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Coventry City Council

Agenda

Health and Social Care Scrutiny Board (5)

Time and Date
11.00 am on Wednesday, 19th November, 2025

Place
Diamond Rooms 1 and 2 - Council House, Coventry, CV1 5RR

Public Business

1. **Apologies and Substitutions**

2. **Declarations of Interest**

3. **Minutes**

   (a) To agree the minutes of the meeting held on 22nd October 2025 (Pages 3 - 8)

   (b) Matters Arising

4. **Prioritisation of NHS Services** (Pages 9 - 42)

   Report of the Chief Transformation Officer and Deputy Chief Executive, ICB.

5. **Early Intervention & CYP Substance Misuse Service** (Pages 43 - 48)

   Report of the Director of Public Health & Wellbeing

6. **Work Programme and Outstanding Issues** (Pages 49 - 56)

   Report of the Scrutiny Co-ordinator

7. **Any other items of Public Business**

   Any other items of public business which the Chair decides to take as matters of urgency because of the special circumstances involved

Private Business

Nil

8. **Early Intervention & CYP Substance Misuse Service** (Pages 57 - 72)

   Report of the Director of Public Health & Wellbeing.

   (listing officer: Rachel Chapman – email: Rachel.chapman@coventry.gov.uk)

9. **Any other items of Private Business**

Any other items of private business which the Chair decides to take as matters of urgency because of the special circumstances involved

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Julie Newman, Director of Law and Governance, Council House, Coventry

Tuesday, 11 November 2025

Note: The person to contact about the agenda and documents for this meeting is Caroline Taylor, Governance Services caroline.taylor@coventry.gov.uk

Membership: Councillors F Abbott, S Agboola, L Bigham (By Invitation), K Caan (By Invitation), S Gray, L Harvard, G Hayre (By Invitation), A Hopkins, S Jobbar, M Lapsa, C Miks (Chair), B Mosterman and D Toulson (By Invitation)

By invitation: Councillors L Bigham, K Caan, G Hayre and D Toulson

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Caroline Taylor, Governance Services
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Coventry City Council
Minutes of the Meeting of Health and Social Care Scrutiny Board (5) held at 11.00 am on Wednesday, 22 October 2025

Present:

Members:	Councillor C Miks (Chair) Councillor B Christopher (substitute for Cllr S Agboola) Councillor S Gray Councillor L Harvard Councillor A Jobbar (substitute for Cllr S Jobbar) Councillor R Lakha (substitute for Cllr A Hopkins) Councillor M Lapsa Councillor B Mosterman
Other Members:	Councillors L Bigham (Cabinet Member for Adult Services), G Hayre, (Deputy Cabinet Member for Public Health, Sport and Wellbeing), D Toulson (Deputy Cabinet Member for Adult Services)
Other Persons:	Leanne Howatt (Healthwatch)
Employees (by Service Area)	
Adult Care, Health & Housing	P Fahy, A Staunton
Law and Governance	G Holmes, T Robinson
Public Health	A Duggal, I Kaur
Apologies:	Councillor F Abbott, S Agboola, K Caan (Cabinet Member for Public Health, Sport and Wellbeing), Cllr A Hopkins

Public Business

7. **Declarations of Interest**

There were no declarations of interest.

8. **Minutes**

The minutes of the meeting held on 17th September 2025 were agreed and signed as a true record.

There were no matters arising.

9. **Improving Lives - Impact on Adult Social Care**

The Board considered a report and presentation of the Director of Care, Health and Housing regarding the Local Integrated Teams element of the Improving Lives programme approximately 12 months post implementation and its impact on Adult Social Care (ASC).

The report outlined how the programme launched as a city-wide service in July 2024, integrating urgent response, therapy, adult social care, and community services through the One Coventry Integrated Teams (OCIT). This person-centred approach prioritises supporting people at home, reducing unnecessary hospital admissions, and promoting independence. Key pathways include care at home, reablement beds, and discharge to assess, all enhanced by therapy-first and digital options. The programme has led to a marked reduction in discharge to assess beds and improved outcomes, with staff reporting more efficient, joined-up support. External recognition, including shortlisting for national awards, highlights the programme's innovative partnership working.

Officers drew attention to the post-implementation Health Check carried out by Newton Europe in May 2025 which evaluated the programme's impact on hospital admission avoidance, internal hospital processes, and supported discharges. The review highlighted strong leadership in embedding the Improving Lives model but emphasised the need for sustained focus and effort to achieve and maintain performance targets, noting that behaviour and culture change take time.

Following the Health Check, the team has:

- Reviewed baseline data and targets, particularly for long-term support, with ongoing monitoring through Adult Social Care meetings and OCIT governance.
- Streamlined case transfers from Local Integrated Teams to Adult Social Care.
- Continued monitoring capacity and demand, especially ahead of seasonal pressures.
- Delivered additional staff training and development.

Additional information on the programme was attached as an appendix to the report.

The Cabinet Member and Deputy Cabinet Member for Adult Services, Councillors L Bigham and D Toulson, introduced the item and highlighted the programme's nature as the vanguard of ASC with its focus on dignity being a key driving factor in its success.

Members of the Board, having considered the report and presentation, asked questions and received information from officers on the following matters:

- The quantitative impacts of the programme – less beds being taken up, influence on ASCOF (Adult Social Care Outcomes Framework) figures, and reduced handoffs between departments.
- The use of operational graphs in the report and their ability to present live data and not management narratives.
- Linking the planned delivery of the programme to cost saving metrics – how achieving targets results in a cost saving of £2 million for ASC.

- How the merging of 3 line management structures had led to improved feedback, the sharing of skills and improved working conditions.
- The use of demographics in the data to track health inequalities and protect the most vulnerable groups.
- An explanation of each of the three pathways and their delivery mechanisms – from home support (pathway 1), residential care (pathway 2), and nursing care (pathway 3).
- That the Virtual Beds initiative was separate to this model.
- Feedback from partner organisations and service users and ensuring its inclusion for the next annual report.
- The options available for further improvement, particularly the complexities of changing a service while still having to deliver that service.
- How further staff feedback would help promote programme delivery.

The Cabinet and Deputy Cabinet Member thanked officers for the report and presentation and reiterated the importance of the programme to provide dignity to service users.

RESOLVED that the Health and Social Care Scrutiny Board (5):

1. **Notes the content of the report and presentation and supports the next steps as identified in the presentation.**

10. **Director of Public Health & Wellbeing - Annual Report**

The Board considered a report and presentation of the Director of Public Health in which this year's annual report focused on the city's cultural diversity and the health inequalities facing vibrant migrant populations.

As summarised by the Director's annual report, focusing on migrant populations enabled change to happen and provided a platform for improving outcomes in population health and healthcare by reducing health inequalities, prioritising prevention and wider determinants, and making services more effective through greater collaboration and integration.

Officers recognised how Coventry is a city that has long been influenced by migration, with residents hailing from a rich tapestry of backgrounds and cultures. The report examined migrant health and wellbeing including the impact of social determinants of health (e.g. accessibility of healthcare, discrimination, and stigma) and the new and longstanding protective and risk factors that influence migrants' ability to rebuild their lives, integrate and thrive. The narrative recognised that changes to the legal frameworks have had an impact on migrant health, with positive and negative effects. It highlighted that Coventry's experience of supporting migrants contains a range of successful policy and practice that supports integrations. It also noted that continued collaboration across ICS partners (including the voluntary sector), and involving the views of new migrants, was vital for future proofing support and integration pathways.

15 recommendations for action grouped by level of priority were attached as an appendix to the report.

The Deputy Cabinet Member for Public Health, Sport, and Wellbeing, Councillor G Hayre, recognised Coventry's history of welcoming migrants to enrich the city's culture. The Cabinet and Deputy Cabinet Member of Adult Services reiterated these comments, thanked officers for the report and presentation and recognised the importance of engagement for different communities.

Members of the Scrutiny Board, having considered the report and presentation, asked questions and received information from officers on the following matters:

- Coventry's long history of supporting migrants and that established migrant communities were still included as part of the report, recognising those communities may have different needs to those who are newly arrived.
- The support process for minority migrant groups, mapping out faith communities in the city, and the use of grants in the facilitation of this support.
- Directions to UHCW (University Hospital Coventry and Warwick) on public transport being communicated through virtual reality (VR) and it's use as an educational tool with benefits for those with neurodiversity.
- The support process for the Positive Youth Foundation which provides tailored intervention for migrant children throughout the school year including booster programs and mental health support.
- The procedure for finding community champions – building on the framework of community connectors following the implementation of HARP (Health Access Refugee Program) to tackle misinformation and mistrust.
- The importance of language skills in migrant integration.

RESOLVED that the Health and Social Care Scrutiny Board (5):

1) **Notes the findings and recommendations of the Annual Report Public Health 2024 for Coventry.**

2) **Endorses the recommendations contained in the report.**

11. **Work Programme and Outstanding Issues**

RESOLVED that the Health and Social Care Scrutiny Board (5):

1) **Notes the Work Programme with the following amendments:**

   - **The meeting due to take place on the 17th December 2025 will now take place at UHCW.**
   - **The meeting due to take place on the 25th February 2026 will invite Age UK as part of the item on the physical activity update.**

12. **Any other items of Public Business**

The Chair of the Board noted how she was invited to the UHCW Oscars recognising the amazing work done at all levels of health and social care.

(Meeting closed at 12.40 pm)

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Coventry City Council

Briefing note

To: Health and Social Care Scrutiny Board **Date: 19 November 2025**

Subject: Prioritisation of NHS services

1 Purpose of the Note

1.1 To provide the Health and Social Care Scrutiny Board with an update from the ICB with regards to the Prioritisation of NHS Services.

2 Recommendations

2.1 Health and Social Care Scrutiny Board are recommended to:

a. Note the information regarding prioritisation in Appendix 1 in light of the following paper regarding gluten free prescribing and to make any further recommendations.

3 Information/Background

3.1 Outline information is provided in the appended briefing note (Appendix 1) and officers will be present at the meeting to share more detail and context on these topics.

4 Health Inequalities Impact

4.1 There are no Health Inequalities impacts directly related to this report.

Appendix 1: Briefing Paper – Prioritisation of NHS Services

Elan Jones
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NHS
Coventry and Warwickshire

Briefing Paper – Prioritisation of NHS services

1. Introduction

1.1. The Integrated Care Board (ICB) is responsible for making sure NHS resources are used in the best possible way for local people. This means making decisions based on evidence of what is working well, focusing on the greatest health needs, tackling inequalities, and ensuring money is spent in a way that delivers real benefits.

1.2. Like many areas across the country, Coventry and Warwickshire is facing serious financial pressures. The ICB must be more selective about what it funds, directing money to services that make the greatest difference. While the work we are doing to reduce waste and be more efficient will continue, we will also have to make some tough choices about which services can be maintained.

1.3. It is vital as we make these decisions fairly and all aspects of a service are considered before making decision on their future. To help with this, the ICB has worked with system partners to create a new approach to prioritisation, bringing together existing methods into one consistent and transparent methodology, so that decisions are fair and based on clear evidence. It will be used to consider the short- and long-term impacts of funding decisions on health outcomes, finances, and inequalities. It will guide a range of decisions, such as whether to stop or reduce funding for a service, restrict or expand access, invest in new technologies or review contracts.

