

Annual Report 2024/25



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Call 0300 123 1461 or email enquiries@staffsstoke.icb.nhs.uk

Alternatively, use the Next Generation Text Service for deaf and hard-of-hearing patients, carers and staff: www.ngts.org.uk

We want our patients, carers, staff and partner organisations to be able to understand our information in the format that is most accessible to their individual needs. This includes identifying and reasonably removing barriers for people accessing our information, services, premises, and any employment or engagement opportunities.

Welcome

A statement from the Chief Executive Officer

Welcome to our latest Annual Report. This has been an eventful year where we have achieved some real tangible success, but also one that has presented new challenges.

This year we have shown great ambition around community transformation and improving the access that local people have to community services, and also on reducing the burden on urgent and emergency care services across the population.

We are doing a good deal of work to ensure, for example, that we reduce the rate of deterioration in people with mild to moderate frailty – ensuring that people stay well for longer and have more independence for longer in their own homes and communities. Activities such as population health management helps us understand the needs of local people better, while building integrated neighbourhood teams ensures we are more flexible to the needs of local people.

This is enabling us to deliver bespoke services in the communities who truly need those specific offerings and to move away from a generic model that historically has not been able to flex and support needs – particularly for people with the most complex requirements.

These services are able to be very proactive and have helped detect conditions at a very early stage before they can deteriorate. A fantastic example is being carried out by East Staffordshire Primary Care Network who are working with other agencies to ensure that more proactive support is provided to the community through initiatives such as life-coaching.

They have even had referrals into general practice from local job centres who have identified individuals with a variety of issues. Life

coaches can help with health problems, but other things can indirectly impact on health – such as not having all the income to which you are entitled. These innovative approaches can be a superb way to capture understanding of need, digital technology can help us ensure that different agencies communicate with each other rapidly, through a single platform.

It is important to acknowledge the financial challenge that the country faces. While allocations to health have been reasonable and welcome, the pot is very limited. This means that for 2025/26 we need to maximise our efficiency and productivity – both within our own organisation and looking at the way resources are allocated across the system. This will help improve productivity to address, for instance, our frailty agenda and community transformation. It cannot be avoided that there will have to be some tough choices.

We're also working up locally-driven plans to deliver the core priorities outlined in the Model ICB Blueprint that was shared in May 2025. We need to ensure these are affordable within our reduced running cost envelope, support the need to build strong strategic commissioning skills to improve population health and reduce inequalities, and focus on the delivery of the three strategic shifts – sickness to prevention, hospital to community, and analogue to digital. The blueprint has functional implications for different parts of the system, and the next steps are being developed through close working with partners nationally and within local systems.

Finally, I announced earlier this year that I would soon be retiring. I would like to thank everyone that I have worked with during and time with the ICB and throughout my NHS career. It's been a pleasure to work with the local population and such fabulous colleagues as I have over the last few years.

Peter Axon

Chief Executive Officer

Staffordshire and Stoke-on-Trent ICB

19 June 2025

Chair's Report

It's a great privilege for me to chair this organisation and to work alongside such committed and enthusiastic staff, who are all dedicated to making a difference to the health and wellbeing of local communities.

I am grateful for their continued confidence in the ICB and for all they do to care for our people. I must also thank the staff across our NHS partnerships, and also those in social care, the faith sector, third sector and people who act as carers – without whom absolutely nothing we are trying to achieve would be possible.

One of our strengths is that we have stakeholder members covering the breadth of health and care provision in Staffordshire and Stoke-on-Trent. These are supported by the Leadership Compact that further strengthens the resilience of the system. We've seen a real growing sense of purpose in developing our plans, most notably the Medium Term Plan which will ultimately support the national 10 Year Plan for health.

While we are still a relatively new organisation, this year has seen a concerted effort to drive improvements in the sustainability of our services, both in terms of our transformation plans and our finances.

This year has seen the Integrated Care Partnership (ICP) focus on the life course model which is “start well, grow well, live well, age well, end well”. This emphasises the importance of addressing health and wellbeing throughout the lifespan, with a particular focus on early life experiences and the social determinants of health, to promote positive outcomes and reduce health inequalities. We have used this framework to guide deep-dive discussions around each of these domains. This will guide the further development of the ICP.

We are dealing with an increasingly complex range of social and welfare issues. There are some difficult conversations to be had, and we must not shy away from them. We should be open and honest about identifying solutions. This will enable us to continue to make improvements and make the best use of resources available to us.

Our ambition remains to make Staffordshire and Stoke-on-Trent the healthiest places to live and work. To do this, we have created seven tightly focused portfolios. Each is led by a Senior Responsible Officer (SRO), supported by a team to deliver the portfolio ambitions.

The portfolios are:

- **Urgent and Emergency Care** – aiming to provide a consistent and simplified offer
- **Planned Care** – with a greater focus on the management of demand
- **End of Life, Long-Term Conditions and Frailty** – underpinned by our work with population health management data and local feedback
- **Primary Care** – delivering more than 6.3 million appointments in general practice
- **Mental Health, Learning Disabilities and Autism** – progressing our inpatient and community mental health transformation
- **Children and Young People and Maternity** – everyone should get the best start in life and have the chance to shape programmes that meet their needs. We will be taking every opportunity to learn from the high-profile maternity investigations to avoid re-occurrence in local services
- **Improving Population Health.**

I would like to pay tribute to our partners throughout the voluntary, community and social enterprise (VCSE) sector. We have been working with these partners to realign contracts so we get maximum value from this vital sector.

And to Peter Axon, our Chief Executive Officer and Paul Brown, our Chief Finance Officer – both of whom are leaving us this year. They have done a superb job of navigating us through our formative stages from our formation in 2022.

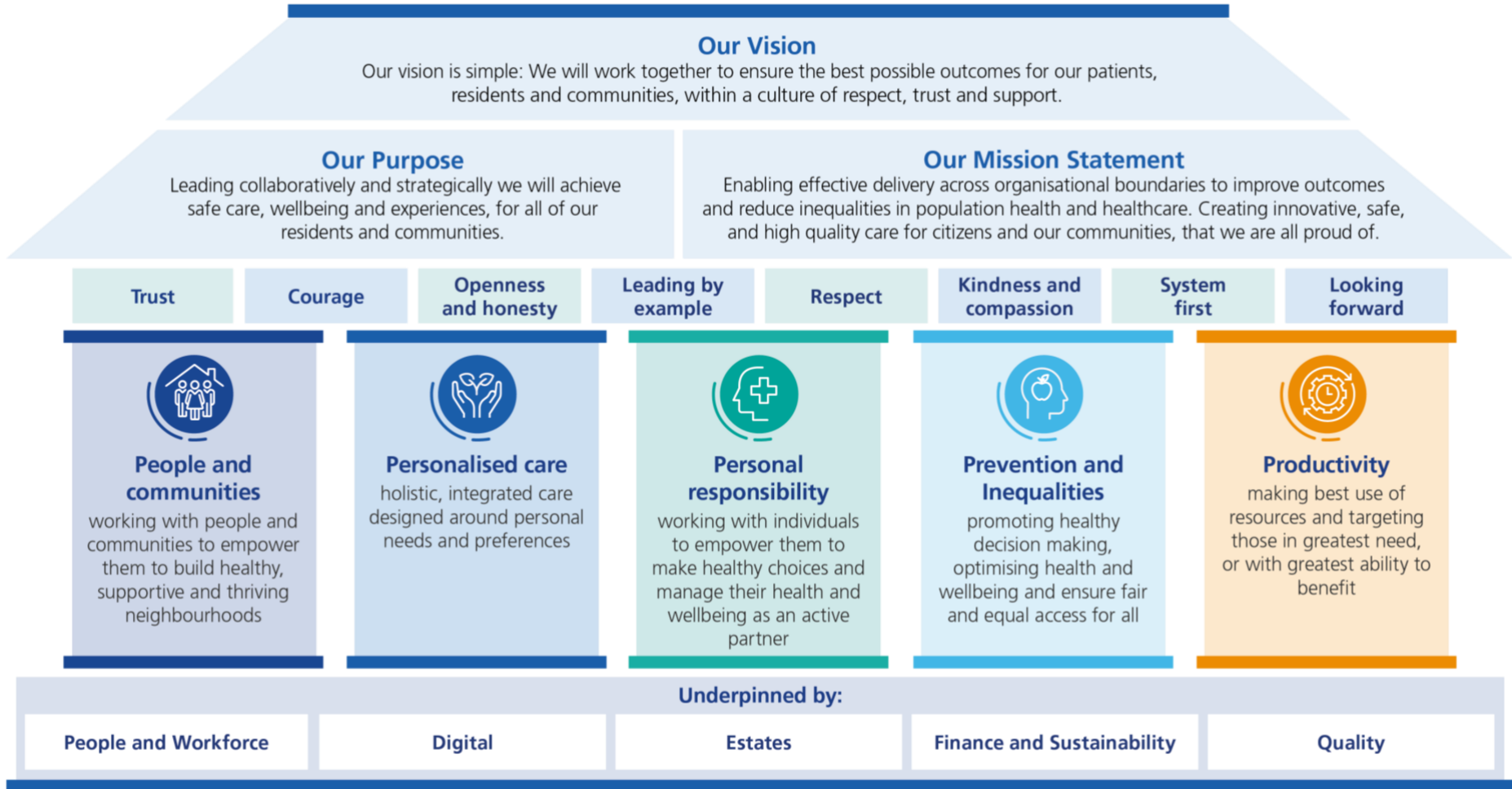
Despite the many challenges, we are continuing to drive forward transformation and make sure that, as a system, we provide the best services for our populations.

David Pearson MBE

Chair
Staffordshire and Stoke-on-Trent ICB
19 June 2025

About us

Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) is responsible for the health and care of 1.1 million people across a geographical area of 1,048 miles. The ICB is aligned with two upper-tier local authorities, Staffordshire County Council and Stoke-on-Trent City Council.



Staffordshire and Stoke-on-Trent Integrated Care System (ICS)

Our uniquely positioned partnership between local people and communities, the NHS, local authorities and the voluntary and community sector enables us to improve all aspects of health and care – including the wider determinants of health and preventing ill-health.



Purpose and activities of the organisation

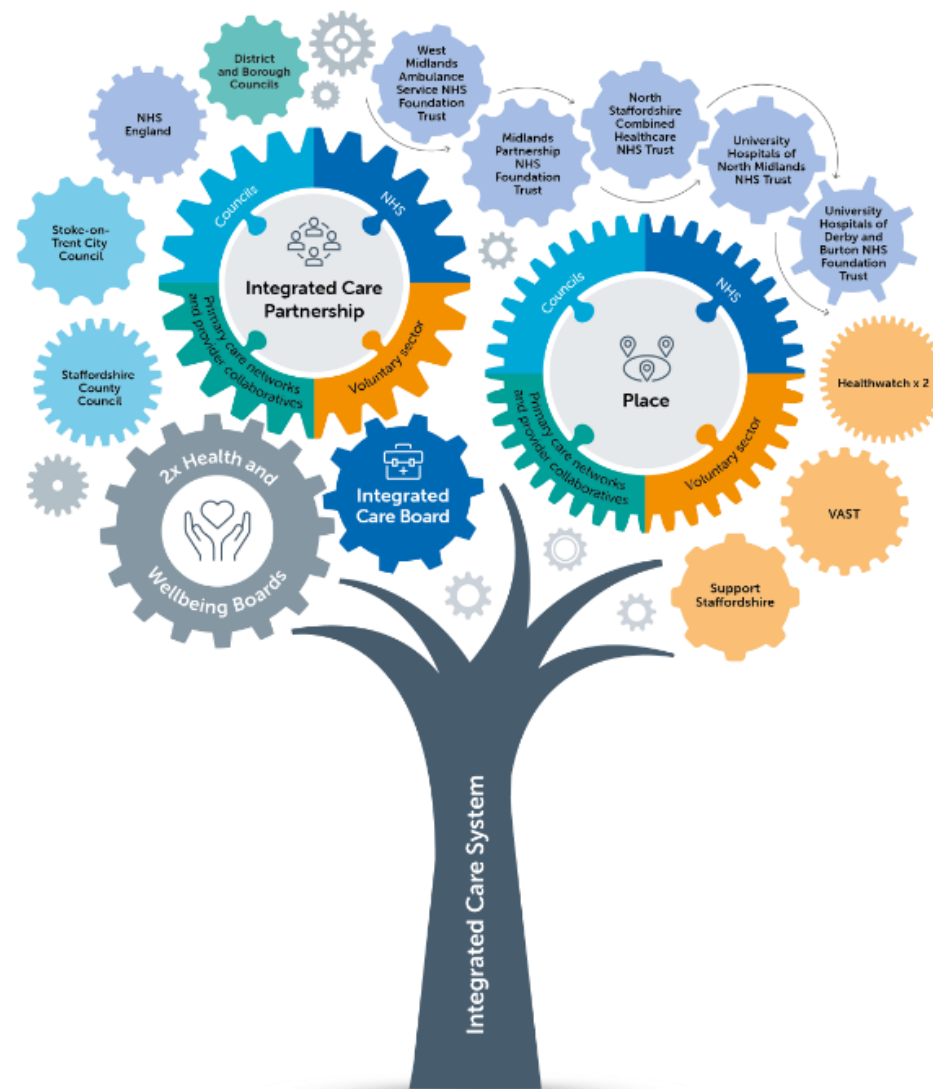
The purpose of ICSs is to bring partner organisations together to achieve the following:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

On behalf of the Integrated Care Partnership (ICP), which has representation from all the system partners, we developed the ICP Strategy to deliver a joined-up approach to care that improves the health, wealth, happiness and wellbeing of our local population.

The **ICP Strategy** addresses the concerns raised by our partners and our local population, who have told us what needs to change:

- Demand on services, putting them under pressure
- COVID-19, which is still with us, leading to a growing backlog for services
- Longer waiting times
- Services are fragmented, with multiple organisations involved
- Our workforce is weary and there are national shortages across key specialities
- Some of our communities can face barriers to accessing services.



Local communities have identified the following high-level issues:

- Long waits for ambulances, delayed handover and corridor care
- Crowded emergency departments with long waits
- Difficult to access primary care and/or seeing a GP
- Difficult to arrange social care and/or community services.

Our objectives and strategies

Given what we know about our population's health and care needs and the feedback from residents, the ICP Strategy will:

- Address the national requirement but – more importantly – be locally owned
- Set out the ambition, vision, and approach for the ICP over the next five years and beyond
- Be co-produced and owned by the ICP and local communities
- Demonstrate how the health, care and wellbeing needs of the local population are to be met
- Build upon local knowledge and strategies to ensure we are greater than the sum of our parts
- Show how we will work towards increased integration of health, social care and other services
- Be underpinned by a population health approach, outlining how the ICP will sustainably deliver more joined-up, preventative and person-centred care for the whole population.



Our challenges and opportunities

Our services are generally safe and well-led, thanks to our incredible staff. However, we are not complacent and there are many challenges that will affect our ability to continue to deliver high-quality care in future.

We are facing increasing demand for services due to demographic changes, more people affected by illness, and the impact of the COVID-19 pandemic, which has driven up elective waiting lists and staff absence.

Reducing unnecessary hospital admissions is key to improving discharge capacity, particularly for frail elderly patients and those at the end of life. Effective out-of-hospital services, including Virtual Wards and rapid response teams, are essential to providing care at home and preventing avoidable admissions.

Urgent care services remain under pressure, leading to long waits and ambulance handover delays. Hospital discharge processes also face challenges, with many patients discharged into bed-based care rather than back home – increasing dependency on continuing healthcare and social care services. Despite the introduction of step-down services like Virtual Wards, they are not yet fully optimised. Addressing these issues requires a coordinated system-wide approach to improve patient flow, reduce duplication, and restore independence.

We have workforce challenges similar to those faced at a national level. Workforce growth has not always kept pace with demand, and nationally there is a workforce supply–demand gap. There are shortages of care workers, midwives, occupational therapists, physiotherapists and diagnostics staff. We need to work together to develop and support the current workforce and seek new opportunities to grow the workforce for the future.

There are communities experiencing significantly higher levels of deprivation, resulting in poorer health and other outcomes compared to the rest of the population.

We acknowledge that the primary drivers of deprivation extend beyond direct health and social care services. However, there is a shared commitment to enhancing the role of health and care services in better supporting these underserved populations.

Stoke-on-Trent

Compared to England as a whole, Stoke-on-Trent has some of the highest premature mortality rates in England:

- **Eighth highest** rate of deaths in under-75s from causes considered preventable
- **Ninth highest** rate of deaths in under-75s from all causes
- **Tenth highest** rate of deaths in under-75s from cancer
- **Tenth highest** rate of deaths in under-75s from respiratory disease
- **Tenth highest** rate of deaths in under-75s from alcoholic liver disease.

- The city has the fourth highest infant death rate in England (based on directly age-standardised rates, 2021 to 2023).
- People spend more years living in poor health.
- Life expectancy at birth is **76.3 for men and 80.1 for women** (2021 to 2023) – three years lower than the national average.
- Healthy life expectancy (the number of years a person can expect to live in good health) at birth is **56.2 for men and 55 for women** (2021 to 2023) – significantly lower than the national average.

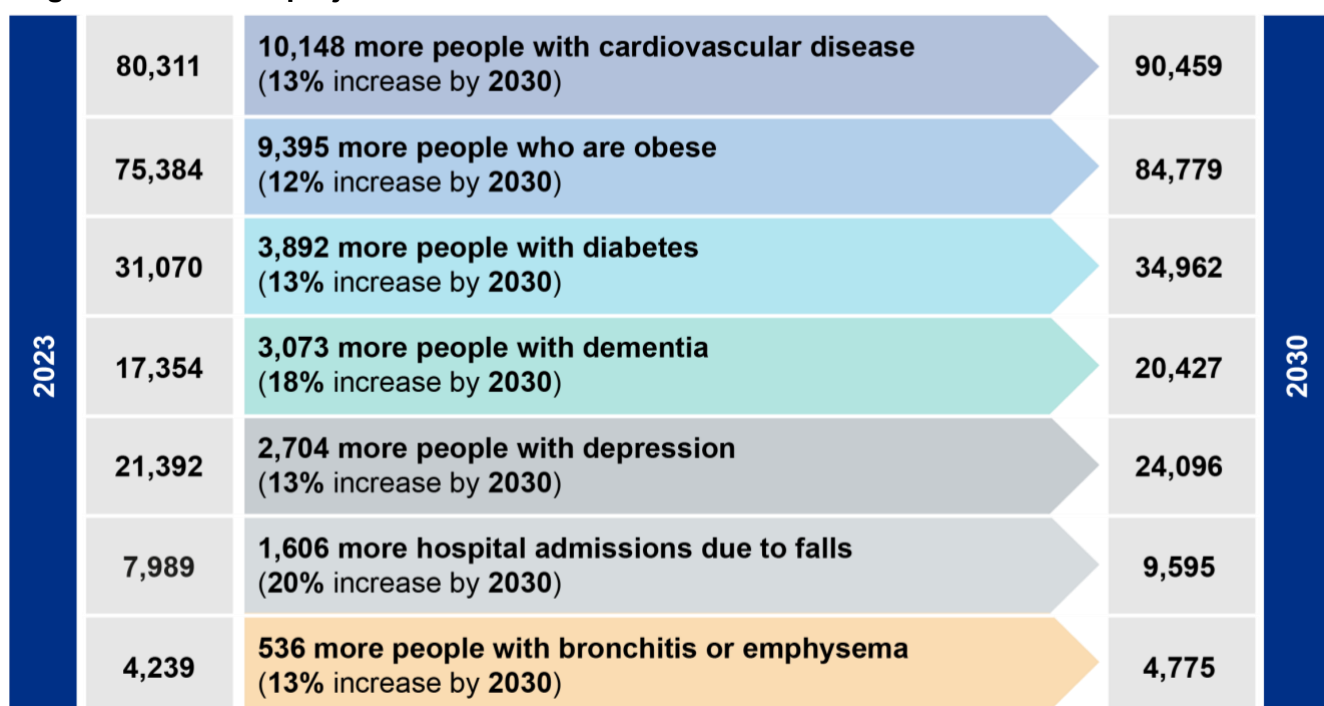
Staffordshire

- Life expectancy at birth is **79.5 for men and 83.2 for women** compared to 79.1 and 83.1 for England (2021 to 2023) – better than the national average for men, and similar to the national average for women.
- Healthy life expectancy at birth is **63.3 for men and 63 for women** compared to 61.5 and 61.9 for England (2021 to 2023) – better than the national average.
- Deprived and ethnic minority communities are at a greater risk of exposure to COVID-19 and are more likely to have poorer outcomes due to existing poor health and adverse lifestyle factors. The control measures that were implemented during the pandemic such as lockdown, social distancing and changes to routine care have resulted in disproportionately worse economic, social and health impacts on disadvantaged populations.

Long-term conditions

The number of people with long-term conditions is increasing, with more than half of over-65s having two or more long-term conditions. The diagram below shows the levels of common long-term conditions in 2023 and how this is expected to grow by 2030 if the current trends persist.


