<input checked="" type="checkbox"/> 8 - Supporting people at home
Key Points:			
<ul style="list-style-type: none"> • The ICB Prioritisation Framework has been co-produced with system partners to ensure a consistent, evidence-based approach to resource allocation across Coventry and Warwickshire. • Following successful testing on live scenarios during March and April, the tool has been finalised and embedded within the ICB’s commissioning and governance processes. • The tool evaluates proposals across seven defined categories, with four being scored to generate prioritisation ratings ranging from ‘Stop’ to ‘Expand’, supporting clear and transparent decision-making. • The first tranche of reviews has been completed, assessing 12 programmes (total value £9.3m), resulting in £5.6m recommended for disinvestment and £3.7m referred for review. • A second tranche, covering 12 further service reviews with a potential £2.3m in savings, is now in progress and due to be considered by the Executive Prioritisation Panel in May 2025. 			
Recommendation:			
Members are asked to NOTE the contents of this report for information.			

Implications						
Conflicts of Interest:	No conflicts identified					
Financial and Workforce:	This work programme recognises the significant financial challenges the ICS face and the necessity to prioritise focus in line with the areas which provide the greatest return on investment.					
Performance:	Quality, safety, and performance standards form a core part of the prioritisation tool					
Quality and Safety:						
Inclusion: The EQIA tool can be found in the EQIA policy here.].	Has an equality impact assessment been undertaken? (Delete as appropriate)	Yes (attached or hyperlinked)		No	N/A	✓
Patient and Public Engagement:	Stakeholder – including Patient, Public and Clinical and Professional engagement forms a key part of the decision-making process incorporated in this prioritisation approach.					
Clinical and Professional Engagement:						
Risk and Assurance:	No risks identified.					

1. Background and Context

- 1.1 The ICB Prioritisation Framework has been co-produced with system partners, drawing on established methodologies from across Coventry and Warwickshire Providers to promote alignment and consistency in how services are evaluated and prioritised.
- 1.2 The testing phase of the prioritisation tool has now been successfully completed. Insights and feedback gathered during live scenario testing in March and April have been reviewed and incorporated, resulting in a finalised tool that is ready to be used consistently across the ICB commissioning process.
- 1.3 The finalised framework (enclosed within appendix 1) is now operational and will guide future commissioning decisions through the established ICB governance processes.

2. Key Features of the Prioritisation Tool

- 2.1 The prioritisation tool will be applied in the following circumstances:
 - Decommissioning or disinvestment decisions
 - Prioritising interventions, services or access either in the context of introducing/expanding services or restricting access so that services are targeted to cohorts who will benefit most
 - Annual planning cycle
 - Transformation investment
 - Assessment of existing commissioned services in context of delivery of clinical and financial value.
- 2.3 The table below shows the key features of the prioritisation tool, including the categories, weightings, and the associated scores:

Category	Weighting
1. Strategic alignment	Start/Stop
2. Population need	25%
3. Effectiveness and Risk	20%
4. Health Inequalities	25%
5. Value	30%
6. Deliverability	Consideration
7. Interdependencies	Consideration

Scores
 0 = minimal confidence
 2 = limited confidence
 4 = strong confidence
 6 = robust confidence

Not weighted, used as a way of planning the speed of implementation, i.e. immediate (within year), year 1, year 2 etc.

STOP <small>Less than 20 points</small> Recommendation is to: Disinvest	REVIEW <small>20 - 48 points</small> Recommendation is to: Restrict Access / Improve Value	CONTINUE <small>49 - 55 points</small> Recommendation is to: Start if Funding is Available	EXPAND <small>Greater than 55 points</small> Recommendation is to: Invest
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- **Evaluation Categories:** The tool assesses services or proposals based on seven categories: Strategic Alignment, Population Need, Health Inequalities, Clinical Effectiveness and Risk, Value for Money, Interdependencies, and Deliverability. Each category includes a comprehensive series of questions/definitions to provide guidance on the evidence required to complete the tool, shown in appendix 1.
- **Scoring and Weighting:** Four out of the seven categories are quantitatively scored. Scoring guidance has been developed to provide a framework for assessing the reviewer's confidence in the evidence that demonstrates the value/benefit of each category. Confidence scores of zero to six reflect the strength, reliability, and clarity of the available evidence in supporting the expected value. The combined score generates a prioritisation rating.
- **Prioritisation Ratings:** The tool can be used to either i) score and rank proposals to identify optimal return on investment, and/or ii) assess a standalone proposal by generating an overall prioritising rating against set thresholds. These ratings range from 'Stop' to 'Expand'.

3. How the tool has been implemented

- 3.1 The prioritisation tool has been tested and refined by the ICB Senior Leadership Team (SLT) and Executive Team. This testing phase involved applying the tool to a range of live commissioning scenarios to assess effectiveness, value, and impact. These scenarios include:
- **Non-recurrent services** – e.g. temporary services introduced during COVID-19 or transformation proof of concept pilots.
 - **Services with upcoming contract expirations** within the next 12 months, requiring value assessment to inform renewal, redesign or exit arrangements.
 - **Commissioned services** to evaluate ongoing outcomes and value for money.
- 3.2 The implementation process follows a structured and multi-disciplinary approach:
- A designated Review Lead (typically the ICB commissioning or programme lead) completes the tool, drawing on expert input from Business Intelligence, Finance, Quality, Contracting, and Clinical colleagues.
 - A multi-disciplinary SLT review team then evaluates the completed tool, assessing the strength of the evidence and assigning preliminary scores to support recommendations.
 - The Executive Prioritisation Panel moderates and finalises the scores, confirming the proposed commissioning outcome.
- 3.3 Each proposal is assigned one of four decision categories based on its overall score and strategic fit:
1. **STOP: Disinvest or decommission** services that do not meet minimum value thresholds.
 2. **REVIEW:** Modify services by **restricting access** or **Improve Value** (introducing clinical/cohort thresholds, negotiating prices, redesign services or re-procurement of provision)
 3. **CONTINUE: Maintain current service** delivery where value and alignment are demonstrated
 4. **EXPAND: Increase investment in services** where value can be demonstrated.
- 3.4 Outputs from the prioritisation tool feed directly into the existing ICB's governance structure. Appendix 2 includes flowcharts that outline the end-to-end decision-making process, including the

necessary engagement with providers, clinicians, and patient representatives. This ensures transparency, inclusivity, and rigour at each stage of the process.

4. Progress to date

4.1 The first tranche of prioritisation programmes has now been completed, covering 12 programmes with a combined indicative value of **£9.3m**. Outcomes from this tranche are as follows:

- 6 programmes were recommended for disinvestment ('**STOP**') and will now be subject to the ICB Decommissioning Policy, with a projected saving of **£5.6m**
- 6 programmes were categories as '**REVIEW**' cases, where services may be reconfigured, restricted, or recommissioned to deliver better value for money, with a total indicative value of **£3.7m**

4.2 The second tranche prioritisation review is now underway. This next set includes 12 services reviews, with an estimated potential saving of **£2.3m**. These reviews are scheduled for consideration by the Executive Prioritisation Panel in May 2025.

5. Conclusion

5.1 The development and implementation of the Prioritisation Tool has enabled the ICB to put in place a robust, transparent, and consistent process for prioritisation locally that meets the core purposes of the ICB. It has been developed with input from system partners and piloted across a range of programme areas.

6. Recommendation

Members are asked to **NOTE** the contents of this report **for information**.

Appendix 1: Prioritisation Tool

Category	Questions	Evidence	Res No.	Start/Stop
Strategic Alignment	Which of ICS Strategic Priority's does this align with?			
	Is this a mandated National Must do that the ICS has agreed to?			

Category	Definition – Overview of the evidence required	Evidence	Score	Weighting	Overall
Population Need	Size of Population affected by this service (Identify cohort i.e. children with Asthma rather than Children per se - PHM useful to identify cohort)			2.5	0
	Define impact on health without this service (Ideally using standard measures such as QALYs, ICERs, VBF, Physical health measures, outcomes i.e. Evidence base to support this population need i.e. Fingertips, PHM HealthIntents, Published peer review papers, NICE. Is this the best available data to evidence this need?				
	Relevant benchmarking - analysis of need Place, Care Collaborative, ICBS,				
Effectiveness	Define net impact on health with this service (Ideally using standard measures such as QALYs, ICERs, VBF, Physical health measures, outcomes i.e. Evidence base to support this i.e. Published peer review papers, pilot programmes, NICE			2.0	0
	What timescale are these health impacts expected to arise? Ideally profiled by month in year, then quarters thereafter				
	Quality Impact				
	Does this service address a significant provider or system risk?				
Health Inequalities	How does this service impact Health Inequalities on the population in scope of the service? (ensure all protected characteristics are considered)			2.5	0
	Will the gap in health life expectancy be impacted and by when and how?				
	Evidence base to support this i.e. Published peer review papers, pilot programmes				
	What timescale are these health inequalities impact expected to arise? Ideally profiled by month in year, then quarters thereafter				
Value	Does the service increase productivity (overall activity increases)? And describe how			3.0	0
	Does the service increase efficiency (unit cost decreases)? And describe how				
	What timescale are costs and financial benefits impact expected to arise? Ideally profiled by month in year, then quarters thereafter				
	Will there be stranded/double running costs that need to be considered what are they? How will these be mitigated and managed?				
	Does this service either increase/reduce/distribute costs and/or activity?				
	What source of funding will support this service?				

Total Score **0** Out of a possible 60

STOP
Less than 20 points
Under 33%

REVIEW
20 - 48 points
33% - 80%

CONTINUE
49 - 55 points
81% - 92%

EXPAND
Greater than 55 points
93% & above

Category	Definition – Overview of the evidence required	Evidence	Planning Consideration/Implementation Approach
Deliverability	What is the timescale for implementation (<6 months, <12 months, 1-2 years, 2+ years)		
	What resource constraints are there? (workforce/estates/digital infrastructure etc.)		
	How are these constraints to be mitigated?		
Interdependencies	What interdependencies are there with other system partners?		
	Have these interdependencies been agreed between partners?		
	If this service is part of a wider pathway, explain how it interfaces with other pathway elements?		

STOP
Less than 20 points
Under 33% effective

Total score indicates that the proposal is not effectively meeting a population need, is not improving health, is not reducing health inequalities and is not providing value for money. Recommendation is to **STOP**.

REVIEW
20 - 48 points
33% - 80% effective

Total score indicates that the proposal has limited effectiveness or is not providing value for money. Recommendation is to **REVIEW**. Consider improving the value, restricting access, pausing or exiting the service after further consideration.

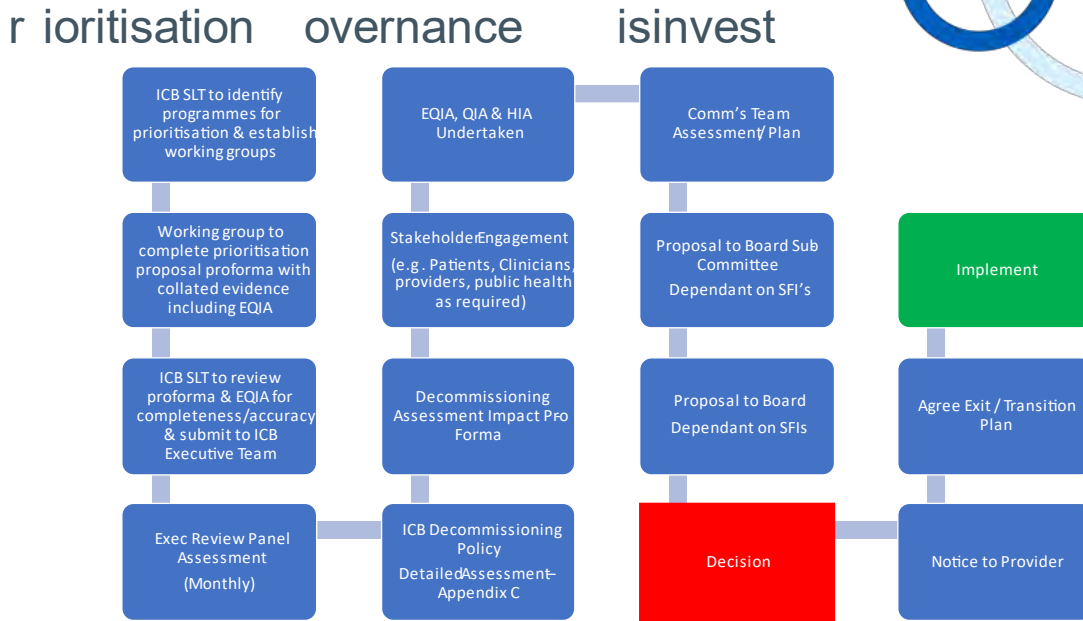
CONTINUE
49 - 55 points
81% - 92% effective

Total score indicates that the proposal is effectively meeting a need or improving health, reducing health inequalities and providing value for money. Recommendation is to **CONTINUE** investing in the service or start if funding is available.

EXPAND
Greater than 55 points
Above 93% effective

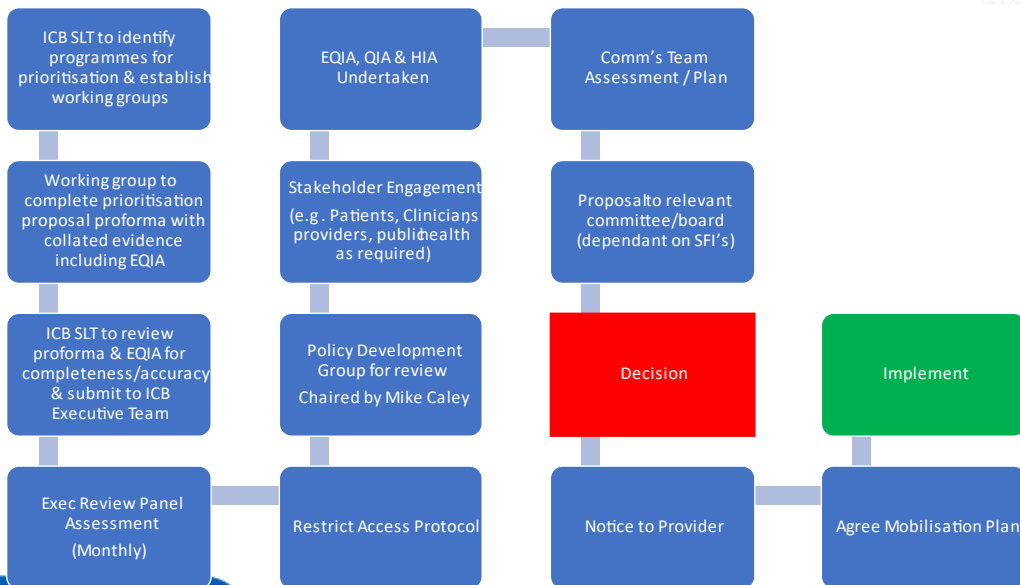
Total score indicates that the proposal is highly effective at meeting a population need, improving health, reducing health inequalities and providing value for money. Recommendation is to **EXPAND** the service or invest .

Appendix 2: Decision-Making Flowcharts



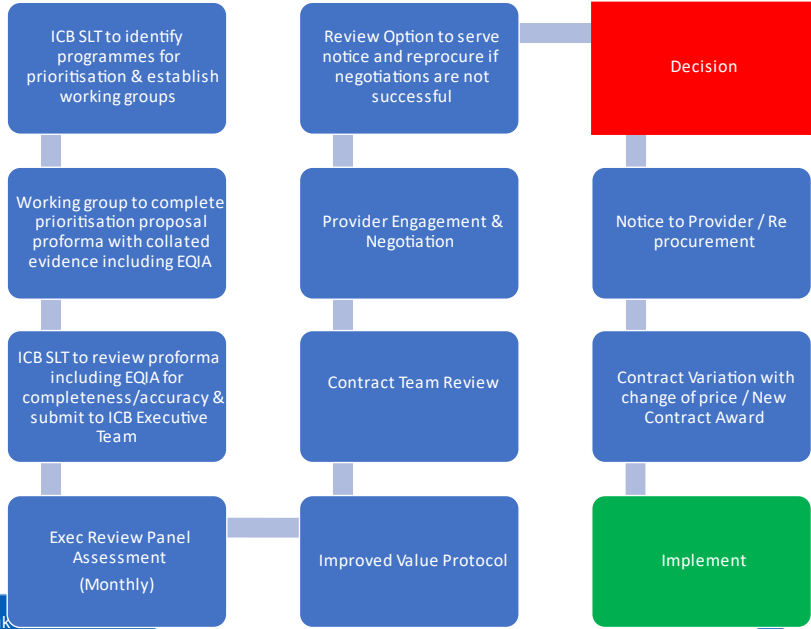
happ health lives.uk

Investment Decision



happ health lives.uk

Procurement Prioritisation Governance Improve Value



happy health lives.uk

Report To and Date:	NHS Coventry and Warwickshire Integrated Care Board – 21 May 2025
Report Title:	Board and Committee Governance
Report From:	Mark Gwynne, Director of Corporate Governance, Coventry and Warwickshire Integrated Care Board
Author:	Mark Gwynne, Director of Corporate Governance, Coventry and Warwickshire Integrated Care Board
Previous Considerations and Engagement:	Finance and Performance Committee – 5 February 2025 Non-Executive Forum – 16 March 2025 Meeting to discuss refocusing Finance & Performance Committee – 31 March 2025 ICB Executive – 7 May 2025
Purpose:	For Approval

Achievement of the following ICP Priorities and Focus Areas is supported:

Priorities	<input type="checkbox"/> 1 - Prioritising prevention and improving future health outcomes through tackling health outcomes	<input checked="" type="checkbox"/> 2 - Improving Access to health and care services and increasing trust and confidence	<input type="checkbox"/> 3 - Tackling immediate system pressures and improving resilience
	<input type="checkbox"/> 1 - Reducing health inequalities	<input type="checkbox"/> 4- Enabling personalised care	<input type="checkbox"/> 8 - Supporting people at home
Focus Areas	<input type="checkbox"/> 2- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities	<input type="checkbox"/> 5 - Improving access to services especially primary care	<input checked="" type="checkbox"/> 9 - Developing and investing in our workforce, culture and clinical and professional leadership
	<input type="checkbox"/> 3- Enabling the best start in life for children and young people	<input type="checkbox"/> 6- Engaging and involving our people, communities and stakeholders	
		<input type="checkbox"/> 7 - Making services more effective through greater collaboration and integration	

Executive Summary and Key Points:

Enhancements are needed to governance processes on a regular basis to ensure they remain appropriate for the Board and Committees. This is particularly important during times of significant change, meaning higher risk, and to take on Board learning from best practice.

To support the changes, a review of the NHSE Insightful Board proposals has taken place, supplemented by a review of existing governance arrangements, feedback from committee chairs and consideration of where added oversight and assurance is required through the ICB change process.

Each of these has highlighted some areas where changes can be made to streamline current working or enhance oversight and assurance arrangements.

Summary of key changes:

- Establishment of a System Finance and Performance Committee, engaging System partners to enhance shared ownership and challenge
- Disestablishment of the system-focused People Committee and the ICB People Committee with key aspects being picked up between revised working of the Finance and Performance Committee, the proposed Finance and Performance (System) Committee and the Remuneration Committee
- Renaming of the Quality, Safety and Experience Committee to the Patient Safety Committee
- Establishment of a Transition Committee to oversee and receive assurance on progress and the pace of change in establishing new ICB working arrangements whilst managing the day to day business of the ICB.

Recommendation:

Members are requested to:

- **APPROVE** the changes proposed to committee structures including dissolution of the People Committees and creation of a Transition Committee and a Finance and Performance (System) Committee.
- **APPROVE** the Terms of Reference for the Finance and Performance (System) Committee.
- **APPROVE** the amended Terms of Reference for the ICB Finance and Performance Committee.
- **APPROVE** the Terms of Reference for the Transition Committee.
- **APPROVE** the direction of travel with changes to the policy approval approach for Audit Committee consideration.
- **DELEGATE** authority to the Audit Committee to approve amendments made to the Remuneration Committee Terms of Reference relating to the transfer of workforce responsibilities from the ICB’s People Committee and a mandated increase in meeting frequency.
- **DELEGATE** authority to the Audit Committee to approve Terms of Reference for the Patient Safety Committee to take forward the Terms of Reference from the Quality, Safety and Experience Committee with appropriate changes to emphasis for responsibilities of the committee.
- **DELEGATE** authority to the Audit Committee to approve amendments to the ICB’s Scheme of Reservation and Delegation in respect of the recommendations set out in this paper which are subsequently approved by the Board.

Implications

Conflicts of Interest:	This report raises no concerns regarding Conflicts of Interest.
Financial and Workforce:	None identified

Performance:	None identified					
Quality and Safety:	None identified at this stage, however, proposals will see an increased committee focus on patient safety, recognising that quality may dip in some areas					
Inclusion						
Has an equality impact assessment been undertaken? (delete as appropriate) An EQIA is required for new services or changes to service delivery. For more information the EQIA Policy and Tool can be found here .	Yes (attached or hyperlinked)		No (state why in the row below)		Not applicable (state why in the row below)	✓
These proposals do not require an EQIA.						
Has a Health Equity Assessment Tool (HEAT) been completed? HEAT may be used for new, changing, or existing services and processes. More information can be found here .	Yes (attached or hyperlinked)		No (state why in the row below)		Not applicable (state why in the row below)	✓
These proposals do not require a HEAT assessment.						
Engagement						
Patient and Public Engagement:	There is no requirement to engage on these proposals, however, committee details and policies will be made available via the ICB's website for transparency.					
Clinical and Professional Engagement:	Relevant colleagues have been involved in informing proposals.					
Risk						
Risk:	Streamlining of committees and ways of working will mitigate some of the risks mentioned within the report.					

1. Introduction

- 1.1 Several dimensions have been considered to propose changes to current governance and committee arrangements within the ICB to better meet current and future needs. Committee chairs have made proposals around changes to some committees and consideration has been given to future challenges in the reconfiguration of ICBs. The latter presents an increased risk to the day-to-day delivery whilst managing the change process at pace.
- 1.2 The reconfiguration of ICBs, as well as presenting increased risk to delivery, also makes implementation of some desired changes problematical in the short term due to overall capacity for change and the longevity of some improvements, whilst also preparing for the future. Once the Model Region and Model National designs and remits are further known, the local approach may need to be updated to reflect any changes and shift in responsibilities or functions.
- 1.3 The key aspects informing the recommendations are highlighted in the following sections.

2. NHS England – The Insightful ICB Board

- 2.1 In November 2024, NHSE published their guidance on Insightful Boards with two papers focusing on Provider Boards and ICB Boards. This flags six functional areas for ICB Boards to consider and be assured that these topics are covered through Board and Committee work programmes to enhance the effectiveness of Boards in delivering for their local communities.
- 2.2 The six themes set out are:
 - Strategy and Planning: Focusing on understanding current and future health needs, resource allocation, and integrated community-based care.
 - Leadership: Ensuring effective collaboration, mutual accountability, and transparency among system partners.
 - Strategic Commissioning: Arranging services based on local needs, focusing on long-term conditions, and ensuring patient choice.
 - Assuring Performance, Quality, and Delivery: Monitoring provider performance, benchmarking against peers, and ensuring value for money.
 - Learning and Transformation: Promoting continuous improvement, innovation, and effective use of data and technology.
 - Effective Governance and People: Ensuring robust governance structures, healthy internal cultures, and effective risk management.
- 2.3 It is not intended that these themes form the basis for structuring meetings, but rather that they are designed to help ICBs effectively fulfil their roles and responsibilities, ensuring high-quality healthcare services and better health outcomes for the population.
- 2.4 A self-assessment against the criteria within the Insightful Board has been drafted and used to help inform future actions to further improve governance and ways of working.

- 2.5 Some of the key improvements already underway or being implemented in response to these themes include:
- Strategy and Planning – embedding Population Health Management within strategy development, refresh and approaches within delivery / action plans
 - Leadership – increasing working at Chair, CEO, and executive level across the system to share learning and explore opportunities for joint working
 - Strategic commissioning – defining strategic commissioning and the Board’s role as a strategic commissioner enabling effective tactical commissioning through collaboratives
 - Effective Governance – enhancing risk management with a total refresh of the Board Assurance Framework and Corporate Risk Register to bring up to date, align to strategy aims and reflect current challenges.

3. Committee Chairs and Non-Exec Forum

- 3.1 Input has been received largely from the committee chairs and a very engaging meeting with Non-Execs across the System. This demonstrated an eagerness to work collaboratively across the System and Non-Executive Directors (NEDs) to take a role in challenging within their respective Trusts, building on their knowledge of the overall System perspective and pressure points. NEDs were eager to be involved in committees, building on the System People Committee to address the System finance challenges. They also found the Audit Chairs meeting to add value, with a similar approach possible linked to the Finance & Performance Committee.

Finance & Performance Committee

- 3.2 There is a need to create a better focus to some committees and enable more working across the system. The Non-Exec Forum was eager to see a System Finance & Performance Committee, replicating what is done for People Committee and incorporating NED finance chairs, or leads, from across the System: enabling the NEDs to be able to take back and provide consistent challenge to their respective organisations.
- 3.3 A review led by the previous Finance & Performance Chair highlighted some areas to improve and it has been agreed that a tighter focus is needed for this committee, as well as implementing the System meeting, to rise to the current financial challenges. The key areas for development are:
- Assist the committee to attain a clearer delineation and focus between the ICB as an entity, the System and how we perform as partners and collaboratives.
 - Increase focus on medium term performance. Emphasis on looking beyond the current year.
 - Changing the way the committee engages with left shift and prevention, considering this a specific area for finance and performance.
 - Elevating our materials to the committee so that we can get really good value out of Executive colleagues and experts in our organisation. Reviewing the business and our approach so that we don’t get caught up in things that could be dealt with elsewhere.

- 3.4 This has resulted in the development of revised Terms of Reference, informed by the new interim chair, and splitting the Committee into two committees each with their own Terms of Reference to ensure clarity of scope and purpose for each (the Terms of Reference are included as Appendices 1 and 2). These revised ToR highlight an increased emphasis on workforce productivity: recognising the inextricable link between staffing and financial performance. This change will specifically help address the Leadership theme of the Insightful Board report.