2. Our method for prioritisation

2.1. When assessing a service or proposal we look at seven key areas: how well it fits with NHS strategy, the level of population need, its impact on health inequalities, clinical effectiveness and risk, value for money, how it connects with other services, and how deliverable it is. Four of these areas are scored and weighted, giving an overall rating from ‘Stop’ through to ‘Expand’. These ratings will help identify where investment should go and ensure decisions are consistent across the system. These ratings and the supporting evidence is then considered by the ICB Senior Leadership Team, who will make a recommendation for the next steps.

2.2. This new approach is about making sure that every pound spent delivers the best possible value for patients and communities. By using a fair and transparent process, the ICB and its partners aim to protect essential services, address inequalities, and ensure the local NHS remains sustainable for the future.

3. Outcomes of the prioritisation process

3.1. As all of our contracts come up for renewal, or new proposals for contracts are received, we are applying our prioritisation methodology to assessing whether, in the case of new contracts they will meet the needs of our population, or for current contracts, that they are delivering against the

goals which we set out when the contract was first introduced. This leads to four possible outcomes being recommended by the Senior Leadership Team.

- **Invest and Expand** – These services are those that score the highest across all categories, where we have robust, validated evidence to show the expected benefits. Outcomes are backed by extensive data or proven success in similar contexts, with independent validation or expert consensus adding further assurance, showing they can, or already are, delivering measurable benefits for our population.

  We will invest in these services in order to allow more of our population to access and benefit from them.

- **Continue to commission, investing if funding is available** – These services have strong, credible evidence which supports the expected value or benefit and is linked to measurable outcomes. There is past success or a clear rationale demonstrating how value will be achieved. While there may be some risk and uncertainty, these are understood and do not significantly undermine confidence in the evidence.

  These are the services we will continue to commission, and if there is additional funding available we will consider investing in them.

- **Review service for value for money and access** – These are services where there is some benefit, but the evidence we hold is weak, incomplete, or indirect. As a result, the ICB cannot be confident that the expected outcomes are being achieved, or that the service is delivering value for money.

  To improve the contract, the ICB may:
  - Aim to negotiate a better price for services.
  - Work with the provider to improve efficiency.
  - Restrict access so that only those most likely to benefit (e.g. over-65s) can use the service.
  - Request stronger evidence from the provider to demonstrate value for money.

  Once these actions have been taken, the contract will be reassessed. If the measures do not demonstrably improve value, the ICB will begin the process of decommissioning the service or decline to invest in a proposed service.

- **Decommission / Disinvest** – These services have little to no evidence to support the value which they add. This means they are unable to provide data which demonstrates the benefits of the service or the data is based on assumptions and anecdotal evidence. In the case where the ICB does not believe that there is an option to improve the service through the methods outlined above, the service is recommended for decommissioning or will decline to invest in a proposed service.

4. The decommissioning process

4.1. For current contracts which have been through the prioritisation process above and received a recommendation of decommissioning, the ICB will then enact its decommissioning policy. This policy outlines the steps needed to safely decommission a service. This includes the production of a Equality and Quality Impact Assessment (EQIA) which aims to identify, remove, or minimise negative impacts on disadvantaged groups which could be brought about by ending the contract. Through the decommissioning policy the ICB will involve stakeholders where appropriate, to ensure it understands the impacts of removing the service.

4.2. Once these steps have been undertaken the ICB will take a final decision to decommission the service, considering both the value and any impacts on service users and patients outlined by the EQIA and other sources. If the decision to decommission is then taken the ICB will support the contract holders with wind down and service closure.

5. Current position of the prioritisation process and next steps

5.1. The ICB will continue to use the prioritisation process to determine the ongoing value for money and effectiveness of contracts, using the mechanisms described in this paper.

5.2. The ICB started the process of assessing services through the prioritisation process in March 2025. As this work is ongoing it is still too early to recognise the scale of savings achieved but we will continue to report through our designated structures as we continue forward.

5.3. Where there is a potential impact identified through the EQIA we are committed to involving the Scrutiny Committee to both understand your views and for you to scrutinise the process, ensuring that we are involving people in an appropriate and proportionate manner.

5.4. The first example of this is the gluten free prescribing paper which is being presented to both Scrutiny Committees in Coventry and Warwickshire for views.

Committee is requested to NOTE the information regarding prioritisation in light of the following paper regarding gluten free prescribing

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Coventry City Council

Briefing note

To: Health and Social Care Scrutiny Board **Date: 19 November 2025**

Subject: Gluten Free Prescribing

1 Purpose of the Note

1.1 To provide the Health and Social Care Scrutiny Board with an update from the ICB with regards to the Coventry and Warwickshire Integrated Care Board (ICB) review on how gluten-free (GF) foods are prescribed for adults and children who have been diagnosed with coeliac disease or dermatitis herpetiformis.

2 Recommendations

Health and Social Care Scrutiny Board are recommended to:

a) Review the paper and associated engagement report
b) Support the decision of the C&W ICB that the information in the paper regarding the engagement undertaken, numbers of patients affected by the change and mitigations outlined are sufficient to go ahead with the proposed service change.
c) Note that if the Board do not agree with the above recommendation, and that the proposals constitute a major service change this then requires further and wider public engagement to understand the impact of the change.

3 Information/Background

3.1 Outline information is provided in the appended briefing note (Appendix 2) and Engagement analysis (Appendix 3) and officers will be present at the meeting to share more detail and context on these topics.

4 Health Inequalities Impact

4.1 A national equality impact assessment found that risks associated with decommissioning GF prescribing were largely mitigated by the availability of naturally GF foods and retail access. Prescribing data across Coventry and Warwickshire shows no correlation between deprivation and prescribing rates, suggesting that prescribing is driven by clinical diagnosis rather than socioeconomic factors.

4.2 Concerns were raised during engagement about affordability and access for individuals, particularly for vulnerable groups. See Section 3 of Appendix 2 for further details.

Appendix 2: Briefing Paper – Gluten Free Prescribing
Appendix 3: Gluten Free Prescribing Engagement Report

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1. Background and Context

1.1. Coventry and Warwickshire Integrated Care Board (ICB) is reviewing how gluten-free (GF) foods are prescribed for adults and children who have been diagnosed with coeliac disease or dermatitis herpetiformis. Prescriptions for GF foods cost the NHS more than it costs to buy them directly in the shop, through a combination of clinician time, dispensing fees, and delivery charges. Currently the ICB spends £240,000 per year on prescription of GF foods and the current CWICB policy restricts prescribing to bread and mixes, capped at 8–10 units per month.

1.2. In 2017, the Department of Health & Social Care conducted a public consultation which led to legislative changes restricting GF prescribing to a limited list of items (bread and flour mixes) under the NHS Drug Tariff. The NHS England guidance (2018) empowers ICBs to further restrict or fully decommission GF prescribing, provided they consider their legal duties around equality and health inequalities.

1.3. Across England, approximately one-third of ICBs have decommissioned GF prescribing, including all East Midlands ICBs and several in the West Midlands (e.g. Hereford & Worcestershire, Shropshire, Telford & Wrekin). Staffordshire and Stoke ICB have retained prescribing only for children under 18. This regional shift reflects a growing consensus that GF prescribing is not clinically essential, given the wide availability of GF products in supermarkets and the existence of naturally GF alternatives (e.g. rice, potatoes).

1.4. As part of the ICB prioritisation process to assess value for money commissioning the ICB has reviewed the case for continuing to provide GF foods on prescription.

2. Evidence Base and Impact Assessment

2.1. Population Need

Coeliac disease affects approximately 1 in 100 people, though local population health management data does not provide a precise figure for Coventry and Warwickshire. Between November 2024 and January 2025, 1401 patients received gluten-free (GF) prescriptions, including 219 children.

When assessing need it is important to note that GF foods are not a “treatment” for coeliac disease in the way that medicines are. Prescribing of GF foods was originally introduced as GF foods were not easily available in supermarkets, making it much harder to adhere to a gluten-free diet. However, GF foods are now commonly available compared to 10 years ago, reducing the population need for foods to be supplied through prescription.

2.2. Health Impact

The Department of Health & Social Care (DHSC) impact assessment concluded that adherence to a GF diet is multifactorial, influenced by education, motivation, and access, not solely by prescription availability. Adherence rates among adults with coeliac disease range from 36–96%. **No significant adverse outcomes have been reported in ICBs that have already decommissioned GF prescribing**. In addition, no research literature has linked any adverse health outcomes to cessation of GF food prescribing.

Patients who do not follow a GF diet are at increased risk of complications such as osteoporosis, ulcerative jejunitis, and intestinal malignancy. However, naturally GF foods and retail options remain accessible, mitigating health risks for most patients.

2.3. Health Inequalities

A national equality impact assessment found that risks associated with decommissioning GF prescribing were largely mitigated by the availability of naturally GF foods and retail access. Prescribing data across Coventry and Warwickshire shows no correlation between deprivation and prescribing rates, suggesting that prescribing is driven by clinical diagnosis rather than socioeconomic factors.

Concerns were raised during engagement about affordability and access for individuals, particularly for vulnerable groups. See Section 3 for further details.

2.4. System Financial Impact

While GF foods are more expensive for individuals to purchase when compared to gluten-containing equivalents, the cost of GF products to the NHS via NHS prescription is even higher due to clinician time, dispensing fees, and delivery charges.

If gluten-free foods were to be fully decommissioned, this is projected to deliver annual savings of £240,000. These savings can be reinvested into areas of greater clinical need. The proposal does not require additional funding, technology, or infrastructure, and will reduce GP appointments and pharmacy dispensing time, thereby improving system productivity.

3. Patient and stakeholder engagement

3.1. As part of the engagement process, Coventry and Warwickshire ICB conducted a survey following approval from Finance & Performance Committee. The survey was widely promoted amongst people who are living with coeliac disease and a total of 232 responses were received, including submissions from local GPs, Coeliac UK and UHCW dietetics teams.

3.2. A full report detailing the responses to the engagement are included with this paper in Appendix A. However, the key themes from the survey are set out below:

3.2.1. **Affordability and Cost of Living**

The most dominant theme was concern over the increased cost of GF foods, which are estimated to be 35% more expensive than standard equivalents. Respondents feared that removing prescriptions would exacerbate financial pressures, particularly for those on fixed incomes, facing deprivation, or relying on food banks. Several responses emphasised the importance of GF prescriptions for children, particularly for school lunches and social inclusion. There was support for means-tested support, such as voucher schemes or subsidy cards, with references to the Welsh model and Luton ICB's pharmacy-led approach.

3.2.2. **Dietary Adherence**

Many respondents, including clinicians and advocacy groups, expressed concern that

decommissioning could lead to reduced adherence to a GF diet, especially among lower-income households, students, carers, and pensioners.

3.2.3. **Product Availability and Quality**
Concerns were raised about the availability and quality of GF products in retail settings, with some noting that brands perceived to be prescription only (e.g. Juvela, Glutafin) are not easily accessible or equivalent in taste and nutrition.