Long-term condition projections in Staffordshire and Stoke-on-Trent for over-65s



POPPI v15.0, www.poppi.org.uk.


Data sources: Institute of Public Care (IPC) and ONS. *Crown copyright 2020*

Other characteristics of our system include:




Staffordshire has a much higher proportion (**24%**) of its residents living in rural areas, although most of its population (**76%**) still lives in areas that are classed as urban.


In contrast, all (**100%**) of the population of Stoke-on-Trent live in areas that are classed as urban



The overall population of Staffordshire and Stoke-on-Trent is estimated to increase to **1.2 million** by 2035



The older population is estimated to see the biggest increase – the population aged **65+** is estimated to **grow by 21%** by 2035



Our local population experiences stark social inequality with **more than half (53%)** of the population of Stoke-on-Trent living in the most deprived **20%** of areas in England.



Less than one tenth (**9%**) of the population of Staffordshire live in the **most deprived 20%** of areas of England. However, we do know that high deprivation areas exist within the urban areas of Staffordshire



In our local population, **88%** of people identify as being **White British**.


The next most common ethnic group is the population identifying as **Asian** or **Asian British**, representing **4.8%** of the population





The higher levels of ethnic minorities are concentrated in urban areas like Stoke-on-Trent and Burton upon Trent

Compared to the national average:


There is a **higher proportion** of people within the ICB have **diabetes, stroke, or heart disease** than the national average and adult obesity is also significantly higher than the national average.







There is a **higher proportion** of people who have **dementia**



There is a **higher proportion of palliative care patients** in the ICB compared to England

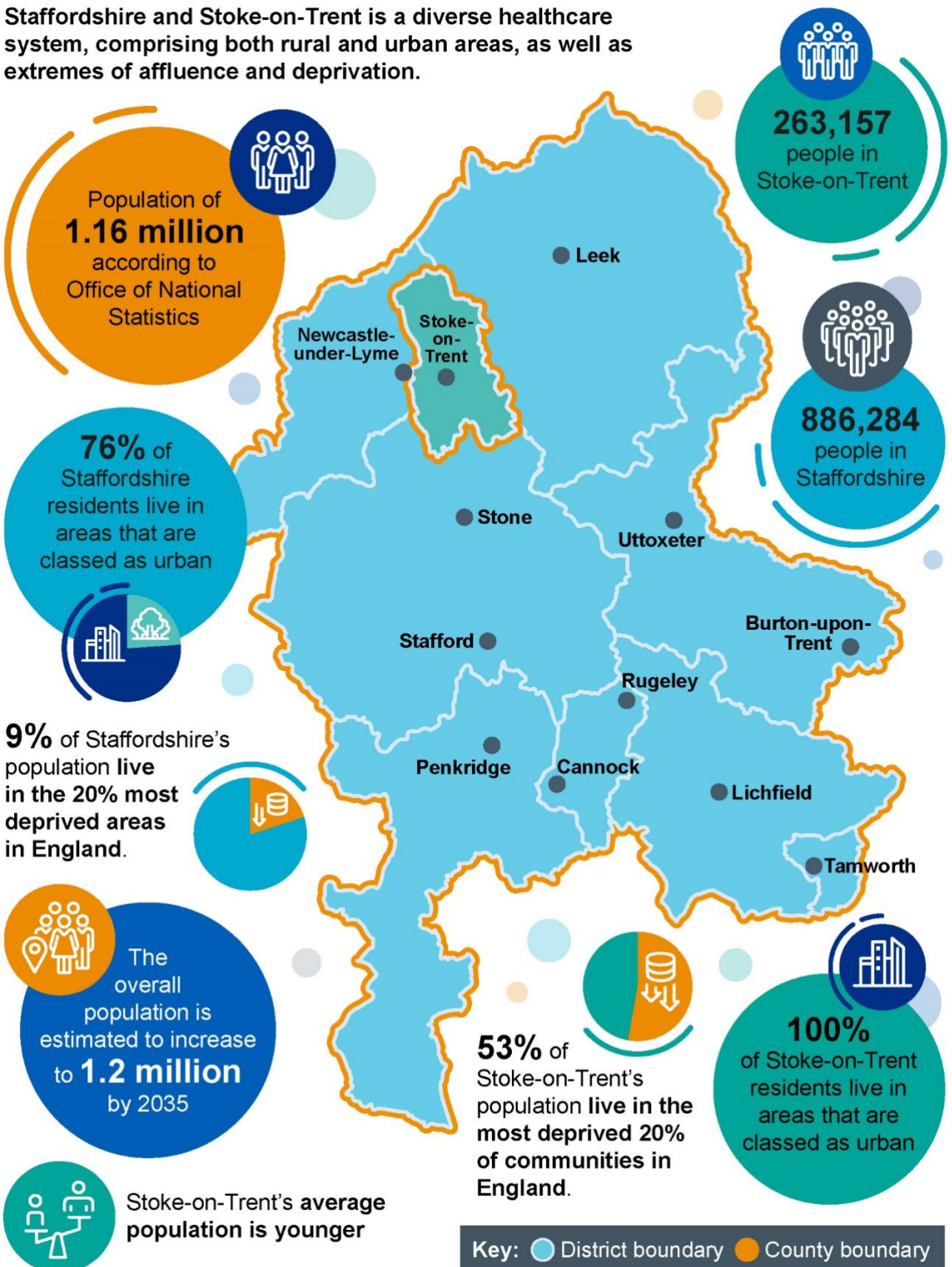


Also we have a higher proportion of people with:

-  hypertension (high blood pressure)
-  cancer
-  epilepsy
-  rheumatoid arthritis

Our population

Staffordshire and Stoke-on-Trent is a diverse healthcare system, comprising both rural and urban areas, as well as extremes of affluence and deprivation.



Stoke-on-Trent and Staffordshire face significant health challenges, with higher-than-average rates of diabetes, strokes, heart disease, and obesity. Life expectancy is lower than the national average, and premature deaths from cancer and cardiovascular disease (CVD) are particularly high. Respiratory conditions, especially lung disease, remain a major issue.

Chronic illnesses are increasing, with over half of those aged 65+ living with multiple conditions – a trend expected to worsen by 2035. Deprived communities experience greater health inequalities, with social exclusion, poor housing, and unemployment contributing to poorer outcomes. In the most deprived areas, people face up to 12 fewer years of good health.

Mental illness rates are high, with individuals experiencing worse physical health outcomes. Stoke-on-Trent also has one of the highest infant mortality rates in the country, nearly double the national average, linked to high birth rates and low birth weights.





Performance overview



As a statutory body, we recognise the importance of providing assurance to our stakeholders and the public so that they have confidence in our ability to plan and deliver safe, high-quality and sustainable services within the resources that we have available.

Oversight and assessment

For more information on the NHS Oversight Framework, see NHS England's website.

Key issues and risks

See the Governance Statement for information about how the ICB manages key issues and risks.

Finance review

The ICB and the ICS have seen a challenging period financially, due to rising expectations for healthcare and significant pressure on all front line services over the course of the financial year.

Early in the year, the system and the ICB forecast a significant deficit against the break-even requirement, and so the financial system was placed into the Investigation and Intervention regime. This led to a requirement for additional monitoring, and a requirement to reduce the run rate. While the system was unable to achieve our break-even, and posted an £18 million deficit, we were successful in significantly improving the run rate, as a number of system-wide improvement initiatives were successful.

Consequently, the outturn position was a vastly improved position on that indicated by performance over the first four months.

The system position was a surplus at MPFT and NSCHT and deficits at UHNM and the ICB. The ICB deficit was £14.9 million and was because we saw pressures in prescribing, Continuing Healthcare packages to support hospital discharge, and Section 117 in mental health cases.

In terms of Continuing Healthcare, the System Collaborative has developed a clinically-led transformation programme aimed at improving the value the taxpayer and the patient receive from the service. The programme has focused on improved governance, assurance and decision making with a collaborative approach to reviewing the value/effectiveness of how one-to-one care needs are met. This programme has delivered significant savings based on projected expenditure within 2024/25.

The ICB has also been working on a Financial Recovery Plan with a key focus on prescribing, streamlining patient care delivery and seeking to receive greater value from contracts via re-procurement.

In summary this was a very challenging year, and that challenge extends into 2025/26. However, the strong second half puts us into a stronger position as we enter the new financial year.

A Section 30 letter was issued by external auditors to the Secretary of State – the ICB has reported a deficit of £14.894 million in its draft financial statements for the period ending 31 March 2025. As a result, the ICB has taken a course of action that is unlawful and has caused a loss. The external auditors are required to refer this matter to the Secretary of State.

Financial position

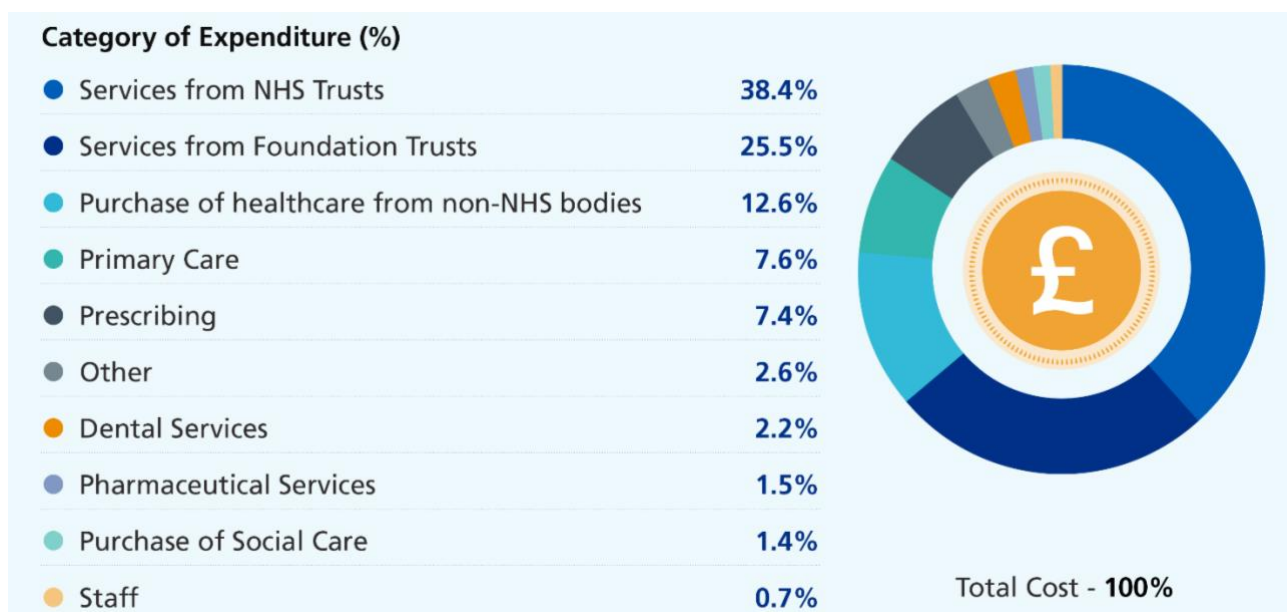
Total resources of £3,215.7 million were available for the 2024/25 financial year including income of £38.8 million and £3,176.9 million of allocations from the Department of Health and Social Care. The ICB committed expenditure totalling £3,230.6 million, leaving the ICB with a deficit of £14.9 million. Further details can be found in the Annual Accounts section of this report.

Considerable work has been undertaken to understand the extent of the financial challenges being faced across the system throughout 2024/25, and the backlog of routine healthcare that has built up. Delivery of high-level transformation has been required to achieve financial efficiencies.

Gross operating costs by category of expenditure

Category of expenditure	2024/25 £'m
Services from NHS trusts	1,240.9
Services from NHS foundation trusts	823.4
Purchase of healthcare from non-NHS bodies	406.8
Primary care	246.7
Prescribing	240.2
Other	85.2
Dental services	71.1
Pharmaceutical services	47.8
Purchase of social care	44.7
Staff	24.0
Total	3,230.6

Category of expenditure as a proportion of gross operating costs



Mental health spend

All ICBs are expected to increase the proportion of their spend of their overall allocation each year on mental health services. ICBs demonstrate this through the Mental Health Investment Standard (MHIS) each year, which ensures the recurrent mental health spend exceeds a target based on the previous year's spend plus additional growth. This is reviewed by independent auditors.

The target expenditure on MHIS for 2024/25 was £240.4 million. The ICB has spent £240.5 million and therefore, subject to audit, has achieved the standard for 2024/25.

For the purposes of MHIS, mental health spend is recurrent spend on mental health services excluding learning disability, autism and dementia. It also excludes spend on Mental Health System Development Funding (SDF) programmes.

As shown in the table below, in 2024/25 the proportion of mental health expenditure by the ICB of the overall resource allocation ringfenced for patient services was 9%.

Mental Health Investment Standard as a proportion of overall patient services expenditure

Category	2024/25 £'m
Mental health spend	240.55
Programme allocation	2,539.90
Mental health spend as a proportion of programme allocation	9%

Statement of financial position

Traditionally known as the Balance Sheet, this financial statement is generally accepted to be a helpful indication of financial health. The statement reviews the assets, liabilities and equity of an organisation.

The ICB's Total Assets less Total Liabilities has moved from a net Liability position of £140.5 million as at 31 March 2024 to £155.7 million as at 31 March 2025 – driven primarily by a reduction in Trade Receivables.

The principal driver of the reduction in Trade Receivables is due to reduced levels of underperformance within the ICB's main NHS provider contracts vis-à-vis the position at the end of 2023/24. The overall Trade Payables value has remained relatively static, with increases in provisions accounting for the main movement.

These provisions are as a result of the ICB seeking to exit contractual arrangements in order to deliver financial efficiencies within its management costs.

Statement of financial position

Category	31 March 2025 £'000	31 March 2024 £'000
Non-current assets		
Property, plant and equipment	144	-
Right of use assets	332	643
Intangible assets	210	-
Total non-current assets	686	643
Current assets		
Trade and other receivables	24,125	38,082
Cash and cash equivalents	1,253	1,424
Total non-current assets	25,378	39,505
Total assets	26,063	40,148
Current liabilities		
Trade and other payables	(174,880)	(175,236)
Lease liabilities	(208)	(330)
Provisions	(6,749)	(4,779)
Total current liabilities	(181,838)	(180,345)
Total assets less current liabilities	(155,774)	(140,197)
Non-current liabilities		
Lease liabilities	-	(293)
Total non-current liabilities	-	(293)
Total assets less total liabilities	(155,744)	(140,489)
Financed by taxpayers' equity and other reserves	(155,744)	(140,489)
Total equity	(155,744)	(140,489)

Going concern

We have assessed our status as a going concern. The ICB and our providers across the system have produced a Financial Strategy, in conjunction with our partners in the ICS. We are implementing this with the aim of returning the system to an underlying financial balance and therefore annual financial balance.

This is based on having established an ICB supported by two local Places, a provider collaborative and seven portfolios, which enables the system partners within the health economy to focus on delivering a collaborative Transformation Plan. This has been supported by strengthened system governance measures, including the establishment of a System Finance and Performance Committee chaired by a Non-Executive Member, supported by the System Performance Group.

These governance arrangements are ensuring that decisions are made in the interest of all residents of the system, and that partners across the system are making good financial decisions.

A public sector body is assumed to be a going concern when it is expected to continue to provide a service, as evidenced by inclusion of financial provision for that service in published documents. The ICB considers whether or not its services will continue to be provided in determining whether to use the concept of going concern in drawing up its financial statements. If services will continue to be provided, the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up as at 31 March 2025 on a going concern basis.

Performance analysis

Our staff are in teams that are either:

- **Primarily portfolio focused** – working with providers and provider collaboratives to deliver the operating plan and work up transformation, or
- **Primarily enablers** – working with the system to ensure the ICB is well governed, has a clearly defined strategy and is delivering its plan through good governance, sound stewardship and with the right focus on clinical safety and our people.

We continue to ensure our portfolios are able to balance the implementation of transformation and redesign with maintaining business as usual.

It is vital that we support partnerships of providers in and out of the system (NHS, local authority, independent sector) to work together at scale to focus on the delivery of our plans.

Our seven portfolios



Mental Health and Learning Disabilities and Autism



Children and Young People and Maternity



Urgent and Emergency Care



Planned Care and Cancer



End of Life, Long-Term Conditions and Frailty



Primary Care



Improving Population Health



Mental Health and Learning Disabilities and Autism



Mental health

We are committed to working in an integrated and collaborative way with our partners across the system to ensure mental health is given the same priority as physical health. This approach ensures that people receive the support they need closer to home and their families.

Our comprehensive mental health programme has led to significant improvements across Staffordshire and Stoke-on-Trent, receiving positive feedback both regionally and nationally for its coordination and performance.

Oversight and assurance are provided by the Staffordshire and Stoke-on-Trent ICS Mental Health, Learning Disability, and Autism (MHLDA) Portfolio Board. There are representatives from across the ICS, including the voluntary sector and a patient representative. Dr Buki Adeyemo, Chief Executive Officer of NSCHT, serves as the CEO Sponsor, while Ben Richards, Chief Operating Officer at NSCHT, is the Senior Responsible Officer (SRO) for the portfolio.

The NHS is committed to improving services for mental health, recognising its critical role in the overall wellbeing of individuals. Plans for 2024/25 were to continue expanding access to mental health support – focusing on early intervention, reducing waiting times, and enhancing the integration of mental health services with primary care.

A key priority for all ICBs is to ensure that mental healthcare is accessible and equitable, with a particular emphasis on supporting communities with the greatest need. Additionally, ICBs are focused on addressing mental health workforce challenges, increasing funding for mental health services, and improving the quality of care for individuals with long-term mental health conditions, learning disabilities, and autism.

The NHS is also prioritising the expansion of crisis care services and ensuring people have access to mental health support when and where they need it most.

Key figures



Significant progress has already been made in advancing mental health services across Staffordshire and Stoke-on-Trent:

Dementia

Dementia diagnosis rates have consistently remained above the national target, which is to diagnose 66.7% of the number of people we would expect to develop dementia. We reached 73.1% by the end of Month 9 (M9) of 2024/25. This rate is among the highest in the Midlands region, and is an increase from the 2023/24 diagnosis rate of 71.9%.

Improving dementia diagnosis

The Alzheimer’s Society has been instrumental in working with Primary Care Networks (PCNs) in North Staffordshire and Stoke-on-Trent to raise awareness of dementia and encourage patients to seek diagnosis.

We are now expanding this effort to engage with PCNs in South Staffordshire, focusing on areas where dementia diagnosis rates are currently falling short.

The Dementia Network across Staffordshire and Stoke-on-Trent remains actively engaged and committed to supporting individuals living with dementia and their carers. There has been an increased awareness and monitoring of disease modifying treatments (DMTs) during 2024/25, and while nothing has been formally approved yet, we continue to engage actively.

This year, we developed a joint Dementia Strategy with Stoke-on-Trent City Council, with significant input from voluntary, community, and social enterprise partners. The Strategy is currently progressing through governance routes and is scheduled for launch in April 2025. Staffordshire County Council has expressed interest in developing a similar joint Strategy, which we plan to collaborate on during 2025/26.

Children and young people’s mental health

The Staffordshire and Stoke-on-Trent Local Transformation Plan (LTP) for Children and Young People’s Mental Health was first approved in October 2015 and has been updated annually in accordance with NHS England guidance.

The most recent update was published in October 2024, offering a review of the progress and challenges faced in improving child and adolescent mental health services (CAMHS) during 2023/24, as well as looking ahead to 2025/26.

This LTP encompasses the entire Staffordshire and Stoke-on-Trent ICB area, with the input of both local authorities. While there are common priorities across the region, the different starting points in each locality have led to variations in investment and progress.

In 2025/26, our focus will be on ensuring services are responsive to local needs and that there is equitable provision across the area.

We are currently reviewing the CAMHS specifications to ensure consistency across the region and to further improve access for all.

A key emphasis is on co-production and participation, ensuring that the voices of children, young people, and their parents and carers are heard, valued, and acted upon.

As with many other services, staffing and capacity challenges have impacted patient access. Targeted recruitment is underway at our two core mental health providers, and we are working with NHS and voluntary sector partners to explore innovative ways to increase capacity and enhance patient engagement with services.

Earlier mental health intervention

Mental health support teams (MHSTs) in schools have created opportunities for early intervention – helping to reduce stigma around mental health issues while fostering resilience within schools that have been part of the project since its start. It has enabled strong mental health and emotional wellbeing support to be provided to children and young people, particularly in areas with high levels of health inequalities.

MHSTs contribute to shorter wait times, ensuring access to the right support when it is most needed. The whole school approach offers flexibility and creativity, tailoring support to the needs of each individual and school.

- NSCHT currently provides coverage to **60%** of schools in North Staffordshire and the Moorlands. Of these, 24 (40%) are part of Wave 12 and will receive full MHST support by January 2026.
- MPFT has confirmed that coverage in the south has expanded to include all districts – 114 schools, with an average coverage of **45%**.
- This brings the overall coverage across Staffordshire and Stoke-on-Trent to approximately **52.5%**.