People Committee

- 3.5 Conversations with the chair of People and ICB People Committees has challenged the need for the continuation of these committees. The committees' business could be conducted elsewhere with inextricable links between workforce and spend, this aspect can be picked up through F&P Committee with an increased focus on workforce productivity. With challenges shared across the System, engagement of appropriate Non-Execs from other organisations has benefited the committee and this engagement within F&P should continue the progress that has been made through the system-focused People Committee. Other aspects need to inform revisions to Terms of Reference for the Collaborative Committees.

- 3.6 For the ICB People Committee, it is also recognised that within the current period of change, several aspects of the committee's work can be picked up through the Remuneration Committee, which as a result may be required to meet more frequently in the shorter term. It is therefore proposed that both the system-focused People Committee and the ICB People Committee be disestablished.

Remuneration Committee

- 3.7 To facilitate the People Committees being disbanded, the Remuneration Committee will require a review of the Terms of Reference and regularity of meetings to ensure that relevant aspects are able to be incorporated into agenda planning in a timely manner.

Quality, Safety & Experience Committee

- 3.8 Recognising the challenges across the System, the Quality, Safety and Experience Committee will be renamed as Patient Safety Committee. There will be slight changes proposed to the refreshed Terms of Reference which will be taken through the committee for endorsement. It is proposed that these changes are then agreed through Audit Committee.
- 3.9 The changes will ensure a strong focus on patient safety and enable better assurance in an increasingly complex environment with a reduction in funding available, which may impact on the quality of provision for services. With greater emphasis on strategic and tactical commissioning rather than direct delivery of services. Increased focus in this area will specifically help address the Assuring Performance theme of the Insightful Board report.

Care Collaborative Committees

- 3.10 Care Collaborative Committees are still in their early stages and continuing to grow, facing many pressures on their agendas and working through refining the roles of the Committee and their

respective forums. Consideration is being given to provision of further material “for information” relevant to their geographical areas which will help in their roles and could include information on out-of-scope services where this is helpful to inform decision making.

- 3.11 Both Care Collaborative Committees have been working their way through a maturity matrix to assess their evolution. This, alongside a committee effectiveness review will take place over the summer, towards the end of the first year of the Care Collaborative Committees being in operation. Following this wider consideration, proposed changes to the role and remit of the Care Collaborative Committees, as well as wider Terms of Reference changes, will be proposed later in the year to enhance and embed the place based working model and pick up appropriate aspects from the People Committee as required to support workforce considerations across primary care.

Transition Committee

- 3.12 A new Transition Committee is proposed to be established to oversee the delivery of existing ICB work as well as being assured as to the pace of change, progress in identifying and moving towards a new ICB operating model and the effective management of risks associated with the change process, as well as seeking assurance on progress, and overseeing the development of organisational design and implementation of change processes.
- 3.13 This committee will draw together Non-Executive and Executive membership, with the Non-Executives being the chair of the People Committees proposed for disestablishment and the Chair of the ICB: recognising the strategic and operational importance of this work as well as the impact on the people working within the ICB as it is currently configured. The Terms of Reference for the Transition Committee are included as Appendix 3.

4. Improving Committee Efficiency and Reporting

- 4.1 With increasing change and uncertainty across the System, there will be pressures on many committee agendas. This means that there is a benefit to increasing the focus on forward planning across Board, Committees and Executive meetings to enable the best use of decision making groups / roles and ensure appropriate oversight at all times. Similarly, effective utilisation of the Integrated Care Partnership meetings broadens ownership across the whole System, drawing in partners often on the periphery of activity, to support improvement in preventative work, access to services and improving health outcomes, whilst addressing inclusivity. To facilitate this, greater forward planning and alignment is happening between the ICP and both Health and Wellbeing Boards.
- 4.2 Lengthy committee agendas can negate the opportunity for providing effective challenge and lengthy reports seldom provide the required assurance due to a lack of focus making it difficult to pull out the most pertinent points. Equally, lengthy packs of committee papers are challenging for Board and Committee members to effectively scrutinise and challenge through meetings. Not all information provided needs to inform decision making, but equally sometimes background information is also helpful to broaden understanding across the whole System.

- 4.3 It is, however, important that decision making is transparent and therefore where Committees or the Board are asked to make a decision, these reports need sufficient time for members to be assured that the decision being recommended is the right one, to ask their questions and to pose any challenge they feel appropriate. In this regard, decision making reports must continue to be included as an item on the agenda rather than within for information papers.
- 4.4 With the changes and uncertainty facing ICBs, there is a need to increase the focus on effective risk management and providing assurance to the Board and Committees. To facilitate this some enhancements to reporting will be introduced, or re-introduced, including:
- Using the Board Assurance Framework (BAF) and key risks to inform agenda setting conversations
 - Greater prominence of BAF and Corporate risks at committees
 - Improved forward planning to drive paper quality and timeliness
 - Greater challenge to papers and focusing decisions
 - Providing information only papers as part of the agenda pack.
- 4.5 Traditionally, all policies have been put through committees for approval. This takes up valuable agenda time, often for limited benefit. It is now proposed that better use is made of senior management to approve many policies and only new policies, or those with significant changes, go through committees. The policies are proposed to be split into four categories to ensure effective oversight and responsibility for their agreement and these changes will be included in a revised 'Policy for Policies' to be considered by Audit Committee in June.
- 4.6 These categories would be, subject to Audit Committee consideration:
- Category 1 – Minor changes such as typos, updating job titles, etc. To be signed off by manager responsible for area and simple version of form to be sent to Policy, Procedure and Strategy Assurance Group (PAG). Changes do not require inclusion in periodic assurance report to Committees.
 - Category 2 – Content changes such as rewording to provide greater clarity, removal of process into a supporting document, etc. To be signed off by Chief / Director or senior deputy and simple version of form to be sent to PAG. Changes do not require inclusion in periodic assurance report to Committees.
 - Category 3 - Content changes that would have a low level impact on staff, services users, finances, performance or compliance. To be signed off by relevant system group e.g. System Finance Advisory Board, System Quality Group, Clinical Forum, Medicines Optimisation Group, ICB Senior Leadership Team (for internal policies e.g. workforce, health and safety), etc and full version of form to be sent to PAG. Summary of changes to be included in regular governance assurance reporting to Committees.
 - Category 4 – All new policies and any content changes that would have a high level impact on staff, services users, finances, performance, or compliance. To be engaged on by relevant system / ICB groups (as per Category 3 list) with full version of form sent to PAG. Following

which policy would be presented via dedicated recommendation report to Committee. As part of this, the Committee would be asked to consider whether the impact of changes required escalation of approval to Board, if not approval would be via the Committee.

- 4.7 For all changes at Categories 3 and 4, the required Equality and Quality Impact Assessments and other processes will be completed to ensure that there are not any adverse impacts on specific groups of residents or patients that need to be more fully considered and presented to the relevant Committee or group as part of the policy update for full consideration.

5. Managing Risks Through the Change

- 5.1 With the inevitable instability caused by the changes, there are several risks to organisational and system delivery which will need to be managed in the short term. These and other significant risks will be picked up through the transition process and can be considered within the appropriate committee(s) remits, recognising that overall responsibility for assurance and oversight of the change process will rest with the new Transition Committee.

- 5.2 These initial new risks are:

- Capacity and workload to manage the transition – including increased turnover and vacancy rates causing greater challenges to delivery.
- ICB focus through the distractions – picking up changing focus for the ICB and NHSE changes impacting on the role.
- System drifts apart – leading to a focus on future direction, providers entrenching and focusing on their own cuts rather than the System.
- Productivity – incorporating the challenges to work efficiently and effectively through the changes.
- Governance – avoiding processes and controls being short circuited, becoming confused or ambiguous as current arrangements continue to evolve and new arrangements are developed alongside.
- Safe transition – including how this is managed effectively for the Board, avoiding gaps in delivery and maintaining an appropriate pace.

- 5.3 As the transition evolves and future requirements become clear, further risks associated with specific aspects of the change process will be identified and included in considerations.

6. Recommendation

- 6.1 Members are requested to:

- **APPROVE** the changes proposed to committee structures including dissolution of the People Committees and creation of a Transition Committee and a Finance and Performance (System) Committee.
- **APPROVE** the Terms of Reference for the Finance and Performance (System) Committee.

- **APPROVE** the amended Terms of Reference for the ICB Finance and Performance Committee.
- **APPROVE** the Terms of Reference for the Transition Committee.
- **APPROVE** the direction of travel with changes to the policy approval approach for Audit Committee consideration.
- **DELEGATE** authority to the Audit Committee to approve amendments made to the Remuneration Committee Terms of Reference relating to the transfer of workforce responsibilities from the ICB's People Committee and a mandated increase in meeting frequency.
- **DELEGATE** authority to the Audit Committee to approve Terms of Reference for the Patient Safety Committee to take forward the Terms of Reference from the Quality, Safety and Experience Committee with appropriate changes to emphasis for responsibilities of the committee.
- **DELEGATE** authority to the Audit Committee to approve amendments the ICB's Scheme of Reservation and Delegation in respect of the recommendations set out in this paper which are subsequently approved by the Board.

End of Report



**Coventry and
Warwickshire**
Integrated Care Board

**Coventry and Warwickshire Integrated
Care Board**

**Finance and Performance (System)
Committee**

Terms of Reference

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1 Document Management

1.1 Revision History

Version	Date	Summary of Changes
0.1	23 April 2025	Incorporated System responsibilities in previous Finance & Performance Committee ToR, removing items that are purely ICB focused.

1.2 Document Control

- 1.2.1 The controlled copy of this document is maintained by Coventry and Warwickshire Integrated Care Board (ICB). Any copies of this document held outside of that area, in whatever format (e.g., paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

2 Introduction and Context

- 2.1 The ICB has a duty to meet the system financial objectives which will require financial balance to be delivered. This will require collaborative working to develop a shared financial framework and system wide plan.
- 2.2 A system financial framework should enable systems to make sure funds are transferred to where they are needed most. The framework comprises a financial strategy and financial mechanisms.
- 2.3 These Terms of Reference describe the scope, function, and ways of working for the committee that are consistent with the Statutory functions of the ICB.

3 Constitution

- 3.1 The Board of the Integrated Care Board (the Board) has established a committee known as the Finance and Performance Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.
- 3.2 The Committee will not function as a corporate decision-making body for the management of those functions delegated by NHS England to the ICB in respect of Primary Medical Services as set out in Schedule 2B, 2C and 2D of the Delegation Agreement.
- 3.3 The Committee will not function as a corporate decision-making body for the management of those functions delegated by NHS England to the ICB in respect of nor for Specialised Services delegated from NHS England to the ICB.
- 3.4 The Committee is a non-executive chaired committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.
- 3.5 The Terms of Reference for the Committee outlined below are defined by the Board and may be amended by the Board at any time.
- 3.6 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

4 Delegated Authority

- 4.1 The Finance and Performance Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

4.2 The Finance and Performance Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

5 Authority

5.1 The Committee is authorised by the Board to:

- Investigate any activity within its Terms of Reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) and ICS within its remit as outlined in these Terms of Reference.
- Commission any reports it deems necessary to help fulfil its obligations.
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and Terms of Reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.

5.2 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these Terms of Reference.

6 Purpose and Scope

6.1 The purpose of the Finance and Performance Committee is to provide assurance to the board that the system and its partners are financially sustainable, meeting their financial targets and performing well enough to achieve system goals and ambitions. Collaborative, system working is integral to the delivery of these goals and ambitions and therefore, relevant System Groups may serve as a source of assurance. A list is provided in Appendix B of the top-level System Groups that are considered to be most pertinent to the work of the Finance and Performance Committee.

6.2 For the avoidance of doubt, the scope of the Committee does not include functions that have been delegated from NHS England to the ICB set out in the Delegation Agreement in Schedule 2B - Primary Dental Services and Prescribed Dental Services, Schedule 2C - Primary Ophthalmic Services and Schedule 2D - Pharmaceutical Services and Local Pharmaceutical Services.

6.3 For the avoidance of doubt, the scope of the Committee does not include oversight and assurance to the Board with respect to those Specialised Services delegated from NHS England to the ICB.

- 6.4 For the avoidance of doubt, in respect of the activities and services which are in-scope of the Coventry Care Collaborative Committee and the Warwickshire Care Collaborative Committee, the relevant Finance and Performance Committee responsibilities will relate to strategic-level oversight and decision making.
- 6.5 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be received by the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.
- 6.6 In carrying out its responsibilities and in its decision making the committee must have regard to the wider effect of decisions, in relation to the health and wellbeing of people in England and the need to address inequalities, the quality of services provided by different bodies, and the efficiency and sustainability in relation to the use of resources.

7 Responsibilities of the Committee

7.1 The responsibilities of the Finance and Performance Committee will be authorised by the ICB Board. The Committee's duties are set out below.

7.1.1 NHS Oversight Framework

- a) To receive assurance regarding the arrangements for discharging, and implications of, the ICB's responsibilities in respect of the following themes under the NHS Oversight Framework:
- Finance – including use of resources;
 - Performance – including access, outcomes and productivity;
 - Local, strategic priorities.
- b) The committee will be responsible for overseeing the monitoring and insights about current and historical performance trends of the themes noted above, and support the Board in developing its forward plan to improve performance.
- c) The committee will receive regular reports including: annual finance, delivery and performance plans; regular financial and operational performance information; details on risks and issues; and other exceptional or significant data relevant.
- d) The committee will be responsible for receiving assurance regarding to the ICS NHS Oversight Framework segmentation assessed level, and where required support the Board in developing its improvement plan.

7.1.2 Finance

- a) Review the ICB's Financial Strategies annually, including financial recovery plans where necessary, and make recommendations to the ICB.
- b) Review the annual financial plans and opening year budgets and make recommendations to the ICB.
- c) Receive and review in year financial monitoring reports and assessment of performance against budgets on a regular basis, pertinent to the ICB and the ICS.

- d) For oversight and assurance, the committee will receive the Estates and Capital Plan.
- e) Receive regular updates on management of working capital balances.
- f) Receive regular reports on the capital programme.
- g) Oversee the delivery of the transformation / efficiency programmes, including the management of risks against delivery and to receive exception reports and rectification plans, as required.
- h) Oversee the delivery of workforce productivity improvement programmes, including the management of risks against delivery and to receive exception reports and rectification plans, as required.
- i) Oversight of the duty to use monies designated for integration for that purpose (the Better Care Fund).

7.1.3 System Financial Management and Resource Allocation

- a) Set the strategic financial framework of the ICS and monitor performance against it.
- b) Develop the system financial information systems and processes to be used to make recommendations to the Board on financial planning in line with the strategy and national guidance.
- c) Ensure addressing health and social inequalities is central to financial decision making.
- d) Take assurance that that the ICS's approach to resource allocation is appropriate to deliver its strategic objectives and be aware of any considerations or unintended consequences in relation to patient safety.
- e) Take assurance that the ICS's approach to transformation funding is appropriate.
- f) Identify and allocate resources where appropriate to address finance and performance related issues that may arise.
- g) Consider major investments / disinvestments outlined in business cases for material service change or efficiency schemes and to agree a process for sign off in line with the ICS policies ensuring the establishment and maintenance of prioritisation tools, policies and frameworks.

7.1.4 System Efficiencies

- a) Ensure system efficiencies are identified and monitored across the ICB, in particular opportunities at system level where the scale of the ICB partners together and the ability to work across organisations can be leveraged.
- b) Receive data and information to enable a review and effective oversight of ICB efficiency schemes.

- c) Ensure financial resources are used in an efficient way to deliver the objectives of the ICB.
- d) Review exception reports on any material breaches of the delivery of agreed efficiency improvement plans including the adequacy of proposed remedial action plans.
- e) Review appropriate and relevant policies.

7.1.5 Performance

- a) Review assurance on performance against the delivery of the relevant core ICB's Strategies and Operational Plan through regular reporting on delivery and the ICB Board Assurance Framework, providing recommendations to the Board where rectifying actions are required.
- b) Review assurance on progress and achievement against key national, regional, and local targets for service improvement, with a particular focus on delivery of the annual planning requirements.
- c) Make recommendations to the Board on developments to the System Performance Assurance Framework.
- d) Receive and review in year monitoring reports covering all national constitutional standards, any additional national or regional performance requirements as specified by NHSE, local priorities targets, patient outcome measures and inequality performance.
- e) To provide assurance on System performance improvement plans and recovery trajectories, making recommendations to the ICB in year on corrective actions, and oversee progress on performance against such plans on a regular basis.
- f) To receive and review assurance on contract management, for both Healthcare contracts, commissioning support service contracts. Receive exception reports on contract performance and oversee improvement plans as appropriate.
- g) To approve the Procurement Strategy and oversee procurement and contracting activity of the ICB, providing assurance to the Board that these activities have been conducted in a manner that meets the legal, statutory, and other obligations of the ICB whilst also delivering best value for patients and taxpayers.
- h) To review assurance on progress and achievement against outcomes and targets agreed with partner organisations.
- i) To receive assurance on the performance of the Population Health Management Roadmap, including the digital and data elements.
- j) To receive assurance on the achievement of NHS performance requirements relating to Inequalities.

7.1.6 Value for Money

- a) Ensure financial management achieves value for money, efficiency, and effectiveness in the sustainable use of resources with a continuing focus on cost reduction and achievement of efficiency targets and productivity improvements.

7.1.7 Sustainability and Innovation

- a) Support the development and implementation of sustainability and innovation strategies that will help the Board and the broader Integrated Care System achieve their strategic priorities.
- b) Oversee system-wide data and digital strategy and plan.

7.1.8 Risk Management

- a) To review relevant risks on the ICB's Board Assurance Framework and the Corporate Risk Register to receive assurance that risks are being managed appropriately.
- b) In conducting the duties set out above, seek assurance that risks have been correctly identified, controls are effective and mitigating actions are being managed appropriately.
- c) Highlight to the Board, as part of the committee's report, any financial risks which exceed the organisation's risk appetite, gaps in assurance or other concerns about key risks.

8 Membership and attendance

8.1 Membership

8.1.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

8.1.2 The Members of the Committee are:

- Two ICB Non-Executive Members, one of whom is the Chair of the Committee.
- ICB Partner Member (Primary Medical Services).
- ICB Chief Finance Officer.
- ICB Chief Medical Officer.
- ICB Chief Transformation Officer.
- Two Local Authority Officers.
- Two Executive Officers from NHS providers in the ICB's area.
- Two Non-Executive Directors from NHS providers in the ICB's area.

8.1.3 Other members of the Committee need not be members of the Board, but they may be.

8.1.4 The Chair of the Board may be a member of the Committee but may not be appointed as its Chair.

8.1.5 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

8.2 Chair and Deputy Chair

8.2.1 In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the ICB appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

8.2.2 Committee members will appoint a Deputy Chair from amongst the members who the Committee considers has the requisite skills and experience to act in that capacity.

8.2.3 In the absence of the Chair and Deputy Chair, or if the Chair and Deputy Chair have a conflict of interest, the remaining members present shall elect one of their number to Chair the meeting.

8.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

8.2.5 The Chair will also meet regularly with the Chairs and / or appropriate Non-Executive Directors of the relevant Board Committees from NHS providers within the ICB's area in order to facilitate system working and so as to ensure that the agenda of the Committee complements and builds on assurances that Board Committees at individual organisations have gained.

8.3 Attendees

8.3.1 The ICB Chief Executive Officer has a right to attend any committee meeting in accordance with their role as the ICB's accountable officer.

8.3.2 Only members of the Committee and the ICB's Chief Executive Officer have the right to attend, but the Chair may invite relevant staff and individuals to attend the meeting (for all or part of a meeting) as necessary in accordance with the business of the Committee. Such attendees will not be eligible to vote.

8.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

8.3.4 The Chair of the ICB may also be invited to attend one meeting each year in order to gain a greater understanding of the Committee's operations.

8.4 Attendance

8.4.1 Where a member or any attendee of the Committee is unable to attend a meeting, a suitable alternative (deputy) may be agreed with the Chair. In the case of members the deputy may speak and vote on the absent member's behalf and will count towards the quorum where necessary.

9 Holding meetings

- 9.1 The Committee will meet at least six times per year and arrangements and notice for calling meetings are set out in the Standing Orders.
- 9.2 Extraordinary meetings may be held at the discretion of the Chair. A minimum of two working days' notice should be given when calling an extraordinary meeting.
- 9.3 In accordance with the Standing Orders, the Committee may meet virtually when appropriate and members attending using electronic means will be counted towards the quorum.

10 Quoracy

- 10.1 The quorum of the Committee is a minimum of six members. This must include an ICB Non-Executive Member and the ICB Chief Finance Officer or their deputy and a partner member.
- 10.2 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- 10.3 If the Committee is not quorate then the meeting may proceed if those attending agree, but no decisions may be taken, or the meeting may be postponed at the discretion of the Chair.

11 Decision Making and Voting

- 11.1 The Committee must have regard to guidance issued by NHS England and will also have regard to NHS policy and best practice.
- 11.2 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 11.3 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- 11.4 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.
- 11.5 If a decision is needed which cannot wait for the next scheduled meeting and it is not appropriate to call an extraordinary meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email, or other electronic communication.

12 Behaviours and Conduct

12.1 Benchmarking and Guidance

- 12.1.1 The Committee will take proper account of National Agreements and appropriate benchmarking, for example guidance issued by the Government, the Department of

Health and Social Care, NHS England, and the wider NHS in reaching their determinations.

12.2 Conflicts of Interest

12.2.1 All members and those in attendance must at the start of the meeting, declare any conflicts of actual or potential conflicts of interest (even if such a declaration has previously been made) in accordance with the ICB's policies and procedures. This will be recorded in the minutes.

12.2.2 Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

12.3 ICB Values and Behaviours

12.3.1 Members will be expected to conduct business in line with the ICB values and objectives and the Board Behavioural principles set out by the ICB.

12.3.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

12.3.3 Members of the Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are selflessness, integrity, objectivity, accountability, openness, honesty, and leadership

12.3.4 The Committee will apply best practice in its deliberations and in the decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

12.3.5 All members of the Committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the Committee.

12.4 Equality and Diversity

12.4.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

13 Operation of the Meeting

13.1 Committee members are required to:

13.1.1 Attend at least 75% of meetings, having read all papers beforehand.

13.1.2 Act as 'champions', disseminating information and good practice as appropriate.

13.1.3 If unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.

14 Secretariat and Administration

- 14.1 The Committee shall be supported with a secretariat function. Which will include ensuring that:
- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead. Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
 - Records are kept of members' appointments and renewal dates and that the ICB is prompted to renew membership and identify new members where necessary.
 - Good quality minutes are taken in accordance with the Standing Orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
 - The Chair is supported to prepare and deliver reports to the ICB.
 - The Committee is updated on pertinent issues / areas of interest / policy developments.
 - Action points are taken forward between meetings.

15 Accountability and Reporting Arrangements

- 15.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities and on assurances received and will escalate any concerns where necessary.
- 15.2 The Committee will submit a report to the Board following each of its meetings. Where deemed necessary, the Committee will include in this report recommendations regarding remedial action relating to any areas of its responsibilities. Where reports identify individuals, they will not be made public and will be presented at the Board meeting held in private. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.
- 15.3 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.
- 15.4 The Committee will advise the Board on the adequacy of assurances available and contribute to the Annual Governance Statement.
- 15.5 The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

16 Review of the Committee

- 16.1 The Committee will produce an annual work plan in consultation with the Board.
- 16.2 The Committee will undertake an annual self-assessment of its performance against the annual plan, membership, and Terms of Reference. This self-assessment will form the basis of the annual report. Any resulting proposed changes to the Terms of Reference will be submitted for approval by the Board.

- 16.3 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

17 Monitoring

- 17.1 Attendance will be monitored as part of the agenda at each Committee meeting and a matrix (see Appendix A) of membership attendees will be used for monitoring purposes.
- 17.2 The Committees Annual Report will include details of its governance cycle, a summary of the business conducted, membership attendance, and frequency of meetings and whether meetings were held in quorum.

Appendix A: Committee meeting attendance record

Year	20__/20__					
Name of Committee	Finance and Performance Committee					
Reports to	Integrated Care Board					
Membership (as per Terms of Reference). Please give names and/or full job title below:	Meeting dates					
Was the meeting quorate? Yes / No						

Appendix B: Source of Assurance System Groups

This is not an exhaustive list of all Sources of Assurance which an Executive may utilise in providing assurance to the Finance and Performance Committee.