3.2.4. **Health Inequalities and Equity of Access**
Respondents highlighted potential impacts on Core20PLUS5 populations and inconsistencies in prescribing practices.

3.3. Although the majority of respondents expressed concerns about the removal of Gluten Free foods on prescription there was a minority who expressed their feeling that gluten free foods should be removed. Their reasoning was primarily centred around the availability of gluten-free foods on prescription, the need to prioritise NHS resources for those with greatest needs, equity with other dietary needs who do not receive food on prescription (such as lactose-intolerance) and waste / inefficiency in the current model.

3.4. The most frequently requested support to manage a gluten-free diet without NHS prescriptions is information about affordable gluten-free alternatives (28%), followed by dietitian advice and help with reading food labels. Many respondents also express a need for financial support or vouchers to offset the higher costs and there were many requests that other models are explored if products are removed from prescription.

4. Consideration of the themes of the engagement

4.1. Following the engagement the ICB considered the themes within the engagement and what risk they posed to the population, should the decision be taken to stop the prescribing of gluten-free foods.

4.1.1. **Affordability and Cost of Living**
It is recognised that GF are more expensive than basic supermarket alternatives, research suggests this additional costs to individuals would be about £11-£14 per month. However, when prescriptions were introduced for gluten-free foods it was in recognition that gluten-free foods were unavailable or very difficult to purchase, not as a subsidy against food costs for those of those who are living with coeliac disease. It is recognised that GF foods are more expensive, but the NHS prescription system is designed to meet clinical need, not to subsidise food costs. The NHS does not provide foods for other patient groups with allergies or intolerances.

Although the majority of respondents in the survey self-identified as having limited financial resources, prescribing data across Coventry and Warwickshire shows no correlation between deprivation and prescribing rates, suggesting that prescribing is driven by clinical diagnosis rather than socioeconomic factors.

Naturally occurring gluten free alternatives (e.g. rice, potatoes, corn flour) are available, affordable and widely understood.

4.1.2. **Dietary Adherence**
Although concerns were raised about the potential lack of adherence if foods were not available on prescription there is no published data to directly link adherence rates to prescription availability is available. Adherence rates among adults with coeliac disease range from 36–96% and no significant adverse outcomes have been reported in ICBs that have already decommissioned GF prescribing. No evidence was presented that linked any adverse health outcomes to GF foods not being available on prescription.

4.1.3. **Product Availability and Quality**
Current prescription brands were perceived to be prescription only (e.g. Juvela, Glutafin) are not easily accessible or equivalent in taste and nutrition, however it should be noted that both the brands referenced are available to purchase online without a prescription.

4.1.4. **Health Inequalities and Equity of Access**
Prescribing data showed no correlation between deprivation and prescribing rates, suggesting clinical diagnosis is the primary driver

5. Considering the options for Gluten Free Prescribing

5.1. Following the findings of the engagement and other research, the ICB considered the four possible options for GF prescribing

- **Option 1: Retain the status quo**
  This would maintain GF prescribing at the costs of £240k per year.

- **Option 2: Restrict to patients with financial hardship only**
  Means-tested support such as voucher schemes or subsidy cards do exist in Wales and Luton ICB. In the Welsh model gluten free food vouchers are funded by local government. In the Luton scheme pharmacies are commissioned to check eligibility of patients based on the receipt of certain benefits.

- **Option 3: Restrict to children only**
  This is more feasible and easier to administer than option 2 but would not be means tested.

- **Option 4: Decommission GF prescribing completely**
  This would remove all gluten-free items from prescription

5.2. These options were all considered by a meeting of the Senior Leadership Team at the ICB which includes a mix of commissioners and clinicians

- **Option 1: Retain the status quo**

This was considered to represent a relatively poor value for money investment and does not result in any meaningful health benefit for our population.

- **Option 2: Restrict to patients with financial hardship only**
  A scheme which is based on financial hardship would move costs to the Local Authority, who already have local and national schemes in place to support those who are suffering from financial hardship. Setting up and administering a new scheme through local government would add additional cost pressures.

  SLT considered whether restricting prescribing to people with certain financial circumstances/benefits payments would be feasible through the NHS (administered by Primary Care). They concluded that whilst technically possible it would be cumbersome to administer and the resulting financial costs would mean any financial savings would be materially eroded to the point of making the overall savings from such a scheme of marginal benefit. There is also no other precedent for this for any other prescribable item.

- **Option 3: Restrict to children only**
  It was agreed that is more feasible and easier to administer through Primary Care than option 2. However, the reason to continue to prescribe to children would solely be on the basis of financial impact to affected families, not for any health benefit. SLT discussed whether making judgements on the provision of NHS services on the basis of financial impact on patients was a sound principle. In conclusion SLT decided that this was not within the remit of clinical prescribing as the NHS prescription system is designed to meet clinical need, not to act as a mechanism for food provision or income support.

- **Option 4: Decommission GF prescribing completely**
  SLT considered that there is no evidence that ceasing prescribing gluten free foods has any demonstrable health impact and therefore it represents poor value for money. A move to decommission gluten free foods would be in line with many other ICBs including Herefordshire and Worcestershire, our local partners. There is also no evidence that current prescribing is related to deprivation or have a direct impact on health inequalities. It would reduce low value prescribing activity in General Practice and community pharmacy

5.3. Following the consideration of these options SLT agreed that the preferred option, which will be recommended to Finance and Performance Committee was that GF prescribing was decommissioned completely.

6. Support available if gluten free prescribing is decommissioned / restricted

6.1. It is important to note that no final decisions have been made on the future of gluten free prescribing. However the ICB has considered that, if gluten free prescribing was to be decommissioned, what mitigations would need to be put in place to support those currently in receipt of prescription, and those who will be diagnosed in the future.

6.2. Affordability and the difficulty of adhering to a gluten free diet were the key issues raised throughout the engagement and, if decommissioning were to go ahead, the ICB will develop materials to support with signposting to dietetic support when needed and will share links on the ICB website. In addition, additional information will be provided to GPs on the support available for those who may be suffering from financial hardship, including food banks and local authority support.

6.3. The savings from decommissioning GF prescriptions may be able to be recycled into prevention programmes as has previously been agreed and would be arranged on a system basis (although a final decision on this is dependent on wider financial considerations)

6.4. Monthly prescribing data will be monitored to track compliance and identify any anomalies or unintended consequences. Practices will be supported to manage patient queries and concerns, particularly for those with complex dietary needs or socioeconomic vulnerabilities.

6.5. Where necessary, patients can be referred for dietetic support to ensure safe and effective dietary adherence post-decommissioning.

6.6. Any changes would be communicated to patients via their GP Practices. Prescriptions would not be stopped immediately following any decision, but a transition period would be put in place to help people to understand the alternatives available and access support where appropriate.

7. Decision making and next steps

7.1. The ICB has completed an Equality Impact Assessment and worked with local stakeholders and patients to understand what the impact would be on changing gluten free prescribing. It has also investigated the plausibility of other models or restricting prescribing to certain groups, as per the feedback in the consultation.

7.2. Representatives of the ICB are now attending Scrutiny Committees in both Coventry and Warwickshire to understand the views of the Committee and to ask if the Committee believe that sufficient engagement has taken place for the ICB to understand the impact of any potential change or if there is more work required.

7.3. Depending on the outcome of these conversations any further activities deemed necessary by the Committees will be undertaken. If the Committees are satisfied with the activities to date, a decision-making business case will be taken to the next Finance and Performance Committee for a final decision to be taken.

Members are asked to review the paper and associated engagement report and determine whether:

1. The Health and Social Care Scrutiny Board agrees that the information in the paper regarding the engagement undertaken, numbers of patients affected by the change and mitigations outlined are sufficient to go ahead with the proposed service change **OR;**

2. That the Board believes that this constitutes a major service change which requires further and wider public engagement to understand the impact of the change.

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Engagement analysis on proposed changes to Gluten-Free prescribing in Coventry and Warwickshire

Contents

Introduction

Coventry and Warwickshire Integrated Care Board (ICB) is reviewing how gluten-free (GF) foods are prescribed for adults and children who have been diagnosed with coeliac disease or dermatitis herpetiformis

At present, a limited range of GF bread loaves and mixes can be prescribed for individuals who meet the criteria - capped at 8-10 units per month. Prescribing of GF foods was introduced at a time when GF foods were expensive and hard to access in supermarkets. Now GF foods are widely available in supermarkets, with a broad range of affordable options. Naturally gluten-free foods such as rice, potatoes, meat, fish, vegetables, fruit, and most dairy products remain accessible.

Prescriptions for GF foods cost the NHS more than it costs to buy them directly in the shop, through a combination of clinician time, dispensing fees, and delivery charges. Currently the ICB spends £240,000 per year on prescription of GF foods. Across England, some ICBs have already stopped prescribing gluten-free foods.

In order to understand the impact of reducing or stopping the prescribing of gluten-free foods, the ICB undertook an engagement exercise to understand the views of people who may be affected by this change.

Methodology

Information was gathered via an online survey where the aim was to ensure that all interested parties received:

- A clear explanation of the question and the rationale behind it, being clear that removing gluten-free products from prescription was an option
- An open invitation to share feedback via the online survey

The survey received **232 responses** and was promoted widely through a range of channels to reach as many affected individuals and stakeholders as possible.

Methods of communication included:

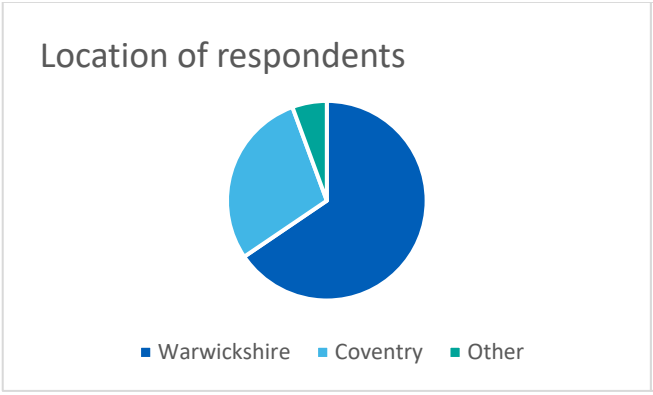
- Creation of a dedicated webpage on the ICS website outlining the proposal, rationale, and survey link.
- Letters sent to key stakeholders, advocacy groups and dieticians encouraging them to share information with patients who may be affected.
- Direct communications to GPs and primary care providers informing them of the proposal and inviting participation.
- A meeting with Coeliac UK to discuss concerns and incorporate feedback about the survey process.
- Social media posts, including in local Facebook groups for individuals accessing gluten-free foods.
- Promotion through the ICS stakeholder newsletter, reaching system partners, communications leads, VCSE colleagues, and through the ICB internal newsletter
- Support from both Coeliac UK and the the department of Nutrition and Dietetics at UHCW to forward the survey link to their contacts, service users and patients