NHS England's 2025/26 priorities and operational planning guidance is to achieve 100% coverage across the country by 2029/30. This ambitious initiative aims to ensure that every school and college has access to dedicated mental health support, providing early intervention and support to everyone who may experience mental health challenges.

The expansion will enable a more comprehensive, proactive approach to mental healthcare, allowing schools to better address the emotional and psychological needs of students. Increasing the reach of MHSTs should strengthen the overall mental health system in schools, reduce the stigma surrounding mental health difficulties, and improve the wellbeing of students.

Opening of Walton House

The opening of Walton House on the St George's Hospital site in Stafford marks a truly exciting and transformative moment for mental health crisis care in South Staffordshire. As part of Midlands Partnership University NHS Foundation Trust's (MPFT) continued commitment to providing accessible, high-quality services, this new £4.8 million facility is a major step forward in delivering the right care, in the right place, at the right time. Walton House has been purposefully designed to support individuals experiencing a mental health crisis in a calm, safe, and responsive environment.

Talking Therapies

MPFT's Talking Therapies service provides life-changing support for individuals experiencing depression, anxiety, stress, low mood, excessive worry, phobias, and other mental or emotional difficulties, including those adapting to life with a long-term health condition. In 2024/25, the service received **41,440** referrals and supported **37,697** patients in line with NICE guidance. An additional 3,743 patients were helped through allied pathways within the service, and **1,825** patients received support from our employment advisors.

Urgent and emergency care (UEC) and crisis support

The UEC and crisis projects are aligned with efforts to improve mental health services, improve collaboration between care providers, and ensure that individuals in crisis have access to coordinated and compassionate care across the system.

The focus is on reducing reliance on hospital settings and instead offering alternative, community-based solutions that prioritise quick, accessible, and compassionate interventions.

This programme encompasses all the mental health-related urgent and emergency care (UEC) and crisis intervention projects in the MHLDA Portfolio. It aims to provide timely, effective care for individuals experiencing mental health crisis, ensuring they receive the appropriate support when they need it most.

All-age 24/7 Crisis Text Service

Launching in spring 2025 across Staffordshire and Stoke-on-Trent, this service will offer significant benefits for patients with mental health issues – providing accessible support whenever it is needed.

Patients will be able to reach out for help at any time of day or night, particularly during moments of acute distress or crisis when they may not feel able to make a phone call. Texting offers a sense of privacy and anonymity, which can be especially important for people who may feel embarrassed or reluctant to speak openly about their mental health struggles. It also allows for discreet communication in situations where talking may not be possible or safe.

This format can also be beneficial for people with communication difficulties or those who are overwhelmed by verbal interaction. By offering continuous availability and support in moments of crisis, it is hoped that the service can help reduce the likelihood of individuals resorting to more severe measures, such as self-harm or suicide, and can ultimately contribute to improved mental health outcomes.

Ambulance response to mental health crisis

Since launching in December 2023, the Mental Health Response Vehicle (MHRV) has played a vital role in improving access to mental health services in Staffordshire and Stoke-on-Trent. Deployed by West Midlands Ambulance Service, the MHRV is staffed by mental health professionals who can assess, intervene, and offer immediate care and support to people in crisis at the scene. This prevents the need for individuals to be transported to A&E.



This service has been particularly beneficial for those in acute distress, as it provides timely and compassionate support in familiar environments, such as at home or in the community.

Through this mobile, on-demand support, the MHRV ensures that people receive the right care, at the right time, in the right place – while helping to reduce pressure on hospitals.

NHS 111 Mental Health

This new service went live in October 2024, providing a crucial access route for individuals in mental health crisis.

Through this dedicated helpline, people experiencing mental health distress can receive immediate, professional support and guidance.

This is important because it offers an accessible, 24/7 service that connects people to the right care at the right time, reducing the need for unnecessary A&E visits and preventing further escalation of crises.

By offering immediate, tailored advice and support, the service ensures that people in crisis are directed to appropriate services, whether that be mental health professionals, crisis teams, or other community-based resources, thereby improving overall mental health care and outcomes.

Right Care, Right Person (RCRP)

All phases of the RCRP have now begun, with trusts actively collaborating with key partners, including the Police, West Midlands Ambulance Service, and other organisations to ensure a coordinated approach. These partnerships are crucial in ensuring that individuals receive the appropriate support from the right professionals with the necessary skills, training, and experience to effectively meet their specific needs.

Inpatient Quality Transformation Programme (IQTP)

ICBs are required to develop a three-year plan for adult inpatient services. We published our Strategy in June 2024: [Transforming adult mental health inpatient services 2024-27](#).

The IQTP is continuously evolving, and a series of engagement events took place across Staffordshire and Stoke-on-Trent to gather valuable feedback on the mental health provision available. They have been an opportunity to listen to individuals' experiences, identify key challenges, and offer solutions for improvement.

Moving forward, the Strategy will focus on a range of areas and transformations, aiming to enhance mental health services and ensure they are more responsive and effective.

These changes will be embedded into service delivery in the future to ensure that mental health support is better aligned with the needs of the community.

Review of intensive and assertive community mental healthcare

NHS England asked ICBs to review intensive and assertive community mental healthcare to ensure this effectively meet the needs of individuals with severe and complex mental health conditions. The review is part of a broader effort to improve care for people who require intensive, community-based support rather than hospital-based or institutional care.

This population often faces significant challenges in engaging with traditional mental health services, and it is crucial to ensure that they receive person-centred, responsive care that helps them stay well in the community.

The review is intended to assess how well existing services are functioning, identify any gaps in provision, and ensure that care is both accessible and tailored to the specific needs of individuals.

By evaluating the capacity, quality, and coordination of services, NHS England plans to help ICBs strengthen the mental health care pathway, reduce unnecessary hospital admissions, and promote recovery-focused approaches.

This also aligns with broader goals of reducing health inequalities and ensuring that care meets the particular needs of the local population.

Learning disabilities, autism and Down's syndrome

The needs of people with a learning disability, autistic people, and people with Down's syndrome are diverse. Inequality can take many forms and has many impacts on health and wellbeing – to which all organisations in the local system need to respond.

Planning ambitions for 2024/25

- Increase the number of people with a learning disability on the LD register – who want to be on the register.
- Increase the rate of annual health checks and action plans for people with a learning disability.
- Reduce reliance on inpatient care for both adults and children with a learning disability, and in particular for autistic people of any age.
- Improve the data quality of autism waiting times and caseloads to understand how services could be improved.
- Analyse data about people with Down's syndrome to inform decision making when the Down Syndrome Act guidance is published.
- Arrange for experts by experience to deliver Oliver McGowan Training to front line staff across the ICS.



Key facts

2% more people on the learning disability register in 2024 compared to 2023.



Fewer adults (-2) and children and young people (-3) in an inpatient setting compared to the year before (total of 27 people as of January 2025, with more discharges planned).



120 more people had their annual health check, and **271** more people had a health action plan in 2024, compared to 2023.



Oliver McGowan Training delivered by experts by experience to more than **3,000** health and social care staff (figure correct at December 2024).



Established **mean wait** for autism assessment data and process for the data to be shared with experts by experience.



Established database of approximately **700** people with Down's syndrome to help support business case planning.





Down's syndrome forum

In March 2025, we had the first meeting of Staffordshire and Stoke-on-Trent's Down's syndrome forum. The forum is a place where people with Down's syndrome, and their families and carers, can come together to talk about health, social care, education, housing and employment, with professionals who work in the services. Working together, we aim to improve services for people with Down's syndrome in Staffordshire and Stoke-on-Trent.

[Watch this video](#) to learn more about the Down's syndrome forum.



Small Changes campaign

Our communications campaign to influence small changes that improve accessibility and experience goes from strength to strength. The impact is helping to make learning disabilities, autism, and Down's syndrome everyone's business across the ICS.

The campaign is leading to a similar approach by the local authorities and facilitated collaborative work with Support Staffordshire to support the voluntary, community and social enterprise (VCSE) sector.

[Find out more about the campaign on the ICS website.](#)



Maternity and Neonatal Services



The Local Maternity and Neonatal System (LMNS) Partnership Board continues to monitor all aspects of maternity quality and safety for those women/birthing people who live in Staffordshire and Stoke-on-Trent.

Assurance processes have been strengthened through the development of a **perinatal quality oversight pack** which is submitted each month to the Quality and Safety Oversight Forum.

Additional to the assurance role of the LMNS, the team work collaboratively with neighbouring stakeholders to introduce and manage **quality improvement projects** to improve the outcomes and experiences of women/birthing people and their families.

A system approach is underway to help reduce infant mortality. The LMNS plays a significant role in the work around neonatal mortality. This includes the oversight and implementation of the **National Saving Babies' Lives care bundle V3**. A new version of the care bundle is expected in April 2025.

Child Death Overview Panel (CDOP)

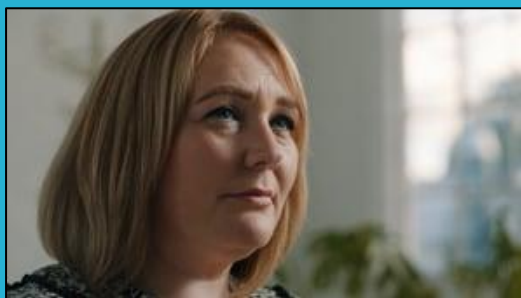
The quality and safety midwives form part of the Infant Mortality steering group and attend the local Child Death Overview Panel (CDOP) meeting.

A key outcome of attendance at this meeting is the development of a leaflet about safer sleep and neonatal cardiopulmonary resuscitation (CPR). It has been co-produced with clinicians, the Maternity and Neonatal Voices Partnership (MNVP), members of the safer sleep working group and the CDOP panel.

The leaflet will also provide a link to a video demonstration which was created by Rowan's Rule in partnership with Derbyshire family hubs.

Video: How to perform CPR (Rowan's Rule)

Trigger warning: this video contains information about baby loss.



The inclusion of neonatal services is paramount to ensuring a perinatal approach is undertaken by the LMNS, through supporting the implementation of the National [PERI Prem passport](#) and the monitoring of its compliance. This aims to improve the outcomes of babies born prematurely and ensure the care provided to these babies is standardised across units within the system.

Another positive development this year has been the introduction of a **Joint Learning Collaborative Forum** with Shropshire, Telford and Wrekin (STW) ICB. The forum is held bi-monthly to share learning across the two systems. This joint working is also supporting improvement work around the STW and SSOT preterm birth pathway which includes birthing families in Shropshire whose babies are born before 27 weeks.

Our maternity and neonatal services have made significant progress in **recruitment and retention** of their workforce, with almost all midwifery vacancies filled. The skill mix of neonatal nurses has improved significantly to more than 50% for qualified in specialty with a good plan to ensure this continues to improve. Neonatal and obstetric medical workforce planning continues positively, with recruitment ongoing.

This means we have also seen sustained improvements in all the areas we were monitoring closely last year:

- **Induction of labour** delays have reduced significantly and consistently
- **Maternity assessment unit midwifery triage** within 15 minutes is consistently over 85%
- **Maternity incentives scheme** Year 6 (Clinical Negligence Scheme for Trusts) compliant with all 10 standards
- **Saving Babies' Lives care bundle** compliance increasing progressively.

Equity and equality

The Staffordshire and Stoke-on-Trent LMNS Equity and Equality Action Plan for 2022-27 is being progressed. The aim of this plan is to:

- Provide equity for mothers/birthing people and their babies from ethnic minority groups and those living in the most deprived areas
- Ensure race equality for staff.

This plan has been refreshed to include national recommendations such as MBRRACE, Ockenden and CQC reports.

More than **100** specific actions have been identified, which are being monitored over a five-year period. They include:

- Implementing COVID-19 actions
- Digital access and inclusion
- Maternal medicine services
- Diabetes prevention programme
- Antenatal care for service users with complex social factors
- Personalised care and support plans
- Perinatal health outcomes
- Staff training
- Interpretation services.

Work is underway to develop a health inequalities system-wide dashboard, capturing data from a variety of sources. This dashboard measures, monitors and informs actionable insight to make improvements to narrow health inequalities for the population that we serve, who are accessing perinatal services.

Equality, Diversity and Inclusion Lead Midwife

As an LMNS, we commissioned an Equality, Diversity and Inclusion Lead Midwife to work alongside culturally diverse and vulnerable groups to address their concerns. They began in post in November 2024.

The role provides assurance to these groups that safe, quality care will be provided in maternity services, and that any barriers that make it harder for women/birthing people and their families to access such care, are removed.

They provide training for staff so that conversations around race and culture are sensitive and meet the needs of the communities we serve.

Maternity and Neonatal Voices Partnership

Our Maternity and Neonatal Voices Partnership (MNVP) works hard to ensure that service user voices are heard and responded to. We now have an independent chair who attends the LMNS Board, chairs the MNVP forum and coordinates MNVP activities such as the 15 steps toolkit and inclusivity visits.

In the coming year, the aim is to strengthen the co-production process, improve how we close the loop by consistently giving feedback about our actions (you said, we did), and ensure we reach out to communities who are less likely to actively engage with us.

The MNVP attended the Staffordshire Association for Black Lives Equality (SABLE) acceleration event on International Women's Day. This was an opportunity to engage with members of the community and to accelerate action, to ensure that all women's voices are included in maternity improvements.

Working with the Breastfeeding Network, an infant feeding listening event was held in Stoke-on-Trent to understand the information and support that women seek postnatally. The feedback gathered will support the generic infant feeding Padlet (a visual, digital bulletin board) which will be made available to women/birthing people upon discharge from UHNM.

Additional funds have been released by NHS England in response to the [Birth Trauma Report](#). This funding is part of a £35 million package of additional investment that recognises the central role MNVPs play in helping to improve care, and the need to strengthen the neonatal parental voice component.

These funds will contribute to the commissioning of a 3D video tour of the maternity unit. This will help our local birthing families to feel less anxious and more familiar with their chosen birth setting.

It will also fund the purchase of the BRAIN tool* to enable women/birthing people to have meaningful conversations with staff, make informed choices and decisions, and help to reduce the potential trauma associated with this. We will create roller banners and a BRAIN card for their booking appointment in each of the top five languages spoken locally.

***A decision-making framework used to help people to make informed choices by systematically considering the Benefits, Risks, Alternatives, Intuition (gut instinct or feeling) and the implications of doing Nothing.**

In addition, four iPads have been donated to our main provider to aid with communication and sharing of information.

Maternal Mental Health Service

The Lotus service supports women/birthing people and their families across Staffordshire and Stoke-on-Trent whose mental health has been significantly affected by issues such as:

- Miscarriage
- Ectopic pregnancy
- Termination of pregnancy
- Stillbirth or neonatal death
- Extreme fear of childbirth (tokophobia)
- Experiencing pregnancy and/or birth as traumatic or difficult
- Neonatal admission or experience of separation from your baby or babies.

The service can offer appointments online and at a range of convenient locations.

As an LMNS, we work with key partners in developing this much-needed service and monitor its accessibility.

For further information, please visit:

- [MPFT website \(Staffordshire residents\)](#)
- [NSCHT website \(North Staffordshire and Stoke-on-Trent residents\)](#).

Perinatal Pelvic Health Services (PPHS)

This service leads on the local delivery of the national NHS Long Term Plan's aim to reduce the number of women living with pelvic health problems postnatally and in later life.

The overarching functions are to:

- Embed evidence-based practice in antenatal, intrapartum and postnatal care to prevent and mitigate pelvic health problems resulting from pregnancy and childbirth
- Improve the rate of identification of pelvic health problems antenatally and postnatally
- Ensure timely access to NICE-recommended conservative treatment for common pelvic health problems antenatally and at least 12 months postnatally in inpatient and outpatient services.

University Hospitals of North Midlands NHS Trust have been commissioned to provide these pathways. As an LMNS, we will monitor access, experience and outcomes of this newly developed service.

For further information, see UHNM's [Perinatal Pelvic Health Services](#) webpage.

Maternity and Neonatal Independent Senior Advocate (MNISA)

We have received confirmation that the MNISA pilot has been extended until March 2026. This role provides support and advocacy to families navigating investigation processes following a significant health complication or the death of a mother or baby.

Over the last year, families have been supported to gain better understanding of what happened to them or their baby, and to feel listened to and heard. A key finding from this engagement is the passion that families have for making improvements to services, to prevent others facing avoidable trauma.

This is evident from the work the LMNS and MNISA have been doing with a local Derbyshire mum following the sudden unexpected death of her baby Rowan.

Working in collaboration with the LMNS midwives, Rowan's story has been shared widely within the system and a leaflet and QR code have been created to share with local families.

[Read more in this article on the UHDB website](#), and see the video from Rowan's Rule at the start of this section.

The MNISA role is currently being formally evaluated, which means stakeholders from Staffordshire and Stoke-on-Trent have the opportunity to shape and influence the future role. This will ensure that we can continue to support families who have experienced trauma, and continue to learn from the positives and negatives that they share from their experiences.



Children and Young People



The good health of children and young people (CYP) is crucial to future wellbeing and prosperity across Staffordshire and Stoke-on-Trent.

This needs to start at the earliest opportunity, from pregnancy and early years, and continue through childhood and as children grow into adulthood. We are committed to delivering better health outcomes for children and young people in our community – we want to see children, young people and families supported to start, grow, and live well.

Our aspiration is to ensure children and young people have the best start in life and the best health.

To achieve this, the Children and Young People's Programme Board published its strategic framework – [Getting the Right Start](#).

This is a real opportunity to approach and solve our challenges collectively, with shared ambition and commitment to improve the health and wellbeing of our children and young people.



Our priorities as a programme will change over time, but these are our initial areas of focus:



Supporting children and young people in challenging situations

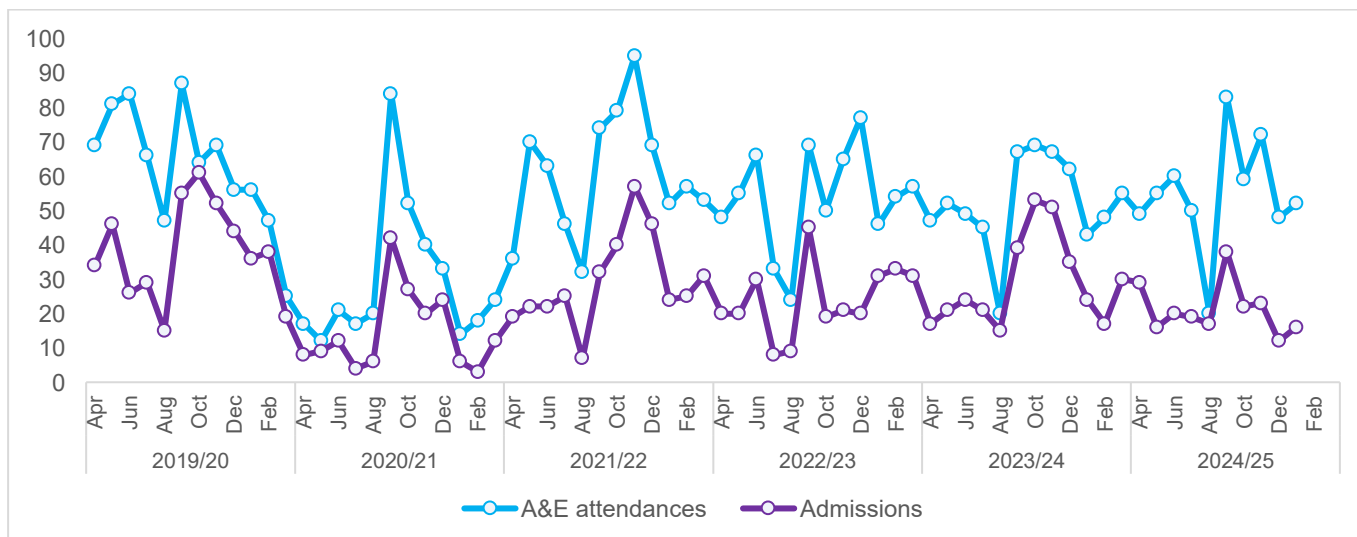
A participation lead and three young people with lived experience have been recruited to support the challenging situation project group. The care leaders were commissioned to support this workstream alongside funding from the West Midlands CAMHS Provider Collaborative.

Four training days have been delivered to more than 300 staff from Staffordshire County Council, Stoke-on-Trent City Council, MPFT and NSCHT in trauma, emotional dysregulation and managing risk when working across organisational boundaries. The project has developed a new crisis pathway and a new workforce model in support of this cohort of children.

National Asthma Bundle of Care

Building on a number of initiatives, we continue to see rates of emergency admissions for asthma decrease – see the below chart.

Seasonal fluctuation in asthma-related A&E attendances and admissions in patients aged 0-17



We have successfully implemented the national Asthma Friendly Schools initiative, with a total of 76 local schools having now expressed an interest. Stoke-on-Trent City Council and Staffordshire County Council are both supportive in raising awareness and encouraging uptake among schools. UHNM and MPFT are now actively raising awareness of the programme among children, young people and parents.