Primary Executive Lead	System Group
Chief Integration Officer - Coventry	Primary Care Group
Chief Finance Officer	Strategic Finance Group
Chief Transformation Officer	Transformation Board



**Coventry and
Warwickshire**
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**ICB Finance and Performance Committee
Terms of Reference**

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1 Document Management

1.1 Revision History

Version	Date	Summary of Changes
1.0	1 July 2022	Not applicable
1.1	3 August 2022	8.1.2 - the number of Local Authority Officers who are members of the Committee has increased from one to two
1.2	15 March 2023	3.2 and 6.1 amended to reflect the delegation of Primary Dental Services and Prescribed Dental Services, Primary Ophthalmic Services and Pharmaceutical Services and Local Pharmaceutical Services from NHS England on 1 April 2023.
1.3	17 May 2023	<p>6.3 amended to state that the Committee will receive an annual programme of business for assurance.</p> <p>7.1.2h - Clarified responsibilities with regards to approval of business cases in line with the Scheme of Delegation (Delegated Financial Limits).</p> <p>7.1.2j – Added that the Committee will have oversight of the duty to use monies designated for integration for that purpose (the Better Care Fund).</p> <p>7.1.3g – Clarified responsibilities with regards to approval of the Procurement Strategy.</p> <p>7.1.5b – Clarified responsibilities with regards to compliance with NHSE Guidance related to Climate Change, including UK net zero emissions target.</p> <p>7.1.5c – Added that the Committee will oversee the system-wide data and digital strategy and plan.</p> <p>7.1.7 – Added that the Committee will have oversight of the delivery of Schedule 2A of the Primary Care Delegation Agreement in accordance with the responsibilities of the Committee.</p> <p>8.1.2 – Removal of two Care Collaborative Members roles and ICB Chief Transformation Officer.</p> <p>10.1 – Reduced quoracy from five to four members to reflect the reduction to the membership total.</p>
1.4	26 June 2023	Section 1.2 (Approved by) removed.
1.5	26 July 2023	<p>6.2 - Statement concerning system groups added, along with a list of groups in Appendix B.</p> <p>8.1.2 - Addition of a second Non-Executive Member (previously agreed by Board).</p>

1.6	10 August 2023	'Primary Care Group' added to list in appendix B.
1.7	18 September 2023	15.2 Sentence added 'Where deemed necessary, the Committee will include in this report recommendations regarding remedial action relating to any areas of its responsibilities.' added.
1.8	20 March 2024	3.3 and 6.2 - Addition of statements regarding Specialised Services.
1.9	15 May 2024	<p>6.3 paragraph added to confirm the Committee's responsibilities with regards to the activities and services that are in-scope of the Care Collaborative Committees.</p> <p>7.1.1 references to System Oversight Framework changed to NHS Oversight Framework due to name change.</p> <p>7.1.3 responsibilities added in relation to the performance of the Population Health Management Roadmap, including the digital and data elements, and NHS performance requirements relating to Inequalities.</p> <p>7.1.7 reference to primary medical services provider mergers and closures added.</p> <p>8.1.2 Chief Performance and Delivery Officer replaced as a member by the Chief Transformation Officer.</p> <p>11.3.1 reference to Board Behavioural Principles added.</p>
2.0	23 April 2025	<p>5.1 added ICS employees to information requirements within the committees remit.</p> <p>6.4 moved to 6.1 to set out more clearly at the start what the purpose of the committee is.</p> <p>7.1 phrase added to explicitly include productivity in the remit.</p> <p>7.1.2 updated to reference (c) System and ICB responsibilities and (h) reflect productivity.</p> <p>7.1.3 added new section on System Financial Management and Resource Allocation, bringing in oversight of prioritisation approaches and revising numbering for later sections.</p> <p>7.1.4 new section on System Efficiencies introducing oversight at system level of efficiencies and financial resources to deliver objectives.</p> <p>7.1.6 included productivity reference.</p> <p>7.1.8 bringing in Board Assurance Framework oversight of relevant risks and strengthening assurance around controls and actions.</p>

		<p>8.1.2-4 splitting the committee responsibilities into ICS and ICB parts with appropriate membership and quoracy updates.</p> <p>8.2.5 updated to reflect that some finance chairs in partners are Executives, so drawing in Non-Executive representation from these system partners.</p> <p>9.3 updated to reflect meetings held virtually when “appropriate” rather than when “necessary”.</p> <p>10.1 revised quoracy to reflect Part A and Part B with appropriate representation and quoracy criteria.</p>
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1.2 Document Control

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- 2.1 The ICB has a duty to meet the system financial objectives which will require financial balance to be delivered. This will require collaborative working to develop a shared financial framework and system wide plan.
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6 Purpose and Scope

6.1 The purpose of the Finance and Performance Committee is to provide assurance to the board that the system and its partners are financially sustainable, meeting their financial targets and performing well enough to achieve system goals and ambitions. Collaborative, system working is integral to the delivery of these goals and ambitions and therefore, relevant System Groups may serve as a source of assurance. A list is provided in Appendix B of the top-level System Groups that are considered to be most pertinent to the work of the Finance and Performance Committee.

6.2 For the avoidance of doubt, the scope of the Committee does not include functions that have been delegated from NHS England to the ICB set out in the Delegation Agreement in Schedule 2B - Primary Dental Services and Prescribed Dental Services, Schedule 2C - Primary Ophthalmic Services and Schedule 2D - Pharmaceutical Services and Local Pharmaceutical Services.

6.3 For the avoidance of doubt, the scope of the Committee does not include oversight and assurance to the Board with respect to those Specialised Services delegated from NHS England to the ICB.

- 6.4 For the avoidance of doubt, in respect of the activities and services which are in-scope of the Coventry Care Collaborative Committee and the Warwickshire Care Collaborative Committee, the relevant Finance and Performance Committee responsibilities will relate to strategic-level oversight and decision making.
- 6.5 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be received by the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.
- 6.6 In carrying out its responsibilities and in its decision making the committee must have regard to the wider effect of decisions, in relation to the health and wellbeing of people in England and the need to address inequalities, the quality of services provided by different bodies, and the efficiency and sustainability in relation to the use of resources.

7 Responsibilities of the Committee

7.1 The responsibilities of the Finance and Performance Committee will be authorised by the ICB Board. The Committee's duties are set out below.

7.1.1 NHS Oversight Framework

- a) To receive assurance regarding the arrangements for discharging, and implications of, the ICB's responsibilities in respect of the following themes under the NHS Oversight Framework:
- Finance – including use of resources;
 - Performance – including access, outcomes and productivity;
 - Local, strategic priorities.
- b) The committee will be responsible for overseeing the monitoring and insights about current and historical performance trends of the themes noted above, and support the Board in developing its forward plan to improve performance.
- c) The committee will receive regular reports including: annual finance, delivery and performance plans; regular financial and operational performance information; details on risks and issues; and other exceptional or significant data relevant.
- d) The committee will be responsible for receiving assurance regarding to the ICS NHS Oversight Framework segmentation assessed level, and where required support the Board in developing its improvement plan.

7.1.2 Finance

- a) Review the ICB's Financial Strategies annually, including financial recovery plans where necessary, and make recommendations to the ICB.
- b) Review the annual financial plans and opening year budgets and make recommendations to the ICB.
- c) Receive and review in year financial monitoring reports and assessment of performance against budgets on a regular basis, pertinent to the ICB and the ICS.

- d) For oversight and assurance, the committee will receive the Estates and Capital Plan.
- e) Receive regular updates on management of working capital balances.
- f) Receive regular reports on the capital programme.
- g) Oversee the delivery of the transformation / efficiency programmes, including the management of risks against delivery and to receive exception reports and rectification plans, as required.
- h) Oversee the delivery of ICB workforce productivity improvement programmes, including the management of risks against delivery and to receive exception reports and rectification plans, as required.
- i) Receive assurance on business cases and approve such cases that are within the Committee's remit (as per the limits set out in the Scheme of Delegation (Delegated Financial Limits)) and where appropriate make recommendations to the Board.
- j) Review and where appropriate agree commissioning policies for approval by the ICB.

7.1.3 Performance

- a) Review assurance on performance against the delivery of the relevant core ICB's Strategies and Operational Plan through regular reporting on delivery and the ICB Board Assurance Framework, providing recommendations to the Board where rectifying actions are required.
- b) Review assurance on progress and achievement against key national, regional, and local targets for service improvement, with a particular focus on delivery of the annual planning requirements.
- c) Receive and review in year monitoring reports covering all national constitutional standards, any additional national or regional performance requirements as specified by NHSE, local priorities targets, patient outcome measures and inequality performance.
- d) To receive and review assurance on contract management, for both Healthcare contracts, commissioning support service contracts. Receive exception reports on contract performance and oversee improvement plans as appropriate.
- e) To approve the Procurement Strategy and oversee procurement and contracting activity of the ICB, providing assurance to the Board that these activities have been conducted in a manner that meets the legal, statutory, and other obligations of the ICB whilst also delivering best value for patients and taxpayers.
- f) To receive assurance on the performance of the Population Health Management Roadmap, including the digital and data elements.
- g) To receive assurance on the achievement of NHS performance requirements relating to Inequalities.

7.1.4 **Value for Money**

- a) Ensure financial management achieves value for money, efficiency, and effectiveness in the sustainable use of resources with a continuing focus on cost reduction and achievement of efficiency targets and productivity improvements.

7.1.5 **Sustainability and Innovation**

- a) Support the development and implementation of sustainability and innovation strategies that will help the Board and the broader Integrated Care System achieve their strategic priorities.
- b) Oversee development of the ICB's Green Development Plan and the ICB's compliance with NHSE Guidance related to Climate Change, including UK net zero emissions target.
- c) Oversee system-wide data and digital strategy and plan.

7.1.6 **Risk Management**

- a) To review relevant risks on the ICB's Board Assurance Framework and the Corporate Risk Register to receive assurance that risks are being managed appropriately.
- b) In conducting the duties set out above, seek assurance that risks have been correctly identified, controls are effective and mitigating actions are being managed appropriately.
- c) Highlight to the Board, as part of the committee's report, any financial risks which exceed the organisation's risk appetite, gaps in assurance or other concerns about key risks.

7.1.7 Oversight of the delivery of Schedule 2A of the Primary Care Delegation Agreement in accordance with the responsibilities of the Committee, including those related to approving primary medical services provider mergers and closures.

8 Membership and Attendance

8.1 Membership

8.1.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

8.1.2 The Members of the Committee are:

- Two ICB Non-Executive Members, one of whom is the Chair of the Committee.
- ICB Partner Member (Primary Medical Services).
- ICB Chief Finance Officer.
- ICB Chief Medical Officer.

- ICB Chief Transformation Officer.

8.1.3 Other members of the Committee need not be members of the Board, but they may be.

8.1.4 The Chair of the Board may be a member of the Committee but may not be appointed as its Chair.

8.1.5 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

8.2 **Chair and Deputy Chair**

8.2.1 In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the ICB appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

8.2.2 Committee members will appoint a Deputy Chair from amongst the members who the Committee considers has the requisite skills and experience to act in that capacity.

8.2.3 In the absence of the Chair and Deputy Chair, or if the Chair and Deputy Chair have a conflict of interest, the remaining members present shall elect one of their number to Chair the meeting.

8.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

8.2.5 The Chair will also meet regularly with the Chairs and / or appropriate Non-Executive Directors of the relevant Board Committees from NHS providers within the ICB's area in order to facilitate system working and so as to ensure that the agenda of the Committee complements and builds on assurances that Board Committees at individual organisations have gained.

8.3 **Attendees**

8.3.1 The ICB Chief Executive Officer has a right to attend any committee meeting in accordance with their role as the ICB's accountable officer.

8.3.2 Only members of the Committee and the ICB's Chief Executive Officer have the right to attend, but the Chair may invite relevant staff and individuals to attend the meeting (for all or part of a meeting) as necessary in accordance with the business of the Committee. Such attendees will not be eligible to vote.

8.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

8.3.4 The Chair of the ICB may also be invited to attend one meeting each year in order to gain a greater understanding of the Committee's operations.

8.4 **Attendance**

8.4.1 Where a member or any attendee of the Committee is unable to attend a meeting, a suitable alternative (deputy) may be agreed with the Chair. In the case of members the

deputy may speak and vote on the absent member's behalf and will count towards the quorum where necessary.

9 Holding Meetings

- 9.1 The Committee will meet at least six times per year and arrangements and notice for calling meetings are set out in the Standing Orders.
- 9.2 Extraordinary meetings may be held at the discretion of the Chair. A minimum of two working days' notice should be given when calling an extraordinary meeting.
- 9.3 In accordance with the Standing Orders, the Committee may meet virtually when appropriate and members attending using electronic means will be counted towards the quorum.

10 Quoracy

- 10.1 The quorum of the Committee is a minimum of three members. This must include an ICB Non-Executive Member and the ICB's Chief Finance Officer or their deputy.
- 10.2 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- 10.3 If the Committee is not quorate then the meeting may proceed if those attending agree, but no decisions may be taken, or the meeting may be postponed at the discretion of the Chair.

11 Decision Making and Voting

- 11.1 The Committee must have regard to guidance issued by NHS England and will also have regard to NHS policy and best practice.
- 11.2 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 11.3 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- 11.4 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.
- 11.5 If a decision is needed which cannot wait for the next scheduled meeting and it is not appropriate to call an extraordinary meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email, or other electronic communication.

12 Behaviours and Conduct

12.1 Benchmarking and Guidance

12.1.1 The Committee will take proper account of National Agreements and appropriate benchmarking, for example guidance issued by the Government, the Department of Health and Social Care, NHS England, and the wider NHS in reaching their determinations.

12.2 Conflicts of Interest

12.2.1 All members and those in attendance must at the start of the meeting, declare any conflicts of actual or potential conflicts of interest (even if such a declaration has previously been made) in accordance with the ICB's policies and procedures. This will be recorded in the minutes.

12.2.2 Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

12.3 ICB Values and Behaviours

12.3.1 Members will be expected to conduct business in line with the ICB values and objectives and the Board Behavioural principles set out by the ICB.

12.3.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

12.3.3 Members of the Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are selflessness, integrity, objectivity, accountability, openness, honesty, and leadership

12.3.4 The Committee will apply best practice in its deliberations and in the decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

12.3.5 All members of the Committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the Committee.

12.4 Equality and Diversity

12.4.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

13 Operation of the Meeting

13.1 Committee members are required to:

13.1.1 Attend at least 75% of meetings, having read all papers beforehand.

13.1.2 Act as 'champions', disseminating information and good practice as appropriate.

13.1.3 If unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.

14 Secretariat and Administration

- 14.1 The Committee shall be supported with a secretariat function. Which will include ensuring that:
- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead. Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
 - Records are kept of members' appointments and renewal dates and that the ICB is prompted to renew membership and identify new members where necessary.
 - Good quality minutes are taken in accordance with the Standing Orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
 - The Chair is supported to prepare and deliver reports to the ICB.
 - The Committee is updated on pertinent issues / areas of interest / policy developments.
 - Action points are taken forward between meetings.

15 Accountability and Reporting Arrangements

- 15.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities and on assurances received and will escalate any concerns where necessary.
- 15.2 The Committee will submit a report to the Board following each of its meetings. Where deemed necessary, the Committee will include in this report recommendations regarding remedial action relating to any areas of its responsibilities. Where reports identify individuals, they will not be made public and will be presented at the Board meeting held in private. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.
- 15.3 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.
- 15.4 The Committee will advise the Board on the adequacy of assurances available and contribute to the Annual Governance Statement.
- 15.5 The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

16 Review of the Committee

- 16.1 The Committee will produce an annual work plan in consultation with the Board.
- 16.2 The Committee will undertake an annual self-assessment of its performance against the annual plan, membership, and Terms of Reference. This self-assessment will form

the basis of the annual report. Any resulting proposed changes to the Terms of Reference will be submitted for approval by the Board.

- 16.3 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

17 Monitoring

- 17.1 Attendance will be monitored as part of the agenda at each Committee meeting and a matrix (see Appendix A) of membership attendees will be used for monitoring purposes.
- 17.2 The Committees Annual Report will include details of its governance cycle, a summary of the business conducted, membership attendance, and frequency of meetings and whether meetings were held in quorum.

Appendix A: Committee meeting attendance record

Year	20__/20__					
Name of Committee	ICB Finance and Performance Committee					
Reports to	Integrated Care Board					
Membership (as per Terms of Reference). Please give names and/or full job title below:	Meeting dates					
Was the meeting quorate? Yes / No						

Appendix B: Source of Assurance System Groups

This is not an exhaustive list of all Sources of Assurance which an Executive may utilise in providing assurance to the Finance and Performance Committee.

Primary Executive Lead	System Group
Chief Integration Officer - Coventry	Primary Care Group
Chief Finance Officer	Strategic Finance Group
Chief Transformation Officer	Transformation Board



**Coventry and
Warwickshire**
Integrated Care Board

**Coventry and Warwickshire Integrated
Care Board**

Transition Committee

Terms of Reference

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1 Document Management

1.1 Revision History

Version	Date	Summary of Changes
1.0	1 May 2022	Not applicable

1.2 Document Control

- 1.2.1 The controlled copy of this document is maintained by Coventry and Warwickshire Integrated Care Board (ICB). Any copies of this document held outside of that area, in whatever format (e.g., paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

2 Introduction and Context

- 2.1 The ICB has a requirement to establish future structures and an operating model taking regard of guidance from NHSE, consideration of future system needs and in line with national policy to enable future fit for purpose ICB operating.
- 2.2 These Terms of Reference describe the scope, function, and ways of working for the committee that are consistent with the Statutory functions of the ICB.

3 Constitution

- 3.1 The Board of the Integrated Care Board (referred to as the Board) has established a committee known as the Transition Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.
- 3.2 The Committee will not function as a corporate decision-making body for the management of those functions delegated by NHS England to the ICB in respect of Primary Medical Services as set out in Schedule 2B, 2C and 2D of the Delegation Agreement.
- 3.3 The Committee will not function as a corporate decision-making body for the management of those functions delegated by NHS England to the ICB in respect of nor for Specialised Services delegated from NHS England to the ICB.
- 3.4 The Committee is a non-executive chaired committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.
- 3.5 The Terms of Reference for the Committee outlined below are defined by the Board and may be amended by the Board at any time.
- 3.6 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

4 Delegated Authority

- 4.1 The Transition Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.
- 4.2 The Transition Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

5 Authority

5.1 The Committee is authorised by the Board to:

- Investigate any activity within its Terms of Reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these Terms of Reference.
- Commission any reports it deems necessary to help fulfil its obligations.
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and Terms of Reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.

5.2 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these Terms of Reference.

6 Purpose and Scope

6.1 The purpose of the Transition Committee is threefold:

- To provide assurance to the Board that the day-to-day working of the ICBs business is being effectively managed through the period of transition.
- That work on developing a future operating model is progressing at the required pace.
- Ensure that staff are supported through the change process, whilst meeting legislative needs.

The Committee will also seek assurance that the relevant areas of change are being addressed and that no aspects are falling through gaps, presenting a risk to progress.

6.2 The duties of the Committee will be driven by the organisation's objectives and the associated risks. A programme of business will be received by the Committee for assurance at the first meeting; however, this will be flexible to new and emerging priorities, opportunities and risks.

7 Responsibilities of the Committee

- 7.1 The responsibilities of the Transition Committee will be authorised by the ICB Board. The Committee's duties are set out below.
- a) Receive updates for assurance on the effective delivery of day-to-day operations of the ICB through the period of transition.
 - b) Oversee the establishment of robust programme management arrangements to deliver ICB transition requirements within the prescribed timeframe.
 - c) Oversee the development of a fit for purpose future ICB operating model. This will include ensuring that the proposed new model:
 - Is designed to effectively deliver revised ICB functions and responsibilities, in line with the Model ICB and Strategic Commissioning Framework, based on a robust 'stop, retain, transfer' assessment across relevant geographies.
 - Delivers required efficiencies and is affordable within the financial allocation for the ICBs.
 - Is developed taking into account the feedback from the workforce of the ICB, as appropriate.
 - d) Oversee the development and implementation of fair and transparent exit and workforce change processes for ICB staff, in line with national guidance and local policy requirements, working in conjunction with Remuneration Committee, as appropriate. This will include oversight of appropriate training and development and health and wellbeing initiatives for ICB staff to ensure they are well supported throughout the transition process.
 - e) Oversee the establishment of effective governance arrangements to support the period of transition the new ICB operating model, and to ensure its ongoing effectiveness.
 - f) Oversee the delivery of timely, open, and transparent staff and stakeholder communications throughout the transition process.
 - g) Oversee the identification and management of risks relating to the transition process and future ICB operating model to receive assurance that risks are being managed appropriately.

8 Membership and attendance

8.1 Membership

8.1.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

8.1.2 The Members of the Committee are:

- Two ICB Non-Executive Members, one of whom is the Chair of the Committee.
- ICB Chief Transformation Officer and Deputy Chief Executive.

- ICB Chief People Officer.

8.1.3 Other members of the Committee need not be members of the Board, but they may be.

8.1.4 The Chair of the Board may be a member of the Committee.

8.1.5 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

8.2 Chair and Deputy Chair

8.2.1 In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the ICB appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

8.2.2 Committee members will appoint a Deputy Chair from amongst the members who the Committee considers has the requisite skills and experience to act in that capacity.

8.2.3 In the absence of the Chair and Deputy Chair, or if the Chair and Deputy Chair have a conflict of interest, the remaining members present shall elect one of their number to Chair the meeting.

8.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

8.3 Attendees

8.3.1 The ICB Chief Executive Officer has a right to attend any committee meeting in accordance with their role as the ICB's accountable officer.

8.3.2 Only members of the Committee and the ICB's Chief Executive Officer have the right to attend, but the Chair may invite relevant staff and individuals to attend the meeting (for all or part of a meeting) as necessary in accordance with the business of the Committee. Such attendees will not be eligible to vote.

8.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

8.3.4 The Chair of the ICB may also be invited to attend one meeting each year in order to gain a greater understanding of the Committee's operations.

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8.4.1 Where a member or any attendee of the Committee is unable to attend a meeting, a suitable alternative (deputy) may be agreed with the Chair. In the case of members the deputy may speak and vote on the absent member's behalf and will count towards the quorum where necessary.

9 Holding Meetings

9.1 The Committee will meet at least six times per year and arrangements and notice for calling meetings are set out in the Standing Orders.

- 9.2 Extraordinary meetings may be held at the discretion of the Chair. A minimum of two working days' notice should be given when calling an extraordinary meeting.
- 9.3 In accordance with the Standing Orders, the Committee may meet virtually when appropriate and members attending using electronic means will be counted towards the quorum.

10 Quoracy

- 10.1 The quorum of the Committee is a minimum of three members. This must include an ICB Non-Executive Member, the ICB's Chief Transformation Officer or their deputy and the ICB's Chief People Officer or their deputy.
- 10.2 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- 10.3 If the Committee is not quorate then the meeting may proceed if those attending agree, but no decisions may be taken, or the meeting may be postponed at the discretion of the Chair.

11 Decision Making and Voting

- 11.1 The Committee must have regard to guidance issued by NHS England and will also have regard to NHS policy and best practice.
- 11.2 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
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- 11.4 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.
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12.1 Benchmarking and Guidance

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12.2 Conflicts of Interest

12.2.1 All members and those in attendance must at the start of the meeting, declare any conflicts of actual or potential conflicts of interest (even if such a declaration has previously been made) in accordance with the ICB's policies and procedures. This will be recorded in the minutes.

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12.3.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

12.3.3 Members of the Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

12.3.4 The Committee will apply best practice in its deliberations and in the decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

12.3.5 All members of the Committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the Committee.

12.4 Equality and Diversity

12.4.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

13 Operation of the Meeting

13.1 Committee members are required to:

13.1.1 Attend at least 75% of meetings, having read all papers beforehand.

13.1.2 Act as 'champions', disseminating information and good practice as appropriate.

13.1.3 If unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.

14 Secretariat and Administration

14.1 The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead. Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records are kept of members' appointments and renewal dates and that the ICB is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
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- 15.3 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.
- 15.4 The Committee will advise the Board on the adequacy of assurances available and contribute to the Annual Governance Statement.
- 15.5 The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

16 Review of the Committee

- 16.1 The Committee will produce an annual work plan in consultation with the Board.
- 16.2 The Committee will undertake an annual self-assessment of its performance against the annual plan, membership, and Terms of Reference. This self-assessment will form the basis of the annual report. Any resulting proposed changes to the Terms of Reference will be submitted for approval by the Board.

16.3 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

17 Monitoring

17.1 Attendance will be monitored as part of the agenda at each Committee meeting and a matrix (see Appendix A) of membership attendees will be used for monitoring purposes.

17.2 The Committees Annual Report will include details of its governance cycle, a summary of the business conducted, membership attendance, and frequency of meetings and whether meetings were held in quorum.

Appendix A: Committee meeting attendance record

Year	20__/20__					
Name of Committee	Transition Committee					
Reports to	Integrated Care Board					
Membership (as per Terms of Reference). Please give names and/or full job title below:	Meeting dates					
Was the meeting quorate? Yes / No						

Report To and Date:	NHS Coventry and Warwickshire Integrated Care Board – 21 May 2025
Report Title:	Future Commissioning of Child and Adolescent Mental Health Services (CAMHS)
Report From:	Dr Imogen Staveley, Chief Medical Officer, ICB
Author:	Matt Gilks, Director of Joint Commissioning, ICB
Previous Considerations and Engagement:	ICB Executive: 8 February, 22 April, 30 April Quality, Safety and Experience Committee (QSEC), 8 April Warwickshire Joint Commissioning Board: various Warwickshire Health & Wellbeing Board - Joint Development Session, 12 March Coventry & Warwickshire Children and Young People Emotional Wellbeing Strategic Board, 26 March
Purpose:	For Approval

Achievement of the following ICP Priorities and Focus Areas is supported:

Priorities	<input checked="" type="checkbox"/> 1 - Prioritising prevention and improving future health outcomes through tackling health inequalities	<input checked="" type="checkbox"/> 2 - Improving access to health and care services and increasing trust and confidence	<input type="checkbox"/> 3 - Tackling immediate system pressures and improving resilience
	<input checked="" type="checkbox"/> 1 - Reducing health inequalities	<input type="checkbox"/> 4 - Enabling personalised care	<input type="checkbox"/> 8 - Supporting people at home
Focus Areas	<input checked="" type="checkbox"/> 2 - Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities	<input checked="" type="checkbox"/> 5 - Improving access to services especially primary care	<input type="checkbox"/> 9 - Developing and investing in our workforce, culture and clinical and professional leadership
	<input checked="" type="checkbox"/> 3 - Enabling the best start in life for children and young people	<input type="checkbox"/> 6 - Engaging and involving our people, communities and stakeholders	
		<input checked="" type="checkbox"/> 7 - Making services more effective through greater collaboration and integration	

Executive Summary and Key Points:

- The ICB and both Councils have identified a need and an opportunity to standardise commissioning arrangements for Child and Adolescent Mental Health Services (CAMHS) in Coventry and Warwickshire with the aim of having new contracting arrangements in place from August 2026 onwards.
- Agreement has been reached to divide commissioning responsibilities into three broad groupings:
 - Prevention and early intervention services jointly commissioned between each Council and the ICB – with one contract and process for Coventry led by the Council, and one contract and process for Warwickshire led by the Council;

- Clinical CAMHS commissioned solely by the ICB;
- Other services (to be finalised) which should be commissioned on a Coventry and Warwickshire footprint led by the ICB in a joint commissioning arrangement with both Councils.
- Each Council will lead a procurement process within its respective footprint for prevention and early intervention services, with equal partnership and representation from the ICB, while the ICB will commission clinical CAMHS.
- While the exact scope and financial envelopes are being finalised, current 2025/26 values and relative contributions from each commissioning entity will be used to guide total amounts for each grouping.
- In a challenging financial context, the ICB will continue to demonstrate its commitment to 'left shift' by investing in prevention and early intervention services while maintaining a focus on timely access to evidence-based and safe clinical care.
- All commissioning intentions will be informed by the system Local Transformation Plan for CAMHS which reflects consensus from local children and young people, parents, carers, families and professionals following significant engagement work, and national best practice.
- These new arrangements will address current inequities and create the space for continuous improvement and transformation in line with local ambitions and national expectations.