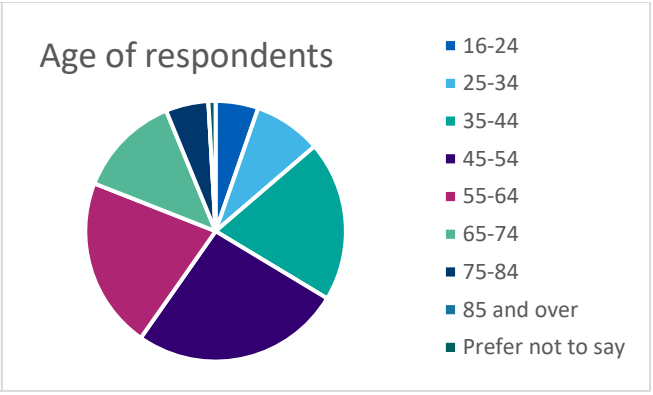
These combined efforts ensured the survey was accessible, transparent, and inclusive of a wide range of views from across Coventry and Warwickshire

A profile of our respondents

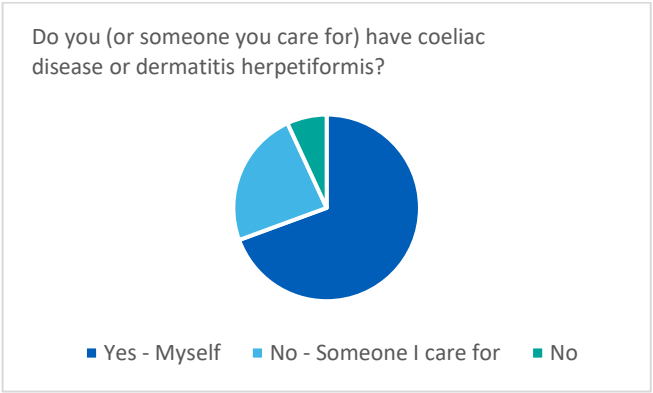
The survey attracted 232 responses, with the majority of participants living in Warwickshire. Around two-thirds of respondents (152 people) reported that they live in Warwickshire, while just over a quarter (66 people) live in Coventry. A small proportion, approximately six percent, indicated that they live elsewhere or did not specify their location.

In terms of age, the profile of respondents leans toward mid-life adults. The largest age group represented was 45-54 years, accounting for just over a quarter of responses. This was closely followed by those aged 55-64 and 35-44, meaning that individuals between 35 and 64 years old made up roughly two-thirds of the sample. Older adults aged 65-74 and 75-84 together comprised about 18 percent of respondents, while younger adults aged 16-24 and 25-34 represented around 14 percent. Only a very small number of people preferred not to disclose their age.





Out of 232 respondents, most reported a direct link to coeliac disease or dermatitis herpetiformis. Specifically, 69% answered “Yes - Myself,” and a further 24% selected “No - Someone I care for.” A smaller number (7%) indicated “No”, including people who identified themselves as GPs.

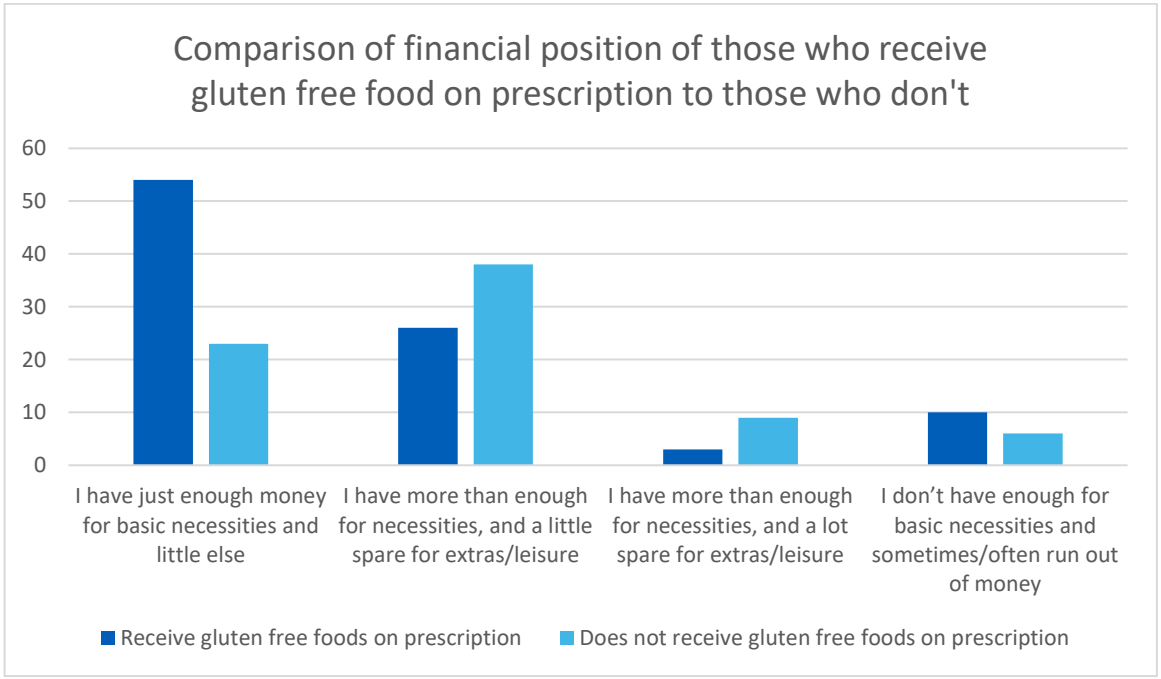


When asked whether they had received gluten-free foods on NHS prescription in the last 12 months, responses were broadly balanced. 51% said “Yes,” 48% said “No,” and 1% were “Not sure.” Taken together, these results show that the survey predominantly reached people directly affected by the condition (either personally or as carers) and that about half of those reported recent access to gluten-free prescriptions.

Financial circumstances varied across the group, but a significant proportion reported being financially constrained. About 42% said they either have just enough money for basic necessities or do not have enough and sometimes run out of money. In contrast, roughly 37% indicated that they have more than enough for necessities, with either a little or a lot spare for extras and leisure. The remaining fifth of respondents preferred not to share details about their financial situation or selected “not known.”

Among respondents who either have coeliac disease or dermatitis herpetiformis themselves or care for someone who does, there are clear differences in financial circumstances between those who received gluten-free foods on NHS prescription and those who did not. People who received prescriptions were more likely to report financial constraints. Nearly half of this group said they have just enough money for basic necessities and little else, and a further small proportion indicated that they do not have enough for essentials and sometimes run out of money. Together, these responses suggest that a significant share of prescription recipients are living with limited financial flexibility.

By contrast, those who did not receive prescriptions were more likely to describe their situation as comfortable. A larger proportion of this group reported having more than enough for necessities, with either a little or a lot spare for extras and leisure. While some respondents in this group also reported financial strain, the overall pattern shows that non-recipients are more financially secure compared to those who rely on prescriptions.



The impact of removing gluten free foods on prescription

Availability on prescription

When asked what the potential impact of removing gluten-free foods from prescription, respondents indicated that this would most commonly increase household food costs - 56% of people selected this. A substantial share (35%*) also said it would make it harder to stick to a gluten-free diet. At the same time 41% indicated they do not currently receive gluten-free foods on prescription (so the immediate impact on them would be limited), and a small minority (4.3%*) felt it would not make much difference.

Additional free-text comments reinforced the financial pressures mentioned above and flagged practical concerns such as the availability and cost of specific flour mixes, the inconvenience of sourcing suitable products, and the potential impact on older people and carers. Overall, the findings suggest that policy changes removing prescriptions would most likely be felt through higher food bills and reduced dietary adherence among many of those affected.

"Three coeliac household including primary aged children. The expense for GF food already has an affect on our food bill each week and the impact on the children will be significant if prescriptions are stopped"

"… my mother who fully relies on these prescriptions she is over 70 and a clearer warning minimum wage if you decided to take this right away this would cause great hardship and difficulty. She fully relies on this to ensure she does not eat gluten which has already damaged her organs "

* Because this question allowed multiple selections, percentages do not add up to 100%.

Accessing gluten free services and support to adhere to a gluten free diet

Most people said they could access gluten-free alternatives, but many flagged challenges. Just under half (44%) said they could access alternatives easily, while a further 42% felt they could do so but with some difficulty. Taken together, 87% believed they could obtain products in principle, though the substantial "with difficulty" share indicates practical barriers remain for a large group.

At the same time, 10% said they would not be able to access gluten-free alternatives, and 3% were not sure. This suggests that around one in eight respondents either cannot access alternatives or are uncertain they could, highlighting a meaningful risk of reduced access if prescriptions were withdrawn - especially for those already facing financial or availability constraints.

It is worth noting that people who currently receive prescriptions are much less likely to say they could access alternatives easily and much more likely to anticipate difficulty or inability. Only 25% of prescription recipients said *"Yes, easily"*, compared with 64% among those who said *"No/Not sure"* to receiving prescriptions (a –39 percentage point difference). A majority of recipients (55%) selected *"Yes, with some difficulty"* (vs 29% in the No/Not sure group, a +26 pp difference), and recipients were also more likely to say "No" outright (16.9% vs 3.5%, a +13.4 pp gap). The share answering "Not sure" was small and similar across groups (~2–3%). In

short, current prescription recipients foresee substantially more access challenges if prescriptions were withdrawn.

When asked what kind of support that people would need to maintain a gluten free diet, the most common form of support requested was information about affordable gluten-free alternatives, selected by 29% of respondents. This suggests that cost and availability are major concerns for people managing a gluten-free diet. The second most frequent response was “I wouldn’t need any extra support,” chosen by 26% respondents, indicating that while many respondents feel confident in managing their diet, a significant proportion still require assistance.

Other responses were more fragmented and often combined multiple options, such as dietitian advice, help with reading food labels, and financial support, but each of these appeared far less frequently in isolation. A small number of respondents mentioned specific ideas like vouchers for gluten-free food, better labelling, or transport to shops, highlighting diverse needs beyond basic information. Overall, the findings point to a strong demand for practical guidance on affordable options, alongside targeted financial and professional support for those who struggle most.

Outside of the specified options, other ideas suggested for support centred around financial help (e.g., vouchers, payment cards, funding/allowances, discounts). Several also referenced specific products (e.g., flour mixes), improving the availability of products or voucher schemes like Wales.

As would be expected people who currently receive prescriptions are notably more likely to say they need practical help. Among the “Yes” group, 66% asked for information about affordable gluten-free alternatives, compared with 42% among those answering “No/Not sure.” Recipients were also more likely to want dietitian advice (29% vs 20%) and help with reading food labels (16% vs 10%). In addition, requests for financial support in the free text answers, including mentions of vouchers or payment cards, were higher among recipients (9% vs 4%), reflecting greater perceived cost pressures in this group.

Concerns and suggestions

In addition to the questions above, respondents to the survey were offered the opportunity to utilise a free text box to tells us about the concerns and suggestions they had about the proposal to remove gluten free food.

166 respondents used this option and their comments are themed and categorised below. The majority of respondents expressed concerns and disappointment in the potential change to prescribing, while a smaller minority were neutral or for the idea.