To support consistency of care across all system partners for asthma, in September 2024 we launched our children and young people asthma guidelines and pathways of care, which was supported by a series of engagement activities. We upskilled our workforce by enrolling **60** local Asthma Champions across primary and secondary care clinicians on an advanced asthma training course.

Infant mortality

In conjunction with the Midlands Infant Mortality Oversight Group and the Office for Health Improvement and Disparities (OHID), a 'deep dive' began to review local data, intelligence and outcomes to identify ways to reduce local infant mortality rates.

In support of this, system partners came together in December 2024 to identify opportunities, improvements and achieve greater impact. This event set 2025/26 priorities for reducing infant mortality in Staffordshire and Stoke-on-Trent.

Emotional health and wellbeing

We have undertaken mapping to understand the gaps and barriers faced by care-experienced children and young people when they try to access support for their emotional wellbeing and mental health.

The recommendations arising from this exercise include:

- **Delivering development days** to bring together practitioners from across the children's services and mental health workforce to build relationships and improve working practices.
- **Review of service specifications** for the NHS child and adolescent mental health services (CAMHS) – see Mental Health portfolio for more detail.
- **Re-commissioning the emotional health and wellbeing service** jointly with the local authority, to include trauma-informed and attachment awareness, prioritising vulnerable cohorts for assessment, and supporting the network around children and young people.

This workstream aims to maximise the number of care-experienced children and young people who are thriving, by improving and simplifying access to services so that more young people can get the help they need, when they need it.

We have developed local standards for procuring psychological assessments, to ensure that assessments effectively identify the needs of children and young people.

We have implemented and delivered a number of pilots and activities:

- Emotionally-based school avoidance (Staffordshire)
- Enhanced mental health pilot in schools (Stoke-on-Trent)
- Emotion coaching training for early years settings (Staffordshire)
- Development of a 'safe online' webpage (Staffordshire).

Diabetes Youth Workers

We introduced Youth Worker posts across our acute health settings to support young people diagnosed with diabetes. Through information and education sessions, they are supported to understand their condition and develop a sense of control in their health and lifestyle choices.

The Youth Workers aim to address barriers to treatment, engage young people back into treatment and improve school and college attendance. We have established a youth forum to provide a young person's voice in the local health system.

In the period April to December 2024, the Youth Workers saw **463** young people, and led initiatives including:

- One-to-one support, group support, activity-based projects
- Monthly youth groups – Insulin Avengers
- Monthly football sessions
- Weekly boxing and gym sessions
- Events – such as a roller disco, bowling night and Christmas pantomime
- Promoting awareness of World Diabetes Day
- Diabetes youth voice communication project
- Providing support to schools and clinical sessions.

Annual Children and Young People's Event



Coinciding with World Children's Day on 20 November 2024, this annual event brought together a range of representatives from across Staffordshire and Stoke-on-Trent to build a powerful network of passionate professionals, committed to improving the lives of children and young people.

To shape topics of conversation for the day, we engaged with representatives from the Staffordshire Youth Union about matters that are most important to them. They kindly produced a canvas (pictured below) and video to explain the chosen topics and their significance.



Video: Talking health – Health challenges for today's youth (Staffordshire Youth Union)

Key topics identified by the Youth Union included: LGBTQ+ healthcare, preventing alcohol and vaping addictions, CYP Healthy Weight (diet and nutrition, obesity, eating disorders and obsessive behaviours), palliative end-of-life care programme, and children and domestic abuse.

[View the ICS's children and young people webpage for copies of the slides and a recording of the event.](#)

The session was very well received, with positive feedback from individuals:

Attendees enjoyed networking and engagement opportunities, the speakers, having time away from the day job, that it was relevant, involvement from young people, the relaxed atmosphere, good organisation, and the ability to join online.

Special educational needs and disabilities (SEND)

In the last 12 months, our joint SEND provider post with MPFT is delivering improvements towards meeting our statutory requirements. This is as a result of increased training and improved processes including data collection and quality assurance of information provided. In October 2024, a similar post commenced at NSCHT with the same aims and objectives.

Through these posts and the Designated Clinical Officer for SEND, the SEND Champions Network has grown and strengthened – we now have networks across both MPFT and NSCHT. This has facilitated increased knowledge of SEND within NHS providers and allows staff to share best practice and take this back to embed into their wider operational teams.

Professionals from several organisations across the ICS worked together to develop a sensory processing needs toolkit to guide and ensure consistent practice across schools. The toolkit is due to launch in spring 2025, and offers strategies for teachers to try, advice on

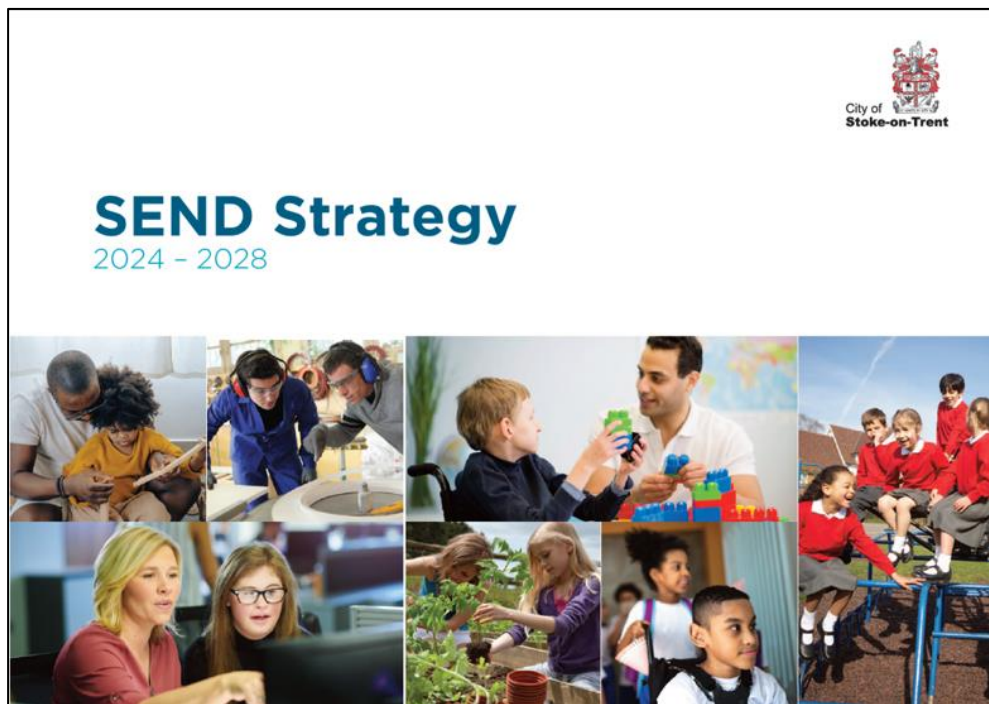
assessing the school environment, and ideas for calming activities, helping children take part in school activities.

Our work with Staffordshire County Council has included embedding the Enhanced Assess Plan Do Review (EAPDR) pathway – supporting schools to meet the needs of children and young people.

Along with other NHS providers, we have supported the council on the Local Area Self Evaluation Framework and have been preparing for Staffordshire's Area SEND Inspection.

Following the outcome of the [Stoke-on-Trent Area SEND Inspection](#) (published April 2024), which found that the local area partnership's arrangements were leading to inconsistent experiences and outcomes for children and young people with SEND, we have been working with Stoke-on-Trent City Council towards the required improvements.

We have also worked with local families, children and young people to identify the priorities and improvements that are important to them. Their suggestions were incorporated into the [Stoke-on-Trent SEND Strategy](#) which was launched in August 2024.





Urgent and Emergency Care (UEC)



UEC covers such services as acute hospital emergency departments (EDs, also known as A&E), NHS 111, ambulance services, community urgent response services and hospital discharge services.

Our main acute hospital provider is University Hospitals of North Midlands NHS Trust (UHNM) and for ambulance services it is West Midlands Ambulance Service (WMAS). Staffordshire and Stoke-on-Trent residents also use services at surrounding hospitals in Burton, Wolverhampton, Birmingham, Dudley, and Walsall. Information on how these providers are performing against national targets can be found in their own annual reports.

NHS England released a two-year UEC delivery plan in January 2023, and a further letter in May 2024 outlining the ambitions set out in the NHS priorities and operational planning guidance 2024/25 to:

- Improve A&E performance with 78% of patients being admitted, transferred or discharged within four hours by March 2025.
- Improve category 2 ambulance response times relative to 2023/24, to an average of 30 minutes across 2024/25.

In-year, we have seen an increase in demand across UEC services. Performance towards the 78% target has continued to improve, although at a lower rate than in previous years. The ICS has developed a specific focused improvement plan, built with all system partners, to refresh focus. Performance improvements against this plan will continue into 2025/26.

During 2024/25, category 2 performance saw an improvement from the previous winter. However, with increasing demands on our ambulance provider and significant increased pressures within our acute providers, category 2 performance has remained challenged. This remains a core focus area for improvement in 2025/26, and we continue to work with WMAS to improve performance.

Our approach to 2024/25 was building on our UEC Improvement Plan in three core areas of access/admission avoidance, in-hospital and post-hospital service improvements.

Performance in 2024/25

- **67.8%** of patients were seen at A&E within four hours (against a target of 78%) – an increase of 0.6% from March 2024.
- **12%** reduction in ambulance category 2 response times compared to the previous year – averaging 35 minutes and 50 seconds in 2024/25.
- **9.35%** of patients spent 12 hours or longer in A&E – a 0.8% increase on the year before.

Admission avoidance

Admission avoidance initiatives heavily focused on increasing availability of alternative pathways within the community, in line with NHS England's Recovery Plan. The initiatives in UEC are primarily our Single Point of Access, Urgent Community Response (UCR) and Virtual Wards.

Acute Care at Home (ACAH) leads our **Urgent Community Response services**, more commonly known as Community Rapid Intervention Service (CRIS) in our system, and Virtual Wards. ACAH is a collaboration between local providers UHNM, Midlands Partnership University NHS Foundation Trust (MPFT), University Hospitals of Derby and Burton (UHDB) and The Royal Wolverhampton Trust (RWT).

The **CRIS** element has continued to expand in-year, and regularly achieves the national target of seeing 70% of patients within two hours. Despite continual workforce challenges, the service has developed a trainee Advanced Clinical Practitioner (ACP) programme to develop the workforce internally, and continues to be supported by the ICS people function and wider system partners to be efficiently staffed to meet demand.

Virtual Wards provide acute-level care within a patient's usual home. NHS England released further operational guidance for Virtual Wards in 2024, and a stock-take against the core components has been completed to further support the model within our system. The outputs of this have helped formulate our 2025/26 improvement plans. During 2024/25, the service has expanded the number of beds available across the system. Over the year, the utilisation of virtual wards has averaged between 60 and 80%.

Embedded roles at Royal Stoke University Hospital provide support to acute provider colleagues and drive use of Virtual Wards – and due to their success, are being expanded across all acute hospital sites in the system.

During 2024, partners worked together to develop a system plan to reduce **ambulance handover delays** across Staffordshire and Stoke-on-Trent. We were the first system in the region to go live with the national initiative of reducing the number of handover delays which exceed 45 minutes. We will continue to embed this further during 2025/26.

Integrated Care Coordination service

In 2024, MPFT took over responsibility for the Single Point of Access and renamed it the Integrated Care Coordination service. A multi-disciplinary team is available from 8am to 8pm to offer advice and guidance to health and social care professionals across the system – supporting onward referral and ensuring patients get the right care for their needs quickly and safely. This leads to improved patient outcomes, regardless of where they seek help.

The service has seen a **64%** increase in referrals – now regularly totalling more than 3,000 a month, mainly received from the ambulance service and care homes. 50% of referrals are supported to alternative pathways away from emergency departments and WMAS.

The service will continue to identify opportunities to expand community services across the system and will be a core component of our 2025/26 UEC Improvement Plan.

In January 2025, the system piloted the expansion of the Integrated Care Coordination service's phone number to be available 24/7.

Early figures show that more than 80% of referrals are being supported in the community, improving access to care for patients in the out of hospital setting. It continues to show a benefit to patients.

Our **NHS 111** service transferred to a regional model, operated by Derbyshire Healthcare United (DHU). The contract is led by Derby and Derbyshire ICB and has supported a standardised approach to access for our patients across the region.

Urgent treatment centres (UTCs)

Work continues to provide an urgent care offer that is less complicated and easier for patients to navigate. A key aspect of this relates to the designation of UTCs across the system – which is informed by the Urgent Care Strategy, alongside national planning guidance and policy.

Our current urgent care provision includes minor injuries units (MIUs) and walk-in centres (WICs), which have varying opening hours and different levels of service. Significant public engagement work in recent months has enabled the ICS to assess awareness of the services available, alongside patient understanding of how to access both urgent and emergency care.

Outputs from this work show that it is not always clear which is the most appropriate service to use, leading to more attendances at EDs, increased pressure on those departments, and longer waits for many patients.

It is our intention that our UTCs will have the same opening hours, offer the same core services and treat patients of all ages across Staffordshire and Stoke-on-Trent, making it clearer for patients what urgent care they can access and when. Patients will also see improvements in services, for example an expansion of X-ray capacity.

Building on the vast amount of preparatory work undertaken previously, during this financial year the ICS has continued to develop and refine system-wide proposals for UTC designation with all key provider partners, shaped by the hugely valuable feedback gathered through our public engagement events and work.

The system will seek to finalise proposals and commence designation of UTCs across the system during 2025/26.

Discharge

Our focus this year for discharge has been to increase the number of patients who require no further increased health and social care support on discharge, known as Pathway 0 and Simple and Timely Discharges.

Across the system, two discharge hubs operate within the north and south areas respectively. This year, the ICS continued to embed good practice from the Integrated Discharge Hub (IDH) that began to operate across UHNM sites in 2023/24. A Care Act assessor working in UHNM's emergency departments (EDs) supports admission avoidance by embedding a role in the infrastructure. This has seen a 12% increase in the proportion of patient referrals discharged from ED.

For winter, a risk stratification tool was embedded into the EDs to identify patients at risk of longer periods of stay in hospital, and of re-admissions. The tool has demonstrated that 20% of patients have existing care and support in their usual home, supporting patients not to be admitted to hospital or to be discharged earlier.

We have worked as a system to create standard working practices with our local borough and county councils to support housing and patients experiencing homelessness, showing our strengths in working together to provide more timely outcomes.

Working with our VCSE partners, we connected our residents with community capabilities (the resources and social systems in a community that can be used to address problems and expand opportunities) in order to reduce impact on core health and social care services.

Staffordshire Fire and Rescue Service's discharge initiative

This year, more than **2,625** patients who were ready for discharge were provided with transport home by the Staffordshire Fire and Rescue Service.

[Read more about the SFRS home from hospital team.](#)

System surge and winter planning

Building on the whole-system approach to winter surge planning in 2023/24, we further developed and implemented plans for expected, forecast, and experienced increased demand for winter 2024/25.

All system partners presented the ICS System Surge Plan to their statutory public Board meetings (or equivalent) and used it to prepare for and manage the increased periods of demand during the winter months.

The System Escalation Plan has also been revised and refreshed, taking learning from previous years, alongside enhancements to align with NHS England's new operational pressures escalation levels (OPEL) framework.

As in previous planning cycles, and indeed as throughout all system working, the ICS Leadership Compact underpinned all governance and planning for UEC. To support continuous improvement and inform future planning cycles, system partners will once again review the System Surge Plan and system-wide management of winter pressures.

A winter 'lessons learned' event will ensure a thorough and robust review of the plan, its implementation and delivery, with oversight provided via the UEC Board, Finance and Performance Committee and the ICB Board.

System Coordination Centre (SCC)

The SCC monitors and provides daily operational support to the ICS, supporting with high-level escalation to other ICBs and national teams. It is visible in both provider and system meetings to offer support and gain assurance of plans in place for delivery, and to reduce the risk of escalation.

The SCC chairs and facilitates twice-daily system calls when needed and provides regular updates to NHS England. It leads on the System Escalation Plan and Ambulance Escalation Plan where ICS partners have agreed specific actions to relieve pressures on our UEC system.

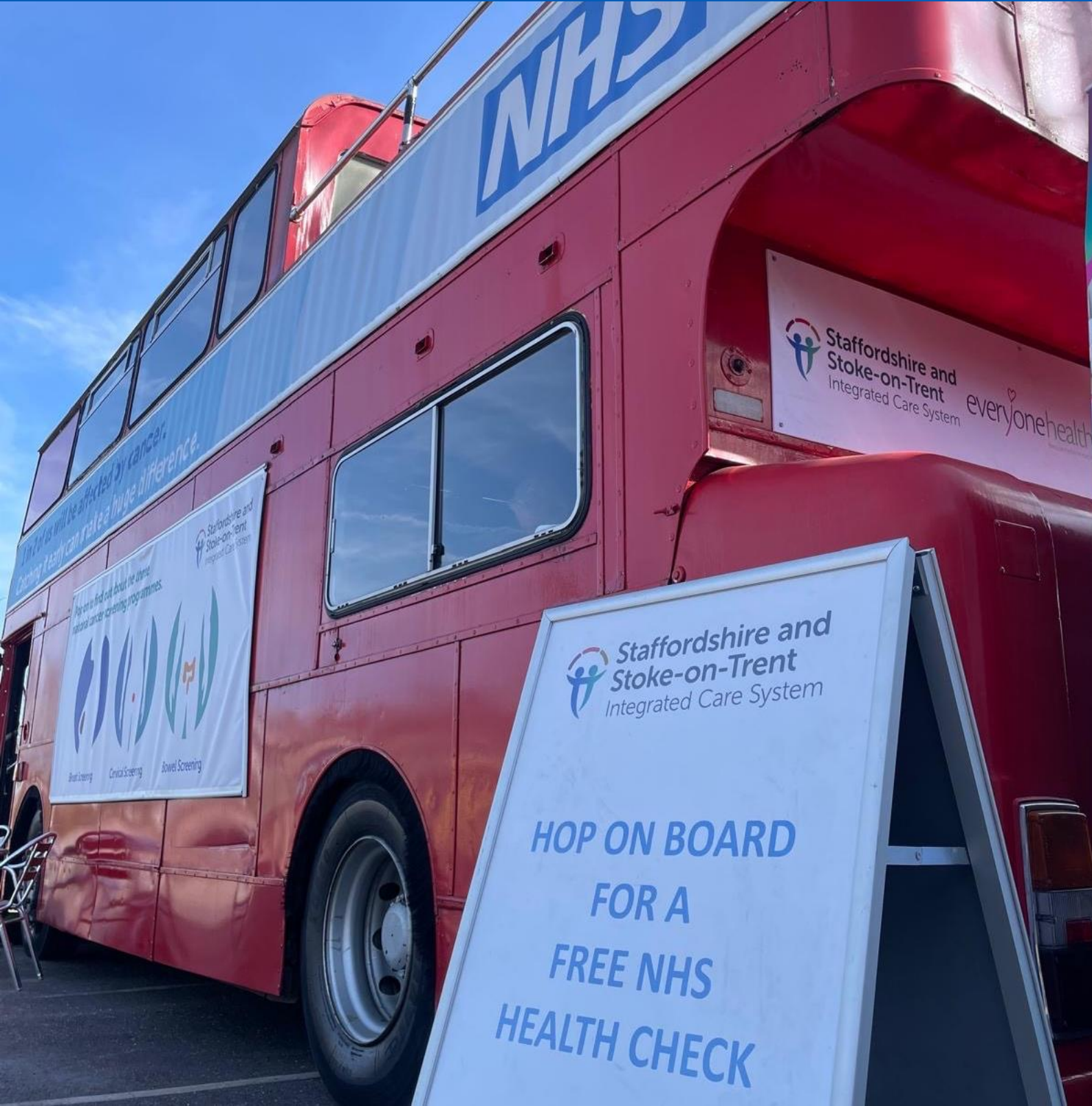
This work has clearly supported the system, as evidenced during recent critical incidents and industrial action.

In 2024/25, NHS England facilitated peer reviews of all the SCCs nationally – Staffordshire and Stoke-on-Trent was awarded national accreditation as a benchmarking SCC. This has shown us nationally as a leader in our field, and we have provided peer support to other SCCs which needed to develop their capabilities.





Planned Care (includes elective, cancer and diagnostics)



Over the last two years, our Planned Care Portfolio has been focusing on harmonising access to services across Staffordshire and Stoke-on-Trent and delivering care closer to home. The two areas that have seen the biggest improvements are ophthalmology and women's health, including gynaecology.

Ophthalmology

Community Urgent Eyecare Services (CUES) were introduced during the COVID-19 pandemic – originally set up by NHS England, NHS Improvement, the College of Optometrists and The Royal College of Ophthalmologists.

The service has two key objectives: the rapid implementation of safe urgent and emergency services, and supporting the wider system by providing patients with alternatives to GPs, EDs, and hospital eye departments.

Providing urgent assessment, treatment, and referral for all ages, the service caters for acute eye problems such as sudden onset visual disruption/distortion, suspected foreign bodies, and minor eye injuries. It continues to reduce secondary care attendances for conditions that can be treated in a community setting.