Executive opinion: I am confident that this approach will lead to a more appropriate commissioning approach to improve our emotional wellbeing and mental health offering for children and young people in Coventry and Warwickshire. I believe that that this method alongside the Local Transformation Plan that supports a THRIVE model and trauma based approach will reduce inequalities and provide a more considered approach for our children and young people.

Recommendation:

Members are requested to:

- **APPROVE** the ICB's collaborative approach to commissioning prevention and early intervention mental health support for children and young people in partnership with Coventry City Council and Warwickshire County Council; and to
- **APPROVE** the ICB's approach to commissioning NHS clinical CAMHS.

Implications

Conflicts of Interest:	N/a
Financial and Workforce:	While the exact splits for each of the two different pots of funding will be finalised in the coming weeks, along with the proportional contributions between the ICB and each local authority, the overall financial envelope for the ICB on CAMHS will remain as per the ICB's 2025/26 financial plan. Please see section 5 for further detail.
Performance:	We will seek to improve timely access to all forms of mental health support for children and young people via these new commissioning arrangements.
Quality and Safety:	We will seek to improve patient experience and outcomes via these new commissioning arrangements, and to stabilise clinical service provision and thereby mitigate against safety risks.

Inclusion

<p>Has an equality impact assessment been undertaken? (delete as appropriate) An EQIA is required for new services or changes to service delivery. For more information the EQIA Policy and Tool can be found here.</p>	<p>Yes (attached or hyperlinked)</p>		<p>No (state why in the row below)</p>		<p>Not applicable (state why in the row below)</p>	<p>✓</p>
<p>An EQIA is not required at this stage.</p>						
<p>Has a Health Equity Assessment Tool (HEAT) been completed? HEAT may be used for new, changing or existing services and processes. More information can be found here.</p>	<p>Yes (attached or hyperlinked)</p>		<p>No (state why in the row below)</p>		<p>Not applicable (state why in the row below)</p>	<p>✓</p>
<p>An HEA is not required at this stage.</p>						
<p>Engagement</p>						
<p>Patient and Public Engagement:</p>	<p>The ICB and both Councils have undertaken a number of engagement and co-production activities relating to the overall Coventry and Warwickshire CAMHS Local Transformation Plan (LTP), which was endorsed by QSEC on 8 April and is due to be considered for further QSEC approval on 10 June.</p> <p>Warwickshire County Council have also undertaken various engagement activities on behalf of the Council and ICB with stakeholders including parents, carers, and children and young people regarding future commissioning priorities.</p>					
<p>Clinical and Professional Engagement:</p>	<p>Clinical, operational and other professional colleagues from Coventry and Warwickshire Partnership NHS Trust (CWPT) and a range of third sector providers have fed into the CAMHS LTP which has in turn influenced the proposed approach to commissioning set out within this paper.</p> <p>Warwickshire County Council have also separately undertaken extensive engagement on behalf of the Council and ICB with a range of professionals from CWPT and third sector provider organisations.</p>					
<p>Risk</p>						
<p>Risk:</p>	<p>There is a risk that not pursuing the changes in commissioning arrangements will perpetuate or worsen inequities.</p>					

1. Introduction and background

- 1.1 There are currently distinct and complex historical commissioning arrangements in place across Coventry and Warwickshire for Child and Adolescent Mental Health Services (CAMHS).
- 1.2 A Warwickshire Children and Young People's Mental Health and Emotional Wellbeing contract, known as 'Rise,' began on 1 August 2017 and is provided by Coventry and Warwickshire Partnership Trust (CWPT). Warwickshire County Council is the Lead Commissioner in a joint commissioning arrangement with the ICB, having first entered joint commissioning arrangements with the then North and South Warwickshire clinical commissioning groups (CCGs) under section 75 of the National Health Services Act 2006 along with an agreement with Coventry and Rugby CCG for the new service to cover Rugby, thus encompassing the full Warwickshire local authority footprint. These arrangements pull in both prevention and early intervention service provision – commonly referred to as (broadly) Tier 1 and 2 services and the commissioning responsibility of local authorities – as well as more specialist clinical CAMHS (Tier 3) services which fall under the commissioning responsibilities of ICBs (as they previously did for CCGs). Initially procured for five years, the contract was extended in 2022 for an additional two years and in 2024 for a further two years, with the current expiration date being 31 July 2026.
- 1.3 Arrangements within Coventry have differed. As Lead Commissioner in joint commissioning arrangements with the ICB, the City Council commissions Tier 1 and Tier 2 services only via a contract with a third sector provider, while Tier 3 clinical CAMHS are commissioned by the ICB alone via the ICB's core block contract with CWPT. Coventry CC will be considering options on extending the contract of their current Tier 2 Provider and recommissioning options from 2026 onwards during June and July.

2. Rationale for change

- 2.1 As well as creating geographical inequities, these differing arrangements in Warwickshire have led to numerous deep challenges for both NHS and local authority commissioners as well as providers (including those sub-contracted by CWPT) in terms of the complexity of joint arrangements and a lack of clarity within current contracts and contract management mechanisms. These have been compounded by confused accountability lines for performance and delivery oversight into NHS England (NHSE).
- 2.2 Moreover, the lead commissioner arrangements in Warwickshire have not reflected the respective financial contributions between the Council and the ICB; although the Council has acted as lead commissioner for the full range of services, it has contributed a relatively lower proportion (c15%) of funding that has remained flat over the duration of the contract, while the ICB has contributed a higher proportion (c85%) of funding as well as accounting for year-on-year inflation growth and investing significant growth monies following a series of positive NHS funding

settlements secured within several government fiscal events. However, WCC have funded other services outside the RISE contract.

- 2.3 Following significant work which began over two years ago, consensus has been reached across the ICB Executive Team and both Councils that a reset and a fresh, much more logical, equitable and aligned approach is needed in the way in which mental health support for children and young people (CYP) is commissioned across Coventry and Warwickshire from August 2026.

3. Future approach

- 3.1 The ICB has reached agreement with both Councils that a consistent approach across both local authority areas is needed, largely in line with current arrangements for Coventry. This would broadly be comprised of three groupings:
- I. Each Council acting as Lead Commissioner in joint commissioning arrangements with the ICB under two new section 75 agreements for Tier 1 and 2 prevention and early intervention services, with one agreement covering Coventry, and one agreement covering Warwickshire;
 - II. The ICB becoming the sole commissioner of Tier 3 NHS clinical services across Warwickshire as it is currently in Coventry i.e. becoming the sole commissioner across the whole ICB footprint;
 - III. The ICB acting as the Lead Commissioner in a single joint commissioning arrangement with both Councils together for a very small number of other relevant service offers deemed suitable and necessary to be commissioned on a full Coventry and Warwickshire-wide footprint, and where financial contributions from all three parties would logically continue (e.g. a digital offer, for which similar arrangements are already currently in place).

Detailed work is ongoing between ICB, Council and CWPT teams to finalise the precise services and service offers in scope for each element along with confirming relevant financial envelopes. This is expected to conclude by the end of June.

- 3.2 The key driver for all commissioned services is to improve health and reduce health inequalities and the key goal is to achieve equity of service across Coventry and Warwickshire. Whilst both local authorities are developing specifications tailored to their individual geography and demography, there will be a similar set of services commissioned across the system meaning that no child or young person will be advantaged or disadvantaged in accessing services as a result of the local authority in which they reside – irrespective of commissioning processes and lead authorities.
- 3.3 For group I, the relevant local authority will lead the procurement process formally commencing this autumn for services within scope, with equal representation from the ICB.

- 3.4 For group II, the ICB will be responsible for commissioning clinical services from an appropriate provider as it presently does via the continuous block contract in Coventry and the current 'Rise' contract in Warwickshire. The ICB will follow national guidance under the Provider Selection Regime (PSR) to determine the commissioning approach for these services. This will take into account the previous market engagement exercise undertaken by Warwickshire County Council on behalf of the Council and the ICB earlier this year.
- 3.5 For group III, a process led by the ICB will be determined following finalisation of potential service offers in scope.
- 3.6 All relevant future contract commencement dates and contract lengths are intended to be coterminous and aligned across all commissioned services in Coventry and Warwickshire as far as possible, with new arrangements due to be in place across the local system from August 2026.

4. Involvement and Engagement

- 4.1 There will be specific contractual expectations set out for all providers regarding engagement and co-production with CYP, parents, families and carers in service design / redesign, delivery, transformation and improvement. This includes underserved and marginalised people and communities who face specific inequalities.
- 4.2 These expectations are in line with the overall system Local CAMHS Transformation Plan, which will be finalised in the coming weeks, with a strong emphasis on the needs-led [THRIVE Framework](#) and trauma-informed care aligned with national best practice. While the Plan has informed and will inform commissioning processes, it goes beyond them and sets a clear collective ambition for the Coventry and Warwickshire system. A number of areas will be explored as part of the Plan outside of commissioning processes, such as how to improve care for young adults beyond age thresholds and personalised approaches to managing transitions between different services.
- 4.3 The Transformation Plan and related commissioning intentions have been informed by extensive engagement undertaken by all statutory partners as well as genuine co-production with CYP, carers, parents, and families.

5. Financial implications

- 5.1 The financial envelopes associated with the current (2025/26) range of contracts will be used as the financial values for the purposes of recommissioning the range of CAMHS services. These envelopes will therefore reflect current levels of funding contributions from each Council and the ICB for the relevant grouping.

- 5.2 This approach will reflect the ICB's commitment to 'left shift' by maintaining a significant level of ICB investment into prevention and early intervention services across both Coventry and Warwickshire through joint commissioning arrangements, while recognising the challenging financial context in which the ICB is now operating to meet its 2025/26 financial plan and strive for longer-term financial balance and sustainability, and noting the historical challenges faced by local authority colleagues in growing their investments into these services over the same period of time during which the ICB has done so.
- 5.3 Given the absence of available NHS growth funding in 2025/26, planning for the movement of ICB funding towards more preventative services is not possible at this stage going into 2026/27 given the high levels of demand which already significantly outstrip current clinical service capacity, as well as significant clinical safety and quality risks relating to CYP with higher levels of presenting acuity – all of which are expected to continue into 2026/27. Any potential movement of funding between commissioning groupings in later years will be through a managed process including a clinically-informed impact assessment, and will be subject to future NHS financial settlements and ICB financial planning.
- 5.4 For jointly commissioned services, revised section 75 and governance arrangements will be established between the ICB and each local authority following a review of current arrangements. Relevant services will be commissioned and managed through refreshed section 75 pooled budget arrangements.

6. Summary conclusion

- 6.1 The proposed approach set out in this paper as agreed between the ICB and Councils will standardise and clarify commissioning arrangements across the Coventry and Warwickshire footprint as is necessary. At a time of high clinical and non-clinical demand and collective financial challenge for the foreseeable future, this will in turn give statutory bodies the best chance of offering equity of access to children and young people in need of mental health support regardless of where they live within our geography. It will also give the ICB a stronger platform to achieve system ambitions as outlined in the C&W CAMHS Local Transformation Plan and to meet current and future likely national NHS expectations.

7. Recommendation

Members are requested to **APPROVE** the ICB's collaborative approach to commissioning prevention and early intervention mental health support for children and young people in partnership with Coventry City Council and Warwickshire County Council; and to **APPROVE** the ICB's approach to commissioning NHS clinical CAMHS.

End of Report

Report To and Date:	NHS Coventry and Warwickshire Integrated Care Board Wednesday 21 May 2025
Report Title:	Integrated Provider Performance Report, March 2025
Report From:	Rachael Danter, Chief Transformation Officer and Deputy Chief Executive Officer Felicity Davies, Chief People Officer Madi Parmar, Chief Finance Officer Ellie Monkhouse, Chief Nurse Coventry and Warwickshire Integrated Care Board (CWICB)
Author:	Rich Woolsey, Head of Planning, Performance and Assurance Michelle Gorrell, Associate Chief Nurse for Nursing and Patient Safety Louise Gallagher, Head of Workforce Kay Speed-Andrews, Deputy Director of Finance Coventry and Warwickshire Integrated Care Board
Previous Considerations and Engagement:	N/A
Purpose:	For Assurance and Information

Achievement of the following ICP Priorities and Focus Areas is supported:

Priorities	<input checked="" type="checkbox"/> 1 - Prioritising prevention and improving future health outcomes through tackling health outcomes	<input checked="" type="checkbox"/> 2 - Improving Access to health and care services and increasing trust and confidence	<input checked="" type="checkbox"/> 3 - Tackling immediate system pressures and improving resilience
	<input checked="" type="checkbox"/> 1 - Reducing health inequalities	<input type="checkbox"/> 4- Enabling personalised care	<input type="checkbox"/> 8 - Supporting people at home
Focus Areas	<input type="checkbox"/> 2- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities	<input checked="" type="checkbox"/> 5 - Improving access to services especially primary care	<input checked="" type="checkbox"/> 9 - Developing and investing in our workforce, culture and clinical and professional leadership
	<input type="checkbox"/> 3- Enabling the best start in life for children and young people	<input type="checkbox"/> 6- Engaging and involving our people, communities and stakeholders	
		<input type="checkbox"/> 7 - Making services more effective through greater collaboration and integration	

Executive Summary and Key Points:

The Integrated Performance Report provides a comprehensive summary of the ICB's progress against key deliverables and priorities, including the NHS Constitution, the National Oversight and Assessment Framework, the ICB financial plan, and NHS operational planning commitments. Dashboards showcasing achievements against key metrics are included in the appendices. For areas of adverse performance, the report identifies key issues and corresponding actions with clear recovery timescales.

In addition, comprehensive monthly reports on Finance, People, Performance, and Quality are distributed to members of the ICBs Finance and Performance, Quality, Safety & Experience (QSEC), and People Committees. At these sub-committees, performance is reviewed, risks and mitigating actions are assessed, improvement plans are scrutinised, and assurance is provided.

ICB programme boards, such as the Finance Advisory Board, System Oversight Group, and Transformation Board, offer further oversight at the programme level. Additionally, Provider and System Review Meetings offer a platform to discuss and escalate concerns both at an individual organisational level and across the System footprint.

The report highlights challenging A&E performance, elective care waits, 62-day cancer waits, and the number of patients waiting for community services. For areas of adverse performance, improvement actions are in place with associated trajectories.

Quality concerns that are subject to Enhanced Surveillance through the Quality Assurance Framework are highlighted in the main body of the report, with no areas under Intensive Surveillance under the Quality Assurance Framework.

The ICS reported a draft year end financial position (unaudited) of £0.193m surplus against a balanced financial plan. Additional funding received by NHSE in recognition of CWICB being an under-target system in terms of national allocations allowed the system to breakeven from a £14.4m deficit position. Flexibilities and other resources have also been utilised to ensure the system breakeven position. The impact of non-recurrent efficiency delivery into 2025/26 remains a challenge in terms of increased efficiency required to bring the system back into balance recurrently and there is a focus now on recurrent efficiency delivery and improved productivity for 2025/26 across the system.

The workforce section describes a high but improving vacancy rate. The substantive workforce has grown by 1159.5 whole time equivalents (WTE) since the end of March 2024. This includes an additional 436.9 WTE nursing and midwifery staff and 83 consultants. Agency usage has decreased by 160 WTE since March 2024 and activities to reduce agency usage have resulted in a 58.7% reduction when comparing March 2023 with March 2025. A system wide Temporary Staffing Assurance Group has been sharing best practice and monitors plans for a reduction in temporary staff. Staff sickness absence and escalation capacity have been the most significant drivers of temporary staffing.

Recommendation:

Members are requested to:

- **Note the contents of the report for assurance** and to note the actions to improve performance and quality as required.
- **Note** the financial position and actions being undertaken to mitigate the current forecast deficit and risks.
- **Note** the risks around workforce which are resulting in sickness and higher turnover.

Implications						
Conflicts of Interest:	Not Applicable					
Financial and Workforce:	See detail within the report					
Performance:	See detail within the report					
Quality and Safety:	See detail within the report					
Inclusion						
<p>Has an equality impact assessment been undertaken? (delete as appropriate)</p> <p>An EQIA is required for new services or changes to service delivery.</p> <p>For more information the EQIA Policy and Tool can be found here.</p>	<p>Yes (attached or hyperlinked)</p>		<p>No (state why in the row below)</p>		<p>Not applicable (state why in the row below)</p>	✓
This report is for assurance and reporting on performance of providers and System and therefore not recommending new services or changes to service delivery.						
<p>Has a Health Equity Assessment Tool (HEAT) been completed?</p> <p>HEAT may be used for new, changing or existing services and processes.</p> <p>More information can be found here.</p>	<p>Yes (attached or hyperlinked)</p>		<p>No (state why in the row below)</p>		<p>Not applicable (state why in the row below)</p>	✓
This report is for assurance and reporting on performance of providers and System and therefore not recommending new services or changes to service delivery.						
Engagement						
Patient and Public Engagement:	Not Applicable					
Clinical and Professional Engagement:	Not Applicable					
Risk						
Risk:	The report includes financial, performance, quality, and workforce risks. Full details including mitigating actions are described in the main body of the report with relevant sections reviewed at the ICB's Finance & Performance, Quality Safety & Experience, and People Committees.					

1. Performance and Quality Update

This section is exception-based and outlines progress against key organisational performance and quality deliverables and priorities. These include, but are not limited to, the NHS Constitution, the National Oversight and Assessment Framework, and NHS operational planning commitments. Separate, comprehensive monthly Performance and Quality reports are sent to members of the ICBs Finance and Performance, and Quality, Safety & Experience Committees. At these sub-committees, performance is reviewed, improvement actions are scrutinised, and assurance is provided.

ICB programme boards, such as the Finance Advisory Board, System Oversight Group, and Transformation Board, offer further oversight at the programme level. Additionally, Provider and System Review Meetings provide a platform to discuss and escalate concerns both at an individual organisational level and across the System footprint.

At the Quarterly System Review Meeting held with NHS England on 30th April, there was a strong emphasis on delivery and maintaining oversight of progress. The system has submitted ambitious operational planning trajectories, committing to meeting the national priorities and success measures for 2025/26. The focus must now shift to delivery.

NHS England identified A&E, cancer, and elective long waits as areas of concern. Progress against these metrics is closely monitored at the fortnightly System Oversight Group. Quality concerns subject to Enhanced Surveillance through the Quality Assurance Framework are outlined and reported in detail to the Quality and Safety Executive Committee. Currently, there are no areas under Intensive Surveillance within the Quality Assurance Framework.

Dashboards presenting achievements against the full suite of performance metrics and key quality indicators are included in the appendices.

The Board is asked to note the following areas of concern:

- 1.1 The proportion of A&E attendances admitted, transferred, or discharged within 4 hours of arrival improved to 70.2% in March, compared to the national expectation of 78.0%. A&E performance has been impacted by a 5.5% (16,880) increase in Type 1 attendances in 2024/25 compared to 2023/24. The three Coventry & Warwickshire acute trusts have submitted operational plans committing to achieving 78.0% by March 2026.
- 1.2 Handover times from emergency ambulances into A&E have shown improvement following the cessation of out-of-area intelligent conveyancing. In March, 77.3% of ambulance handovers were completed within 30 minutes of arrival, compared to 72.7% in February. Discussions continue regarding the implementation of the 45-minute handover policy to support 999 response times, with learning being taken from other systems within the region that have adopted the policy. The "Call before Convey" initiative continues to be reinforced with WMAS to reduce the number of ambulances conveyed to A&E and encourage the utilisation of Same Day Emergency Care.
- 1.3 The elective waiting list increased to 135,873 in February, 18.2% above the operational planning trajectory of 114,915. As previously highlighted the increase is driven by the changes post EPR

implementation at UHCW. The trust has signed a MOU during 2025/26 agreeing to take part in the national sprint validation, given the challenges post EPR this should significantly improve their overall PTL and give a clearer picture of any increase to the overall system PTL from the end of March 2024. The waiting list includes 2,831 patients who have waited more than 52 weeks for treatment, of which 96 have waited more than 65 weeks. Orthodontics remains a risk due to the specialist nature of the service and local and national capacity constraints. The independent sector and mutual aid are being utilised to expedite treatment and mitigate the risk of long waits. The number of 65-week waits is expected to continue to reduce in line with the submitted 2025/26 operational planning trajectories.

- 1.4 The Faster Diagnosis Standard was met in February. The proportion of patients receiving a cancer diagnosis or having cancer ruled out within 28-days improved to 78.8%, surpassing the 77% national standard. However, the percentage of patients receiving a first definitive treatment for cancer within 62 days was 59.2% in February, below the national expectation of 70.0%.
- 1.5 At the end of February, 72 people had waited more than 52 weeks for community services. This excludes data for adult safeguarding, looked after children, and children and young people's safeguarding, which is only published at a national level. Performance, although above the operational planning trajectory of 21, has fallen from 105 at the end of January. Challenging performance partly reflects data quality issues. The system Community Health Services Data Group is working to ensure that waiting list returns accurately reflect performance, and where required, data quality improvement plans are in place.
- 1.6 The rate of adult learning disabilities and/or autism inpatients per million population reduced to 50.0 in February. This performance exceeds the operational planning trajectory of 43.7 and the national expectation of 30. The ICB and NHS England have agreed a revised improvement trajectory to deliver a rate of 49.1 per million by the end of March 2025. An improvement action plan is in place, and performance is forecast to meet the revised expectation.
- 1.7 The dementia diagnosis rate improved by 0.6 percentage points to 58.6% in February. Performance remains below the operational planning trajectory of 59.5% and the national expectation of 66.7%. This indicator is not included within the 2025/26 Priorities & Operational Planning Guidance.
- 1.8 The quality areas subject to Enhanced Surveillance through the Quality Assurance Framework are outlined below. The areas of concern are identified, assurance arrangements assessed, and the population and system impact considered.
- 1.9 Enhanced Surveillance;
 - Primary Care - Enhanced Surveillance. There are currently 8 of 119 GP practices on enhanced surveillance.
 - Paediatric Audiology - Enhanced Surveillance. A clinical records review is in progress of all babies who had hearing assessments between 2019-2024 (total 242 cases).

- 1.10 Routine Level Surveillance;
- There are nine quality concerns on 'routine' level of surveillance that are being proactively managed as business as usual by the relevant lead Commissioner.
- 1.11 A summary of the health inequality activities by programme area is outlined with key actions in the main body of the report.

Limited Assurance (Performance)

Key Area	Committee Update	Key Actions for Next 3 Months
Cancer 62 day Waits	<ul style="list-style-type: none"> On the 13th April, the system 62-day backlog stood at 484. Of these, 141 patients had been waiting over 104 days. The head & neck backlog for patients on the urgent suspected cancer pathway at UHCW has shown significant improvement in recent weeks falling from 156 in mid-October to 54 as of 13th April. 62 Day performance remains challenged, achieving 59.2% at system level in February against the 70% target. At Trust level GEH delivered 55.2%, SWUFT (55.6%), and UHCW (59.4%). 	<ul style="list-style-type: none"> Updated improvement plans and associated trajectories covering the most challenged tumour sites have been submitted by UHCW with ongoing review and oversight at the SOG. Bi-weekly 28/62 days system meeting in place with trust cancer leads. This includes oversight of backlogs and facilitates the sharing of good practice. GEH continue to work with Royal Wolverhampton Trust to improve validation and booking processes. UHCW continue to work through their backlog of head and neck patients, which has resulted in bottlenecks further along the pathway. Sustainable recovery of the service is a priority, to prevent the need for additional radiology and theatre sessions to support. SWUFT implemented a new Cancer Access meeting to track patients on an individual basis, supporting a reduction in the backlog. Providers have bespoke urology improvements in place supported by the Area Network and the Cancer Transformation sub-group, with mutual aid in place within the system to support clearing of the backlog.

Actions – Health Inequalities

Key Area	Committee Update	Key Actions for Next 3 Months
Urgent Care	<ul style="list-style-type: none"> An initial meeting has been held between housing and social care to consolidate the UHCW discharge pathway for homeless patients with on-going care and support needs. There has been an agreement to develop the pathway and identify appropriate temporary accommodation. Progression of the Social Prescriber programme at the Coventry Urgent Treatment Centre, including move to proactive case finding focussed on most frequent attenders at UTC and appropriate cases at UHCW A&E department. On-going work to establish a Coventry and Warwickshire homelessness and access to healthcare group. 	<ul style="list-style-type: none"> Working with the social prescriber team at UTC to ensure proactive case finding is in place and data collection is sufficient to enable demonstration of service outcomes. Homelessness Pathways Lead nurses working to develop a pathway for travellers and gypsies and for veterans. Psychological Informed Environment training to be rolled out at UHCW. Development of purpose and terms of reference for strategic health and homelessness group.
Elective Recovery	<ul style="list-style-type: none"> Initial evaluation results from UHCW DNA reduction project (part of the Healthy Hospital project) are starting to show reductions in missed appointments, with full data still to be pulled. Issues addressed by the volunteer callers are mainly related to patients being unaware of appointments or confused about appointment times. Ongoing support for embedding tackling inequalities within recommissioning of the diabetes education and self-management service, DESMOND. Two Community Engagement Officers have commenced in post to support cancer inequalities work. Work will focus on engagement with traveller communities in North Warwickshire and reaching out to LGBTQ+ communities, as well as scoping work to engage with men in Black communities around prostate cancer. The stop smoking preoperative pathway at SWUFT, launched in January 2025, is now fully operational and demonstrating 	<ul style="list-style-type: none"> Action plan to be developed by the ICB Elective Care team to tackle inequalities, including review of missed appointments through a health inequalities lens, accessible communication, better use of intelligence data to identify inequalities, and improving ethnicity data recording. Awaiting ethnicity recording toolkit from NHS England to support teams in improving data. #CovConnects programme working with a Warwick Business School MSc student to explore economic and environmental impacts of the programme with aim to produce report and ongoing monitoring tool after 3 months. Development of 'Device Hub Starter Kits' and promotion of these alongside the digital skills offer to be pushed out widely in comms to engage more digital champions. Cancer bus tour to commence in May.