Key overall themes identified for retaining gluten free prescribing

Affordability dominates: The single strongest theme is that withdrawing prescriptions would increase household food costs, with many people saying gluten-free (GF) staples remain *significantly* more expensive and sometimes difficult to source (stock, freshness, range). People consistently reference bread and flour as core staples.

“Gluten free products need to be affordable. I am currently paying for my daughters gluten free products and is causing financial strain and I am unable to afford them.” Coventry, Age: 16-24

Adherence risk: Many respondents anticipate reduced adherence to a GF diet if prescriptions stop—especially among lower-income households, carers, students and pensioners—linking this to longer-term clinical risks and cost-shifting back to the NHS/social care.

""If GF foods were no longer available on prescription this would not be affordable for me to buy myself. I would also be asking that this cost is shunted over to social care… so no savings overall just a moving of the costs from health to social care. …Costs will not be saved and will just move to social care instead of health…" Warwickshire, Age: 55–64

Targeted mitigation, not "no support": Even among those open to change, there is widespread support for means-tested help or a voucher / pre-paid subsidy card, with multiple references to the Welsh model. Others suggest retaining bread/flour for defined cohorts (children, low-income, elderly).

"Why can't we have a monthly allowance we use at any supermarkets to buy basics. My bread cost £3.60 per loaf and I get ten slices, how is it fair." – Coventry, Age 55-64

Product availability & quality: Numerous comments say some prescription-only mixes (e.g., Juvela, Glutafin) are not available or not equivalent in supermarkets; users feel supermarket GF bread is expensive, perishes quickly, or is inferior nutritionally/taste-wise.

"The Juvela bread I receive is what I like and have never seen it available anywhere else. …the fresh alternatives to buy at the supermarket are expensive and do not keep very well so I would end up wasting some and having to buy more." Coventry, Age: 65–74

Inequalities & consistency: People highlight inequity (Core20-type concerns), inconsistent practice-level access, historic awareness gaps ("I didn't know prescriptions existed"), and ask for clear, proactive communication if decisions change. GP respondents also request robust comms to avoid unmanaged spill-over to practices.

"The removal of gluten free foods on prescription would further increase inequality and inequity for those with Coeliac Disease. A gluten free diet is the only medical treatment that is effective for managing disease. Gluten Free foods are not accessible for everyone due to the significant cost of supermarket products. Adherence is vital to prevent development of associated long term consequences such as nutritional deficiencies, infertility, cancer, other autoimmune conditions and many other conditions. The cost of treating those would be far greater than supporting an individual with Gluten Free staple foods on prescription." ID 205

Key themes supporting the removal of gluten free food on prescription

Although these themes did not come out as strongly, there was a clear (minority) cohort arguing that gluten-free (GF) prescribing should be stopped or significantly curtailed. Their comments cluster into a handful of recurring themes.

Retail availability has changed the context: They believe mainstream supermarkets now stock adequate GF basics, so prescriptions feel outdated

"I'm a GP rather than coeliac but I've been saying for years that I have no idea why we prescribe them. They can be purchased easily in any supermarket." GP, Warwickshire

Prioritise NHS budgets for medicines/clinical care: With finite resources, food items are seen as a poor use of funds compared with drugs, treatment, or dietetic education.

"I am a prescriber (GP) of Gluten free foods. I think that their removal from prescription status is long overdue. As is known, Gluten free foods are now widely accessible in supermarkets and the cost to the NHS is significant." GP, Warwickshire

Fairness with other dietary needs: People with other medical diets/allergies don't receive food on prescription; GF should be treated consistently.

"There is plenty of availability in shops. People with other allergies do not receive free food from the NHS so why should Coeliacs?!" Coventry, Age: 35–44

Waste/inefficiency in the current model: Practical problems—bulk ordering, short shelf life, uncollected items—are cited as reasons to stop the current approach.

"Why don't we change the process for gluten free food and rather than doing it via prescription where products are expensive, people are given vouchers to use in supermarkets (like the old milk tokens) We don't get the gluten free products are prescription anymore as you had to order some much bread and some would go to waste, and it felt like we were then wasting resources. A different process would be more cost effective whilst still supporting those with coeliac disease" Coventry, Age: 45–54

Replace universal scripts with targeted financial support: Many suggest means-testing or a voucher/subsidy card (often referencing the Welsh model) to protect people on low incomes or families with coeliac children.

"Supermarket vouchers for gluten free foods should be supplied to all those with coeliac" Coventry • Age: 35–44

Nutrition and product quality concerns: Some describe prescription items as ultra-processed, arguing for education and "naturally GF" choices instead.

"The current GF prescriptions are for limited foods e.g., loaves of bread, and the quality is not particularly great in contrast to what you could purchase in store. Also the quantity provided on a prescription is excessive, leading to many, including myself to not want to follow up with a prescription. The cost of gf food however is considerably more and as a coeliac, not a choice diet. It would be more preferred if we could have a food voucher / food payment card…" Warwickshire, Age: 35–44

A full breakdown of the themes by stakeholder group can be found at the end of this document.

Summary of findings

- The majority of respondents (63%) report either having just enough money for basic necessities or less, and 40% say they would only be able to access gluten-free alternatives with difficulty or not at all if prescriptions were stopped. These numbers rise amongst those currently in receipt of gluten-free foods on prescription and highlights significant financial vulnerability in the population.

- The most common anticipated impact if gluten-free foods were no longer available on NHS prescription is increased household food costs (mentioned in 49% of responses), often combined with concerns about difficulty maintaining a gluten-free diet (27%). This suggests that the impact of removing gluten free foods on prescription would potentially be an increase levels of illness due to lack of adherence to a gluten free diet.

- The most frequently requested support to manage a gluten-free diet without NHS prescriptions is information about **affordable** gluten-free alternatives (28%), followed by dietitian advice and help with reading food labels. Many respondents also express a need for financial support or vouchers to offset the higher costs and there were many requests that other models are explored if products are removed from prescription.

Throughout the survey, the key concern for people was financial, which a significant majority of responses expressing real concern that removing gluten-free prescriptions would disproportionately affect those with limited financial means and therefore could lead to poorer dietary adherence and increased health risks.

Detailed Demographic Information

Place of residence

Most respondents live in **Warwickshire** (about two-thirds), with just under a third from **Coventry**, and a small minority from neighbouring/other areas.

Area	Responses	%
Warwickshire	152	65.5
Coventry	67	28.9
Outside area	13	5.6

Relationship to the condition

Around **seven in ten** respondents live with coeliac disease or dermatitis herpetiformis themselves, and almost **one in four** are carers completing the survey on behalf of someone else. A small share reported **no** direct link. This mix gives a strong first-person perspective while also capturing caring roles.

Relationship	Responses	%
Self (has condition)	161	69.4
Carer for someone with condition	55	23.7
No	16	6.9

However, only **just over half (55%)** of those currently living with coeliac disease or dermatitis herpetiformis are in receipt of gluten-free foods on prescription

In receipt of gluten free foods	Responses	%
Yes	118	51
No	111	48
Not sure	3	1

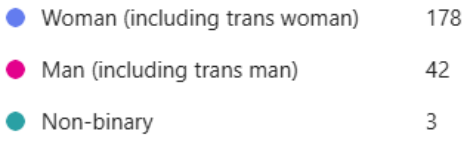
This was split equally across Coventry and Warwickshire respondents

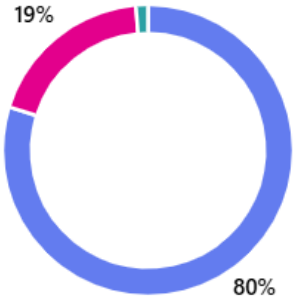
Total respondents living in **Warwickshire:** 152 → **50.0%** of which received prescriptions.

Total respondents living in **Coventry:** 67 → **52.2%** of which received prescriptions.

Sex/gender identity

The sample is predominantly **women**, with a smaller share of **men** and a small number identifying as **non-binary**. A handful did not state their gender identity. This skew is typical of many health consultations and may reflect patterns in condition awareness, help-seeking, and caregiving.

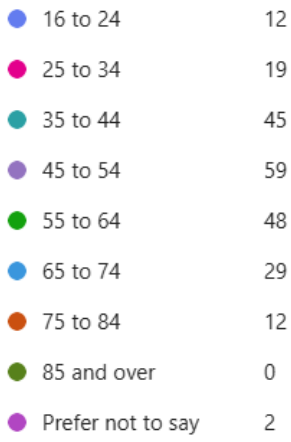


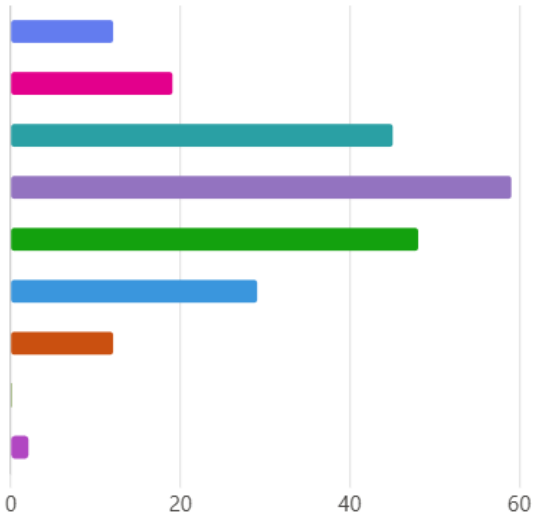


Sex / gender identity	Responses	%
Woman (including trans woman)	178	76.7
Man (including trans man)	42	18.1
nan	9	3.9
Non-binary	3	1.3

Age profile

Responses span the adult life course. The largest groups are **45–54** and **55–64**, followed by **35–44** and **65–74**. Younger adults (**16–24**, **25–34**) and **75–84** are also represented, though in smaller numbers. A small number did not state an age band.

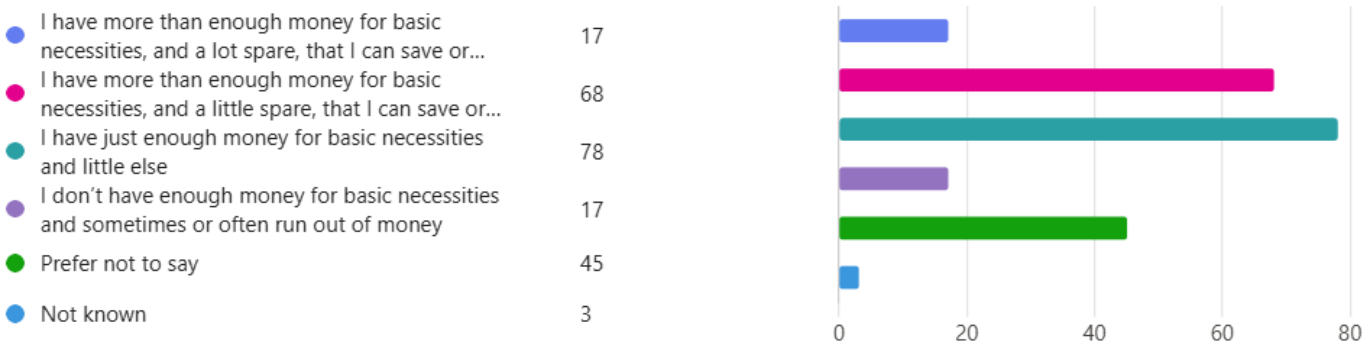




Age band	Responses	%
45 to 54	59	25.4
55 to 64	48	20.7
35 to 44	45	19.4
65 to 74	29	12.5
25 to 34	19	8.2

16 to 24	12	5.2
75 to 84	12	5.2
nan	6	2.6
Prefer not to say	2	0.9

Financial situation



When considering those only those who **answered either:**

1. "Yes – Myself", or
2. "No – Someone I care for"
   to "Do you (or someone you care for) have coeliac disease or dermatitis herpetiformis?"