The service is delivered through telemedicine and face-to-face appointments by accredited optometrists. The telemedicine service provides a single point-of-access phone number for patients who need urgent eyecare. Following an initial telephone triage, a remote consultation enables a specialist telemedicine optometrist to assess the patient's clinical signs and symptoms to determine the most appropriate management.

With the exception of East Staffordshire, the service was available across Staffordshire and Stoke-on-Trent. In October 2024, the service was extended to ensure that East Staffordshire residents also had access to the emergency eyecare service at locations closer to home to reduce attendances at the ED at Queen's Hospital, Burton.

Cancer

With the support of West Midlands Cancer Alliance, we have delivered public education in Staffordshire and Stoke-on-Trent through 12 cancer awareness campaigns, a cancer bus tour, and by strengthening relationships with local care providers.

Educating the public about cancer remains a key focus for us. We continue to encourage people to come forward for screening and as soon as they notice symptoms that cause concern. Early cancer treatment improves chances of recovery and survival.

A data-driven approach has ensured our awareness campaigns have been both targeted and effective. We analysed local population health data, screening uptake rates, and cancer incidence trends to identify priority areas and the demographics most in need of intervention. Each campaign was tailored to specific communities and used appropriate messaging and materials to encourage early detection and improve outcomes.

Methods of delivery have included patient advocate videos, instructional videos, and strategically placed posters – for example in high-footfall public areas such as toilet cubicle doors. These campaigns are essential for increasing awareness, promoting early cancer screening, and ultimately supporting the NHS Long Term Plan's ambition to improve survival rates through earlier diagnosis.

We particularly focused on building and strengthening relationships with our colleagues in primary, secondary and the voluntary care sectors. By analysing performance data, we identified GP practices that are facing challenges with cancer referrals and engaged directly with them to provide tailored support.

Fostering strong partnerships with secondary care providers and the voluntary sector has ensured a collaborative, integrated approach to cancer care.

We also work closely with Primary Care Networks (PCNs) to deliver patient-focused care and strive to achieve national cancer targets.

Cancer care coordination

This year, we have funded Cancer Care Coordinator (CCC) roles in 15 of our PCNs. CCCs offer support to people living with cancer as well as their families and carers, and strive to increase attendance for cancer screening. Improvements in early diagnosis are already being seen – particularly for cervical screening.

Many patients have benefited from the CCCs' individual support. We are also forging links with secondary care providers to support patients in their journey. Progress and best practice are shared across the ICB to improve care for all.

Key figures*

- **457,587** patients were referred via e-Referral service (ERS) and referral assessment service (RAS) – a 2% decrease on 2023 but a 4% increase on 2022.
- **222,353** patients were referred by their GP for outpatient follow-up appointments – a 9% increase on 2023 and a 22% increase on 2022.
- **423,913** procedures (daycase, elective and outpatient) were completed – a 15% increase on 2023 and a 32% increase on 2022.
- **613,855** diagnostics were completed – a 9% increase on 2023 and a 25% increase on 2022.

* These figures are for the calendar year (Jan to Dec) rather than the financial year (Apr to Mar). Source: ERS data.



Cancer bus

The cancer bus tour of Staffordshire and Stoke-on-Trent was launched to raise awareness of cancer symptoms, promote cancer screening, and address barriers to accessing healthcare.

By bringing cancer services directly to the community, we hope to encourage early diagnosis and support the NHS Long Term Plan's target of diagnosing 75% of cancers at stage 1 or 2 by 2028, and for 55,000 more people each year to survive for five years or more.

Public outreach is essential to achieving this goal, ensuring more people recognise symptoms early and feel supported in attending screenings.

Diagnostics

Patients typically see their GP or primary care clinician for one of two reasons – either they have new symptoms, or they require ongoing monitoring of a condition or illness. They need to have a diagnosis in order to receive appropriate care and support – and in order to be diagnosed early with a condition or illness we need to have patient pathways of care.

We have continued our work to improve access to diagnostic tests through the development of a number of symptom-led diagnostic pathways relating to gastroenterology, liver, gynaecology, and breathlessness.

Colleagues and clinical experts from across primary care and our local hospitals have collaborated to develop these and ensure that they reflect best practice.

By introducing these new pathways, patients will be referred to have the right test much more quickly. This will help to achieve better outcomes from earlier diagnosis as patients will get any treatment they require more quickly.

Our work relating to diagnostic pathways is a positive reflection of how key partners have worked together to support health improvements for patients. Building on this, we will look to develop other pathways such as urology, musculoskeletal (MSK) and ear, nose and throat (ENT) in 2025.

Environmental improvements for patients living with dementia

In 2024, we successfully bid for some additional funding from NHS England that has enabled us to partner with the Alzheimer's Society to lead on two really important areas. This work will improve access to Community Diagnostic Centres (CDCs) for people living with dementia.

Working directly with UHNM, UHDB and RWT, the Alzheimer's Society will provide a series of recommendations relating to environment adaptations and enhancements based on the experiences of people living with dementia as well as people with learning disabilities and/or autism.



For example, to someone living with dementia, a black mat at the entrance of our CDCs may look like a hole in the ground. A blue mat may look like water. This may deter them from entering the building meaning they do not access the tests they need. One simple yet very effective recommendation from the Alzheimer's Society is for the CDC to choose a colour of entrance mat which does not present as a potential barrier.

The funding also supports the Alzheimer's Society to develop and roll out an accredited dementia awareness training programme to staff working in the CDCs and wider diagnostic services. This training will improve colleagues' understanding of how a person living with dementia experiences a hospital visit, so they can better support them to have a positive, successful and personalised encounter.

All partners are supporting this work, and we have seen tremendous early successes. NHS England have invited us to support a national CDC shared learning event, which we hope will lead to our successes being replicated in other areas of the country.



End of Life, Long-Term Conditions and Frailty



Professional and public engagement has been at the heart of the development of several key strategies for community transformation throughout 2024/25.

These strategies were published early in 2025/26 – representing a significant milestone in our collective commitment to continuing to improve these areas of care for our communities:

- [All-Age Palliative and End of Life Care Strategy 2025-28](#)
- [All-Age Respiratory Strategy 2025-30](#)
- [Healthy Ageing and Frailty Strategy 2025-30](#).

In developing these strategies, we have engaged extensively with partners across the health and care system, as well as with individuals and communities who bring invaluable lived experience.

Nearly **600** members of the public took part in the public engagement for the strategies, along with 174 health and care professionals. Their insights and perspectives have shaped the strategies' priorities and provided assurance that they reflect the needs and aspirations of Staffordshire and Stoke-on-Trent's diverse population.

“The goals should align with mine, and I should be given options of where I want to receive care, particularly my end of life care.” – **public feedback for the All-Age Palliative and End of Life Care Strategy**

“I miss my reviews; it is so easy to do so. My GP sends a text to book an appointment, but I am too busy to make an appointment.” – **public feedback for the All-Age Respiratory Strategy**

“To make best use of the clinical workforce, it's essential that the most appropriate professional provides the care.” – **public feedback for the Healthy Ageing and Frailty Strategy**

End of life

Over the past year, through strong partnership working we have made significant strides in improving palliative and end of life care (PEoLC) across Staffordshire and Stoke-on-Trent, ensuring that individuals and their families are supported with compassion, dignity, and coordinated care.

Central to this progress has been the publication of our all-age, three-year strategy – which has been co-produced with the people and professionals it serves.

In alignment with the national direction for palliative and end of life care, as outlined in the Ambitions Framework, this Strategy is tailored to address the specific needs and priorities of our local population. To inform this approach, a strategic needs assessment was undertaken.

The Strategy was informed by extensive engagement with our communities and professionals. We are deeply grateful to the

248 members of the public who took the time to share their experiences, insights, and hopes for PEoLC services. Their powerful personal stories and feedback provided rich qualitative insight and shaped the direction of our priorities.

Additionally, two online workshops were held for professionals and providers, bringing together more than **70** participants from across a wide range of health, care, and voluntary sector organisations. This collaborative, whole-system approach clinically led by a Strategy Development Group has resulted in a strategy that reflects local needs, values, and aspirations.

There will be a need to revisit and continue that engagement throughout the lifetime of the Strategy. This will build on the strategic needs assessment, with equity of access and population health in mind.

Our Strategy sets out six key objectives for system-wide improvement:

1. Developing a PEOLC website

A central, accessible digital platform is being developed to serve both the public and professionals. It will include a comprehensive directory of services, educational resources to improve skills and knowledge, and practical tools to support those involved in end of life care.

2. Supporting preferred place of death

We are committed to helping individuals die in their place of choice, through early identification of need, proactive care planning, and by reducing avoidable emergency department visits. A key focus is on normalising end of life conversations and embedding them as part of compassionate, person-centred care.

3. Professional Collaboration Forum

A new forum is in development to enable professionals and providers to share learning, best practice, and improve communication across sectors. This aims to reduce siloed working and strengthen partnership approaches across the system.

4. Out-of-hours access and support

We are prioritising improvements in out-of-hours support, including access to medication, streamlined processes for authorisation paperwork, and enhanced availability of specialist palliative care advice.

This involves working closely with primary, community, and social care providers, alongside voluntary and community sector (VCSE) partners.

5. Electronic Palliative Care Coordination Systems (EPaCCS)

A key enabler of better coordinated care, the development of EPaCCS is already underway. A fortnightly task and finish group is supporting the rollout, and pilot sites are now live in primary care and at Douglas Macmillan Hospice. EPaCCS will allow shared access to patients' preferences and care plans across all relevant professionals, overcoming longstanding issues of fragmented communication.

6. Building resilient and compassionate neighbourhoods

We will continue working with local authorities and VCSE organisations to foster compassionate communities, through a new conversation focused on neighbourhoods.

An outline delivery plan is in place, and an outcomes framework is in development – aligned with the broader community transformation portfolio and emerging neighbourhood health guidance. The PEOLC Clinical and Professional Improvement Group will play a key role in driving the implementation of this strategy and translating it into meaningful change.



Strengthening collaboration: Forming an all-age Clinical and Professional Improvement Group

To support equitable delivery of our strategy across all life stages, we have merged the previously separate adult and children's clinical and professional improvement groups into a single all-age group. This integrated group provides a valuable platform for shared learning across the age spectrum, ensuring that insights from children's and adult services inform and enhance one another.

By bringing together expertise and experience from both areas, we are strengthening our approach to transitions in care, aligning practice, and driving system-wide improvement in a consistent and coordinated way.

24/7 palliative care advice line

During 2024/25, local hospice providers provided a 24/7 advice line for palliative care, ensuring that both the public and healthcare professionals have access to timely, expert guidance at any hour of the day or night. This service remains a vital support to those navigating complex and emotional care needs, particularly during times of uncertainty or crisis.

We have worked with providers to understand the model and the impact of the helpline and agreed to contribute funding to ensure continuation of the helpline in 2025/26.

Driving change: Recruiting a Macmillan Transformation Lead

Following a successful bid for funding to the national Macmillan Cancer Support charity, a major milestone this year has been the recruitment of a Macmillan Transformation Lead for Staffordshire and Stoke-on-Trent. This role is part of a UK-wide two-year initiative, the PEOLC Transformational Leadership Programme.

Macmillan wants to invest and work collaboratively with system partners, to ensure that everyone at the end of their life has their vital needs met by high-quality, sustainable services. These new transformational roles support the strategic design and direction of services, rather than direct delivery.

This key leadership role will play a pivotal part in shaping the strategic direction and design of PEOLC services across the region.



Palliative care registration and ReSPECT* roll out

Identifying patients in the last 12 months of life is crucial for ensuring timely and appropriate care planning, including the use of ReSPECT plans.

The ReSPECT process enables personalised recommendations for clinical care and treatment during a future emergency when the individual is unable to make or communicate decisions.

We have been actively promoting the early identification of palliative care patients within primary care settings. This initiative has been supported by training provided through the Staffordshire Training Hub and delivered by our community care provider.

The national Quality and Outcomes Framework (QOF) data published in 2024 shows a significant increase in palliative care prevalence within Staffordshire and Stoke-on-Trent. This improvement has elevated us to the third highest ICB nationally in terms of palliative care identification. While the overall prevalence across England for 2023/24 stands at 0.55%, we reported a higher prevalence of 0.84%.

For more information, see the Digital ReSPECT section on page 82.

***ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment.**

Long-term conditions

Respiratory

We are pleased to introduce Victoria Campbell, who has been successful in securing the position of Respiratory Champion, sponsored by Asthma and Lung UK, the main national charity for lung disorders.



Respiratory champions target areas of high need for change, and identify ways to improve outcomes for adults living with asthma and chronic obstructive pulmonary disease (COPD).

Applications were invited from healthcare professionals in England to apply for six respiratory champion roles across the country. There were 150 expressions of interest, and Victoria was selected to represent Staffordshire and Stoke-on-Trent ICS.

The contract is for 12 months, working one day per week. Victoria will also receive support from Asthma and Lung UK to access data, provide expertise in Quality Improvement, and provide specialist knowledge and facilitate networking and sharing of best practice.

Victoria has developed an action plan for the areas she will be working on in the coming months.

Diabetes

The NHS Type 2 Diabetes Path to Remission Programme is a joint initiative between NHS England and Diabetes UK. Since September 2023, it has been available free of charge to people in Staffordshire and Stoke-on-Trent living with type 2 diabetes who are overweight or obese. Through the programme, a specially formulated total diet replacement (soups and shakes) is provided for three months, alongside support and monitoring for a total of 12 months including re-establishment of food after the initial three-month period.

The programme is provided by Reed Wellbeing, who offer support from a coach either in person or digitally. Research has shown that this approach helped people to lose more than 10kg in weight, improve blood sugar levels, reduce diabetes-related medication and, in almost half of participants, put their diabetes into remission.

The programme has been very successful in recruiting patients, with **505** referrals to date, and participants like Rob are sharing their success stories.

Rob breaks the habit with the Path to Remission Programme

“I was diagnosed with diabetes at the end of last year. Since attending the sessions, I have lost nearly six stone. I still have a bit to lose, but I look and feel much better, and I have more energy for doing things with my family.

“[The programme] has given me a second chance at life. I have seen my dad suffer for many years with diabetes, and now I can hopefully stay in remission for as long as possible.”



[Read Rob's story in full.](#)

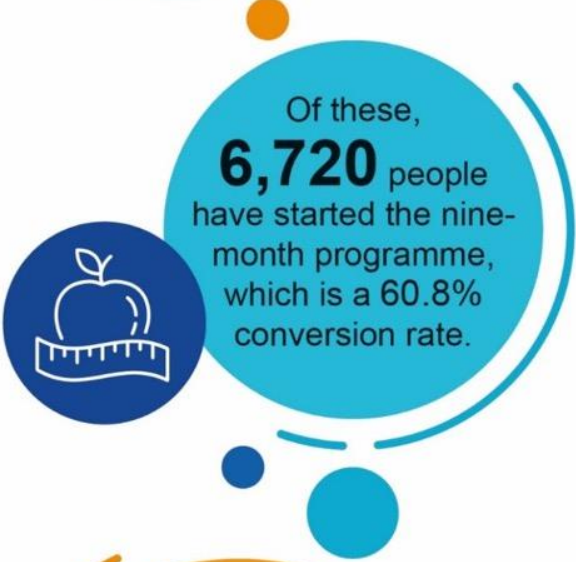
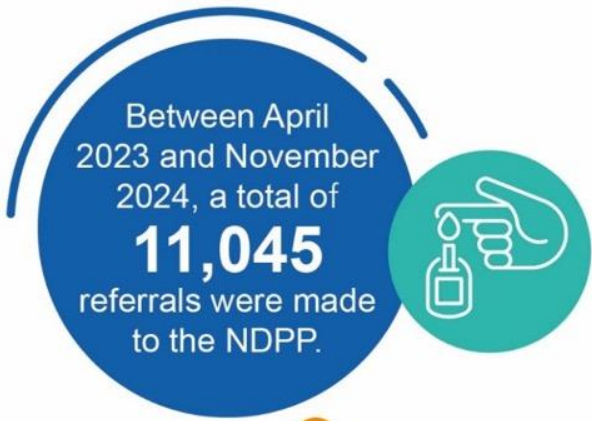
NHS Diabetes Prevention Programme (NDPP)

Any patient identified as being at risk of developing type 2 diabetes should be referred by their GP to the National Diabetes Prevention Programme – a free, evidence-based lifestyle change programme.

Courses run across Staffordshire and Stoke-on-Trent, in a range of formats:

- **Face-to-face** – through a series of 13 friendly and supportive group sessions over nine months with a health coach
- **Digital** – on your phone or online using an app, plus regular contact from a health coach
- **Remote** – tailored remote sessions are available for participants who may have visual or hearing impairments, language requirements or gestational (pregnancy-related) diabetes.

Participants receive personalised support to manage their weight, eat more healthily and be more physically active – which together have been proven to reduce the risk of developing type 2 diabetes.



Research shows the NHS Diabetes Prevention Programme has reduced new diagnoses of type 2 diabetes in England, saving thousands of people from the potentially serious consequences of the condition.

It cuts the risk of developing type 2 diabetes by more than a third for people completing the programme.

There is an excellent referral rate into the programme, and we have seen some very good feedback and results.



Feedback on the NHS Diabetes Prevention Programme

“Good instructions given by course leader.”

“The session was very informative and carried out in a very relaxed manner. The time went really quickly.”

“The provider was well organised. He interacted well with the whole group. He made everyone feel comfortable and able to ask questions. He made the session fun but at the same time made us realise the importance of what we were undertaking.”

Eight care processes – diabetic annual review

Everyone with diabetes is entitled to receive an annual review, which can be carried out within primary care or through the Eight Care Diabetic Service based at MPFT.

Following a sharp decrease in the number of reviews being completed since the COVID-19 pandemic, the number of reviews has risen again over the past few years:

Patients with type 1 diabetes receiving their diabetic annual review

Location	2020/21 %	2021/22 %	2022/23 %	2023/24 %
England	27.4%	35.2%	40.5%	47.2%
Staffordshire and Stoke-on-Trent	17.5%	26.2%	41.7%	50.6%

Patients with type 2 diabetes receiving their diabetic annual review

Location	2020/21 %	2021/22 %	2022/23 %	2023/24 %
England	36.9%	47.9%	57.8%	62.4%
Staffordshire and Stoke-on-Trent	24.2%	38.5%	55.5%	63.4%

Information provided by Long Term Conditions and Prevention Clinical Networks, NHS England – Midlands

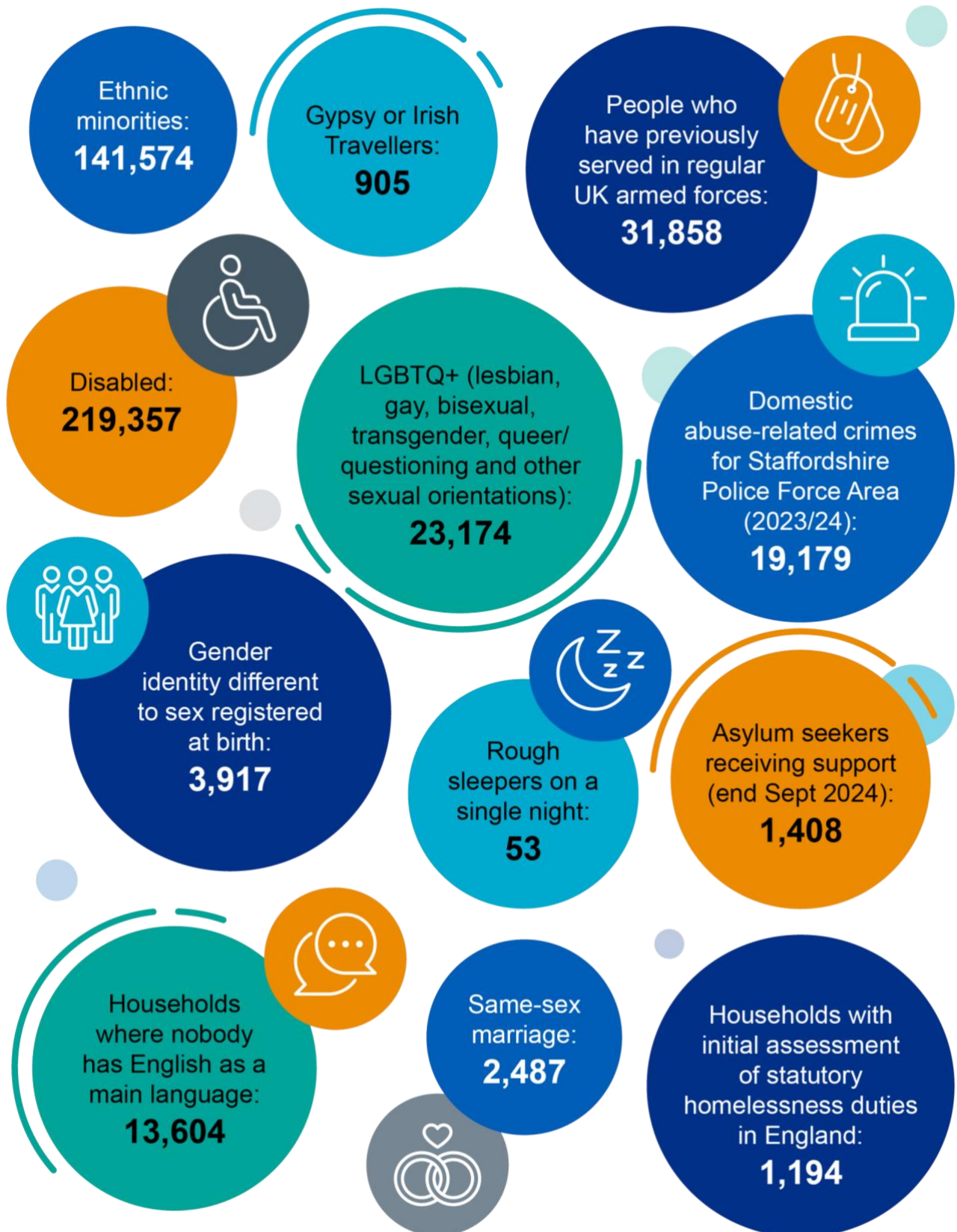


Improving Population Health



We are a member of Staffordshire Health and Wellbeing Board, which brings together local organisations to improve health and wellbeing and ensure fair access to good-quality health and care services.