Key Area	Committee Update	Key Actions for Next 3 Months
	<p>promising early results, with approximately 20–30% of those engaging with the service achieving a confirmed 28-day quit.</p> <ul style="list-style-type: none"> Community heart failure mobile clinic roadshows in place and embedded as business as usual in Warwickshire North. An additional £9,200 has been secured from Women’s Health funding to offer screening and education services targeting menopausal women at higher risk of cardio-vascular disease. #CovConnects programme has launched skills sessions, delivered through WATCH (VCSE organisation) including one to one sessions in people’s homes for people who are housebound. The development of digital hubs in partner organisations is underway, including training of digital champions, hardware bundle, assistance with set-up, and on-going support. Launch of Digital Lifelines – Jangala Report for Coventry pilot in temporary accommodation: Digital Lifelines - Jangala 	
Primary Care	<ul style="list-style-type: none"> The third Health Justice Partnership (HJP) site has gone live, taking the programme into Warwickshire through Nuneaton & Bedworth PCN, in partnership with Bedworth, Rugby and Nuneaton Citizens Advice Bureau. The first two HJP sites are both in Coventry. Launch of the Physical Health Checks for Veterans in Warwickshire North, including funding secured to extend the programme to include spouses/partners/carers and recognition of additional costs for primary care. Results from the commissioned digital health platform, VISO, hypertension monitoring pilot programme are positive, with almost 1 in 5 patients moving from uncontrolled to controlled hypertension. Navigation PCN officially added digital inclusion and digital champion training to their new digital transformation framework as a result of work with #CovConnects. 	<ul style="list-style-type: none"> Continuing to work with Primary Care colleagues to progress the health inequalities focused projects via the development funds. Working with primary care colleagues on the homelessness and health strategic group. Development of programme for veteran’s health checks in local community settings, utilising libraries and WCC Community Partnership Team. Carrying out survey of VISO patients to explore outcomes and patient experience.

Key Area	Committee Update	Key Actions for Next 3 Months
Mental Health	<ul style="list-style-type: none"> The Core20 Connectors programme is now live in Coventry and Warwickshire North, supporting people with severe mental illness to access healthy lifestyle services following a physical health check. Volunteer community connectors have been recruited and trained. Referral pathways are in place between CWPT and the healthy lifestyles services, Fitter Futures and HLS. Work is ongoing in CWPT to embed the patient and carer race equality framework (PCREF), which will include confirmation of CWPT as an Anti-Racist Trust. Development of an extensive action plan and wide-reaching communications plan is in progress. The inequalities projects funded through the MH Inequalities pot are progressing. 	<ul style="list-style-type: none"> Continuation of the PCREF meetings and associated actions. With the MH Inequalities projects, the focus will continue to be upon increasing engagement in the community with the targeted population, considering language solutions, tailored workshops and collaborative working, and addressing volunteer commitment. Delivery will continue for all MH funded projects.
Maternity	<ul style="list-style-type: none"> The Maternal Circles programme continues, with referrals picking up in March following a Christmas slow-down. Three volunteers have been recruited to support coffee mornings and workshops. Change Grow Live (CGL) training has been completed, supporting the work with families with addiction. Partnership working is in place with Edible Links to support families to access pregnancy and baby-care supplies. Work is underway with Warwick University to evaluate the programme. Launch of Planning for Pregnancy campaign with Tommy's, the pregnancy and baby charity. Roll out of free healthy start vitamins, to pregnant women and infants up to the age of 4 with asylum seeker and refugee status living in hotel accommodation in Warwickshire. 	<ul style="list-style-type: none"> Monitoring and evaluation for the vaccinator midwife role including overarching impact and return of investment. The Maternal Circles programme will launch the 'Blissful Bumps' service. Service delivery for courses is being reviewed and providing lunch being trialled to see if attendance increases. The service is currently awaiting clearance from the Course Delegated Ethical Approval committee, acting on behalf of the Biomedical and Scientific Research Ethics Committee, and once ethical approval is granted the evaluation study will proceed.
LDA	<ul style="list-style-type: none"> Links made with LDA Workforce and Health Inequalities Programme Manager. There will be a review of the approach regarding health literacy and resource platforms to support health 	<ul style="list-style-type: none"> As part of Primary Care key area, LDA populations have been cited as high priority for all workstreams – CVD, cancer, COPD and diabetes. Commencement of utilising the development

Key Area	Committee Update	Key Actions for Next 3 Months
	<p>professionals and communication on a range of conditions/services such as cervical cancer screening.</p> <ul style="list-style-type: none"> • Legal duties KPIs are showing that the percentage of people with a learning disability receiving their annual health check has increased slightly from 2023 to 2024. • The system continues to analyse the Assuring Transformation inpatient dataset through the lenses of deprivation, gender, and ethnicity where possible. 	<p>funding to drive enhanced delivery of the Directed Enhanced Services in primary care, and focus on health inequalities.</p> <ul style="list-style-type: none"> • LD Friendly Practices birthday event planned for May to celebrate first year of accredited practices and showcase best practice examples.
Newly arrived communities	<ul style="list-style-type: none"> • Continuing to provide leadership and co-ordination regarding the health and wellbeing needs of asylum seekers and refugees. Mobilisation of enabling appropriate primary care access via the Dunchurch Park Hotel Health Partnership group. • HARP (Health Access for Refugees) project in Coventry continues, with women's Health clinic days held in February and March, creation and distribution of the HARP handbook, and working with UHCW oncology department around needs of refugee and asylum seekers. This project has been extended to October 2025 through funding from Coventry City Council. • Recruitment and contract reviews have been finalised for the Migrant Mental Health project, alongside an agreed approach for training and monitoring success. Outreach work and therapy service fully operational with all providers. 	<ul style="list-style-type: none"> • As part of Primary Care key area, promoting the Safe Surgeries and encouraging sign up and engagement. Partnership working with Health Access Refugee Programme (HARP) to increase active surgery involvement. • Health and Wellbeing event to take place at Dunchurch Park Hotel. Seeking a range of health and educational services to attend, such as cancer screening, health checks etc. • Referral links to be strengthened through provider collaboration for the Migrant Mental Health project (MH Investment). • HARP project leading multi-agency group to explore and influence nutrition in asylum seeker hotels. Work will progress with cancer services through creating more personalised resources.

2. Finance Update

2.1 ICS Position

- The yearend draft financial position (i.e. unaudited) for the ICS is a surplus of £0.193m against a balanced financial plan.
- The year end variance is made up of – deficit in SWFT £1.3m and GEH £3.7m, with surpluses at UHCW of £0.3m, ICB £2.7m and £2.2m CWPT.
- The system efficiency programme overperformed in 24/25 by £3.6m. However, 61% was delivered non recurrently with 39% recurrently.
- The total 24/25 Operational Capital budget C&W ICS is £54.2m. The system is within its allowable capital limit for core capital and additional programme funding received. Resulting in a £2.3m underspend.

2.2 ICB Position

- The yearend draft financial position (i.e. unaudited) for the ICB is reporting a £2.7m surplus against plan of £2.0m resulting in a surplus of £4.7m.
- The ICB is forecasting spend to £226.9m MHIS target, which delivers achievement of the MHIS with an overperformance of £0.1m.
- The MH S75 closing balance is forecast to be £7.3m, an increase from a £6.2m opening balance.

2.3 Table 1 – System Financial Position

Financial Performance Metrics				
Surplus / (Deficit) - Financial Position	YTD Surplus / (Deficit)			
	Plan £000	YTD £000	Variance £000	Variance %
C&W ICB	2,022	4,676	2,654	0.1%
CWPT	1,000	3,192	2,192	0.8%
GEH	706	(2,976)	(3,682)	(1.4%)
SWFT	1,300	1	(1,299)	(0.3%)
UHCW	(5,028)	(4,700)	328	0.0%
ICS Total	(0)	193	193	0.0%

System Update

- 2.4 Additional funding received by NHSE in recognition of CWICB being an under-target system in terms of national allocations allowed the system to breakeven from a £14.4m deficit position. Flexibilities and other resources have also been utilised to ensure the system breakeven position.

2.5 Table 2 – Statement of Comprehensive Income

System SOCI	Original Plan £M	Plan £M	Actual £M	Variance £M	Variance %
Commissioner Income					
System Allocation	(2,364)	(2,590)	(2,590)	0	0.00%
Provider Income					
Operating income from patient care activities	(1,795)	(1,942)	(2,048)	106	(5.44%)
Other Operating Income	(132)	(136)	(170)	35	(25.64%)
Total Provider Income	(1,927)	(2,078)	(2,218)	140	(6.76%)
Provider Expenditure					
Employee expenses	1,245	1,377	1,443	(66)	(4.80%)
Operating expenses, excluding employee expenses	656	648	761	(113)	(17.47%)
Net Finance Cost, non-op ex and other adjustments	56	55	19	36	66.11%
Total Provider Expenditure	1,957	2,080	2,223	(143)	(6.87%)
Commissioner Expenditure					
Acute	1,078	1,246	1,257	(11)	(0.88%)
Mental Health	272	289	293	(3)	(1.10%)
Community	165	169	170	(1)	(0.50%)
Continuing Care	125	118	118	(0)	(0.07%)
Primary Care	206	211	212	(1)	(0.45%)
Delegated Primary Care Co-Commissioning	193	208	207	0	0.03%
Delegated Pharmacy, Ophthalmic and Dental	84	98	97	1	1.23%
Delegated Specialised Commissioning	194	204	200	4	1.94%
Other Commissioned/ Programme Services	30	27	14	13	47.97%
Running Costs	16	18	17	0	1.60%
Reserves	0	0	0	0	0.00%
Total Commissioner Expenditure	2,362	2,588	2,585	3	0.10%
TOTAL Provider Surplus/(Deficit)	30	2.0	4.5	(2.5)	0.1%
TOTAL ICS Surplus/(Deficit)	27	(0.0)	0.2	0.2	0.0%

2.6 Capital

- The 24/25 Operational Capital budget C&W ICS was allocated was £54.2m.
- Included within this allocation was £10.96m that was recovered by NHSE & £4m for direct use on UEC and so does not form part of the overall quantum.
- The available operational capital allocation for use by system providers was £38.96m.
- In year there was additional Critical Infrastructure Risk (CIR) funding successfully obtained to the value of £3.6m – this derisked the overall capital position.
- The system arrived at a year-end underspend of £2.3m. This, in the main, was due to slippage of schemes in CWPT regarding Caludon rectification works and gains on disposals.
- The 25/26 planning round has now finished. The funding allocation is significantly lower at £36.5m.
- Allocation of this has been disseminated on a apportionment basis as per the 24/25 allocation, after adjusting for transfer of services and technical adjustments regarding share purchases.

2.7 Efficiency

- The CW ICS Business as Usual (BAU) efficiency programme outturn for 24/25 totals £128m. This is £3.6m above plan due to additional Non recurrent savings at CWPT and UHCW. 61% was delivered non recurrently with 39% recurrently.
- Table 3 – Efficiency Delivery

	Plan Outturn £000	Actual Outturn £000	Variance Outturn £000	Variance %
Provider Efficiencies				
Recurrent				
Pay - Recurrent	39,204	21,448	(17,756)	-45.3%
Non-pay - Recurrent	18,700	13,680	(5,019)	-26.8%
Income - Recurrent	1,900	2,726	826	43.5%
Total recurrent efficiencies	59,804	37,855	(21,949)	-36.7%
Non recurrent				
Pay - Non-recurrent	16,814	20,369	3,555	21.1%
Non-pay - Non-recurrent	31,458	50,543	19,085	60.7%
Income - Non-recurrent	2,118	5,275	3,157	149.1%
Total non-recurrent efficiencies	50,390	76,187	25,797	51.2%
ICB Efficiencies				
Recurrent	13,734	12,699	(1,035)	-7.5%
Non-recurrent	589	1,347	758	128.6%
Total System recurrent	73,538	50,554	(22,984)	-31.3%
Total System non-recurrent	50,979	77,534	26,555	52.1%
Total System Efficiencies	124,516	128,087	3,571	2.87%

2.8 Agency

- ICB Agency spend as at M12 is £1.6m. This relates to clinical costs within Continuing Healthcare
- Provider agency spend at M12 is under plan with a favourable variance of £1.8m. The system agency cap is £41.9m. This represents 2.8% of total pay expenditure.

2.9 ERF

- The ERF Core target percentage for 2024/25 is 105.5% with Specialised Commissioning at 110.9%.
- Forecasting of the Elective Recovery Fund at month 12 shows achievement at 119.7% against a target of 105.6%. This results in overperformance of £35.9m of which £5.6m relates to 2023/24 performance.
- The ICB has received confirmation from NHSE that our ERF allocation for 24/25 is now capped at £35.8m (and £685k for spec comm).
- NHSE have also confirmed underperformance will be clawed back in 25/26 but there will be no additional funding available for final reported overperformance above the capped allocation and will be a risk to Provider organisations.

Provider Update

- 2.10 **UHCW** is reporting a FOT deficit of £4.7m, which is an improvement of £0.3m against Plan (£5.028m). The drivers of the deficit are:
- Pressures relating to Direct Access pathology continues to increase from previous years (£1.10m).
 - In year Pay Award impact (£2m) and Blocked pass-through drugs (£1.06m).
 - This is offset by Waste Reduction Program (WRP) which is showing a favourable variance of £4.3m and £0.2m non patient income/slippage on developments.

The YTD Agency spend is £15.1m against a £18.2m spend cap. Nursing gaps filled through international recruitment is a key driver behind the reduced agency spend.

- 2.11 **CWPT** - Month 12 adjusted position is reporting a £3m surplus in line with agreed forecast outturn for 2025/26.

The additional surplus compared to plan is as a result of an improvement in position agreed with the ICB, achieved through the receipt of income that was uncertain at the time the plan was set, plus NR deficit support funding.

Pay costs remained overspent - agency and bank usage on medical staff and inpatient nursing as well as non-delivery of pay related CIP plans. This overspend is offset by NR income and non-pay savings

- 2.12 **GEH** - month 12 financial position is £2.978m deficit, resulting in £3.68m deficit against plan.

- 2.13 **SWUFT** – month 12 position financial position is £1k surplus, resulting in £1.3m deficit against plan.

ICB Update

- 2.14 The yearend draft financial position (i.e. unaudited) for the ICB is reporting a £2.7m surplus against plan of £2.0m resulting in a surplus of £4.7m. The position reflects cost pressures within Prescribing, Urgent and Emergency Ambulance Cat 2 response performance, EPR support and Continuing Healthcare agency/legal costs, offset with the underspend in Delegated Dental, Ophthalmic and Pharmacy (DOP), System IT, release of SDF allocation and slippage on vacant posts and release of prior year.
- 2.15 The ICB efficiency programme is underperforming at M12 by £0.3m due to under delivery in Continuing Healthcare and Mental Health. This is a £0.3m improvement on M11 reporting.
- 2.16 The ICB is forecasting spend to £226.9m MHIS target, which delivers achievement of the MHIS with an overperformance of £63k.
- 2.17 ICB Agency spend as at M12 is £1.6m. This relates to clinical costs within Continuing Healthcare.

- 2.18 The MH S75 closing balance is forecast to be £7.3m, an increase from a £6.2m opening balance.
- 2.19 The ICB has a ringfenced capital allocation for GP IT of £1.733m which has been fully utilised.

Financial Performance					
Indicator Measure	Latest Month	Full Year Forecast Performance £m			RAG
		Plan / Ceiling / Envelope	Actual	Variance	FOT
Delivery against system plan	Mar-25	(0.0)	0.2	0.2	Green
Efficiency	Mar-25	124.5	128.1	3.6	Green
Agency & Contract Staff (including capitalised staff costs)	Mar-25	39.5	40.1	(0.6)	Red
Agency spend as % of agency cap	Mar-25	94%	96%		Red
Agency Spend vs Ceiling	Mar-25	41.9	40.1	1.8	Green
Charge against Capital Allocation (exc IFRS16)	Mar-25	53.9	51.6	2.3	NA
Elective Performance	Mar-25	105.6%	119.7%		Green
Mental Health Investment Standard	Mar-25	226.8	226.9	0.1	Green

3. People Update

NHS Provider Workforce

- 3.1 Workforce vacancies remain static. At 2023/24 year end, vacancies were 7.44% (1661.6 WTE) and at the end of Month 12 2024/25 were 6.39% (1488.7 WTE) which was an improvement on the Month 10 position. This vacancy position is against a backdrop of an increase in establishment between M12 2023/24 and M12 2024/25 of 4.8% (986.6 WTE). Our substantive workforce has grown by 1159.5 WTE since the end of March 2024. Progress has been made in nursing and midwifery, where actual staff in post has grown by 436.9 WTE since end March 2024. The total nursing and midwifery vacancies have decreased by 205.8 WTE since March 2024 with an establishment increase of 207.7 WTE. Within adult nursing specifically vacancies have decreased by 63.5 WTE since March 2024 with an establishment increase of 231.1 WTE. The consultant workforce has grown by 83 WTE since March 24, vacancies are 85 WTE (9.76%) which is a decrease on March 2024 despite an establishment growth of 37.9 WTE.
- 3.2 Our 2024/25 Workforce Plan submitted as part of operational planning, contained ambitious targets for reduction in the temporary staffing workforce with a 30.3% reduction in agency staff and a 25.3% reduction in bank staff. Agency usage has decreased by 160 WTE since March 2024, and activities to reduce agency usage have resulted in a 58.7% reduction when comparing March 2023 with March 2025. Currently we are 25.72 WTE below plan for agency usage and have been 16.7 WTE on average below plan. Bank usage has reduced by 252.7 WTE between March 24 and March 2025. Throughout Q1 providers were below plan and in each month of Q2 -Q4 bank usage exceeded plan with M12 373.1 WTE above plan. Trusts have sought to move temporary staffing from Agency to Bank, where temporary staffing needs are approved. All Trusts continue to focus on plans to reduce agency staffing usage, combined with a focus on high-cost placements. A system wide Temporary Staffing Assurance Group has been sharing best practice and monitors

plans for a reduction in temporary staff. Weekly monitoring of bank and agency shifts including price cap breaches is in place, this data is submitted to NHSE for benchmarking and monitoring purposes. NHS Providers have now eliminated off framework usage except in true break-glass circumstances of which there have been three. High levels of staff sickness absence and escalation capacity have been the most significant drivers of temporary staffing.

- 3.3 The 2025/26 Operational Planning Guidance has set ambitious targets for further reductions in bank and agency staff as part of an overall strategy to improve productivity and achieve activity levels through a non-premium workforce. In the 27 March submission, an overall workforce reduction of 238 WTE was submitted which incorporated a 21% reduction in bank and a 48% reduction in agency staffing.
- 3.4 The rolling 12-month sickness absence for the system is 5.77% and we are off target for a year end cumulative trajectory of 4.1%. This rate is consistent with peers across the NHS in the Midlands. Rolling 12-month turnover is at 9.3% in M12 which is a decrease on M1(10.42%).
- 3.5 Progress on implementation of the Refreshed People Plan continues with high level system wide plans now in place for the 4 themes of our People Plan. These are designed to mitigate against our strategic workforce risks which are:
 - Workforce availability impacted by high vacancy rates across health and care and an ageing workforce;
 - Workforce affordability impacted by high temporary staffing usage and other factors impacting productivity;
 - Staff experience including bullying and harassment and high levels of sickness particularly mental health related absence;
 - Leadership skills in management of a diverse workforce with increasingly flexible work patterns.

Under the refreshed plan, the themes remain unchanged, and the number of priorities reduces from 8 to 7. An efficiency priority as referenced in 3.4 above is introduced. System Identity is now an enabling theme. A robust programme management approach to delivery will continue with dashboards in place to highlight risks and measure key performance indicators.

- 3.6 Under the OD and Culture theme, all Inclusive Recruitment sessions have now been delivered and an evaluation is awaited. A participant who personally achieved her career goals as a result of the learning from the programme presented to both the People Board and People Committee in April. Champion training sessions for the Active Bystander programme have taken place with positive feedback from both participants and EDIB leads. Further train the trainer sessions are planned and full roll out for training will commence in the autumn. The My Menopause Platform has supported 304 colleagues to develop personalised action plans. A specific mental health workstream has been established to support reducing sickness level relating to this. As a pre-emptive response to next year's winter pressures, a flu vaccination group is being established to support colleague uptake.
- 3.7 Under the Attract Recruit and Retain theme, the Health and Care Employability Academy continues to support local population opportunities in attaining meaningful education training and employment in health and social care. Specific population cohorts are supported including care leavers, people

with refugee status, people with disabilities and other underrepresented groups. In the eight months of 2024/25, there have been 546 interventions (against a target of 650) to support preparation for work and 47% (306 out of a target of 325) of these have had positive outcomes (either employment or volunteering). Partnership work with social care colleagues is expanding to include bespoke social care interventions, introducing participants to roles in social care. All attraction workstreams are now in place with implementation plans in progress to:

- Expand the 'Your Nursing Career Here' website
- Simplify recruitment practices and processes
- Enable movement
- Focus on social care.

3.8 Following an attraction workshop, system priorities were agreed which include expansion of the 'Your Nursing Career Here' website, simplification of the application and on boarding process, a focus on social care attraction and work to enable movement across our system. These commence in April 2025. A retention workshop is planned for May to review core themes from the annual staff survey. Our People Promise Managers are presenting their achievements at this workshop in order to support sustainability of the work. Our Nursing and Midwifery Recruitment and Retention Steering Group continues to govern focused work to support nursing and midwifery attraction and retention with the previous programmes of work showing tangible improvements in vacancy levels and staff experience as measured by the National Staff Survey with Nursing and Midwifery achieving above average scores in all aspects of the People Promise and Engagement and Morale.

3.9 Under the People Development theme, there are 5 priority areas.

Increase the availability and uptake of level 6 healthcare apprenticeships.

A System Levy sharing agreement and process has been drafted with partner NHS Trusts, with the aim of sharing levy to utilise 100% across all health and care organisations. For sign off at the Future Skills Board on 28th April.

4 healthcare apprenticeship programmes are awaiting regulator sign off, to be delivered within Coventry and Warwickshire from September 2025 (Nursing, ODP, OT and Biomedical Science). A new Podiatry apprenticeship will commence January 2026 and Diagnostic Radiography and Midwifery apprenticeships are under development for delivery September 2026.

An employer apprenticeship support offer is under development, including building an apprenticeship costing tool, a comprehensive website and employer engagement events to showcase the new apprenticeships available from September 2025.

Inspiring children and young people.

We are working with 2 Primary Schools in Coventry to pilot a change to the way health and care interact with schools, moving away from a purely careers based approach to adding greater social value through a quality partnership. The science curriculum has been identified as the focus for a pilot, with years 3-4. Health and care ambassadors will support the delivery of science lessons and work is underway to ensure our ambassadors are representative of our at-risk professions. Lesson plans are currently being developed with teachers.

We have funded the expansion of the Explore Nursing badge, an HSJ workforce innovation of the year winner, developed at South Warwickshire University Hospital NHS Foundation Trust. The expansion will see the development of the badge to an additional 5 professions, providing an insight

for children and young people in uniformed groups (e.g. Brownies, Scouts, Rangers) into the 6 at risk professions across Coventry and Warwickshire.

Support Worker development.

The Higher Development Award pilot is underway in partnership with Coventry College, with the first cohort starting on programme on the 16 May 2025.

Having scoped the current work across the system on delegated healthcare activities, we are convening a workshop of key stakeholders across the system on 05.06.25, facilitated by NHS Elect. Delegated healthcare activities could help us move away from managing sickness to enabling prevention; to promote living well and staying out of hospital; support NHS resource management and increase workforce skills development. In this workshop we will work towards agreeing an approach to adopting and spreading the existing programmes of work to delegate healthcare activities across the system, ensuring robust governance, and identify further areas where delegated healthcare activities would have the biggest impact.

Funding has been identified to employ 2 clinical educators in care homes with nursing across Coventry and Warwickshire. This will support workforce competence assessment, role modelling of evidence-based practice, support recruitment and retention, as well as increase placement capacity and support apprenticeship take-up in adult social care.

Learner retention

Retaining our healthcare learners is key to ensuring a future workforce across the system on qualification. A multi-professional exercise is underway across all NHS Trusts to assess clinical placement areas against the 10 priority areas of the national Safe Learning Environment Charter. A process to do this across Primary Care has been established, in line with the Midlands Learning Environment Application Form, which is required by all primary care providers who place learners. Work has progressed with the Training Hub and Coventry University to increase primary care placement capacity through simulated practice learning. Work continues mapping new and innovative placements across primary care, supported by the new training academy.

National Education and Training Survey results are being analysed and will then be triangulated with placement evaluations and the National Student Survey results.

Digital Upskilling

Digital literacy of the workforce is identified as a priority need and we are working in partnership with Coventry University on a digital upskilling offer for the clinical workforce.

- 3.10 Under the workforce innovation theme work on the operational planning round for 25/26 is concluding with a final submission due on 30th April 2025. The emphasis is on efficiency and control of the temporary workforce and reductions in corporate services function growth since 2020. The Temporary Staffing Assurance Group will monitor progress in respect of delivery of temporary staffing reductions and offer best practice and system solutions where applicable. UHCW hosted a variable pay event and learning from this will be shared with this group. It is also proposed that a Workforce Transformation and Education Steering Group is formed to understand the workforce impact of redesign programmes to encourage and support innovation in workforce redesign. For the People Digital priority an outline business case is in progress should investment capital be identified for progressing priorities.