We compared the financial position of those who received the prescription to those who didn't.

- **Received prescription (Yes): 117**
- **Not received (No): 96**
- **Not sure: 2** *(shown for completeness; very small)*

Financial situation by receipt of prescription

Financial situation	Received (Yes) — **n=117**	Not received (No) — **n=96**
I have just enough money for basic necessities and little else	54 (46.2%)	23 (24.0%)
I have more than enough for necessities, and a little spare for extras/leisure	26 (22.2%)	38 (39.6%)

Financial situation	Received (Yes) — **n=117**	Not received (No) — **n=96**
Prefer not to say	24 (20.5%)	17 (17.7%)
I have more than enough for necessities, and a lot spare for extras/leisure	3 (2.6%)	9 (9.4%)
I don't have enough for basic necessities and sometimes/often run out of money	10 (8.5%)	6 (6.2%)
Not known *(survey category)*	0 (0.0%)	3 (3.1%)

Percentages are within each prescription group; rounding may cause totals to ≈100%.

Detailed thematic analysis - Responses to the potential for changes to gluten-free prescribing

Thematic analysis of respondents who expressed concern - broken down by key stakeholder groups

People with Coeliac Disease (Self-Reported)

- **Affordability:** Strong concern that removing prescriptions will significantly increase food costs, especially for bread and flour, which are much more expensive gluten-free.
- **Dietary Adherence:** Many fear they will struggle to maintain a strict gluten-free diet without support, risking health complications.
- **Product Availability:** Some prescription-only products (e.g., Juvela, Glutafin mixes) are not available or not equivalent in supermarkets.
- **Fairness:** Repeated comparisons to other long-term conditions (e.g., "You wouldn't take away insulin for diabetics—this is our treatment").
- **Awareness Gaps:** Some were unaware prescriptions were available, highlighting inconsistent information and access.

"A gluten free diet is crucial for people with coeliac disease to adhere to and this is for medical reasons not just a fad diet. Gluten free foods in supermarkets are very overpriced which makes it very hard for people on a low income. It is very important to be able to access staples via prescription."

— Warwickshire, 45–54

“Just because flour is available elsewhere does not make it accessible financially. I rely on this prescription as any other person suffering with a chronic illness relies on prescription medication.”

— Coventry, 16–24

“The Glutafin multipurpose flour mix isn’t available elsewhere and is by far the easiest to bake with. Without prescription for gluten free foods most people go without food and become sick as they can’t afford to buy the food in supermarkets.”

— Warwickshire, 35–44

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2. Carers and Parents

- **Children’s Needs:** Emphasis on the importance of gluten-free prescriptions for children, especially for school lunches and social events where safe alternatives are limited.
- **Household Impact:** Multi-coeliac households and carers report a significant financial burden, with some already struggling to afford gluten-free staples.
- **Equity:** Concerns that children and vulnerable dependents will be disproportionately affected if support is withdrawn.

“We are a middle class family with professional jobs and so receive no financial support and we already struggle to cover our bills and food costs with 2 coeliac children. I am absolutely appalled at these proposed changes.”

— Warwickshire, 35–44

“My daughter has coeliac disease and currently receives bread and flour through the NHS prescription. If she was to lose her prescription this would dramatically increase our food bill which I am not sure we could manage to cover.”

— Coventry, 35–44

“Adults I agree should not get prescriptions but children should be entitled to their bread free as this is an important part of their nutrition.”

— Warwickshire, 25–34

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3. Low-Income Households, Students, and Pensioners

- **Cost-of-Living Pressures:** These groups are most likely to report that they would be unable to afford gluten-free foods without prescriptions.

- **Health Inequalities:** Fears that withdrawal will worsen health inequalities, particularly for those already facing deprivation or on fixed incomes.
- **Mitigation Requests:** Strong support for means-tested support, vouchers, or a pre-paid card system (Welsh model) to protect those most at risk.

“I am a student and find it very expensive to buy gluten free food. I would love to receive prescriptions to help me.”

— Warwickshire, 16–24

“I do not ask for GF foods on prescription as I can afford to buy them but GF alternatives are more expensive and if I were on a limited income it would be a struggle and therefore I do not think they should be removed from prescription.”

— Warwickshire, 65–74

“I don’t have enough money for basic necessities and sometimes or often run out of money. Gluten free food is extremely expensive as it is, will cause a lot of frustration and somewhat financial worry if I have to fund it all myself.”

— Coventry, 25–34

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4. People with Multiple Allergies or Complex Needs

- **Limited Alternatives:** Those needing gluten-free plus other dietary restrictions (e.g., dairy, egg, nut-free) report even fewer suitable supermarket options.
- **Risk of Malnutrition:** Fear that without prescriptions, they may go without essential foods, risking malnutrition and further health complications.

“I have multiple allergies and only get items I can’t get in supermarkets so without prescription I would have to go without because I can’t afford them or can’t get gluten free dairy free nut free & eggs free items as they always put one of these ingredients in product to replace the gluten which is dangerous for me.”
— Warwickshire, 45–54

Thematic analysis supporting the removal of gluten free food on prescription – broken down by key stakeholder groups

As the respondents who supported the removal of GF prescribing were smaller, they have been broken down into two groups – patients and carers and GPs

1. Patients and Carers

1) Supermarket availability makes prescriptions unnecessary

Respondents argued GF staples are now easy to buy; some still favour a different kind of support (e.g., vouchers).

“GF food readily available in shops and supermarkets. Not on prescription, a voucher scheme to reduce to average price of bread etc maybe better so people are not disadvantaged by dietary needs.”

— Warwickshire, 25–34

“I would support the full withdrawal of free prescriptions for gluten free foods.”

— Warwickshire, 45–54

“I find it staggering that people are getting prescriptions for products which are widely available in every supermarket and which some of us have been buying forever.”

— Warwickshire, 35–44

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2) NHS funds should prioritise medicines/clinical care, not food

Several respondents framed scripts for food as a poor use of limited budgets.

“the money for medicine people need instead.”

— Warwickshire, 35–44

“I think these should not be on prescription… Eating bread is not a God-given right, and the money would be better off used for dietetic support helping people build affordable, healthy dietary habits.”

— Warwickshire, 35–44

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3) Fairness with other dietary needs

People questioned why coeliac diets receive food on script when others don’t.

“There is plenty of availability in shops. People with other allergies do not receive free food from the NHS so why should Coeliacs?!”

— Coventry, 35–44

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4) Waste/inefficiency in the current model

Practical complaints about bulk ordering, shelf life, and uncollected items.

“The pharmacist had to explain [to a patient] she would need to come back as they had fulfilled the prescription but because she had not collected it, the bread had gone out of date and they had destroyed [it] and would have to reorder.”

— Warwickshire, 55–64

“We don’t get the gluten free products on prescription anymore as you had to order so much bread and some would go to waste.”

— Coventry, 45–54

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5) Replace universal scripts with targeted financial support

Even among those favouring withdrawal, many proposed means-testing or retail-based subsidy.

“A means-tested approach to protect vulnerable people would prevent avoidable hardship.”

— Warwickshire, 55–64

“Issue some sort of 50% off cost prescription voucher for limited use per month… Also… only if the prescription was available if diet is reviewed with a dietitian every 12 months.”

— Warwickshire, 35–44

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6) Quality/nutrition of prescription items

A smaller cluster argued prescription products are overly processed; prefer education/naturally GF foods.

“I think it’s about time too as the prescription food is ultra processed with no real nutritional value and the cost to the NHS is exorbitant.”

— Warwickshire, 55–64

2. GPs

GP/prescriber comments are not monolithic but lean toward ending routine GF prescribing, paired with operational caveats. The predominant clinical rationale is that retail access has improved while NHS spend and dispensing inefficiencies remain; however, several GPs emphasise mitigation to avoid widening inequalities and adding practice workload.

Availability & cost case: Prescriptions are viewed as no longer clinically necessary given supermarket access, and as an avoidable draw on NHS budgets.

Equity & adherence risks: Some GPs warn that abrupt removal could reduce dietary adherence among lower income patients, with downstream health consequences; they advocate targeted support (e.g., means tested help or retail subsidy) rather than an unmitigated stop.

“I’m a GP rather than coeliac but I’ve been saying for years that I have no idea why we prescribe them. They can be purchased easily in any supermarket.”

— Warwickshire, GP

“I am a prescriber (GP) of gluten free foods. I think that their removal from prescription status is long overdue. As is known, gluten free foods are now widely accessible in supermarkets and the cost to the NHS is significant.”

— Warwickshire, GP

“I am a GP – i am concerned that coeliac patients less likely to be compliant with gluten free diet and health problems may result, especially if patients in lower socio-economic group such that they would otherwise receive free prescriptions.”

— Warwickshire, GP

“Presently I am a GP in Warwickshire… Surely a food voucher system would be better than continuing prescribing GF foods, or an alliance with one of the supermarkets.”

— Warwickshire, GP

Coventry City Council

Briefing note

To: Health & Social Care Scrutiny Board

Date: 19th November 2025

Subject: Early Intervention & CYP Substance Misuse service

1 Purpose of the Note

1.1 To provide an overview of the current Early Intervention & CYP Substance Misuse (known as 'Positive Choices') provision.

1.2 The contract for Positive Choices will end in March 2027, and we are therefore bringing this briefing to Health & Social Care Scrutiny Board to engage the Board with the future model and delivery of the service.

2 Recommendations

2.1 The Health and Social Care Scrutiny Board (5) are recommended to:

a) Actively engage in the recommissioning process to provide insight and feedback on the proposed service to the Cabinet Member.

b) Provide contributions in shaping the service specification and identifying priorities for the new contract.

c) Provide input to the planning stage by sharing Member experience in the following areas:

- What do Members see locally in terms of CYP needs?
- Are Members aware of any local services / best practice?
- Are there links with other services we need to consider?
- Would Members like to be involved as the service model develops?

3 Background and Information

3.1 The Public Health Team at Coventry City Council commissioned an integrated Early Intervention and CYP Substance Misuse service in 2018 to support children and young people who are using, or at risk of using, substances, those who are at risk of exploitation and those who need support with developing healthy relationships.

3.2 The contract was awarded to Change Grow Live (CGL) who launched the "Positive Choices" service. This service contributes to Coventry's preventative approach to improving outcomes for children and young people. It forms part of the City's integrated early help and prevention offer and aims to reduce harm and behaviours that may increase vulnerabilities leading to poor outcomes and future interventions.