The demographic profile of Staffordshire and Stoke-on-Trent



Sources for statistics on previous page:

[Domestic abuse prevalence and victim characteristics, England and Wales: year ending March 2024. ONS](#)

[Statutory homelessness in England: Apr-Jun 2024, Ministry of Housing, Communities and Local Government](#)

[Asylum statistics, Research Briefing, House of Commons Library. 20 December 2024.](#)

This information has been developed in conjunction with the Health and Wellbeing Board and was agreed to be included in this year's Annual Report.

Reducing health inequalities

The Health and Wellbeing Board meets to understand local needs, agree priorities and promote joint working between the NHS, Staffordshire County Council and other partners, including commissioning services together where possible.

The Health and Wellbeing Board plays a role in integration of health and social care through leadership and facilitation of relationships, as well as oversight of the Better Care Fund.

The Joint Strategic Needs Assessment (JSNA) is a statutory requirement for all upper tier local authorities and ICBs, and is an example of our contribution to the HWB in 2024/25. It provides an overview of the health and wellbeing needs of the population and can be used to identify areas of greatest need, monitor trends, target interventions and evaluate impact. The JSNA informs the Health and Wellbeing Board Strategy as well as the ICP Strategy.

Together with Staffordshire County Council, Healthwatch and the District and Borough Councils, we have developed an interactive online JSNA dashboard that offers easily accessible, up-to-date data and intelligence at different levels (such as county, district/borough, PCN). This allows end users to self-serve their own data, with the dashboard built to automatically draw through new data whenever it is updated.

A summary document highlights the key findings and trends from the dashboard. It follows the life course approach, mirroring the dashboards, and provides interpretation of the data. The JSNA will continue to be developed and will include information on specific topics for Staffordshire – including a greater depth of information to enable a better understanding of key local issues. As the JSNA dashboard is developed, the summary report will also be updated.

Core20PLUS5

Core20PLUS5 is NHS England's approach to inform action to reduce healthcare inequalities at both national and system levels. It defines a target population – the 'Core20PLUS' – and identifies five clinical areas of focus requiring accelerated improvement.

'Core20' refers to the proportion of our residents who are among the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). This applies to 53% of residents in Stoke-on-Trent, and 9% of residents in Staffordshire.

We have continued to deliver the Core20PLUS5 Connectors programme in Cannock Chase with Support Staffordshire, supporting marginalised communities to access blood pressure checks and engage with cancer diagnostic services.

In Stoke-on-Trent, the Community Health Champions programme delivered by Voluntary Action Stoke-on-Trent (VAST) have focused on health literacy training, Raising Community Voice, and brokering engagement within marginalised communities.

'PLUS populations' can be identified at a local level and should represent inclusion groups and those with protected characteristics or other factors that make them particularly vulnerable to health inequalities. Our chosen PLUS group is vulnerable populations.

Veterans

In recognition of the fact that veterans often struggle to access and navigate health services appropriately, the ICB and UHNM have jointly funded an 18-month pilot of a support worker from the Defence Medical Welfare Service (DMWS). The role is embedded at UHNM, to support veterans through their secondary care experience.

The DMWS Officer won the Impactful Newcomer award at the 2024 Defence Medical Welfare Service Staff Recognition Awards, which recognised the significant positive impact made in a relatively short period of time.

Asylum seekers/resettled migrants

We have supported asylum seekers and resettled migrants during 2024/25, including families and single males as well as unaccompanied minors. The number of beds commissioned varied over time, depending on national direction and demand.

There are three local hotels for asylum seekers and a site housing Afghan resettled individuals at the moment, with around 500 individuals placed. Most have been accommodated within our most deprived wards, adding an additional layer of complexity and potential disadvantage – reduced access to primary care, poorer educational and employment opportunities and higher rates of crime.

A true multi-organisational partnership approach has been needed to support them – including primary and community care, mental health and secondary care, public health and local authorities as well as the voluntary, community and social enterprise sector.

Those at risk of serious violence

A multi-organisational task group has been set up – the Violence Reduction Alliance.

They are hosting a Serious Violence Project Coordinator to bring focus and action to support those at risk, while also acting as a bridge between the NHS and other agencies – highlighting when and how to incorporate a public health approach into any interventions.

Women at risk of having, or who have had, one or more children removed from their care

With Stoke-on-Trent City Council, we have jointly funded the PAUSE programme which works with these women individually to make positive sustainable changes.

Family Matters Programme

Statutory and VCSE partners across Stoke-on-Trent have formed a Family Matters Network (FMN) and developed an improvement programme, focused on enhancing collective impact through system-wide collaboration.

The key focus is to design and implement solutions to prevent families falling into crisis, which harms their children and their life chances, by addressing inequalities experienced by the city's most disadvantaged children and young people and to improve skills and resilience.

The inputs are designed to realise the following outcomes:

- Reduced infant deaths
- Improved early development scores
- Improved school attendance
- Reduced school exclusions
- Reduced first-time youth offenders
- Improved CYP mental health recovery rates
- Reduced rates of domestic abuse and violence
- Reduced adolescent self-harm
- Improved child dental health
- Improved physical activity levels.

MMR Vaccine Equity Partnership

As part of a continued collaboration with the Staffordshire and Stoke-on-Trent COVID-19 Vaccine Health Equality Group, the Community Health Champions project supported the facilitation and organisation of childhood MMR (measles, mumps and rubella) vaccine clinics at local venues across Staffordshire and Stoke-on-Trent.

These clinics were hosted by champion organisations Stepping Stones and the Chell Area Family Action Group (CAFAG), and the Sudanese community. The project has therefore strengthened the connection between champion organisations and public health.

The initiative also aimed to enhance vaccine uptake by providing parents with vital information and consultation opportunities with healthcare practitioners. The clinics offered the opportunity for healthcare professionals to reassure those who are hesitant about vaccines.

This collaboration continues through the identification and targeting of communities with low vaccine uptake. Currently, efforts are underway to engage the Pakistani community, which has the lowest COVID-19 vaccine uptake, through targeted discussions to identify and overcome barriers to vaccination.

Together with Stoke-on-Trent City Council, we will invest health inequalities money in the following specific initiatives:

A new family support model

Locally trusted organisations from the voluntary, community and social enterprise (VCSE) sector will be commissioned to pilot a new family support model, working collaboratively at a local level with other VCSE organisations and statutory agencies.

There will be one in each of the four city areas, responsible for:

- **Developing a family support coordinator service** which works actively with families to address issues before they escalate and connects and amplifies existing community and statutory provision. This will involve working with families to address a range of needs – including debt advice, housing issues, education, family learning and employment, food and nutrition, smoking, dental health, physical activity, domestic abuse, and alcohol and drug issues.
- **Evaluating local provision in relation to the needs of families** – working directly with each community to identify and address needs related to inequalities.
- **Managing a micro-grant funding budget for local groups** to develop initiatives to address need, facilitate family resilience and address inequalities. For example: funding to improve play provision for very young children to improve speech and language, socialisation and school readiness, helping to improve Early Years Development scores and future educational attainment.

Early years academy

Providing training and support to the early years workforce helps to develop children's attachment, brain development and sets them on a path of better wellbeing for the future.

Investment will be focused on supporting the health and care workforce across Stoke-on-Trent to support local families.

Statement on information on inequalities

As part of our response to NHS England’s Statement on Information on Health Inequalities (duty under section 13SA of the NHS Act 2006), we will publish a separate report on health inequalities. This will provide more detailed information on health inequalities in Staffordshire and Stoke-on-Trent, covering multiple indicators across 10 domains.

The report covers indicators that are aligned to the five priority areas for addressing healthcare inequalities set out in national priorities and operational planning guidance, and the Core20PLUS5 approach for adults, children and young people.

[View our Health Inequalities Report.](#)

Health and inequalities

Liaison with Health and Wellbeing Boards on our local Health and Wellbeing Strategies

The ICB is a member of two Health and Wellbeing Board (HWBBs) – the Staffordshire Health and Wellbeing Board and the Stoke-on-Trent Health and Wellbeing Board, which bring together local organisations to improve health and wellbeing and ensure fair access to good quality health and care services.

Examples of our contributions to the two HWBBs in 2024/25 include contributing to the four workstreams that underpin both HWBBs’ Joint Health and Wellbeing Strategies (both available via each HWBB’s main webpage):

1. Ageing Well – 2. Healthy Weight – 3. Health in Early Life – 4. Good Mental Health.

There is joint commissioning with Staffordshire County Council and Stoke-on-Trent City Council through the Better Care Fund, which is regularly reported to Boards. This information has been developed in conjunction with HWBB input, and was agreed to be included in this year’s Annual Report.

Local Government Association (LGA) review and collaboration with ICB – Staffordshire HWBB

The Health and Wellbeing Board reviewed its governance arrangements and secured Local Government Association support to define ‘Place’ in Staffordshire and clarify the role of the HWBB.

The ICB has actively participated in all stages of the review. The [findings](#) will help shape future partnership arrangements for both the HWBB and the ICB/ICS in 2025/26.

Regular programme updates on HWBB Strategy key programmes and associated Annual Reports

This includes children and young people and ‘Beat the Cold’ and fuel poverty (Stoke-on-Trent), Safeguarding Partnership and Directors of Public Health Annual Reports (both HWBBs), and updates to the Joint Commissioning Boards.

Health Inequalities Strategy

See also the complementary section on the ICS-wide Integrated Care Strategy and work of the Integrated Care Partnership.

The ICB has led on a whole ICS approach to tackling health inequalities across Staffordshire and Stoke-on-Trent, with support from the Public Health and Prevention Team at Staffordshire County Council.

Key stakeholders from across the system, including both tiers of local government, the VCSE sector, and other system partners, were brought together to design a strategy for how health inequalities will be tackled.

The principles of the Strategy include:

- Taking a population health approach to tackling health inequalities
- Aligning data in order to focus efforts on those most likely to experience poor outcomes
- A commitment to build on the successes already being delivered across the system, rather than re-inventing the wheel.

The Strategy is complemented by the ICB funding and Public Health funding streams (through the localities improvement framework and the Supportive Communities Programme), aimed at enabling local strategic partnerships to establish their own priorities based on the key issues for their areas.

Development of Joint Strategic Needs Assessments (JSNAs) online, interactive dashboard and district profiles

The interactive JSNAs and district profiles have been developed this year by the Public Health and Insight Teams at both councils, in partnership with the ICB.

These include population-level data and community insight for the county of Staffordshire and its eight districts and the city of Stoke-on-Trent, by providing up-to-date data and insight on key health needs as well as the wider determinants of health.

There are district profiles containing insight at ward level. The dashboards are now being shared with partners across the system and will be used to support the development of local and strategic priorities.

An advantage of the web-based version is that changes to data can be regularly updated, rather than reliance on a static PDF version. Users are also able to drill down into the data to highlight areas or items of interest.

Health Inequalities Director's Group

This group brings together senior representation from the ICB, Staffordshire County Council, all eight district and borough local authorities as well as the city of Stoke-on-Trent.

The group has facilitated specific interventions delivered by district and borough councils to tackle health inequalities. Acting as a platform, it better engages NHS partners in locality wellbeing discussions and activities.

Joint Alcohol Strategy

The ICB has consulted both Health and Wellbeing Boards on the development of a Joint Alcohol Strategy that is being led by the Staffordshire Police, Fire and Crime Commissioners' Office Drugs and Alcohol Partnership.

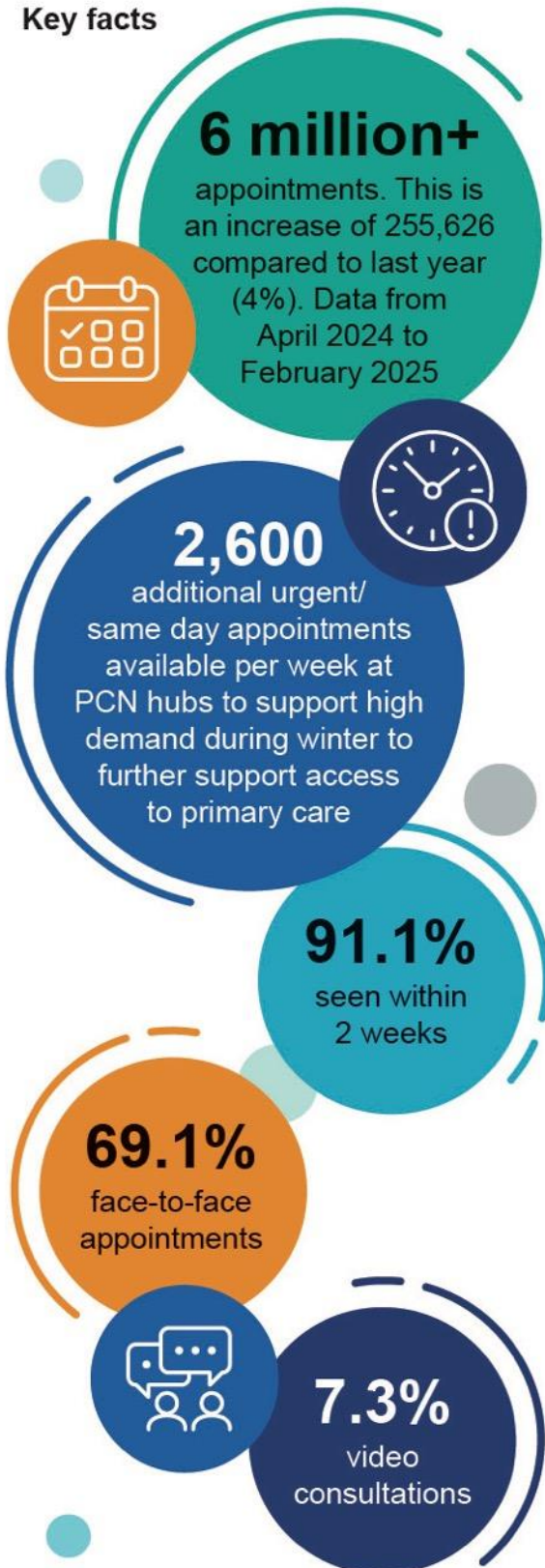


Primary Care



There are 141 practices and 25 Primary Care Networks (PCNs) in Staffordshire and Stoke-on-Trent. We have continued to deliver against our five-year GP Strategy (published April 2023) and our ambitions for patients to access high-quality, sustainable and resilient general practice services and to reduce inequalities and variation of service.

Key facts



In 2024/25 we have delivered against five key priorities, with the following highlights.

Improving health outcomes via collaborative working

PCNs are improving access to services and outcomes focusing on populations such as people with learning disabilities, people from ethnic minority groups, and frail patients. This involves working closely with other partners across the health system to develop approaches to best support our patients.

A number of PCNs have focused on improving access to **cancer screening** services for patients. To overcome language barriers, one PCN contacted patients over the phone in their home language to discuss how they access these services, and produced leaflets about cancer screening in a range of alternative languages. Another PCN provided cancer screening drop-in sessions for their patients who had learning disabilities. This was achieved by working collaboratively with the local hospitals.

PCNs have held various community events with other partners across health and the voluntary sector to promote **'living well'** messages. These include raising awareness of signs and symptoms of cancer, and enabling patients to ask questions and learn more about groups and activities they can access.

Social prescribers have been key in connecting patients to practical, social and emotional support in the community. Together with community providers and the voluntary sector, they are improving access to services for patients and supporting a consistent approach.

PCNs have been accessing **organisational development support** to enable effective working across teams and to develop clear priorities.

Support has been provided to 16 PCNs, and plans are underway for further work across PCNs into 2025/26.

Social prescribing

East Staffordshire PCN has harnessed the relationship with a local football club and the power of innovative social prescribing technology to catalyse neighbourhood health creation and generate valuable insights into neighbourhood needs. Reducing the footfall in GP practices and reducing levels of inequality are the focus of the model, to ensure primary care can provide the service that residents need.

The social prescribing experience is based on 'what is the most important thing' for people and aims to connect residents to their neighbourhood to achieve their goals and support other members of their neighbourhood.

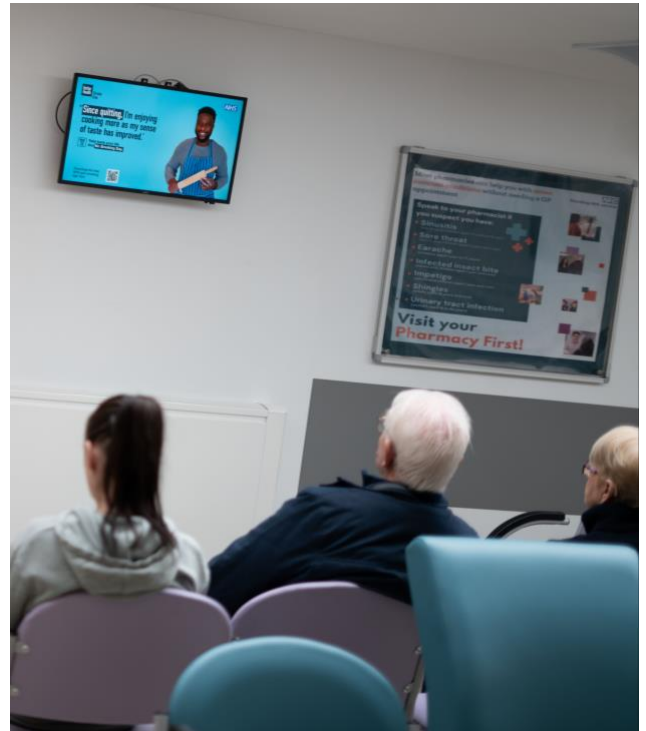
[Read the full case study.](#)

Providing safe and high-quality services

The Care Quality Commission (CQC) has rated **131** (93%) of our GP practices as **Good or Outstanding**. Where this is not the case, action plans are in place for improvement prior to re-inspection. We continue to support all practices in readiness for future CQC inspections.

We have ways to identify practices that may need additional support (through bringing information and feedback together) and that may be experiencing challenges.

We also promote a **positive learning culture** through capturing and sharing positive news stories and good practice between practices and PCNs.



In terms of **prevention**, practices and PCNs have continuously contributed to and worked on a range of quality improvement projects to protect patients' health and wellbeing, and to prevent illness.

These have included:

- **626,294** COVID-19 and flu vaccinations delivered as part of the 2024 autumn/winter campaign, of which 367,925 were given by general practices and PCNs (58.7%). Getting vaccinated every year will top up your protection and reduce your risk of getting severe symptoms of these infections.
- More than **5,198** (82.6%) people with a learning disability received an [annual health check](#) this year (120 more than last year). These checks can improve people's health by spotting problems earlier.
- On track to deliver our 2024/25 ambition to complete physical health checks for 60% of people (more than 4,300 individuals) with serious mental illness. These checks can find health problems earlier so treatment can be provided, or patients can be supported to stay well (as at December 2024).



We have successfully awarded **new contracts** for the provision of primary medical services (GP practices) for Meir Park and Weston Coyney Medical Practice in Stoke-on-Trent, and Essington Medical Practice in South Staffordshire.

Temporary caretaker arrangements have been put in place for Gordon Street Surgery in Burton upon Trent, and a longer-term solution will be put in place during 2025/26.

Digital inclusion

PCN member practices identified an NHS App Ambassador and organised a community event to encourage patients to sign up to the NHS App, as well as increasing usage by those who already had a log in.

Patients were supported to download and access the app, and any issues they had were resolved in-person during the event. On that day, the NHS App QR code was scanned more than 600 times.

Supporting the local farming community

Sister Rose Bain, based at Barton Family Practice, was awarded the Queen's Nurse title last year and is keen to support the healthcare needs of the local farming community. Rose was asked by Staffordshire Agricultural Society to attend Loxley ploughing event in September 2024, and was joined by fellow Queen's Nurse, Gill Boast.