Social Care Workforce

- 3.11 The Skills for Care Adult Social Care workforce dataset was released in October 2024 for the 2023/24 year. This is a valuable source of workforce demographic and trend data for both independent providers and directly employed adult social care staff and is being used to inform our priorities for action across the themes in the refreshed People Plan. The vacancy rate is estimated as 7.4% and turnover 27.6% for the year 2023/24. For Coventry turnover is 23.8% and for Warwickshire this is 29.8% against a range of 8.5% to 36.5% nationally (average 24.8%) Most recent data from Independent Providers gives a vacancy rate of 7.1% for Q3 24/25 against a national average of 7%. This is an increase from 6.6% in Q3. Most recent data from Independent Providers on turnover shows an increase in Coventry and Warwickshire from 27% (Q2) to 28.7% (Q3) which is slightly above the national rate of 25.8%. Our attraction social care subgroup is currently pulling together a number of initiatives from the People Plan to develop a comprehensive offer for social care staff in our system. Funding has now also been secured to support Clinical Educators see 3.9 above.

Primary Care Workforce

- 3.12 Of 42 ICBs, Coventry and Warwickshire have the lowest leaver rate for qualified permanent GPs and as at September 2024, it was the lowest across the Midlands at 4.1% and has decreased by over 2% since December 2023. Salaried GP numbers and GPs in Training have continued to increase.

Nursing numbers remain stable, despite a general nursing workforce shortage and due to increasing demand administrative and clerical roles see an increase. MDT/ARRS have steadily increased, supported by a well-established team of Ambassadors at the Training Hub providing a dedicated point of contact for all MDT.

Local programmes for GPs and Nurses are known to be having a direct impact on retention. In addition, other programmes supporting retention include a large education, training and development offer; a comprehensive health and wellbeing package and an equality, diversity, inclusion and belonging strategy which includes a freedom to speak up guardian.

A Primary Care Strategy has been published and an aligned Primary Care People Plan Workforce Strategy is currently proceeding through the ICB governance processes. Key priorities for 2025/26 include continuing to invest in general practice leadership skills; supporting service transformation; ensuring the general practice have the skills to deliver today and in the future and a greater focus on workforce planning.

The Training Hub is awaiting results of its first staff survey and this together with results for general practice across Coventry and Warwickshire will shape the action plan for our support offer for 2025/26.

4. Recommendation

Members are requested to:

- **Note the contents of the report for assurance** and to note the actions to improve performance and quality as required.
- **Note** the financial position and actions being undertaken to mitigate the current forecast deficit and risks.
- **Note** the risks around workforce which are resulting in sickness and higher turnover.

End of Report

Appendix 1: Integrated Performance Summary

Coventry and Warwickshire ICB: Integrated Performance Summary



Quality of care, access and outcomes Quality of care, access and outcomes (cont'd)

PROVIDER VIEW								POPULATION						PROVIDER VIEW						
Urgent Care	Latest month	Actual	Target	In month	Variation	Assurance	Bench-marking	Elective Care	Latest month	Actual	Target	In month	Variation	Assurance	Bench-marking	Actual	Target	In month	Variation	Assurance
A&E 12 hour breaches (DTA)	Mar 25	399	0	⊗	⊗	⊗		Patients waiting over 78 weeks	Feb 25	3	-	⊗	⊗	⊗	⊗	4	0	⊗	⊗	⊗
A&E 12 hour breaches (Time in dept)	Mar 25	2713	-	⊗	⊗	⊗		Patients waiting over 104 weeks	Feb 25	1	0	⊗	⊗	⊗	⊗	0	0	⊗	⊗	⊗
% A&E 12 hour breaches (Time in dept)	Mar 25	8%	2%	⊗	⊗	⊗		RTT total waiting list	Feb 25	135873	-	⊗	⊗	⊗	⊗	137206	114915	⊗	⊗	⊗
% Ambulance handovers within 15 mins	Mar 25	35%	65%	⊗	⊗	⊗	25%	Diagnostic waiting list	Feb 25	26654	-	⊗	⊗	⊗	⊗	25988	-	⊗	⊗	⊗
% Ambulance handovers within 30 mins	Mar 25	77%	95%	⊗	⊗	⊗	60%	Diagnostics performance	Feb 25	94%	85%	⊗	⊗	⊗	77%					
Ambulance 60 minute handover breaches	Mar 25	657	0	⊗	⊗	⊗		Cancer 62 day performance	Feb 25	59%	70%	⊗	⊗	⊗	71%					
Ambulance average response times: Category 1	Mar 25	00:08:54	-	⊗	⊗	⊗	00:07:57	Cancer 62 day backlog	20/04/2025						495	-	⊗	⊗	⊗	
Ambulance average response times: Category 2	Mar 25	00:21:26	-	⊗	⊗	⊗	00:23:09	Cancer 28 day Faster Diagnosis	Feb 25	79%	77%	⊗	⊗	⊗	78%					
Patients with LOS >=21 days	Mar 25	331	-	⊗	⊗	⊗		Elective activity vs 2019/20	Feb 25	125%	107%	⊗	⊗	⊗	109%					
								Diagnostic activity vs 2019/20	Feb 25	120%	120%	⊗	⊗	⊗	131%					

Mental Health, Community and Primary Care Finance and use of resources

Mental Health, Community and Primary Care								Finance								
Mental Health, Community and Primary Care	Latest month	Actual	Target	In month	Variation	Assurance	Bench-marking	Latest month	YTD Performance £m			Full Year Forecast Performance £m			RAG	
									Plan	Actual	Variance	Plan/Ceiling/Envelope	Actual	Variance		
Adults with LDA in a MH Bed Per Million Population	Mar 25	47	30	⊗	⊗	⊗	41	Delivery against system plan	Mar 25	(0.0)	0.2	0.2	(0.0)	0.2	0.2	
Dementia Diagnosis Rate	Feb 25	59%	67%	⊗	⊗	⊗	65%	Efficiency	Mar 25	124.5	128.1	3.6	124.5	128.1	3.6	
Talking Therapies Reliable Recovery	Feb 25	50%	48%	⊗	⊗	⊗	47%	Agency & contract staff (inc capitalised costs)	Mar 25	39.5	40.1	(0.6)	39.5	40.1	(0.6)	
Talking Therapies Reliable Improvement	Feb 25	75%	67%	⊗	⊗	⊗	67%	Agency spend as % of agency cap	Mar 25	94%	96%		94%	96%		
Community 2 hour UCR response	Feb 25	87%	70%	⊗	⊗	⊗	84%	Agency spend vs ceiling	Mar 25				41.9	40.1	1.8	
Primary care appointments	Mar 25	485190	-	⊗	⊗	⊗		Charge against capital allocation (exc IFRS16)	Mar 25				53.9	51.6	2.3	NA
Recovery of primary care appointments (vs 2020)	Mar 25	131%	100%	⊗	⊗	⊗	132%	Elective performance	Mar 25				105.6%	119.7%		NA
% with a positive experience of their GP practice	2024	78%	-	⊗	⊗	⊗	74%	Mental Health Investment Standard	Mar 25				226.8	226.9	0.1	
% satisfied with GP practice phone access	2024	58%	-	⊗	⊗	⊗	50%									
% satisfied with GP practice appointment times	2024	74%	-	⊗	⊗	⊗	66%									

Quality People

Quality								People									
Quality	Latest month	Actual	Target	In month	Variation	Assurance	Bench-marking	Latest month	Actual	Target	In month	Variation	Assurance	VARIATION			
														Special Cause Concerning variation	Special Cause Improving variation	Common Cause	
Clostridium difficile infections	Feb 25	16	-	⊗	⊗	⊗		Provider Substantive staff	Mar 25	21820	21247	⊗	⊗	⊗	⊗	⊗	
MRSA infections	Feb 25	1	-	⊗	⊗	⊗		Provider Bank staff	Mar 25	2045	1672	⊗	⊗	⊗	⊗	⊗	
E-coli infections	Feb 25	55	-	⊗	⊗	⊗		Provider Agency staff	Mar 25	287	313	⊗	⊗	⊗	⊗	⊗	
Still birth rate (per 1k births)	Feb 25	3.2	3.3	⊗	⊗	⊗		Primary Care workforce	Mar 25	2786	2814	⊗	⊗	⊗	⊗	⊗	
Neonatal mortality rate (per 1k births)	Feb 25	1.2	1.7	⊗	⊗	⊗		Provider 12 month sickness absence rate	Feb 25	6%	4%	⊗	⊗	⊗	⊗	⊗	
Total Providers on CQC escalation	Feb 25	26	0	⊗	⊗	⊗		Provider 12 month turnover rate	Feb 25	10%	11%	⊗	⊗	⊗	⊗	⊗	
QAF escalations on intense surveillance	Feb 25	0	0	⊗	⊗	⊗											
QAF escalations on enhanced surveillance	Feb 25	2	0	⊗	⊗	⊗											
% standard NHS CHC referrals completed <= 28 days	Dec 24	92.0%	80.0%	⊗	⊗	⊗	76.0%										

BENCHMARKING Where possible, performance in Coventry and Warwickshire has been benchmarked nationally. Where the benchmarking is red, C&W is performing worse than the national average - green indicates C&W outperforming the national average.

Appendix 2: NHS Operational Planning Metrics

The dashboard reports progress against NHS Operational Planning metrics (OPM). Some measures are also Integrated Health Care Delivery Plan Key Performance Indicators (denoted by the 'X' in the "IHCDP" column) and/or NHS Oversight Framework metrics (signified by the 'X' in the "NOF" column). The colour-coding relates to achievement against 2024/25 Operational Planning trajectories. The amber rating, which signifies that performance is within 5% (or percentage points) of target, has been introduced to help distinguish the biggest performance challenges. Where there is a national standard or expectation this is shown in the "Standard" column.

	Description	IHCDP	NOF	OPM	Basis	Level	Standard	Plan	Period	Performance		
										ICB	Midlands	England
UEC & Flow	Ambulance Cat 2 Response Time WMAS	X	X	X	Month	Provider	30-Mins	40-Mins	Mar-25	22.05	-	28:34
	A&E 4 Hour Waits	X	X	X	Month	Provider	78.0%	78.0%	Mar-25	70.2%	73.1%	75.0%
	Same Day Emergency Care Attendances <i>Providers not flowing data</i>			X	Month	Provider	-	3,725	Mar-25	0	-	-
	Bed Occupancy Patients with Average LOS >=21 Days			X	Month	Provider	-	237	Mar-25	332	2,956	18,666
	Bed Occupancy Adult G&A Overnight Beds	X	X	X	Month	Provider	-	99.9%	Mar-25	98.3%	95.1%	94.5%
	Virtual Ward Occupancy	X	X	X	Month	Provider	80.0%	80.0%	Mar-25	85.3%	77.0%	76.2%
	Discharge Beds Occupied by Adults Not Meeting Criteria to Reside		X	X	Month	Provider	-	15.6%	Mar-25	13.6%	-	-
Planned Care	RTT Incomplete Pathways			X	Snapshot	ICB	-	114,915	Feb-25	135,873	1,399,422	7,402,148
	RTT Completed Admitted Activity			X	Month	ICB	-	5,047	Feb-25	4,700	54,102	310,271
	RTT Completed Non-Admitted Activity			X	Month	ICB	-	15,948	Feb-25	14,138	215,668	1,147,315
	RTT Incomplete Pathways >52 Week Waits			X	Snapshot	ICB	0	1,273	Feb-25	2,831	34,040	193,516
	RTT Incomplete Pathways >65 Week Waits	X	X	X	Snapshot	ICB	0	0	Feb-25	96	1,274	13,223
	RTT Incomplete Pathways >52 Week Waits Children Aged <18			X	Snapshot	ICB	0	0	06-Apr-25	311	-	-
	Patient-Initiated OP Follow-Up Moved to PIFU Pathway <i>UHCW not flowing data</i>			X	Month	ICB	-	6,769	Jan-25	2,605	34,299	182,028
	Diagnostics Diagnostic Activity			X	Month	ICB	-	41,991	Feb-25	42,147	-	-
Diagnostics Waited <6 Weeks for Diagnostic Test			X	Snapshot	ICB	95.0%	95.2%	Feb-25	94.5%	80.5%	83.3%	
Cancer	Cancer Faster Diagnosis Standard	X	X	X	Month	ICB	77.0%	77.8%	Feb-25	78.8%	79.6%	80.2%
	Cancer First Definitive Treatment <62 Days of Referral	X		X	Month	ICB	70.0%	68.9%	Feb-25	59.2%	61.5%	67.0%
	Cancer Suspected Non-Specific Symptoms Referrals			X	Month	ICB	-	135	Feb-25	17	511	3,768
	Cancer Lower GI Suspected Cancer referrals with FIT result			X	Month	ICB	80.0%	80.1%	Feb-25	74.9%	82.9%	80.8%
Mental Health	Dementia Diagnosis Rate	X	X	X	Snapshot	ICB	66.7%	59.5%	Feb-25	58.6%	65.3%	65.4%
	Active Inappropriate Out of Area Placements			X	Snapshot	ICB	0	3	Feb-25	0	60	406
	Talking Therapies Reliable Recovery	X		X	Month	ICB	48.0%	48.0%	Feb-25	50.3%	47.9%	47.4%
	Talking Therapies Reliable Improvement			X	Month	ICB	67.0%	67.0%	Feb-25	75.0%	69.6%	67.3%
	CYP Mental Health Services Access		X	X	R12Mth	ICB	-	12,950	Feb-25	12,985	155,620	822,031
	SMI Physical Health Checks	X		X	R12Mth	ICB	75.0%	62.9%	Dec-24	49.2%	59.0%	58.5%
	Perinatal Mental Health Access	X	X	X	R12Mth	ICB	-	1,067	Feb-25	1,050	12,725	63,858
Transformed Community Mental Health Services Access			X	R12Mth	ICB	-	8,742	Dec-24	7,980	130,500	577,403	

	Description	IHCDP	NOF	OPM	Basis	Level	Standard	Plan	Period	Performance		
										ICB	Midlands	England
LDA	Mental Health Inpatient Setting Adults with a Learning Disability and/or Autism	X	X	X	Snapshot	ICB	30	43.7	Feb-25	50.0	-	41.0
	Mental Health Inpatient Setting Children with a Learning Disability and/or Autism	X		X	Snapshot	ICB	15.0	41.7	Feb-25	26.0	-	-
	Learning Disability Annual Health Checks	X	X	X	YTD	ICB	75%	65.6%	Feb-25	70.0%	70.8%	71.0%
Other	General Practice Appointments			X	Month	ICB	-	451,140	Feb-25	467,172	-	-
	General Practice Appointments Seen <2 Weeks		X	X	Month	ICB	-	90.0%	Feb-25	93.8%	89.4%	88.7%
	Seen by NHS Dentist Adults Seen Within Last <24 Months			X	R12Mth	ICB	-	43.7%	Feb-25	41.8%	39.1%	35.5%
	Seen by NHS Dentist Children Aged <18 Seen Within Last <12 Months			X	R12Mth	ICB	-	57.4%	Feb-25	59.5%	60.9%	59.0%
	Units of Dental Activity Delivered			X	Quarter	ICB	-	345,021	Feb-25	297,680	-	-
	Community Services Bed Occupancy			X	Month	ICB	-	98.5%	Feb-25	-	-	-
	Urgent Community Response All Referrals			X	Month	ICB	-	2,557	Jan-25	3,285	15,630	97,115
Community Services >52 Week Waits			X	Snapshot	ICB	0	21	Feb-25	72	19,073	74,177	

Appendix 3: NHS Oversight & Assessment Framework Metrics

The dashboard presents performance against the NHS Oversight & Assessment Framework (NOF) metrics. Achievement against these indicators helps determine the ICBs NOF segmentation score. Organisations are ranked based on delivery against the respective measures with the top (best) quartile shaded 'green', the second and third quartiles are coloured 'amber', and the bottom (worse) quartile is shaded 'red'. The data contained within the dashboard is extracted from the OKTA platform and subject to a time lag as such the numbers presented may differ from those reported in the preceding NHS Operational Planning metrics dashboard, which is produced locally using the latest available data.

	Description	IHCDP	NOF	OPM	Basis	Level	Standard	Period	Performance			Rank
									ICB	Midlands	England	
UJC & Flow	A&E 4 Hour Waits	X	X	X	Month	Provider	78.0%	Jan-25	69.6%	71.9%	73.0%	33/42
	Bed Occupancy Adult G&A Overnight Beds	X	X	X	Month	Provider	-	Jan-25	97.7%	96.2%	95.8%	36/42
	Virtual Ward Occupancy	X	X	X	Month	Provider	80.0%	Jan-25	76.8%	82.3%	80.5%	30/42
	Discharge Beds Occupied by Adults Not Meeting Criteria to Reside		X	X	Month	Provider	-	Jan-25	14.0%	13.0%	14.4%	22/42
Planned Care & Cancer	Elective Activity VWA Growth vs Target		X			ICB	-	30/11/24				1/42
	RTT Incomplete Pathways >65 Week Waits	X	X	X	Snapshot	ICB	0	Dec-24	82	1,371	15,278	8/42
	Diagnostics Waited <6 Weeks for Diagnostic Test		X		Snapshot	ICB	5.0%	Sep-24	14.1%	24.2%	21.9%	11/42
	Cancer 62 Days Backlog		X		Snapshot	ICB	335	02/02/25	112.6%	97.2%	95.6%	29/42
	Cancer Faster Diagnosis Standard	X	X	X	Month	ICB	77.0%	Dec-24	78.6%			19/42
Infection Control	Infection Control MRSA Bacteraemia Rate		X		YTD	ICB	0	Mar-24	10	145	909	8/42
	Infection Control Clostridium Difficile Rate		X		YTD	ICB	100.0%	Mar-24	105.2%	142.7%	126.1%	7/42
	Infection Control E. Coli Bloodstream Rate		X		YTD	ICB	100.0%	Mar-24	117.6%	121.5%	125.0%	10/42
	Primary Care Prescribing Antibiotics		X		Month	ICB	100.0%	Jul-24	95.2%	98.2%	93.8%	23/42
	Primary Care Prescribing Broad-Spectrum Antibiotic		X		Month	ICB	10.0%	Jul-24	7.8%	7.8%	7.8%	19/42
Prevention	MMR Vaccination Rate 2 Doses Children Aged 5		X		Quarter	ICB	95.0%	Sep-24	83.8%		83.4%	33/42
	Seasonal Flu Vaccination Aged >65		X		YTD	ICB	85.0%	Dec-24	75.2%	74.1%	73.8%	22/42
	Cervical Screening Coverage 25-64 Year Olds		X		Quarter	ICB	75.0%	Jun-24	68.1%	70.0%	69.7%	34/42
	Hypertension Patients Treated to Target		X		Quarter	ICB	80.0%	Sep-24	65.7%	66.4%	66.8%	27/42
	Patients at Risk of CVD Treated with Statins		X		Quarter	ICB	60.0%	Sep-24	62.4%	63.3%	62.4%	16/42
People	NHS Staff Survey Harassed, Bullied or Abused Managers		X		Annual	ICB		Dec-23	10.3%	10.0%	9.9%	27/42
	NHS Staff Survey Harassed, Bullied or Abused Other Colleagues		X		Annual	ICB		Dec-23	18.0%	18.0%	17.7%	25/42
	NHS Staff Survey Harassed, Bullied or Abused Patients/Public		X		Annual	ICB		Dec-23	24.2%	24.3%	25.1%	19/42
	NHS Staff Leaver Rate		X		R12MTH	ICB		Dec-24	7.1%	6.3%	6.9%	26/42
	NHS Staff Sickness Absence Rate	X	X		Month	ICB		Sep-24	5.6%	5.3%	5.0%	38/42
	NHS Staff Survey Engagement Theme Score		X		Annual	ICB		Dec-23	6.99	6.86	6.89	13/42
	NHS Staff Survey Career Progression Fairness		X		Annual	ICB		Dec-23	58.0%	57.2%	56.4%	17/42
	NHS Staff Survey Compassionate Culture People Promise Sub-Score		X		Annual	ICB		Dec-23	7.15	7.02	7.09	19/42
	NHS Staff Survey Raising Concerns People Promise Sub-Score		X		Annual	ICB		Dec-23	6.48	6.42	6.46	21/42
	NHS Staff Survey Compassionate and Inclusive Theme Score		X		Annual	ICB		Dec-23	7.33	7.26	7.30	20/42

	Description	IHCDP	NOF	OPM	Basis	Level	Standard	Period	Performance			Rank
									ICB	Midlands	England	
Mental Health	Talking Therapies Access	X	X		Month	ICB	100.0%	Mar-24	52.0%			35/42
	CYP Mental Health Services Access		X	X	R12MTH	ICB	100.0%	Mar-24	93.0%			18/42
	Inappropriate Out of Area Placements Bed Days		X		Snapshot	ICB	0	Mar-24	670			20/42
	Dementia Diagnosis Rate	X	X	X	Snapshot	ICB	66.7%	May-24	57.4%	64.4%	64.8%	40/42
	Community Mental Health Services Access		X		R12MTH	ICB	100.0%	Mar-24	82.0%			32/42
	Perinatal Mental Health Access	X	X	X	R12MTH	ICB	100.0%	Mar-24	87.6%	87.1%	82.8%	20/42
LDA	Mental Health Inpatient Setting People with LDA Rate Per Million	X	X	X	Snapshot	ICB	30	Dec-24	56	43.7	42.4	40/42
	Learning Disability Annual Health Checks	X	X	X	YTD	ICB	75%	Dec-24	46.7%	50.5%	51.1%	33/42
Primary Care	Direct Patient Care Staff in Primary Care per 10,000 Patients		X		Quarter	ICB		Dec-24	6.99	7.86	8.00	36/42
	General Practice Appointments Seen <2 Weeks		X	X	Month	ICB	-	Dec-24	94.0%	89.4%	88.7%	2/42
	GP Patient Survey Good Experience of Making a GP Appointment		X		Annual	ICB		Dec-23	59.2%	52.9%	54.4%	8/42
Other	Urgent Community Response Response <2hrs	X	X		Month	ICB	70.0%	Nov-24	87.1%	82.5%	83.4%	16/42
	Units of Dental Activity Delivered		X		Month	ICB	100.0%	Apr-24	101.3%	88.9%	87.0%	2/42

Appendix 4: Health Inequalities Key Performance Indicators

The dashboard presents performance against a select number of Health Inequalities metrics. The inequalities data highlighted in this report focusses on deprivation, however healthcare inequalities are wider than simply socio-economic status and relate to additional factors, including ethnicity, age and gender. More detailed breakdowns of indicators by ethnicity, gender and age can be found on the [Healthcare Inequalities Legal Duties](#) document on the ICB website.

Priority Area	Key Performance Indicator	IHCDP	NOF	OPM	Basis	Level	Standard	Period	ICB	IMD 1-2	IMD 9-10
Early Stage Cancer Diagnoses	Early Cancer Diagnosis by IMD Quintile 2023				Month	ICB	75.0%			51.9%	59.9%
	DNA Rate for 2 Week Wait Referral 2024				Month	ICB	-			9.3%	4.9%
Vaccination Coverage	Autumn/Winter 23/24 COVID Booster uptake				YTD	ICB	95.0%			37.6%	66.5%
	Flu Vaccination Uptake 23/24		X		Month	ICB	85.0%			35.7%	59.2%
SMI Physical Health Checks	Overall Number of SMI Physical Health Checks	X		X	R12Mth	ICB	75.0%				
Hypertension	Hypertension Patients Treated to NICE Target		X		Quarter	ICB	80.0%			68.8%	76.4%
Maternity	Continuity of Care % Placed on Pathway at 29 Weeks				Month	ICB	-				
	Preterm Births <37 Weeks				Month	ICB	-			8.3%	7.9%
Elective Care	Waiting List by IMD				Month	ICB	-				
	Elective Activity vs Pre-Pandemic Levels (Adults)				Month	ICB	-				
Children & Young People: Oral Health	Oral Health Admissions				Month	ICB	-			25.8%	18.9%
Children & Young People: Asthma	KPI's Under Development.				Month	ICB	-				
Children & Young People: Epilepsy	KPI's Under Development.				Month	ICB	-				
Children & Young People: Diabetes	KPI's Under Development.				Month	ICB	-				
Data Quality: Recording Ethnicity	Records with Completed Ethnicity				Month	ICB	95.0%				

Report To and Date:	NHS Coventry and Warwickshire Integrated Care Board Wednesday 21 May 2025
Report Title:	Finance Update: Overview, recovering and savings programme
Report From:	Madi Parmar, Chief Finance Officer, CWICB
Author:	Madi Parmar, Chief Finance Officer, CWICB
Previous Considerations and Engagement:	Finance and Performance Committee – Financial planning papers various (January 2025 to May 2025).
Purpose:	For Information and Discussion

Achievement of the following ICP Priorities and Focus Areas is supported:

Priorities	<input type="checkbox"/> 1 - Prioritising prevention and improving future health outcomes through tackling health outcomes	<input checked="" type="checkbox"/> 2 - Improving Access to health and care services and increasing trust and confidence	<input checked="" type="checkbox"/> 3 - Tackling immediate system pressures and improving resilience
	<input type="checkbox"/> 1 - Reducing health inequalities	<input type="checkbox"/> 4 - Enabling personalised care	<input type="checkbox"/> 8 - Supporting people at home
Focus Areas	<input type="checkbox"/> 2- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities	<input type="checkbox"/> 5 - Improving access to services especially primary care	<input type="checkbox"/> 9 - Developing and investing in our workforce, culture and clinical and professional leadership
	<input type="checkbox"/> 3- Enabling the best start in life for children and young people	<input type="checkbox"/> 6- Engaging and involving our people, communities and stakeholders	
		<input checked="" type="checkbox"/> 7 - Making services more effective through greater collaboration and integration	

Executive Summary and Key Points:

- The purpose of this report is to provide a high-level summary update to the Board on the opening 2025/26 financial year plan, underlying position, scale of efficiency savings programme and risks to delivery.
- The System has a balanced plan for the 2025/26 financial year, which requires the delivery of a £12.5m ICB surplus and delivery of a System efficiency programme of £161m, or 6.1% of allocation.
- Longer term sustainability requires a greater percentage of this cost reduction to be delivered recurrently.