3.3 The service works collaboratively with schools, health professionals and other organisations such as Youth Justice to provide education, guidance and one-to-one support.

3.4 Prior to the integrated Positive Choices service being commissioned in 2018, there were two separately commissioned contracts, these being:

3.4.1 Early Intervention service: Behavioural change support to CYP identified as being at risk of substance misuse, poor relationships, poor sexual health to avoid higher levels of intervention in future

3.4.2 Young Person's Substance Misuse service: service for targeted and specialist interventions for young people (under-18s) involved in problematic substance misuse

3.5 With the service now being integrated, this has enabled Positive Choices to support children and young people with more than one presenting need.

4 Description of the service

4.1 Positive Choices offer support for the following presenting needs:

4.1.1 Substance misuse: Substance misuse among children and young people refers to the harmful or risky use of alcohol, drugs, or other substances. It can stem from curiosity, peer influence, stress, trauma, or underlying mental health issues. Misuse can affect physical health, emotional wellbeing, relationships and education, and may increase vulnerability to exploitation or criminal involvement. Early intervention, education, and supportive, non-judgemental approaches are key to helping young people reduce harm and make safer choices.

4.1.2 Relationships, Online Safety and Sexual Health (ROSH): Support helps young people develop healthy relationships, stay safe online, and understand sexual health. It covers consent, respect, cyber safety, puberty, contraception, and STI awareness, enabling informed decisions and reducing risk. Holistic guidance promotes safety, resilience, and positive development.

4.1.3 Hidden Harm: This describes the often-unseen impact of parental or carer substance misuse, mental ill health, or domestic abuse on children. It can affect their safety, wellbeing, and development, sometimes leading to neglect or caring responsibilities. Early identification, joint agency work, and child-focused support are key to recognising and reducing this hidden impact.

4.1.4 Low level exploitation: This refers to early or less overt forms of child exploitation that may not yet meet safeguarding thresholds but indicate emerging risk. It can involve children being influenced, groomed, or manipulated—often through friendship groups, social media, or older peers—to carry out small tasks, share personal information, or exchange favours for money, gifts, alcohol, or attention. Examples include being asked to deliver items, share indecent images, or associate with risky individuals. and these situations can quickly escalate. Early recognition and intervention are vital to prevent further grooming and protect the child's wellbeing.

4.1.5 CYP coming through the Youth Justice Service (YJS): referrals from YJS are prioritised by the service. These can be for any of the issues described above. The service is working with YJS to better join up support across both services.

4.2 Family offer:

4.2.1 Positive Choices understand the unique challenges that families face when affected by substance use and other issues affecting children, young people, and families. The support is designed to help families feel empowered, connected, and strengthened.

4.2.2 The team provides parenting support using the Solihull Approach, a trusted and evidence-based model that helps parents build stronger emotional connections with their children, manage behaviour positively, and support their child's development with confidence. The service hosts a regular group for parents, run by an experienced Children and Families team. This informal group offers a welcoming environment which focuses on a different theme each session, where parents can connect with others, share experiences, and access expert advice.

4.2.3 For those who need more tailored support, there is an offer of one-to-one phone calls or face-to-face appointments, either with the young person's dedicated worker or a member of the Children and Families team. This provides a safe space for parents to talk through concerns, ask questions, and receive practical guidance specific to their family's needs.

4.2.4 Positive Choices also offers diversionary activities for families to enjoy together. These include fun sessions at the community allotment (see below), where families can spend time outdoors and enjoy nature, as well as exciting activities like climbing, which help build positive memories for the families.

4.2.5 Positive Choices are committed to supporting the whole family—offering encouragement, understanding, and opportunities to reconnect in a safe and supportive environment.

4.3 Working with schools

4.3.1 Positive Choices have co-located in several schools across the City to support an early intervention offer around ROSH (relationships, online safety and sexual health) and substance misuse.

4.3.2 In September 2025, Positive Choices committed to support the Coventry Alternative Provision (CAP) service, which is a group offer to schools who refer

young people to the CAP programme. These groups will also be focused on ROSH and substance misuse.

4.3.3 CAP will also be offered to primary schools and therefore a Hidden Harm programme will be available for primary age children.

5 Commissioning

The current Positive Choices contract ends in March 2027. A re-commissioning process has been initiated to award a new service contract after that time.

6 Engagement

6.1 An engagement plan has been developed to ensure a comprehensive and inclusive approach to commissioning.

6.2 Engagement activities will target a range of audiences, including children and young people (CYP) currently using the service, those not known to the service through school-based engagement sessions, and professionals such as Family Nurse Partnership teams, school nurses, Early Help practitioners, police, colleges, and the youth offending service. Parents and carers of CYP, both those known and not known to the service, will also be engaged.

6.3 A variety of engagement methods will be used, including ‘Let’s Talk’ questionnaires, group engagement sessions, and market engagement with potential providers.

6.4 Young people will also play an active role in the evaluation of the tender process to ensure their voices are reflected in service design and decision-making.

7 The wider CYP service offer

7.1 There is also a wider piece of work to review the range of current services for children and young people (CYP) in Coventry who are at risk of poor outcomes..

7.2 This includes looking at the city-wide service offer, the target population, and the data and local need that inform commissioning and delivery.

7.3 The objectives are to understand the current service provision, assess the needs of this group, identify areas for improvement, and plan strategic actions to improve outcomes.

8 Needs

8.1 We have recently reviewed the data on health risk behaviours in CYP. The full report is in draft form and includes a review of the literature and analysis of available data. We lack any up-to-date local data on these behaviours in our population of children and young people. National data is based on surveys from a sample of schools so produced general findings that cannot be disaggregated at a local level. In addition, those who are most vulnerable and at greatest risk are also least likely to be surveyed and captured in routine data e.g. because of absence from school. This section provides a short summary of some of the key findings of that review.

8.2 Most risky behaviours such as alcohol and substance use and misuse, smoking, anti-social behaviour etc. are initiated in adolescence and tend to cluster, so any person engaging in any one of these behaviours has a greater risk of engaging in other risk behaviours. These behaviours put individuals at risk of long term health and wider outcomes including lower educational attainment, being bullied, mental health problems, obesity, teenage pregnancy, problem gambling and being in

trouble with the police. Longer term poor health outcomes include cancer, cardiovascular disease, liver disease and mental illness including depression.

8.3 At a national level, there has been a small decline in the number of school pupils who have ever drunk alcohol, from 44% to 37%, and the proportion of 11-15 year olds who had drunk alcohol in the preceding week (at time of the survey) in the West Midlands had reduced from 10% to 8%[1]. However, this means that a significant proportion of young people are continuing to consume alcohol at a very young age. Nationally, 17% of 15-year-olds report having had their first alcoholic drink at aged 10 or younger. This is slightly higher amongst boys than girls (19% to 13%), but peaks at 14 years for both boys and girls. In those who drink, the most common age that girls report getting drunk for the first time is 14 (45%), for boys this is age 15 (34%).

8.4 There is a similar pattern in drug use at a national population level, with a small decrease in recent years but still a significant prevalence. From the national SDD survey (2023, NHSE), the number of pupils who had ever taken drugs increased from the age of 11 to the age of 15, with almost one in every four pupils aged 15 had ever taken drugs in England. Almost one in every five pupils had taken them in the last year (at time of the survey). The most taken drug was cannabis, followed by volatile substances (inhaled solvents) and then psychoactive substances (e.g. heroin, cocaine, amphetamines). Those pupils taking drugs at younger ages reported doing so because they 'wanted to forget their problems' (a peak of 23% at 13 years old). This may suggest that those who have preexisting mental health conditions may be more at risk of substance misuse. One of the challenges with illicit substances is the constantly shifting market, with the emergence of new substances and therefore new risks, e.g. nitrous oxide and more recently ketamine which is being linked with long term health issues in young people. Another significant challenge is the lack of understanding of young people of the risks to their short and long term health of using these substances.

8.5 Unhealthy relationships are difficult to measure. A consequence can be risky sexual behaviours, resulting in sexually transmitted infections (STIs). The rate of diagnosis for new sexually transmitted infections (STIs) in Coventry residents (905 per 100,000) is higher than the England rate (694 per 100,000), and the average rate for its nearest neighbours (698 per 100,000)[2]. This disproportionately affects young people, with 49% of all new STI diagnoses in the West Midlands in 2021 amongst those 15-24 years old. Another consequence can be teenage pregnancy; the under 18s conception rate in Coventry is 21.2 per 1,000 which is significantly higher than the national levels (13.9 per 1,000)[3]. In addition, unhealthy relationships can put young people at risk of being victims or perpetrators of domestic abuse, sexual violence and exploitation.

8.6 National data suggests 1 in 5 CYP aged 8-25 years have a probable mental health disorder[4].

9 Impact of the service

9.1 The Early Intervention and Young Person's Substance Misuse service delivers impact by providing early, targeted support that prevents young people from developing more serious substance misuse issues and the associated wider harms.

[1] Smoking, Drinking and Drug SDD Use Survey 2023 NHSE

[2] Sexual Health report, Fingertips

[3] 2022 data, Child and Maternal Health data, Fingertips

[4] Mental Health of Children and Young People in England, NHSE, 2023

9.2 By working with young people at the earliest signs of risk, the service helps to reduce demand on future costly interventions across health, social care, education and the criminal justice system.

9.3 This means fewer young people entering care, fewer hospital admissions, improved school attendance, improved mental health and emotional wellbeing, and reduced anti-social behaviour. There is potential for these impacts to be seen across the lifecourse.

9.4 The impact of this service goes beyond financial benefits; it builds stronger families, supports community wellbeing and contributes to giving every child and young person the best possible start in life.

9.5 The service will also support the Families First Partnership Programme when established, continuing to contribute to more effective joint working between partners in the City and resulting in better outcomes for children, young people and families.