Rose and Gill ran a 'health hub' for farmers to take blood pressure readings and offer other health and lifestyle advice. Rose has been asked to attend again in 2025, and is looking at other ways to help the farming community with their health.



Improving patient experience

The National GP Patient Survey results for 2024 (conducted January to March 2024) demonstrated an improvement with overall patient satisfaction, which was 76% in 2024. In Staffordshire and Stoke-on-Trent, we also had higher scores than the national average for most of the questions asked.

Improving access to GP services has continued to be a key focus for us when working with our practices and PCNs – including:

- Working towards a better experience for patients when phoning their GP practice through the use of improved digital telephony
- Simple methods for online requests
- Faster care navigation, assessment and response for patients to receive the right support at the right time with the right professional to manage their needs.

We have showcased our good work to national and regional teams. In October 2024, we hosted a visit from Dr Claire Fuller, Primary Care Medical Director for NHS England.

Recruiting and retaining our valuable general practice workforce is key to a sustainable general practice. In 2024, our Primary Care Workforce Implementation Group developed a Local Workforce Delivery Plan which includes a broad range of initiatives.

The plan is closely linked and aligned to the [NHS People Promise](#) principles to ensure a positive culture, improved engagement, increased morale and better staff experience. This is a partnership approach across the ICS, including with our Staffordshire Training Hub.

We have increased our [primary care workforce](#) to support improvements in access:

- As part of a wider workforce that our patients can access, PCNs recruited 697 (whole time equivalent) additional roles including physiotherapists, mental health workers, care coordinators and paramedics.
- The innovative General Practice Nurse Foundation School (led by our Staffordshire Training Hub) supported 15 new nurses coming into general practice during their first year, through training, learning, support and supervision.

A smooth transition to digital telephony

Lyme Valley Medical Centre always had a good uptake of digital access, but had wanted to move to a more modern telephony system which better met their needs. Supported by ICB funding, the practice changed provider to X-On who provided very comprehensive pre-go-live support and training. Staff felt all communications from X-On were clear, concise and informative.

Since making the switch, positive feedback has been received from patients and admin staff. Clinicians find the call recording feature reassuring. This also helps admin staff to reflect on calls, with support from managers, and consider if anything could have been handled differently.

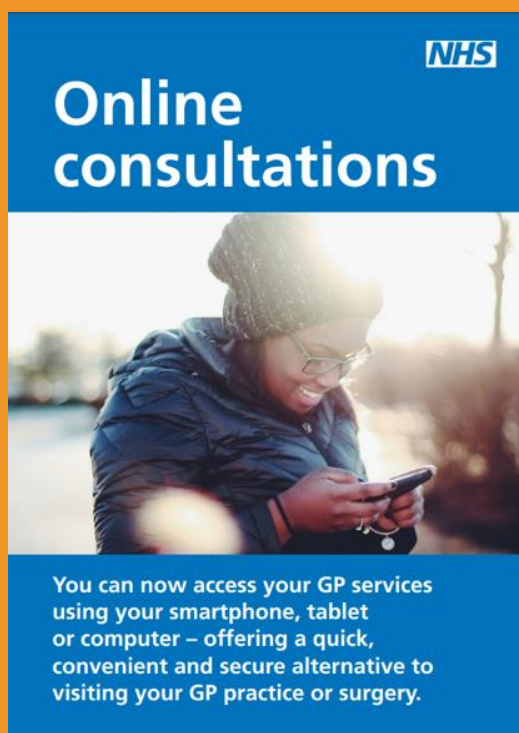
Five months on, the practice feel that digital telephony is well embedded.

Online consultations

A digital software solution adopted by one GP practice has enabled patients to initiate online consultations for various non-urgent requests.

This has reduced the total call volume by 35% and enhanced efficiency, with reception staff processing double the number of consultations compared to the traditional model of managing requests over the phone.

Patient satisfaction has increased, with more than 90% of patients rating the service as excellent and showing a preference for online consultations.

A graphic for an NHS leaflet titled 'Online consultations'. It features the NHS logo in the top right corner. Below the title is a photograph of a woman wearing a blue jacket and glasses, looking down at her smartphone. At the bottom of the graphic, there is a blue box with white text that reads: 'You can now access your GP services using your smartphone, tablet or computer – offering a quick, convenient and secure alternative to visiting your GP practice or surgery.'

[See the national patient leaflet explaining online consultations.](#)

Further initiatives to support our general practice workforce include:

- Staff psychological wellbeing support has been made accessible through a hub model to support our staff in their day-to-day life at work.

- We launched the General Practice Long Service Award to celebrate those staff who have each dedicated between 25 and 50 years' service and commitment to general practice and the wider NHS – more than 4,000 years were celebrated at the event in October 2024.

The following are just a few examples of the digital advances we have made over the last year to improve patient experience via the use of digital technology.

- 100% of practices are providing patients with access to their (prospective) record via the NHS App – if they wish to access it.
- Our free digital registration service allows patients to choose to register at a GP practice in-person or online at a convenient time for them. All practices are required to have this service live, and we are pleased to confirm that 100% of our GP practices have made this service available to their patients.

Reducing variation and commissioning universal services

We set up 35 Primary Care Spirometry hubs – giving access to diagnostic testing for chronic obstructive pulmonary disease (COPD) to 100% of the population. This helps patients get quicker access to tests, outside of a hospital setting.

A new **Acute Home Visit Service** has been put in place for South Staffordshire patients. The new provider will provide a four-hour urgent response to patients at home who are acutely unwell and would otherwise have needed to call 999 or NHS 111.

We have reviewed 25 **Local Enhanced Services** (LES) to ensure patients have access to a range of universal services at their local GP practice, instead of needing to visit a hospital setting. The review has ensured that services reflect any new guidelines, deliver value for money and reduce variation in provision.

Ensuring fit-for-purpose estate provision and maximising digital alternatives

All of our 25 PCNs have an estates plan that looks at how they use the estate available to them and identifies opportunities for major developments.

Some of the key work this year includes:

- More than **£127,000** has been invested via Premises Improvement Grants in 2024/25. Further support has been given (via Section 106 funding) to complete building projects at existing premises, providing more clinical rooms.
- Working with local estates partners, we have implemented a single booking system for rooms that were not previously used, meaning space can be used more flexibly by our practices and PCNs.
- We have progressed with two major estate projects that were identified as strategic estate priorities in Burton upon Trent and Burntwood – including securing **£1.15 million** Community Infrastructure Levy funding via Lichfield District Council to support this.
- We have continued to work with our local authority partners, the development industry and cross-boundary systems, and secured £1.7 million of Section 106 funding to support estate development – in recognition of local housing growth and to ensure general practice estate is fit for the future.

The change in government has resulted in several changes to the town and country **planning system** in England, with policy changes expressed via the National Planning Policy Framework.

There has been a focus on the shortfall of housing land supply nationally, and consequently policies on housing delivery have been updated.

We will continue to work with local authorities to create a shared understanding of what this means for health service provision and infrastructure planning. We will support PCNs with their estate plans, which may need to be adapted in the light of policy changes.

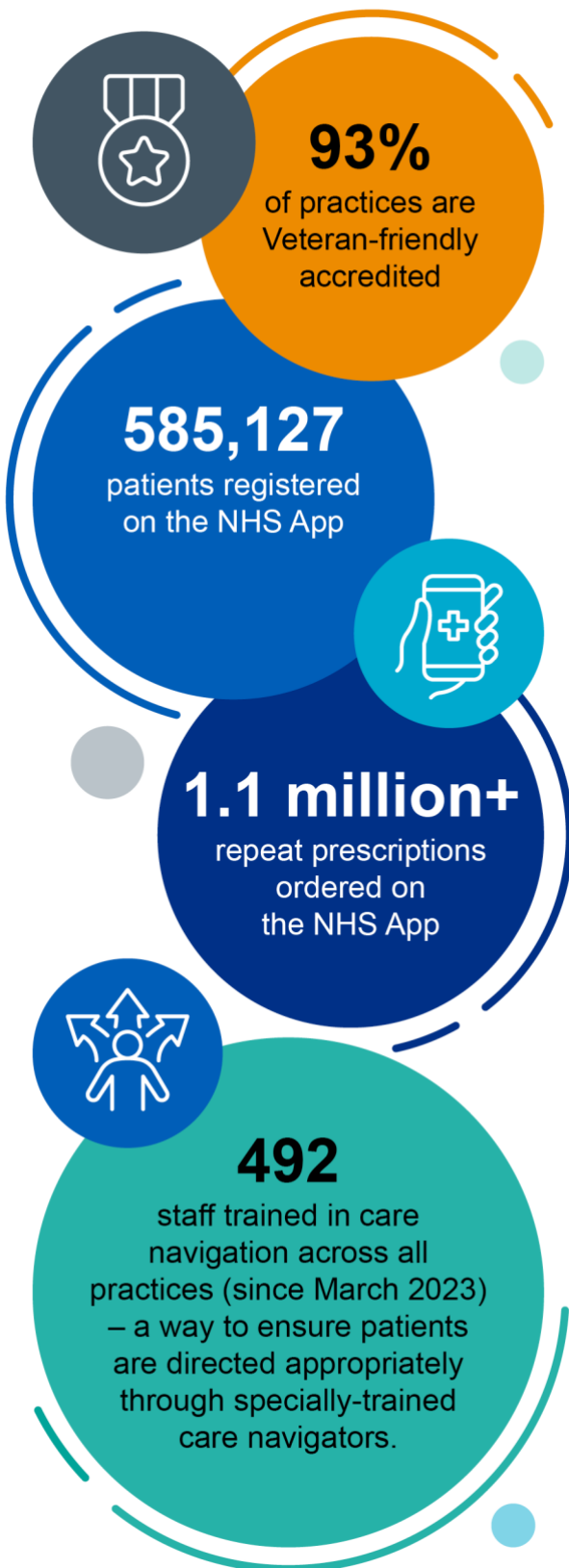
Behavioural science

Behavioural science techniques used in GP practice communications have supported a reduction in missed appointments from 4% to 2% – equivalent to 100 appointments per month.

Since using the resources in the Behavioural Science Cancer Toolkit:

- **14.1%** of previous non-responders returned bowel screening kits
- **5.8%** of previous non-responders attended cervical screening.

Other achievements



Wider primary care services

Pharmacy, dental and optometry

As part of our delegated responsibility for the commissioning of community pharmacy, dental and optometry services, we continue to develop local relationships and approaches.

We have been building positive relationships with our dental colleagues to understand the issues they are facing, which has supported the development of our local dental plan for 2025/26. The plan also has a focus on the dental workforce and how we continue to engage and support them.

Our aims are to improve access to dental care and enhance oral health services which promote toothbrushing and mouthcare programmes to children and care home residents.

We have been working with local pharmacies who have played an important role this year in supporting access to primary care and improving patient experience.

The [Pharmacy First](#) scheme provides advice and treatment for a number of common minor illnesses such as insect bites, sore throats and urinary tract infections. See next page for details.

Optometrists continue to provide access to a range of eye care services, including urgent eye conditions.



Medicines optimisation

Community pharmacy services

234 community pharmacies are commissioned to provide pharmacy services across Staffordshire and Stoke-on-Trent ICB. In addition to their traditional role in dispensing and advising on the best use of prescribed medicines, our pharmacies now undertake other important services which support primary care colleagues.

Pharmacy First was launched in early 2024 and our local community pharmacies saw more than **82,000** people in Staffordshire and Stoke-on-Trent by the end of the year. The scheme allows patients to be seen and where appropriate to be treated directly by the pharmacist for seven clinical conditions (urinary tract infections (UTIs), sore throat, sinusitis, shingles, impetigo, infected insect bites and stings, and acute otitis media) – saving GP, out of hours and urgent care appointments for patients with more serious or complex conditions.

Community pharmacy also offers an **NHS contraception service** which offers advice and where appropriate resupply or starting of oral contraceptives following a consultation with the pharmacist. More than **13,000** patients have benefited from this service during 2024/25. The service will be expanded to include emergency contraception from October 2025.

As all newly qualified pharmacists will be able to prescribe from 2026, four of our pharmacies have been taking part in a national pathfinder programme to explore the role of pharmacists in **independent prescribing**. Areas being explored include safer prescribing of anticoagulants, antidepressants, antihypertensives and treatment of common ailments. The programme will be evaluated in summer 2025 and will inform future

commissioning of community pharmacy services.

Hypertension case finding

Pharmacists have taken an active role in hypertension case finding – completing more than **70,000** blood pressure checks over the last year.

They have confirmed high blood pressure using ambulatory monitoring in 3,895 of these patients, and worked closely with GP colleagues to ensure patients' high blood pressure can be managed.

Assuming these patients comply with management for the next five years, this will prevent:

- 31 deaths
- 58 strokes
- 39 myocardial infarctions (heart attacks).

Medicines safety

Our Medicines Optimisation team has an important role in ensuring the safe use of medicines across our population – focusing on some of the higher risk medicines commonly used in primary care.

During 2024/25, work has focused on **opioid medicines**. While they have important clinical uses, opioids can unfortunately be subject to misuse and dependency if not closely monitored and regularly reviewed. A multidisciplinary working group was established, and the team worked with GP practices to ensure that all opioids have clear indications for use and that prescribed quantities were limited to a maximum of 30 days.

The team developed social media messages for patients, and also put in place training and guidance on tapering doses for practices to aid safer management. Further work is planned for 2025/26.

The team undertook a discharge audit on the accuracy of discharge information for high-risk drugs to enable timely and safe **medicines reconciliation** in primary care. Quality improvement opportunities were identified, and work is proceeding across the system to implement these.

Reviewing anti-epileptic drug prescriptions

The Medicines Safety team leads on the implementation of the National Patient Safety alerts. A key objective this year has been improving care for people with epilepsy, bipolar disorder and conditions for which valproate or topiramate is prescribed.

These drugs have been associated with harm to unborn babies during pregnancy, and are now contra-indicated in pregnancy (not suitable for use while pregnant). However, local healthcare organisations have to put processes in place to ensure safe use in female patients who could potentially become pregnant in the future.

A system-wide valproate working group was established to review current processes for how these drugs are prescribed and reviewed in order to identify any gaps and risks in the current system. Female patients taking these medicines have been identified and referred to specialist clinicians for review of their treatment, and clinical templates have been produced to support safe primary care prescribing of these drugs going forward.

Staffordshire and Stoke-on-Trent Medicines Formulary

Historically there were two medicines formularies (lists of preferred medicines to ensure cost-effective treatment options) covering the Staffordshire and Stoke-on-Trent area.

Following a multi-year piece of work in collaboration with primary and secondary care colleagues, the Medicines Optimisation team harmonised these in 2024 and moved to a single combined formulary website. This has removed most discrepancies from the two formularies, and going forward, any addition or amendment to the formulary can be made uniformly across the ICS.

A new piece of work was agreed in 2025 to undertake a chapter-by-chapter review of the newly unified formulary to ensure that the drug choices and information provided are up to date and in line with current clinical practice. This work will require a collaborative approach with providers across the system, in the same vein as the previous formulary harmonisation project.

Implementation of NICE Technology Appraisals

The Institute for Health and Care Excellence regularly publishes Technology Appraisal Guidance which makes recommendations on the use of new and existing medicines and other treatments within the NHS.

Depending on the nature of the medicines, either NHS England or the ICB are required to ensure that NICE-recommended treatments are provided within their commissioned services.

During 2024/25, NICE issued 61 medicines-related technology appraisals, and **19** of these were a responsibility for the ICB to take forward for implementation.

We directed guidance-covered medicines for a wide range of conditions such as glaucoma, osteoporosis, migraine, COVID-19, overactive bladder syndrome, prostate cancer, ulcerative colitis, uterine fibroids, and obesity.



Safeguarding, child deaths and looked after children



Through strong leadership and partnership, the Safeguarding team have continued to carry out their required statutory duties, monitor compliance and competence through their contracts, and reinforce the message that safeguarding is everyone's business.

We are represented on Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board and the Staffordshire and Stoke-on-Trent Safeguarding Children Partnership Board, and subsequent sub-groups and workstreams.

Our priorities over the past year have been:

- Representing the ICB in many statutory **safeguarding review processes** such as Rapid Reviews, Child Safeguarding Practice Reviews (CSPRs), Child Death Overview Panels (CDOPs) and Child Death Reviews (CDRs), Domestic Abuse Related Death Reviews (DARDRs) and Safeguarding Adult Reviews (SARs).
- Developing the **Safeguarding Accountability and Assurance Framework** in accordance with national guidance.
- Developing an **audit process** through the Provider Collaborative for safeguarding adults which aligns to the work of the safeguarding partnership boards.
- Continuing to develop the **governance process for Safeguarding Adult Reviews** with the relevant sub-group, and working with the community safety partnership to develop a joint process for SARs and DARDRs.
- Continuing to **support GP practices to represent themselves** in safeguarding statutory review processes.
- Supporting **safeguarding practice improvements** with primary care staff, utilising the Joint Safeguarding Self-Assurance Tool (JSSAT), and further developing One Health and Care to enhance information sharing.
- Shaping the **Domestic Abuse and Sexual Violence Strategy** and the **Serious Violence Strategy** to ensure the health economy is fully engaged with action planning and delivery.
- Successful partnership working to **address cross-border related issues** with the implementation of the 'Pick up the Phone' campaign, recognised by NHS England as an excellent initiative for the improved sharing of safeguarding information.
- Supporting the development and delivery of the **HOPE Project Boxes** for women who are separated from their baby close to birth due to safeguarding concerns. This project was a collaboration with Derby and Derbyshire ICB and University Hospitals of Derby and Burton NHS Foundation Trust at Queen's Hospital, Burton.
- Continuing to engage with multiple agencies to deliver on **children's safeguarding reforms** such as Working Together 2023, Stable Homes, Built on Love 2023, and Keeping Children Safe, Helping Families Thrive 2024.
- Representing the health economy on both Prevent Boards and facilitating the **Health Prevent Forum**, through chairing and contribution to decision making, and showcasing good practice. The team presented a mental health services case scenario to Staffordshire Prevent Board.

Health and wellbeing of Looked After Children

ICBs have statutory duties and legal responsibilities in relation to Looked After Children.

To support this, we have access to the expertise of two Designated Doctors and a Designated Nurse for Looked After Children who represent the ICB on both Staffordshire and Stoke-on-Trent Corporate Parenting Boards. There is also ICB representation at other partnership meetings for Looked After Children across both local authorities.

Priorities over the past year in relation to Looked After Children have been:

- Understanding the local risks and challenges through working with local health providers and the local authorities – with specific focus on the **timescales for initial and review health assessments** as compliance has not been in line with statutory timescales. **Medical reports for adoption proceedings** have also not been provided as quickly as we would like.
- The ICB has allocated financial resource to health providers on a recurrent basis to enable them to meet the local demand for all aspects of **Looked After Children health assessments**.
- Developing a system-wide dataset and dashboard to **demonstrate compliance against key health indicators**, in line with statutory guidance. This includes timeliness of health assessments, dental checks, immunisations, medical reports and adult health assessments, and quality assurance of Review Health Assessments. The dataset also highlights areas of challenge or potential risk as well as good practice.
- Developing a quality assurance framework for Looked After Children across both health providers, to **incorporate service user feedback and quality assurance** of initial and review health assessments.

Child Death Overview Panel (CDOP)

Child death review partners (local authorities and the ICB) are responsible for conducting child death reviews when a child dies, in any circumstances. Promoting safer sleep continues to be a priority, with awareness and training being rolled out across the area. There have been specific training events and face-to-face multi-agency sessions which are based on learning from local case reviews.

The emphasis of this training is to use the 'Make Every Contact Count' approach and highlight that it is everyone's responsibility to share and reinforce clear and consistent messages to ensure that babies are laid down to sleep safely.

The CDOP also identified a rise in the number of suicides in the teenage population – instigating a deep-dive audit into these cases. The findings will be presented to the CDOP in April 2025, with the aim of identifying any trends, gaining an insight into which children may be at risk of suicide, and looking at interventions which can prevent suicide and future deaths.



Quality and patient safety, assurance, and improvement

Our ICB [Quality Strategy](#), co-produced with NHS partners, has been designed to complement the overarching ambitions of the ICS priorities and the ICS Joint Forward Plan, with quality and safety being the golden threads running throughout.

It describes our quality aims, supports our delivery of the [NHS Patient Safety Strategy](#) and [NHS IMPACT](#) (Improving Patient Care Together), outlines our quality risk response following the National Quality Board guidance, and is underpinned by our delivery plan.

The ICS implemented the [Patient Safety Incident Response Framework](#) (PSIRF) on 1 December 2023.

We collaborate with partners across the ICS to deliver our statutory duties to secure continuous improvement in the quality of services.

We are proud of the following achievements that support our successful transition to a new way of working:

- All partners received **accredited oversight and/or investigator training** to support improving patient safety through a systems approach.

System-wide learning events

Monthly touchpoints and system-wide learning events (held in May and October 2024) have maximised learning and improvement from patient safety incidents.

We are proud of the positive energy and engagement with these bi-annual events, with attendance from NHS trusts both in and out of system, non-NHS organisations, NHS England, and Health Innovation West Midlands.