Recommendation:

Members are requested to:

- **NOTE** the contents of this report **FOR INFORMATION** and
- **DISCUSS** the associated risks to delivery of the plan.

Implications

Conflicts of Interest:	n/a
Financial and Workforce:	Failure to deliver the plan would result in missing the ICB and wider System’s joint statutory responsibilities and impact the System’s ability to invest in services to improve care.
Performance:	
Quality and Safety:	

Inclusion

Has an equality impact assessment been undertaken? (delete as appropriate) An EQIA is required for new services or changes to service delivery. For more information the EQIA Policy and Tool can be found here .	Yes (attached or hyperlinked)		No (state why in the row below)		Not applicable (state why in the row below)	(✓)
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Update paper – EQIAs to be undertaken on individual decisions per decommissioning policy

Has a Health Equity Assessment Tool (HEAT) been completed? HEAT may be used for new, changing or existing services and processes. More information can be found here .	Yes (attached or hyperlinked)		No (state why in the row below)		Not applicable (state why in the row below)	(✓)
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Update paper – HEAT to be undertaken on individual decisions per decommissioning policy

Engagement

Patient and Public Engagement:	n/a
Clinical and Professional Engagement:	n/a

Risk

Risk:	Failure to deliver the plan would result in missing the ICB and wider System’s joint statutory responsibilities and impact the System’s ability to invest in services to improve care.
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1. Introduction

- 1.1 The purpose of this report is to provide a high-level summary update to the Board on the opening 2025/26 financial year plan, underlying position, scale of efficiency savings programme and risks to delivery.
- 1.2 In the absence of any agreed NHS allocations beyond 2025/26, funding for 2026/27 and subsequent years is unknown, but a comprehensive spending review and the NHS ten-year plan are expected to be published and so a requirement to produce both a response to these and a detailed 3-5 year financial plan will need to follow.
- 1.3 The 2025/26 financial plan was approved, as delegated, at an Extra-ordinary Finance and performance committee, with wider Board members in attendance on 26th March 2025. This set out:
- The ICB planned position of £12.5m surplus, offsetting a net provider deficit.
 - A balanced system plan, meeting the statutory duty to live within available resources including support of £13m of NHSE deficit support allocation and £15m of 'Distance to target' funding allocation, in recognition of CWICB being an "under target system" (reported as (3.16%) or -£85.2m on a full fair shares basis in the 1st April NHSE letter (Ref: [NHS England » Working together in 2025/26 to lay the foundations for reform](#)). This letter also highlighted that if allocations moved back to +/- 2.5% distance from target based on the national funding formula, that this would increase CWICB allocation by £17.9m, thus the funding support for 25/26 is in line with this.
 - A total system efficiency requirement of 6.1%, or £161m, of which £26.4m relates to ICB efficiency, including a target of £11m of disinvestment decisions. The total efficiency requirement for the wider Midlands region is £2,271m with % of allocation requirements for individual systems ranging from 6.1% at the lower end to 9.5% at the higher end, 7.4% on average.

Table 1: 2025/26 system plan key data return.

2025/26 Key Data Summary 2025/26 Plan: 30 April 2025	Plan £m	Plan %
Total Provider Net Position Surplus/(Deficit)	(12.6)	(0.5%)
Total ICB Net Position Surplus/(Deficit)	12.6	0.5%
Total ICS Net Position Surplus/(Deficit)	0.0	0.0%
Total System Efficiencies	161.2	6.1%

- 1.4 A subsequent resubmission window was re-opened by NHSE to resubmit the plan, focusing on granular triangulation of finance, workforce wte and activity, but this did not change the headline position agreed.

1.5 The system successfully closed the 2024/25 financial year with a pre-audit system surplus of £0.2m and thus achieved its statutory financial duty to live within its allocated resources for a third year running (all the years of its existence as a distinct legal entity i.e. 2022-2025). The wider Midlands regional position is a draft deficit of £114m (in excess of deficit support where provided).

2. Savings programme

2.1 The system has a 6.1% efficiency requirement to deliver the break-even plan. This is shown by organisation below in Table 2 below.

Table 2: System efficiency plan by organisation

Efficiency Profile	Recurrent Efficiencies	Non Recurrent Efficiencies	Total Efficiencies			2024/25 Prior Year			
	Plan	Plan	Plan	Recurrent %	Baseline/ Allocation	Plan	Outturn	Actual FOT Recurrent %	Actual % of Allocation / Baseline
2025/26 Plan: 30 April 2025	£'m	£'m	£'m	%	%	£'m	£'m	%	%
NHS Coventry And Warwickshire ICB	26.4	0.0	26.4	100.0%	1.0%	14.3	14.0	90.4%	0.5%
Coventry And Warwickshire Partnership	5.4	6.8	12.2	44.4%	4.4%	13.0	14.0	59.2%	4.6%
George Eliot Hospital	15.0	8.0	23.0	65.2%	7.7%	18.8	17.4	57.0%	5.8%
South Warwickshire University	9.8	13.7	23.5	41.8%	4.7%	20.0	20.0	32.9%	3.8%
University Hospitals Coventry And Warwickshire	38.2	37.9	76.1	50.1%	6.9%	58.4	62.7	20.9%	5.4%
Less: ICB Efficiency impact on Providers	0.0	0.0	0.0			0.0	0.0		
NHS Coventry and Warwickshire ICS	94.8	66.4	161.2	58.8%	6.1%	124.5	128.1	39.5%	4.9%

Give the onus on delivery and the need to improve the recurrent nature of cost reductions, the plan is being monitored closely on a scheme by scheme and weekly basis with the ICB and system provider partners. Table 3 below shows the summary week on week progress to date.

Table 3. Summary weekly CIP tracker.

CIP Return Summary	15-Apr £000s	22-Apr £000s	29-Apr £000s	06-May £000s
Implemented	5,281	5,771	5,936	10,929
Fully Developed	38,322	37,817	37,906	61,067
Plans in Progress	55,988	56,078	56,037	51,880
Opportunity	28,372	28,350	28,681	17,711
Pre pipeline	11,783	13,528	11,911	7,286
Unidentified	21,262	19,464	20,537	12,134
Total CIP	161,007	161,007	161,007	161,007
Non recurrent	55,717	55,717	54,376	55,706
Cash releasing	89,314	89,314	82,533	110,103

2.2 The ICB target of £26.4m includes £11m of required disinvestment decisions. The ICB identified circa £40m of potential opportunities and each of these is subject to a prioritisation scoring triage process, with the involvement of a multi-disciplinary senior management team and outcomes classified as Stop, Review, Continue, Expand. So far, 2 tranches of schemes have been through this process and circa £6m of expenditure has been identified to progress through to formal de-commissioning. The ICB has a formal de-commissioning policy which outlines all necessary steps to be taken including quality and equality impact analyses and relevant board governance

for approval etc. the ICB has also identified non recurrent mitigations of c£5m should slippage occur.

- 2.3 Provider organisations are also engaged in running a number of initiatives to improve productivity and efficiency e.g. UHCW recently a full variable pay event and identified c £26m of potential savings.

3. Underlying position and recovery

- 3.1 The reported underlying deficit for the system is £118.3m as identified in Table 4 below. This is largely driven by planned non recurrent delivery of efficiency and other expected cost pressures. However, the system has reported a similar level of underlying deficit for several years and yet has a good track record of achieving plan delivery, so further work is being undertaken looking at the classification of recurrent and non-recurrent expenditure and efficiency delivery. Clearly a focus on delivering the planned efficiency recurrently would significantly reduce the underlying deficit back down to being within the range of the distance from target under allocation.

Table 4 – Underlying financial position.

	System Total	ICB	Coventry and Warwickshire Partnership NHS Trust	George Elliot Hospital NHS Trust	South Warwickshire University NHS Foundation Trust	University Hospitals Coventry And Warwickshire NHS Trust
Bridge Summary	Coventry and Warwickshire ICS	Surplus/ (Deficit)	Adjusted Financial Performance	Adjusted Financial Performance	Adjusted Financial Performance	Adjusted Financial Performance
2025/26 Plan: Underlying Bridge	£m	£m	£m	£m	£m	£m
Month 11 Forecast Outturn	(0.0)	4.6	3.1	(3.0)	0.0	(4.7)
2024/25 Exit Run Rate/Underlying Position	(152.2)	(13.5)	(6.9)	(25.5)	(24.5)	(81.8)
2025/26 Plan	(0.0)	12.6	2.2	(6.1)	2.3	(11.0)
Planned non-recurring efficiencies	(59.6)	0.0	(6.8)	(8.0)	(6.8)	(37.9)
Planned deficit support funding	(13.3)	0.0	(2.2)	(5.1)	0.0	(6.0)
FYE of planned recurring efficiencies - cash out	6.5	0.0	6.5	0.0	0.0	0.0
FYE of planned investments	0.2	0.0	0.0	0.2	0.0	0.0
Gains and losses and donations including PFI remeasurement	(0.6)	0.0	0.0	0.0	0.0	(0.6)
Other impacts	(51.6)	(6.8)	(4.0)	(2.2)	0.0	(38.6)
2025/26 Underlying Plan	(118.3)	5.8	(4.3)	(21.2)	(4.5)	(94.1)

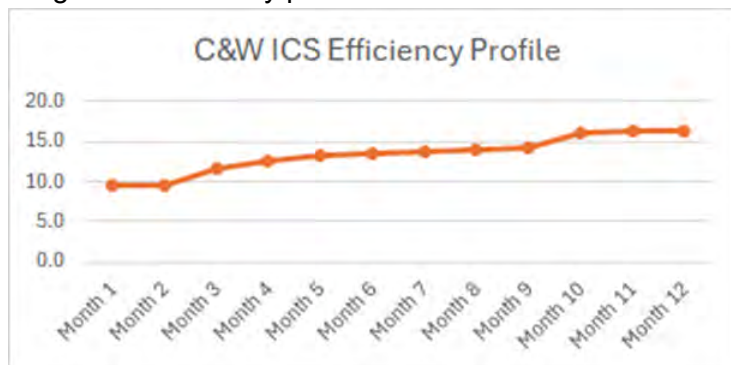
- 3.2 If the system were to be able to further improve productivity and reduce waste; this would enable to creation of headroom to support pump-priming of prevention and left shift initiatives for greater long-term sustainability.

4. Risk

- 4.1 The two main risks to the delivery of the financial plan can be summarised as: non delivery of efficiency and increased capacity costs to deliver performance and access; these risks have been assessed as representing circa £65m but with non-recurrent mitigations identified to give net risk of £5m. This is detailed further in Appendix 1, tables 5 to 8.

- 4.2 Efficiency delivery is weighted towards the second half of the year, albeit this profile is less marked than in prior years.

Figure 1. Efficiency profile



5. Assurance

- 5.1 For this financial year, the Finance and performance committee terms of reference have been reviewed and it is proposed to structure this as a meeting of two halves to provide more focussed scrutiny on a) delivery of the ICB plan as strategic commissioner and b) delivery of the required efficiency savings and workforce plan for the system, with system provider partners included in the latter.
- 5.2 Finance and performance committee will also take a lead role on overseeing workforce planning and pay cost reduction delivery.
- 5.3 System efficiency delivery is subject to weekly monitoring and scrutiny at a detailed level.
- 5.4 Any areas prioritised for disinvestment will be subject to the ICB decommissioning policy and due governance processes.

6. Summary conclusion

The System has a challenging plan to deliver but processes are in place for close monitoring and challenge at provider and at system level.

7. Recommendation

Members are requested to:

- **NOTE** the contents of this report **FOR INFORMATION** and
- **DISCUSS** the associated risks to delivery of the plan.

End of Report

Appendix 1

Table 6 System risks and mitigations

Risks and Mitigations 2025/26 Plan: 30 April 2025	Plan £'m
(Risks)/(Offsets to benefits):	
ICB (Risks)/(offsets to benefits) - value	(7.6)
Provider (Risks)/(offsets to benefits) - value	(57.5)
Total ICS (Risks)/(offsets to benefits) -Total Value	(65.2)
Mitigations/Benefits:	
ICB Mitigations/Benefits - value	7.6
Provider Mitigations/Benefits - value	52.5
Total ICS Mitigations/Benefits -Total Value	60.2
Total ICS Net	(5.0)
Clawback recognised in risks:	
ICB ERF Clawback	0.0
Provider ERF Clawback	0.0
Total clawback recognised in risks	0.0
ICB Allocation	2,637.4
(Risks)/(offsets to benefits) as a % of total allocation	2.5%
Total Net Risk as a % of total allocation	0.2%

Table 7 – provider risks and mitigations

Provider Scenario analysis (Risks)/Mitigations or Benefits/(Offsets to benefits) 2025/26 Plan: 30 April 2025	Provider Total £'m	Coventry And Warwickshire Partnership £'m	George Eliot Hospital £'m	South Warwickshire University £'m	University Hospitals Coventry And Warwickshire £'m
(Risks)/(Offsets to benefits):					
Additional cost risk (capacity, pressures, winter, COVID)	(15.4)	(3.0)	(2.0)	(3.7)	(6.7)
Additional cost risk (inflation)	(4.5)	0.0	(0.5)	(3.0)	(1.0)
COVID risk	0.0	0.0	0.0	0.0	0.0
Efficiency risk	(34.8)	(3.0)	(8.5)	(3.3)	(20.0)
Income risk	(2.8)	(1.0)	0.0	(1.8)	0.0
Mitigations/benefits:					
Additional cost control or income	20.8	4.0	4.0	4.8	8.0
Efficiency mitigation	18.3	3.0	0.0	3.3	12.0
Transformational / Pathway changes	2.7	0.0	0.0	1.7	1.0
Non-recurrent mitigation	10.7	0.0	2.0	2.0	6.7
Mitigations not yet identified	0.0	0.0	0.0	0.0	0.0
Total Provider Net Risk	(5.0)	0.0	(5.0)	0.0	0.0

Table 8 – Phasing of the efficiency plan

Efficiency Profile 2025/26 Plan: 30 April 2025	Q1 %	Q2 %	Q3 %	Q4 %
NHS Coventry And Warwickshire ICB	25.0%	25.0%	25.0%	25.1%
Coventry And Warwickshire Partnership	7.4%	24.2%	32.4%	36.0%
George Eliot Hospital	14.8%	19.6%	21.2%	44.5%
South Warwickshire University	14.7%	26.5%	28.4%	30.3%
University Hospitals Coventry And Warwickshire	20.2%	25.7%	26.7%	27.4%
0				
0				
Less: ICB Efficiency impact on Providers				
NHS Coventry and Warwickshire ICS	18.4%	24.7%	26.3%	30.5%

Report To and Date:	ICB Board – 21 May 2025
Report Title:	Procurement of All Age Mental Health, Learning Disabilities and Autism Individual Packages of Care
Report From:	Madi Parmar – Chief Finance Officer, CWICB Ellie Monkhouse – Chief Nursing Officer, CWICB
Author:	Marie West – Head of Contracts, CWICB
Previous Considerations and Engagement:	Finance and Performance Committee May 2025
Purpose:	For Approval

Achievement of the following ICP Priorities and Focus Areas is supported:

Priorities	<input type="checkbox"/> 1 - Prioritising prevention and improving future health outcomes through tackling health outcomes	<input type="checkbox"/> 2 - Improving Access to health and care services and increasing trust and confidence	<input checked="" type="checkbox"/> 3 - Tackling immediate system pressures and improving resilience
	<input type="checkbox"/> 1 - Reducing health inequalities	<input type="checkbox"/> 4- Enabling personalised care	<input type="checkbox"/> 8 - Supporting people at home
Focus Areas	<input type="checkbox"/> 2- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities	<input checked="" type="checkbox"/> 5 - Improving access to services especially primary care	<input type="checkbox"/> 9 - Developing and investing in our workforce, culture and clinical and professional leadership
	<input type="checkbox"/> 3- Enabling the best start in life for children and young people	<input type="checkbox"/> 6- Engaging and involving our people, communities and stakeholders	
		<input checked="" type="checkbox"/> 7 - Making services more effective through greater collaboration and integration	

Executive Summary and Key Points:

The ICB Board at its meeting in January 2025 gave approval to proceed with a procurement process for commissioning and delivery of All Age Mental Health, Learning Disabilities and Autism Individual Packages of Care.

The first stage of this process was to undertake market engagement to determine market interest, receive feedback from providers on the proposed service model, and to inform a recommendation for the next stage of the procurement process.

The market engagement process has now been concluded, which received significant interest from the market. An outline of the process that was undertaken, together with the response and outcomes received are summarised in the full report.

The outcome from the market engagement supports the ICB in making an informed decision on the next stage of the procurement process.

Recommendation:

Members of the Board are requested to:

1. **ENDORSE** the market engagement process undertaken to date.
2. **APPROVE** the ICB proceeding to a competitive tender process for the commissioning and delivery of All Age Mental Health, Learning Disabilities and Autism Individual Packages of Care.
3. **NOTE** and **APPROVE** next steps and timelines.

Implications

Conflicts of Interest:	Conflicts of Interest became apparent through the market engagement process, with CWPT and Arden and GEM CSU as potential bidders. The ICB have initiated a process to manage and mitigate any perceived and actual Conflicts of Interest
Financial and Workforce:	Potential TUPE implications. Anticipated financial benefits through an integrated service model.
Performance:	Anticipated performance improvement through an integrated service model.
Quality and Safety:	No perceived impact.

Inclusion

Has an equality impact assessment been undertaken? (delete as appropriate) An EQIA is required for new services or changes to service delivery. For more information the EQIA Policy and Tool can be found here .	Yes (attached or hyperlinked)	()	No (state why in the row below)	(✓)	Not applicable (state why in the row below)	()
	Will be undertaken as part of the procurement process					

Has a Health Equity Assessment Tool (HEAT) been completed? HEAT may be used for new, changing or existing services and processes. More information can be found here .	Yes (attached or hyperlinked)	()	No (state why in the row below)	()	Not applicable (state why in the row below)	(✓)
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[State reason here]

Engagement	
Patient and Public Engagement:	n/a at this stage of the process as no proposed change in service offer
Clinical and Professional Engagement:	Clinical engagement as part of development of the service specification
Risk	
Risk:	The recommendation of the preferred option is considered to carry limited risk to the organisation and supported by legal advice.

1. Introduction

A Paper was presented to Finance and Performance Committee in October 2024 and to ICB Board in January 2025 outlining a case for change, options appraisal, and a recommendation to initiate a process under the Provider Selection Regime (PSR) for services that support individuals requiring a package of care where their needs cannot be met by Mental Health (MH) and Learning Disabilities (LD) core health care services.

The ICB Board approved proceeding with a procurement process to commission an end-to-end service (including clinical delivery).

The ICB has now conducted a market engagement process. This report summarises the outcome of that process and a recommendation on the preferred procurement route.

2. Overview of Service

2.1 The services considered within scope are currently commissioned and/or delivered by the ICB or CWPT and comprise of a number of clinical teams, together with support functions such as contracting and procurement, finance, business intelligence, etc.

A copy of the service specification is attached at Appendix 1 which outlines the detail of the services.

2.2 The draft annual 2025/26 financial envelope of services within scope is circa £84m. Of this £81.6m relates to packages of care and £2.4m to staffing and non-pay costs.

2.3 It is proposed that the contract be awarded for an initial contract term of 5 years, with an option to extend up to a further 5 years.

3. Market Engagement Process

3.1 A Prior Information Notice (PIN) was published in early March 2025 advising the market that the ICB wished to undertake a market engagement event to support a proposed procurement of the services. The PIN stated that a market engagement event would be held on 24th March, and invited providers to give their initial feedback by way of completing a survey which could be found by expressing an interest in the opportunity.

The ICB made certain high-level information available to the market in order that they could gauge a more informed opinion as to their ability to provide the services. The documents included:

- Draft service specification; and
- Additional information which included broad information with regard to:
 - the budget for 25/26
 - the workforce currently engaged in providing the service, and potential TUPE requirements
 - current contract arrangements
 - snapshot of the current care pathways

By carrying out the market engagement, the ICB was seeking to understand the overall interest and, to a degree, the capability of the market to perform the functions required of them as described in the service specification. In turn the ICB wished to better understand what procurement route under The Health Care Services (Provider Selection Regime) Regulations 2023 would be most appropriate. The main focus for this decision was on the Most Suitable Provider (MSP) approach or the Competitive Process route.

The draft documentation was shared with the ICB's Senior Leadership Team for review and comment prior to publication.

3.2 The market engagement process was led by the following ICB representatives:

Jamie Soden	-	Deputy Chief Nurse
Liz Flavell-Smith	-	Director of Finance
Marie West	-	Head of Contracts

supported by ArdenGEM CSU Procurement Team in facilitating the process.

The ICB has established an ethical wall to oversee the procurement process. This is to ensure that individuals involved in day-to-day business as usual activities with potential bidders for the services within scope, do not have access to information or influence decisions that could create a conflict of interest as part of the procurement process.

3.3 The interest from the market was significant. Headline responses are:

- 58 expressions of interest
- 22 organisations completed pre-event survey
- 9 organisations were represented at the market engagement event
- 13 organisations requested a one-to-one appointment, of which
 - a) 9 providers attended their requested one-to-one
 - b) 4 providers did not attend their requested one-to-one

3.4 The conversations at one-to-one discussions revealed two distinct types of organisation:

- Organisations that fully understood the scope of the service specification and who were likely to be able to submit a credible bid; and
- Organisations that hadn't fully understood the scope of the service specification and who, once it was explained to them, recognised that they were unlikely to be able to provide the services.

Whilst the majority of organisations fell into the latter category, there were some organisations who demonstrated the likelihood that they could meet the requirements of the service specification.

FAQS were subsequently published to respond to clarifications sought through the market engagement process, together with a survey seeking confirmation from providers of their continued interest in bidding for the services. Eight providers responded to the survey, the majority of whom indicated their intention to submit a bid.

- 3.5 Based on all the feedback received from the market engagement process outlined above, there is a strong indication that there would be more than one interested bidder. On this basis and in consideration of the available procurement routes under PSR procurement regulations, it is recommended that the ICB proceed with a competitive tender process.
- 3.6 The ICB has sought legal advice at each stage of the process and in terms of determining the recommended preferred procurement route.
- 3.7 Dialogue has also taken place with the NHSE Assurance Team prior to market engagement to up-date on progress and next steps. They advised that their expectations would be for the required assurance template to be completed and signed off as part of any final contract award report.

4. Next Steps

If approval is given to proceed with a competitive tender, the indicative procurement timelines are as follows:

Tender Published to Market July 2025
 Contract Award January 2026
 Service Commencement April 2026

5. Key Performance Indicators (KPIs), Measures of Success and Metrics

The key outcomes identified within the market engagement process are as follows:

Outcome Domains	
A. Least restrictive approach that promotes independence	Commissioning of services that promote the least restrictive approach allowing the individual to reach optimum independence and support the individual to reach their full potential.
B. Prevention	Reduction in independent sector hospital, hospital rehab placements and individuals subject to a S117 Effective commissioning and proactive management to prevent hospital admissions, support rapid discharge and effective ongoing care package and support to prevent deterioration of the condition. Targeted investment from any savings into early interventions and redesign of pathways to reduce reliance on individual packages of care.
C. Integration and Collaboration	Organisational systems, structures, staff and cultures are designed and developed so teams across MH LDA teams, social care as well as third sector partnerships, can work together in collaboration - sharing resources and information, and forming MDTs dedicated to supporting people to

	achieve independence, reduce reliance on individual packages of care and prevent hospital admissions.
D. Patient Experience	The design and delivery of pathways and commissioning of services will be led by the voice and needs of patients and carers to access support in the way that makes sense for them. Services commissioned will be built around the patient, which ensures the individual is given every opportunity to reach the optimum level of recovery and will take the least restrictive approach to care.
E: Recovery and Rehabilitation	To support people to maximise their potential and reduce reliance on additional packages of care.
F: Value for Money and reduced spend	Live within our means, reducing waste and maximising productivity, to reduce overall spend within the area, whilst maintaining and improving patient outcomes, to enable reinvestment in local services (in agreement with CWICB)
G Reduction in out of area placements	A reduction in out of area placements to enable individuals to be connected to local networks and services.
H Provider Market management and effective commissioning.	An increase in utilisation of providers that have been through a procurement of qualifying process to ensure quality and value for money. Improve procurement, contract management and placement by reducing unwarranted variation in spend and placement pricing through standardised complex care specification(s), improved sharing of placement data and integrated 'at scale' commissioning practices

The detail of how the above outcomes will be monitored will be developed as part of the next stage of the procurement process.

6. Risk

The ICB has sought specialist procurement and legal advice at each stage of the process to limit any risk to the ICB in the actions taken and recommendations being made.

Proceeding with a competitive procurement process is considered to carry limited risk to the ICB.

7. Assurance

The purpose of this procurement is to achieve a more integrated commissioning and delivery pathway rather than the fragmented delivery model currently in place, which should give any future provider the opportunity to transform pathways and achieve cost efficiencies to reinvest in patient care.

8. Summary Conclusion

The ICB has concluded its market engagement process to determine market interest, receive feedback from providers on the proposed service model, and to inform a recommendation for the next stage of the procurement process.

9. Recommendation

Members of the Board are requested to:

- a) **ENDORSE** the market engagement process undertaken to date.
- b) **APPROVE** the ICB proceeding to a competitive tender process for the commissioning and delivery of All Age Mental Health, Learning Disabilities and Autism Individual Packages of Care.
- c) **NOTE** and **APPROVE** next steps and timelines.