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Health and Social Care Scrutiny Board Work Programme 2025/26

Last updated: 10 November 2025

17 September 25
Adult Social Care Performance - Self-Assessment and Annual Report (Local Account) 2024/25 Cabinet Member Portfolio Priorities Training of Care Staff supporting patients with Dementia
22 October 25 (moved from 8th)
Improving Lives – Impact on Adult Social Care Director of Public Health's Annual report
19 November 25 (moved from 12th)
Young person's risky behaviours service Prioritisation of NHS Services i) Prioritisation Process ii) Gluten-free prescribing
17 December 25
UHCW Performance – to take place at the hospital
21 January 26 **25 February 26**
Virtual Beds Update end of 25/26 Update on The Physical Activity and Sport Strategy
1 April 26
Primary Care Healthwatch Annual Report (April 26)
TBC
Digital Access to Health Update on ICB Blueprint / ICB Clustering Integrated Health and Care Delivery Plan Safeguarding Adults Annual Report Disabled Facilities Grant Public Health and Social Care - Prevention Rugby St Cross Mental Health Community Pharmacists Trans/Non-binary/Intersex Health Ambulance Service / Fire Service / WMP Access to Dentistry and All age Oral Health Older People and A&E Health and care of students in Coventry Neighbourhood Health Early Adopter Programme Impact of Climate Change on Health Family Health and Lifestyles Service

Date	Title	Detail	Cabinet Member/ Lead Officer/ Organisation
17 September 25	Adult Social Care Performance - Self-Assessment and Annual Report (Local Account) 2024/25	To consider the Cabinet Report of 30th September 2025 and identify any further recommendations.	Andrew Errington / Cllr Bigham / Pete Fahy
	Cabinet Member Portfolio Priorities	To invite Cllrs Caan and Bigham to identify their priorities for the coming year to identify future items and hold Cabinet Members to account	Cllr Caan / Cllr Bigham
	Training of Care Staff supporting patients with Dementia	Sufficiency of training of care staff who support patients with dementia	Cllr Bigham Pete Fahy Jon Reading
22 October 25 (moved from 8th)	Improving Lives – Impact on Adult Social Care	A follow up item from the meeting on 10th April 2024, to review following 12 months of implementation of a whole city approach To include clarification around how ASC is allocated based from need. (Referred from SCRUCO Transformation Programme Item)	Pete Fahy UHCW Cllr Bigham Cllr Caan
	Director of Public Health's Annual report	This report focuses on the city's rich cultural diversity and health inequalities that are facing migrant populations.	Cllr Caan, Allison Duggal
19 November 25 (moved from 12th)	Young person's risky behaviours service	Update on service development before recommissioning	Cllr Caan/ Rachel Chapman
	Prioritisation of NHS Services i) Prioritisation Process ii) Gluten-free prescribing	Led by ICB	Rose Uwins

Date	Title	Detail	Cabinet Member/ Lead Officer/ Organisation
17 December 25	UHCW Performance – to take place at the hospital	To consider steps being taken in the light of the league table position. To include: Updates on waiting times – complaints on hospital appointments availability. Review following 12 months of SB5 last visit - to identify any changes and improvements	UHCW Andy Hardy ICB - Ali Cartwright Cllr Caan
21 January 26			
25 February 26	Virtual Beds Update end of 25/26	Update on the development of Virtual Wards	UHCW/P Fahy / Cllr Bigham
	Update on The Physical Activity and Sport Strategy	Progress of the draft Physical Activity and Sport Strategy to be brought back to the Board in the 2025/26 Municipal Year. To include the 6 play zones being delivered across the city and work to encourage older people to be active, as well as link with Public Health and other partner organisations such as Age UK	P Fahy / J Hunt / D Nuttall / Cllr Caan
1 April 26	Primary Care	Update in 12 months' time - To cover access to GP's and other primary care, particularly in relation to reducing pressure on A&E. For Coventry City Council to use its resources to work as a conduit with community organisations to improve knowledge of and access to the NHS for all residents of Coventry	R Uwins / Alison Cartwright – Coventry Care Collaborative / Cllr Caan/ Pete Fahy
	Healthwatch Annual Report (April 26)	To consider the work of Healthwatch and how scrutiny can use their findings	

Date	Title	Detail	Cabinet Member/ Lead Officer/ Organisation
TBC	Digital Access to Health	Partners supporting switch to digital To include: The number of patients using the NHS App month by month including a demographic breakdown if available. How to raise awareness of the NHS App including linking with the Council's Digital Inclusion Team and Cov Connects on Digital Inclusion.	Rose Uwins / A Duggal / Caan
	Update on ICB Blueprint / ICB Clustering	An item requested at the meeting on 17th January to look in more detail at the proposed actions to make significant efficiency savings at the ICB. To include an update on the future plans around the ICB Blueprint. Transition plan expected from September - SB5 involvement to oversee the implementation of the transition plan	Rose Uwins
	Integrated Health and Care Delivery Plan	To identify which of the 3 areas of focus the board would like to look at. Including work with newly arrived communities. Understand how the transition to this cluster will be managed - What will be the positive/negative impacts for Coventry residents from the clustering	ICB Rose Uwins
	Safeguarding Adults Annual Report	Update	R Eaves Cllr Bigham
	Disabled Facilities Grant	Delivery and waiting times	Cllr Bigham P Fahy Aideen Staunton
	Public Health and Social Care - Prevention	How Public Health and Social Care are working together to prevent ill health.	P Fahy/ A Duggal/

Date	Title	Detail	Cabinet Member/ Lead Officer/ Organisation
			Cllrs Caan/ Bigham
	Rugby St Cross		Justine Richards – Jamie Deas Cllr Caan
	Mental Health	Mental health services, particularly the demand and availability of local services, and the impact of long wait times. To include input from the Crisis teams.	CWPT
	Community Pharmacists	To include Pharmacy First	
	Trans/Non-binary/Intersex Health		A Duggal Cllr Caan
	Ambulance Service / Fire Service / WMP	Partnership working - Improved partnership working between the ambulance, fire and police services. To include WMFS to provide further information on safe and well, or strong checks that's provided within the City	Kirsty Tuffin and Vivek Khashu, Rachel Danter ICB Area Manager – Matthew Stanton
	Access to Dentistry and All age Oral Health	Update from recommendations raised during January 2025 - Public Health to work collaboratively with the ICB on the following: o dental promotion o promotion of dental hygiene in school settings o appointment availability across the city o dental availability and awareness in areas of inequality and deprivation across the city.	

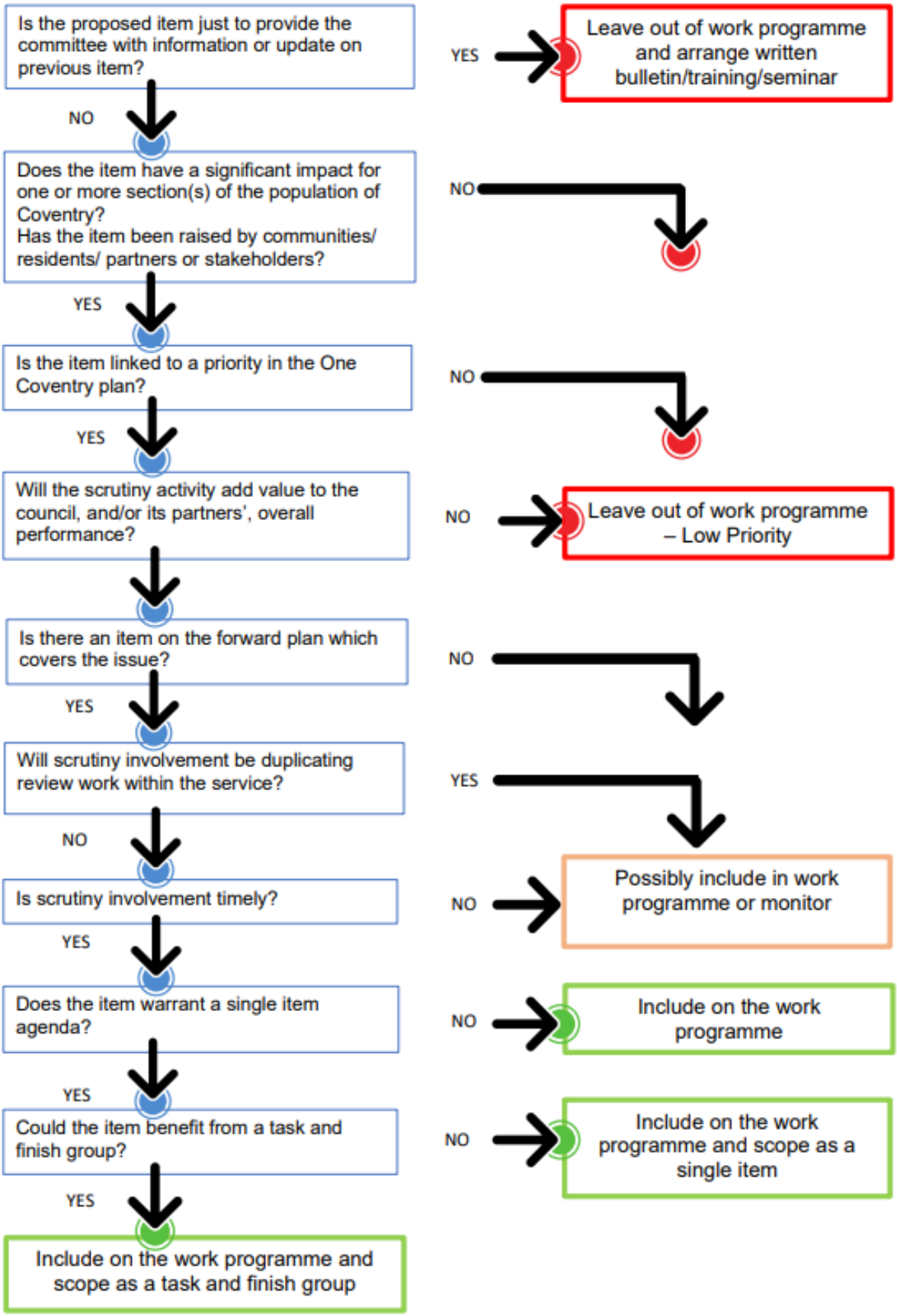
Date	Title	Detail	Cabinet Member/ Lead Officer/ Organisation
	Older People and A&E	Update around work undertaken by Age UK of experience of elderly in A&E - 'Corridor Care'	
	Health and care of students in Coventry	Visit to Warwick University for members, health, and care of students in the City	
	Neighbourhood Health Early Adopter Programme	SB5 involvement potentially if the bid is successful	Pete Fahy Cllr Bigham
	Impact of Climate Change on Health	How health services are geared up to respond to the impact of climate change on health	Cllr Caan Cllr O'Boyle Allison Duggal/ Rhian Palmer
	Family Health and Lifestyles Service	Referred from SB2 - To looking in more detail at how the service is tackling health inequalities and targeting services at those in need on a localised basis. School nurse and health visiting provision. Also how the service is supporting Early Help. from Dec25/Jan26	A Duggal / Cllr Caan

Frequently Used Health and Social Care Acronyms

- ASC – Adult Social Care
- CQC – Care Quality Commission
- CWPT – Coventry and Warwickshire Partnership Trust
- CWS – Coventry Warwickshire Solihull
- DFG – Disabled Facilities Grant
- DPH – Director of Public Health
- ENAS – Extended non-attendance at school

- EOL – End of Life
- GEH – George Elliott Hospital
- JHOSC – Joint Health Overview and Scrutiny Committee
- H&WB – Health and Wellbeing
- H&WBB – Health and Wellbeing Board
- HOSC – Health Overview and Scrutiny
- ICB – Integrated Care Board
- ICP – Integrated Care Partnership
- ICS - Integrated Care System
- LMC – Local Medical Council
- MAT – Multi Academy Trust
- MSP – Making Safeguarding Personal
- PCN – Primary Care Network
- SAB – Safeguarding Adults Board
- SAR – Safeguarding Adults Reviews
- SWFT – South Warwickshire Foundation Trust
- UHCW – University Hospitals Coventry and Warwickshire
- WMAS – West Midlands Ambulance Service
- WMFS – West Midlands Fire Service

Work Programme Decision Flow Chart



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