End of Report

Report To and Date:	NHS Coventry and Warwickshire ICB Board, 21 May 2025
Report Title:	Independent Mental Health Homicide Review into the tragedies in Nottingham (TASK56940)
Report From:	Imogen Staveley, Chief Medical Officer, ICB Richard Onyon, Chief Medical Officer, CWPT Viral Kantaria, Chief Integration Officer (MHLDA), CWPT Matt Gilks, Director of Joint Commissioning, ICB
Author:	Liz Moore, Senior Transformation Manager, ICB Claire Potts, General Manager, CWPT
Previous Considerations and Engagement:	CWPT internal stakeholders and external partners workshop – 23 August 2024 Long Term Plan Delivery Group Meeting – 12 September 2024 Maturity Index Self-Assessment Action Planning – 17 September 2024 Quality, Safety and Experience Committee meeting – 24 November 2024 Quality, Safety and Experience Committee meeting – 8 April 2025
Purpose:	For ASSURANCE

Achievement of the following ICP Priorities and Focus Areas is supported:

Priorities	<input checked="" type="checkbox"/> 1 - Prioritising prevention and improving future health outcomes through tackling health outcomes	<input checked="" type="checkbox"/> 2 - Improving Access to health and care services and increasing trust and confidence	<input type="checkbox"/> 3 -Tackling immediate system pressures and improving resilience
	<input checked="" type="checkbox"/> 1 - Reducing health inequalities	<input checked="" type="checkbox"/> 4- Enabling personalised care	<input checked="" type="checkbox"/> 7 - Making services more effective through greater collaboration and integration
Focus Areas	<input checked="" type="checkbox"/> 2- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities	<input type="checkbox"/> 5 - Improving access to services especially primary care	<input checked="" type="checkbox"/> 8 - Supporting people at home
	<input type="checkbox"/> 3- Enabling the best start in life for children and young people	<input checked="" type="checkbox"/> 6- Engaging and involving our people, communities and stakeholders	<input checked="" type="checkbox"/> 9 - Developing and investing in our workforce, culture and clinical and professional leadership

Executive Summary and Key Points:

NHS England require ICBs to review and update their submitted action plan (approved November 2024) for Intensive and Assertive Community Mental Health Treatment which requires discussion in both trust and ICB public board meetings before June 2025.

The NHSE-commissioned Independent Mental Health Homicide Review into the tragedies in Nottingham identified a number of key recommendations of which systems are asked to ensure are sufficiently being addressed within their action plans with additional inclusions required where necessary. These include:

- personalised assessment of risk across community and inpatient teams;
- joint discharge planning arrangements between the person, their family, the inpatient; and community team (alongside other involved agencies);
- multi-agency working and information sharing;
- working closely with families; and
- eliminating Out of Area Placements in line with ICB 3-year plans.

In March 2025, senior staff from Coventry & Warwickshire ICB and Coventry & Warwickshire Partnership Trust reviewed and updated the submitted action plan in line with the recommendations to ensure all elements were included and explicit within the plan (attached as Appendix 1).

This paper has already been considered by the ICB Quality, Safety & Experience Committee in April 2025 who were assured by the process that has been followed and is now coming to Board for final sign off. Going forward, regular updates as needed will be presented to relevant Trust and ICB Board Committees.

Executive opinion: The review and update required has been through a sufficient process to ensure that all elements from the Independent Review have been explicitly captured within the action plan. This provides assurance that the keys areas for improvement have been identified. Updates against the action plan will be provided to the Board as required.

Recommendation:

Members are requested to be **ASSURED** that the NHSE ask to review and update action plans following receipt of the independent report recommendations has been completed and has been considered by QSEC who were assured by the process that has been followed.

Implications

Conflicts of Interest:	None identified
Financial and Workforce:	Whilst there are no direct financial implications from this report, resourcing and workforce considerations form key elements of the action plan
Performance:	While Review of Intensive and Assertive Community Mental Health Treatment action plan is not a performance indicator in itself, it is an assessment of the system's ability to achieve key targets.

Quality and Safety:	The review and self-assessment have considered the quality and safety implications for the Intensive and Assertive Community Mental Health services with input from clinical colleagues and wider stakeholders. This has been considered in the development of the action plan.					
Inclusion						
Has an equality impact assessment been undertaken? (Delete as appropriate) An EQIA is required for new services or changes to service delivery. For more information the EQIA Policy and Tool can be found here .	Yes (attached or hyperlinked)		No (State why in the row below)	✓	Not applicable (State why in the row below)	
The review contains equality assessments as part of the maturity index which has already been completed.						
Has a Health Equity Assessment Tool (HEAT) been completed? HEAT may be used for new, changing or existing services and processes. More information can be found here .	Yes (attached or hyperlinked)		No (State why in the row below)	✓	Not applicable (State why in the row below)	
The review contains equity and access considerations as part of the maturity index which has already been completed.						
Engagement						
Patient and Public Engagement:	The self-assessment process and completion of the maturity index involved Experts by Experience, and operational, clinical, medical, and allied health professionals. Outputs from these engagements were included within the action plan.					
Clinical and Professional Engagement:						
Risk						
Risk:	The self-assessment process and completion of the maturity index, before the development of the action plan, was in itself an element of risk assessment from which risks were likely to be identified.					

1. Introduction

- 1.1 CWPT deliver adult mental health services to working age adults through three Community Mental Health Teams (CMHTs) which were formed as part of the transformation of community mental health services in April 2024. These teams align to PCNs in each place. These teams are now implementing a well-established (implemented June 2014) model of Flexible and Assertive Community Treatment (FACT) to meet the needs of patients who find more traditional models of care delivery difficult to engage with. It is within the context of those teams that the review has been

undertaken. The review includes an ongoing audit to identify the cohort of patients who might benefit from the FACT approach.

- 1.2 The 2024/25 NHS Priorities and Operational Planning Guidance requires that all Integrated Care Boards (ICBs): “Review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge.” As a result, all ICBs were asked to review their local policies and practices in relation to providing intensive and assertive community care.
- 1.3 While it is more likely that someone with severe mental illness will harm themselves rather than other people, Serious Untoward Incidents (SUIs) such as the tragic events in Nottingham in 2023 serve to highlight the need for services to seek to engage and treat individuals that pose a risk of harm to others when unwell.
- 1.4 To support ICBs with this process NHS England produced guidance on Intensive and Assertive Community Mental Health Treatment and required systems to submit their findings from such reviews. Alongside this, NHSE produced a Maturity Index self-assessment tool to assist ICBs to undertake the reviews and ICBs were required to complete a template summarising the findings for submission in Q4.
- 1.5 A local action plan was developed in December 2024 based on the Maturity Index self-assessment.
- 1.6 Regional NHS England teams led an evaluation of the Maturity Index self-assessment returns to determine gaps and themes to address across system.
- 1.7 On 5th February, the Independent Review from the tragedies in Nottinghamshire was published alongside 5 key recommendations for ICBs to ensure that relevant issues were being actively addressed within the system. There is a requirement for systems to review and update action plans ensuring inclusion of actions against these recommendations. Updated action plans are required to be discussed in both trust and ICB public board meetings before June 2025.

2. Review and Update of Action Plan

- 2.1 The action plan developed in Q4 was collaboratively reviewed in March 2025 by CWPT and the ICB. This included information provided from the *Regional Summary of Midlands ICB Community Mental Health Review - Maturity Index Returns Coventry and Warwickshire Benchmarking Report* as well as the five recommendations from the Independent Review covering:

- Personalised assessment of risk across community and inpatient teams;
- Joint discharge planning arrangements between the person, their family, the inpatient

and community team (alongside other involved agencies);

- Multi-agency working and information sharing;
- Working closely with families; and
- Eliminating Out of Area Placements in line with ICB 3-year plans.

The below sections outline how CWPT with relevant partners are acting accordingly in each of these domains.

2.2 Personalised assessment of risk across community and inpatient teams

- A new approach to risk assessment is underway within CWPT and initial training has been delivered to teams. By the summer of 2025 the new risk assessment will be ready in an online version as well as supported by the roll out of face-to-face training.
- Robust risk assessment / safeguarding audit to be implemented.
- Training to be available for staff around risk assessment, Early Warning Signs, safeguarding.
- Embed a robust process into teams around case formulation using Multi - Disciplinary Teams and specific space for formulation.

2.3 Joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)

- Create an improved transitions process between services to improve the patient journey and experience and reduce the bounce between services, including communication and escalation.
- Review of non-attendance policy to ensure people are not discharged due to lack of engagement. Ensure policy is shared with staff and measured against process via audit.
- Strengthen recording around discharge and MDT decisions around signposting / discharge.
- Strengthen links between community, inpatient and urgent care services to enhance the discharge process.

2.4 Multi-agency working and information sharing.

- Develop the opportunity for multi-agency complex case discussions.
- Strengthen relationships and knowledge with local providers / Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations to improve the patient journey and timely access to the right service.
- Develop strong links and working relationships with housing providers.
- Review joint working with current local agencies such as Change Grow Live (CGL), REACH and Rethink to ensure equality across all places and review outcomes.
- Review where Information Sharing Agreements would support a multi-agency response to people's needs.

2.5 Working closely with families

- Re-establish listening clinics to provide a forum for feedback for both service users and carers.
- To ensure the Friends and Family group is rolled out beyond Early Intervention teams for people to access carers support and education.
- To embed the principles of the Triangle of Care into the model via self-assessment through to accreditation.

2.6 Eliminating Out of Area Placements in line with ICB 3-year plans

- CWPT is planning to maintain the usage of out of area beds at zero which was achieved throughout 24/25.
- The CWPT Enablement Team is working closely with the Clinical Review Team to review and bring Coventry and Warwickshire residents back from out-of-area rehabilitation placements where appropriate and possible.

3. Involvement and Engagement

- 3.1 CWPT, as the commissioned provider of these services, have supported the review and led the previously completed maturity self-assessment index in collaboration with the Joint Commissioning Team from the ICB. The organisations have worked jointly to review and update the action plan against the Review recommendations.
- 3.2 The self-assessment included stakeholder workshops with partner organisations and experts by experience. The assessment was clinically led and involved a variety of clinicians and professionals and the outputs and findings from the workshop have been collated and considered by a small group of clinical and management leaders from the Trust and the ICB.
- 3.3 Colleagues across the ICB and CWPT form part of the regional review group facilitated by NHSE to work together to gain updates from the national team and well as share progress against actions, learning and best practice on a monthly basis.

4. Action Plan update

4.1 Achievements to date:

- CMHTs have implemented an allocate all process to ensure that patients being discharged from services such as Inpatients, Urgent Care, Children and Young People's Services and Veterans' services are allocated as priority and do not sit on long waiting lists.
- Progress is being made on the reviewing of Standard Operating Procedures (SOPs) and policies within the action plan to ensure monitoring and process is strengthened for those requiring intensive and assertive support.
- SNOMED coding is now rolled out within Community Mental Health Services to support better recording of clinical information.
- CWPT are currently exploring potential implementation of the Management and Supervision Tool (MaST), a dashboard which uses predictive analytics to identify those people who are most likely to require crisis services..
- FACT model refresh in progress in all three teams to ensure the model is used and working effectively in all areas.
- Agreed process for understanding patients who meet the criteria for intensive assertive support via using the alert system on the current Electronic Patient Record (EPR). Identification has commenced. As of 29th April, the cohort of patients identified as meeting the criteria was 194, the cohort once identification is completed is estimated to be between 400 – 500 patients.
- Audit to scope all individuals who meet the criteria for intensive assertive support in progress in order to inform modelling of service provision required.
- Complex case forums implemented into place-based teams.

- Keyworker role reviewed and SOP completed for sign off and implementation.
- A review and update of the action plan following receipt of NHS England feedback has been conducted.

4.2 Risks:

- Capacity to reduce current caseloads in line with guidance to manage an intensive assertive caseload, supported via audit outcomes.
- Current gaps in interventions for intensive assertive caseload which will be identified through audit outcomes.

5. Next Steps

- Report to CWPT Board – 21st May 2025
- ICB submission to NHSE – 30th June 2025


6. Governance and Assurance

- 6.1 The CWPT Quality and Safety Board Committee will receive regular updates regarding the improvement plan for Intensive and Assertive Community Mental Health Treatment.
- 6.2 Updates on progress will be reported to the ICB Quality, Safety and Experience Committee, ICB Board and CWPT Board as required.

7. Recommendation

Members are requested to be **ASSURED** that the NHSE ask to review and update action plans following receipt of the independent report recommendations has been completed and has been considered by QSEC who were assured by the process that has been followed.

End of Report

Key	
On-track/ progressing	
Delayed	
Significa	

No.	Date	Action	Action Owner	To be completed by when	*RAG Status	Comments / Updates	Date completed	Status (Open / Closed)
1. Function of assertive outreach / intensive case management								
1.1	01-Oct-24	Develop a new model within CMHT to establish the function of intensive case management with the transformation of CMH.	Ops Managers, clinical and professional leads	30-Jun-25		18/3: Identify specific workers. Audit to scope current caseloads. Add new alert to identify patients. Audit due by 31/3.		Open
1.2	01-Oct-24	Digital solution to be available around the population of people with SMI and engagement challenges.	Systems team, Operational Managers, PH Team, cultural inclusion network, Health Inequalities Lead, Digital colleagues	30-Apr-25 March 2026		18/3: 1) new alert to be set up to identify patients for this pathway. Needs to be included in SOP. Can be put on following audit. Alerts to be further developed for new EPR. 2) MAST tool to be considered for this cohort of patients. In development.		Open
1.3	01-Oct-24	Psychosis SOP to be updated and amendments made to reflect intensive support function and process.	Psychology lead, Ops managers S&Q	30-Apr-25		18/3: Under review to be finalised.		Open
1.4	01-Oct-24	Review and refresh of the FACT model within CMHT.	Ops Managers, Team Managers Heads of service	31-May-25				Open
2. Clinical Pathways								
2.1	01-Oct-24	Psychological interventions to be reviewed in line with nice guidance.	Psychology leads, clinical and operational leads	30-Aug-25				Open
2.2	01-Oct-24	Capacity and demand modelling for psychological interventions to be completed.	Psychology leads, clinical and operational leads	30-Aug-25				Open
2.3	01-Oct-24	Engagement and joint working with VCSE to improve pathways and access to support for individuals, to include information sharing agreements where needed.	Clinical and operational leads with VCSE leads	30-Aug-25				Open
2.4	01-Oct-24	Create improved transitions between services to improve the patient journey and experience and reduce the bounce between services, including communication and escalation.	Clinical and Operational Leads	31-May-25				Open
2.5	01-Oct-24	Review of how new transformation pathways can enhance the care offer by becoming more integrated e.g Homelessness / Enablement, dual diagnosis.	Clinical and Operational leads, team and service leads, including clinicians	30-Jun-25				Open
2.6	01-Oct-24	Review of how services are working following the transformation.	Clinical and Operational leads, team and service leads, including clinicians	28-Feb-25			28-Feb-25	Closed
2.7	01-Oct-24	Develop the opportunity for multi-agency complex case discussions.	Clinical and Operational leads, team and service leads, including clinicians	30-Aug-25				Open
3. Workforce								
3.1	01-Oct-24	Develop a new process to ensure staff read and understand policies and processes and that managers are assured that staff understand.	S&Q, clinical and operational leads	30-Jun-25				Open
3.2	01-Oct-24	Ensure compliance with CMH SOP around reallocation of cases via regular audit.	Team leads and operational support	30-Jun-25				Open
3.3	01-Oct-24	Build in team opportunities for reflective practice where gaps are identified.	Clinical and Professional leads	30-Jun-25				Open
3.4	01-Oct-24	Menu of interventions work in progress to guide staff.	Clinical leads forum	30-Apr-25				Open
3.5	01-Oct-24	Training plan to be developed as well as competencies for all staff to maintain skills and confidence.	Clinical and Professional leads, S&Q, operational leads	31-May-25				Open
3.6	01-Oct-24	Loira worker device process to be embedded and monitored within the services to improve use.	Operations and team leads	21-Mar-25			21-Mar-25	Closed
3.7	01-Oct-24	Pursue the use of MaST within CMH.	Operational leads, Business and Transformation, Finance and EPR support	30-Jun-25				Open
3.8	01-Oct-24	Review keyworker role and define responsibilities across band / Disciplines.	Clinical and operational leads	30-Apr-25				Open
4. Risk assessment and safety planning								
4.1	01-Oct-24	Risk assessment process under review, this only covers suicide prevention.	Lead for suicide and risk prevention with input from clinical leads	31-Aug-25				Open
4.2	01-Oct-24	Robust risk assessment / safeguarding audit to be implemented.	Clinical and operational leads, S&Q	31-Oct-25				Open
4.3	01-Oct-24	Training to be available for staff around risk assessment, EWS, safeguarding.	Clinical, professional and operational leads	31-May-25				Open
4.4	01-Oct-24	48 hr follow up reporting and recording process to be strengthened.	Systems, information, operational leads	28-Feb-25			28-Feb-25	Closed
4.5	01-Oct-24	Embed a robust process into teams around case formulation using MDTs and specific space for formulation.	Clinical/ operational team leads and including clinicians	30-Apr-25				Open
5. Legislation								
5.1	01-Oct-24	Monitoring sections of policies to be strengthened to ensure policies are followed.	Clinical operational leads, S&Q, Policy Review Group	31-Dec-25				Open
6. Interface with other services								
6.1	01-Oct-24	Ensure all policies explain the role of VCSE at point of referral.	Clinical and operational leads, VCSE leads	28-Feb-26				Open
6.2	01-Oct-24	Strengthen policies to ensure that links with emergency services are clear.	Clinical and operational leads, VCSE leads	28-Feb-26				Open
6.3	01-Oct-24	Develop strong links and working relationships with housing providers.	Clinical and operational leads	30-Aug-25		18/3: Review of HACT with view to move into CMH.		Open
7. Recovery and personalisation								
7.1	01-Oct-24	Ensure all policies for CMH are recovery and personalisation focussed by reviewing all policies.	Clinical and operational leads	28-Feb-26				Open
8. Meeting the needs of diverse populations								

No.	Date	Action	Action Owner	To be completed by when	RAG Status	Comments / Updates	Date completed	Status (Open / Closed)
8.1	01-Oct-24	Addressing inequalities needs to link with the Patient and Carer Race Equality Framework (PCREF).	Clinical and operational leads	30-Dec-25				Open
8.2	01-Oct-24	Address data and data quality issues to allow us to understand our population and their needs.	Health inequalities lead, Clinical and operational leads, Physical Health Lead	30-Dec-25				Open
8.3	01-Oct-24	Differentials in detentions work in progress but to be implemented into practice within services.	Health inequalities lead, Clinical and operational leads, Physical Health Lead	30-Dec-25				Open
8.4	01-Oct-24	To strengthen links with community services to facilitate engagement.	Clinical, operational and VCSE leads / partners	30-Dec-25				Open
9. Medication management								
9.1	01-Oct-24	Regular medicines management training required annually.	Community pharmacy, clinical and operational leads	30-Aug-25				Open
9.2	01-Oct-24	Competency development around meds management to be roles and band specific.	Community pharmacy, clinical and operational leads	30-Aug-25				Open
10. Experts by Experience								
10.1	01-Oct-24	Review the role for EBEs within community services and to further develop and build roles into future CMHT delivery.	Operational leads, Business and Transformation	30-Aug-25				Open
10.2	25-Mar-25	Link at EBE and Carers family involvement as part of co-producing the pathway and development of SOPs and policies.	Operational leads	30-Aug-25				Open
11. Discharge from services								
11.1	01-Oct-24	Review of DNA policy to ensure people are not discharged due to engagement.	Clinical and operational leads, S&Q	30-Apr-25				Open
11.2	01-Oct-24	Ensure policy is shared with staff and measured against process via audit.	Clinical and operational leads, S&Q	30-Jun-25				Open
11.3	01-Oct-24	Ensure audit of letters to GP to ensure they are completed, good quality and within specified timeframes.	Clinical and operational leads, S&Q	30-Aug-25				Open
11.4	01-Oct-24	Strengthen relationships and knowledge with local providers / VCSE to improve the patient journey and timely access to the right service.	Clinical and operational leads, S&Q, VCSE partners	30-Dec-25				Open
11.5	01-Oct-24	Strengthen recording around discharge and MDT decisions around signposting / discharge.	Clinical and operational leads, S&Q	31-Jan-25			31-Jan-25	Closed
12. Data								
12.1	01-Oct-24	Ensure that data dashboards and themes are filtered to team level.	Clinical and operational leads, Team Leads	31-Mar-26				Open
12.2	01-Oct-24	DIALOG data to be reviewed to inform service development.	Clinical and operational leads, Team Leads	30-Jun-25				Open
12.3	01-Oct-24	Gain access to and understand local population data to inform service development.	Clinical and operational leads, Team Leads	31-Aug-25				Open
12.4	01-Oct-24	Improve the IWGC submissions to gain greater feedback.	Clinical and operational leads, Team Leads	28-Feb-25			28-Feb-25	Closed
12.5	01-Oct-24	Roll out SNOMED codes across Community Mental Health to improve data.	Clinical and operational leads, Team Leads	01-Nov-24			01-Nov-24	Closed
12.6	01-Oct-24	Ensure diagnostic coding is completed and correct.	Clinical and operational leads, Team Leads, Medical Leads	30-Aug-25				Open
13. Policy variation control								
13.1	01-Oct-24	Review of all policies (CRHT / admission / discharge / CMH SOP) with strengthened monitoring to have assurance and evidence that the processes are followed.	Ops Managers, Business and Transformation, clinical and professional leads	28-Feb-26		18/3: In progress. Need to work with wider stakeholders for their SOPs/Policies to also be updated.		Open
13.2	18-Mar-25	All policies and SOPs reviewed to ensure joint discharge planning arrangements between the person, their family, the inpatient team and community team are covered.	General Manager, clinical and professional leads, Heads of service	28-Feb-26		18/3: In progress. DNA completed sent for sign off. Psychosis SOP in progress. Rapid Re-entry due for review March. Transfer SOP, CMH SOP, MDT meetings SOP.		Open
14. Governance								
14.1	01-Oct-24	Ensure clinicians have the opportunity to feed into planning groups / boards as appropriate and ensure information is fed up and down.	Clinical and operational leads	28-Feb-26				Open
15. Family and Carers								
15.1	26-Mar-25	Re-establish listening clinics to provide a forum for feedback for both service users and carers.	Clinical and operational leads	30-Jun-25				Open
15.2	26-Mar-25	To ensure the Friends and Family group is rolled out beyond Early Intervention teams for people to access carers support an education.	Clinical and operational leads	31-Oct-25				Open
15.3	26-Mar-25	To embed the principles of the Triangle of Care into the model via self assessment through to accreditation.	Clinical and operational leads	30-Aug-25				Open

The principles of how we behave as a Board

We create an environment where we are always **LISTENING** to patients, citizens and each other, giving what we hear our full attention and committing to sharing open and honest feedback and knowledge.

We are always **LEARNING** and acting on what we hear, putting people first, thinking ahead. taking ownership and working collectively to do the right thing.

This means across the system we are **LEADING** by example, setting the direction and focusing on the outcomes we want for our population, steering how our system improves health and removes inequalities.

Put people first	Open & honest	Set the direction	Do the right thing	Outcome focused
We will keep the needs and priorities of our citizens and patients at the front of our thinking	We will check our understanding of each other and our intent, commit to honesty and openness	We will stay focused on the strategic and cross-cutting issues that only we as a Board can tackle – ‘steering not rowing’	We will create a sense of moral purpose as well as collective responsibility, putting people at the heart of our decision-making process	We will ensure we remain focused on the impact for our populations – limiting excessive bureaucracy or process
<p>We will demonstrate we put people first by:</p> <ul style="list-style-type: none"> Creating an environment where our citizens and patients share their stories and lived experiences Listening to patients and citizens and making their feedback count Being passionate about improving health outcomes and removing inequalities Having a positive ‘can do’ attitude Reaching out proactively to tackle inequalities 	<p>We will be open & honest by:</p> <ul style="list-style-type: none"> Communicating consistently and transparently, having open and honest conversations Giving our full attention and ‘being present’ for conversations Being open to giving and receiving constructive and timely feedback with the intention of improvement Proactively sharing knowledge and skills Identifying and celebrating successes Leading by example, role modelling professional behaviour 	<p>We will demonstrate we set the direction by:</p> <ul style="list-style-type: none"> Setting the direction, strategic plans, and priorities Focusing on our vision and aims and striving to make them happen Seeking assurance on the delivery of plans and priorities 	<p>We will demonstrate we do the right thing by:</p> <ul style="list-style-type: none"> Focusing on our vision and having a collective understanding of our purpose ‘why we are here, what we care about and why’ Taking personal and collective responsibility and ownership Always looking for opportunities to work collaboratively to achieve more together Doing the right thing for our citizens and patients Learning when things do not go to plan 	<p>We will be outcome focused by:</p> <ul style="list-style-type: none"> Having clear outcomes for our populations Championing continuous innovation and excellence Anticipating problems and thinking ahead being solution focused Striving to continuously improve Doing what we say we will do Accepting it’s OK to take acceptable risks and do things differently
<p>We will not:</p> <ul style="list-style-type: none"> Work in isolation or silos Be out of touch with our citizen and patient needs Fail to involve or draw on the experience of our citizens and patients. 	<p>We will not:</p> <ul style="list-style-type: none"> Demonstrate and role model negative and disruptive behaviour and allow negative behaviours to go unchallenged Disregard the views and ideas of others that aren’t similar to our own and discourage people for sharing their views Create barriers that prevent effective engagements 	<p>We will not:</p> <ul style="list-style-type: none"> Get into the operational detail Set strategy that is short term and does not fully address the future outcomes Get distracted by things we cannot collectively resolve Undermine our priorities by failing to direct our resources accordingly 	<p>We will not:</p> <ul style="list-style-type: none"> Avoid taking responsibility for our actions Blame each other when things go wrong Take the ‘easy’ decision Work in silos Prioritise organisation before system by making financial decisions without considering the wider impact 	<p>We will not:</p> <ul style="list-style-type: none"> Do things the way they have always been done and not to ask questions Let bureaucracy get in the way of achieving the outcomes for our population. Ignore issues that require resolution Fail to communicate a clear vision Hit the target but miss the point