- We received '**substantial assurance**' from the ICB's internal auditors in April 2024, following a review of the delivery of PSIRF.
- **Level 1 (all staff) has been included in mandatory training** since April 2024. Level 2 (clinical staff) will become mandatory from April 2025.

Patient Safety Partners

We recruited two volunteer Patient Safety Partners (PSPs) to advocate for patients, carers, and families to ensure that their perspectives and considerations are prioritised.

The volunteers report to our Patient Safety Specialist, support the work of the ICB, and collaborate with the PSPs of system partners.

- We recruited three **Patient Safety Specialists (PSSs)** from our existing clinical workforce. One has completed Level 3 and 4 training already, and the others will be trained in 2025.

- We are now focusing on a pragmatic approach to PSIRF for non-NHS organisations as well as supporting primary care to deliver the **Primary Care Patient Safety Strategy**.

All ICS NHS partners undertook the NHS IMPACT baseline in August 2023 and self-assessment in February 2024 to guide plans on embedding improvement.

The ICS Continuous Quality Improvement Subgroup routinely shares organisational updates on development work linked to NHS IMPACT and areas of collaboration at an ICS level:

- We continue, with system partners, to promote and grow the **ICS Quality Improvement Network**, NHS IMPACT 'Lunch and Learn' and Masterclasses and national Learning and Improvement Networks. Our joint Quality Improvement Network with Shropshire, Telford and Wrekin ICS meets quarterly, and there are now more than 650 people on the distribution list – an increase of 58% since this time last year.
- Our **Continuous Quality Improvement (CQI) Framework** (December 2024) commits us to actions that will realise our vision, aligned to the five NHS IMPACT components. In the first instance, this means building improvement capability and capacity, with a focus on establishing a community of practice and embedding a culture of improvement and learning. A list of training opportunities has been regularly promoted to all ICB staff to increase their understanding, experience, and confidence in CQI. This is supported by a library of CQI tools and resources.
- Discussions are taking place with system partners on how to adapt the training to build a **bespoke industry standard accredited (Lean Competency System) training programme** to support the ICB/ICS. We will also integrate the national Board and Executive Development Programme and the Operational and Clinical Leadership Programme into our training approach when these are released by NHS England and the National Improvement Board.

- We are members of the **NHS IMPACT ICB Network for Improvement** to learn from other systems and think through common challenges with peers.
- CQI has been identified as a key enabler to support the ICS Medium Term Plan. Programmes of work will self-assess against the **NHS IMPACT Improvement Guide for Programmes** to ensure that best practice principles in adopting improvement as a method for design and delivery are embedded and access available system support. This includes signposting to tools/resources, training, improvement coaching, brief intervention or prioritised tailored support, and enabling the programme to deliver their aims through their adoption of CQI principles.

The ICS recognises the essential role of all partners in providing oversight of the quality of care given, and in creating and sustaining a culture of openness, learning and continuous improvement. Our System Quality Group is well established and routinely involves wider partners including the Care Quality Commission, Healthwatch organisations, and NHS England. This provides a forum to facilitate engagement, intelligence-sharing, learning and quality improvement across the ICS.

Our [Quality Impact Assessment \(QIA\) Policy](#) (March 2024) outlines how we will have regard for all likely effects of decision-making in relation to the quality of service. We are also committed to collaborating with NHS partners. Our NHS partners in Staffordshire and Stoke-on-Trent agree that we are one system, and therefore do not wish to have separate QIAs for system transformation work and associated engagement.

Quality improvements to All-Age Continuing Care

2024/25 has been a transformational year for All-Age Continuing Care in Staffordshire and Stoke-on-Trent, with a plethora of quality and safety improvements that have contributed to better experience and outcomes for our residents and our workforce.

Transformational improvements include:

- Establishing daily **Eligibility and Care Assurance Meetings** in a multi-disciplinary manner with local authority colleagues to enhance and provide assurance of statutory duty.
- Developing a **Joint Operational Protocol** for adults with local authority colleagues and other system partners.
- Taking a case management approach to **reviews and ongoing assurances** of appropriate care.
- Improved use of assistive technology.
- Supported **96%** of individuals to achieve preferred place of care/death.
- Improved timeliness and achievement of the **48-hour target for discharge/transfer** for end-of-life care.
- Reduced over-restrictive care by **40%**.
- Developed and implemented a Continuing Health Care (CHC) Equity Policy.
- Reduced CHC overdue reviews by **125%** between January and December 2024.
- Improved the workforce sickness absence rate from 13.55% at the start of the year to **10.9%**.

Learning from lives and deaths – people with a learning disability and/or autism (LeDeR)

LeDeR reviews

In 2024/25, our LeDeR Programme team recruited an internal team to complete LeDeR reviews, because of issues with the previous external commissioned provider.

Following the successful recruitment and implementation of the review team (in April and May 2024), the team have completed the backlog of LeDeR reviews inherited from the previous provider and have made significant improvements and progress against the national key performance indicators.

As of April 2025, **81%** of all reviews in Staffordshire and Stoke-on-Trent were completed within the national NHS England target (within six months of notification). Although the target is 100%, this is a significant improvement from the 24% achieved in April 2024.

Despite the LeDeR programme team's priority focus being reducing the backlog of reviews and improving performance, several service and quality improvement projects have also been delivered from the learning identified from completed reviews.

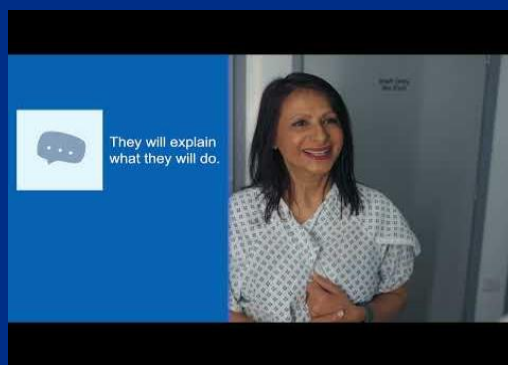
We commissioned the delivery of face-to-face dysphagia and epilepsy awareness training sessions, aligned to local LeDeR priority areas.

We produced bi-monthly LeDeR briefings for health and social care colleagues, sharing positive practice, learning and improvements, and useful resources identified from completed LeDeR reviews. These briefings have been well received and found to be supportive in driving the necessary improvements for people living with a learning disability and/or autism.

Easy read video about breast cancer screening

We worked with screening services, experts by experience and system colleagues to produce an easy read breast cancer screening video aimed at those living with a learning disability and/or autism.

Easy read video: What to expect from your breast screening appointment



Work is underway to produce easy read videos for each of the national screening programmes.



Digital



We have a number of digital transformation achievements to celebrate this year.

ICS-wide Security Operations Centre

The Security Operations Centre (SOC) provides monitoring and threat hunting capability 24 hours a day, 365 days a year.

These services are provided across all stakeholders in Staffordshire and Stoke-on-Trent ICS – removing disparity and driving standard levels of cyber maturity, posture (readiness) and risk appetite across health and care.

One Health and Care (OHC)

Our shared care record grows from strength to strength – supporting clinicians and care providers to have visibility of our patients' whole health record. St Giles Hospice and Douglas Macmillan Hospice have joined OHC – improving our ability to work together effectively.

Key figures

January 2025 was a record-breaking month in terms of use. The shared care record has saved thousands of administration hours – freeing up our professionals' time for patient-facing care.

- **103,946** patient records accessed in January 2025 compared to 11,100 in January 2021
- **6,175** unique user logins in January 2025 compared to 1,050 in January 2021.

Clinicians are using a range of dashboards and information generated by One Health and Care to better focus care to those who need it most. Examples include:

- **'Beat The Cold'** – a collaborative partnership that utilises the Fuel Poverty dashboard in conjunction with GPs to support community members in reducing cold-related illnesses and fuel poverty
- The **Preparing for Adulthood** dashboard is used to facilitate an effective transition for children receiving care services as they move into adulthood.

Digital ReSPECT

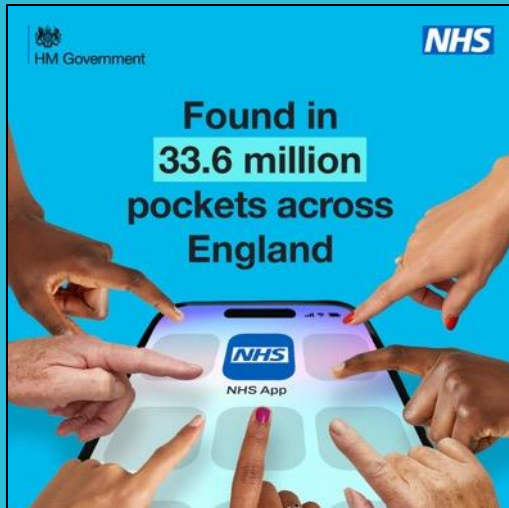
In Staffordshire and Stoke-on-Trent, around 1,400 ReSPECT* forms have been completed, with more than 20,000 views supporting individual care journeys.

We have conducted three training sessions, which have been attended by more than 120 clinical and social care professionals.

Currently, UHNM, St Giles Hospice, Douglas Macmillan Hospice, and 23 GP practices are using ReSPECT forms alongside traditional paper versions, and are planning to transition to digital forms in the future.

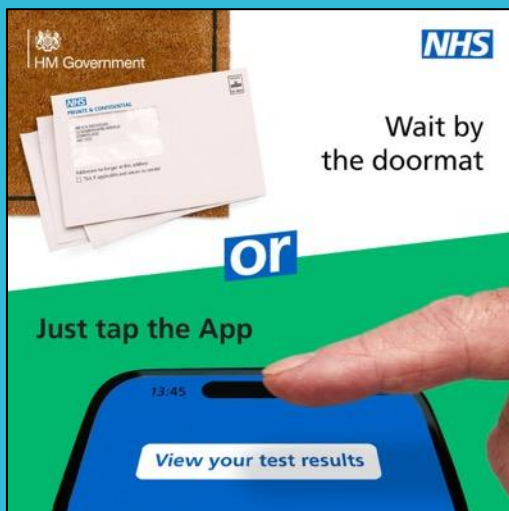
***ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. A ReSPECT form is hosted in One Health and Care to enable access by all care providers. The process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they are not able to make decisions or to express wishes.**

NHS App and Patient Knows Best (PKB)



57% of our community are now using the NHS App. Additionally, the roll out of PKB across our hospital services (also accessible via NHS App) continues to grow, supporting hospital appointments, care plans, results and information sharing.

More than **230,000** patients are now registered to use this service.



Digitising adult social care

This year, **180** care settings have been allocated funding to support digitisation and enablement of the digital social care record.

By the end of March 2025, 161 care settings had gone live, and a further 19 were awaiting the go-live evidence.

Data and Intelligence Strategy

We developed and approved the Data and Intelligence Strategy in April 2024 – a system-wide delivery plan for transforming into a more effective, data-driven system is underway.

Robotic Process Automation and Artificial Intelligence (AI) adoption

More than **20** processes have been implemented across our ICS partners – supporting administration and improvements in both efficiency and accuracy.

AI is also being explored and adopted in various hospital and primary care processes to enhance service delivery.



Environmental matters



Climate change presents an immediate and growing threat to health. The UK is already experiencing more frequent and severe floods and heatwaves, as well as worsening air pollution.

Up to 38,000 deaths a year are associated with air pollution alone – disproportionately affecting the most deprived and further [exacerbating health inequalities](#).

The impact of climate change will also be expensive for society and the NHS, with the costs of [heat-related deaths from climate change](#) estimated at £6.8 billion a year in the 2020s, rising to £14.7 billion a year in the 2050s.

Conversely, action to tackle climate change brings direct benefits for public health, health equity and taxpayers. Our vision is to achieve net zero healthcare in Staffordshire and Stoke-on-Trent, in line with [Delivering a Net Zero NHS](#) – which is now issued as statutory guidance. Reducing the NHS’s environmental impact will help to build an NHS that provides world-leading healthcare and supports the government’s mission to make Britain a clean energy superpower.

This will be achieved through a number of actions, including:

- Supporting **high-quality, preventative and low-carbon care**, in line with the NHS’s goal to boost out-of-hospital and digitally-enabled care, improve prevention of ill-health, and reduce health inequalities.
- **Reducing air pollution** by [decarbonising the NHS fleet](#), which is estimated to save the NHS more than £59 million every year and deliver a range of health benefits valued at more than £270 million.
- Modernising and [decarbonising the NHS estate](#) to **reduce energy costs** while creating a better environment for patient care.
- **Minimising waste through circularity** – where reusable, remanufactured or recycled solutions are used – which is often cost-saving and helps protect against external supply disruptions.

In 2024/25, the ICS worked collaboratively to manage resources and performance and deliver the ICS Green Plan, integrating climate change and sustainability as part of business as usual:

- Wider system ambitions and practical actions, activities and programmes that are relevant to all partners, portfolios, providers and the system.
- Ambitions, actions and key themes for individual partners, portfolios and providers that when joined up collectively deliver for the system.
- These have all been linked to the nine areas of focus of the ICS Green Plan which is now being refreshed.

Green Champions

We now have a network of **17** Green Champions sitting across multiple portfolio areas within the ICB who meet on a regular basis.

The Champions aim to lead by example in adopting sustainable habits, to share ideas for improving sustainability, and to help put those ideas into practice and establish them as the new business as usual. The group acts as a critical friend, offering constructive feedback on proposals. It enables the sharing of diverse perspectives from the wide range of teams, portfolio areas, and social backgrounds represented by its members.

As of December 2024, we had **582** Green Champions in total across the Staffordshire and Stoke-on-Trent ICS.

The new Green Plan guidance for the 2025-28 update was released by NHS England in February 2025. We will now review progress to date based on the new guidance and set out new priorities for the system as well as continuing to build on achievements to date.

Nine areas of focus

1. Workforce and system leadership

We continue to build awareness of our net zero targets and obligations through education and training of our workforce. **98%** of all ICB staff have completed the 'Building a Net Zero NHS' training, which has now been made mandatory.

Since making connections with our VCSE partners, representatives will now be attending Greener Delivery Group meetings to contribute to and build on a joined-up approach to delivering the ICS Green Plan.

2. Clinical transformation (replaced Sustainable Models of Care)

University Hospitals of North Midlands (UHM) achieved a reduction of 391 tonnes of carbon dioxide equivalent (tCO₂e) of nitrous oxide in 2024/25 compared to 2019/20 baseline – which equates to a 15% reduction in emissions.

The ICB supports work to reduce emissions across patient pathways, spanning primary, secondary and community care and the third sector. We consider net zero principles in all service change, reconfiguration programmes and pathway redesign and aim to achieve this through the implementation and completion of Sustainability Impact Assessments (SIAs).

3. Digital transformation

Our Green and Digital teams are working with the Remote Care Programme to support the further development of the Virtual Wards carbon footprint workstream.

One Health and Care – our confidential digital shared care record for people living in Staffordshire, Stoke-on-Trent, Shropshire, Telford and Wrekin and The Black Country – brings data together from our system health and social care providers.

This allows doctors, nurses and other registered health and social care professionals directly involved in patient/client care to view relevant information to provide better and safer care, as well as speeding up the patient journey.

This significant piece of digital infrastructure also supports reductions in carbon emissions through fewer phone calls, emails, data transfers and the transfer of physical paper records between health professionals in local authorities, primary and secondary care.

One Planet Standard

Staffordshire and Stoke-on-Trent ICS have been awarded bronze level certification by the One Planet Standard, which further demonstrates our progress towards delivering the Green agenda, implementing regional greener priorities, and delivering a net zero NHS.



The standard provides a familiar, well-proven framework to increase motivation and effect gradual culture change. It helps to embed an awareness of environmental sustainability and foster an ethos of continuous improvement.

This recognised toolkit supports and aligns with the Welsh government's public sector emissions reporting toolkit and the values and objectives of the Wellbeing of Future Generations Act.

It is not an audit – there are no additional key performance indicators or measurements to be met. The standard helps measure progress and gain recognition for achievements.

As a system, our firm commitment to achieving sustainability and green priorities and our significant progress in reducing our ecological footprint has contributed to this achievement.

Greener by Design

In 2024, we were awarded funding from NHS England's Greener by Design programme to review both manual and automated carbon foot printing tool for IT to standardise and improve accuracy of carbon capture data for the NHS. This is a collaboration between the ICB, the Greener by Design team and the Subject Matter Experts at Midlands and Lancashire Commissioning Support Unit (MLCSU).

We recommended an NHS-led approach over a commercial solution due to greater control and flexibility, transparent methodology, reduced ongoing costs, tailored to NHS needs, the opportunity for knowledge building and option for selective use of specialist tools where most valuable.

In May 2025, we showcased our findings to the Greener by Design team who will now take this recommendation forward as part of the programme's next steps.

4. Travel and transport

Cycle to work leads and salary sacrifice cycle to work schemes are now in place for staff at trust organisations. We continue to implement the actions and recommendations made in the national Net Zero Travel and Transport Strategy, progressing the core deliverables of decarbonising vehicle fleets and encouraging take up of ultra-low emission vehicles (ULEVs) and zero emission vehicles (ZEVs) across both the NHS estate and staff choices.

5. Estates and facilities

The Keep Warm, Keep Well initiative, a collaboration between UHNM and fuel poverty charity Beat the Cold, is making a positive impact in the community and is now working with system partners to expand the scheme further and incorporate into other trusts and primary care.

6. Medicines

We are continuing to reduce nitrous oxide emissions and emissions from inhalers. According to the Greener NHS dashboard, the overall carbon equivalent emissions (tCO₂e) baseline for 2019/20 was 24,901 tCO₂e.

As of 31 March 2025, the total emissions was **17,131 tCO₂e**.

This is a **5%** reduction from 2023/24 and a **28%** reduction from 2019/20.

Total emissions (tCO₂e) from inhalers supplied

Month	2019/20	2023/24	2024/25
April	1,886	1,430	1,489
May	2,036	1,545	1,509
June	1,900	1,580	1,393
July	1,974	1,464	1,508
August	2,048	1,470	1,394
September	1,966	1,459	1,408
October	2,102	1,530	1,484
November	2,034	1,537	1,413
December	2,114	1,542	1,480
January	2,119	1,563	1,460
February	1,871	1,414	1,263
March	2,843	1,429	1,330
Annual total	24,893	17,963	17,131

Source: [Greener NHS dashboard \(NHS Organisations\): Primary care inhalers – Tableau Server](#)

Other projects over the last 12 months include implementing greener inhaler formulary choices on net formulary. In the next few months, we will be working with our communications colleagues to promote dry powdered inhalers, inhaler recycling and initiating an asthma review project – all of which will have positive impacts on carbon emissions from inhaler use.

7. Supply chain and procurement

In addition to the successful adoption of a minimum 10% net zero and social value weighting for all new procurements, all suppliers will be required to publicly report targets and emissions. They will also have to publish a Carbon Reduction Plan for global emissions aligned to the NHS net zero target, for all their scope 1, 2 and 3 emissions.

8. Food and nutrition

As per the new Green Plan guidance for trusts to measure food waste in line with the Estates Returns Information Collection (ERIC) and set reduction targets, we will be capturing food waste measurements and reporting each quarter through our ICS Green dashboard.

In addition, through the ICS Greener Delivery Group, trusts have outlined opportunities to make menus healthier and reduce carbon emissions by supporting the provision of seasonal menus high in fruits and vegetables and low in heavily processed foods. All the trusts within Staffordshire and Stoke-on-Trent ICS have added plant-based options to their patient menus.

9. Adaptation

Environment and Sustainability students from Keele University have been working with us on student-led projects focusing on the climate resilience and decarbonisation potential of local GP practices.

Taskforce on Climate-related Financial Disclosures (TCFD)

The Department of Health and Social Care (DHSC) Group Accounting Manual has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures. This is part of the sustainability annual reporting requirements for NHS bodies, which stems from HM Treasury's TCFD-aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse emissions under TCFD requirements, as these are computed nationally by NHS England.

As interpreted and adapted for the public sector by the HM Treasury TCFD-aligned disclosure application guidance, the recommended disclosures will be gradually incorporated into sustainability reporting requirements on a phased basis up to 2025/26.

We continue to follow climate change guidance issued to the NHS and government bodies in our procurement and contracting activities.

This includes guidance set out in the Procurement Policy Note: 'Taking account of social value in the award of central government contracts' and in the NHS guidance: 'Applying net zero and social value in the procurement of NHS goods and services'.

A Greener Delivery Board has been established, which reports to the ICB Board via the Strategic Commissioning and Transformation Committee. If there are any financial consequences to a pending decision, then approval is also sought from the ICB Finance and Performance Committee.

Patient experience and complaints

The System Quality Group receives a quarterly Patient Experience Report, as well as an Annual Patient Experience Report, which includes an overview of the key themes and trends in patient feedback. The reports also include a snapshot of actions taken in response to patient and public complaints, MP letters and Patient Advice and Liaison (PALS) contacts.

Annual complaints analysis

All patients who are unhappy about a service that is funded or provided by the NHS have a right to make a complaint.

We actively encourage patients and their families to complain when they are not satisfied and where they feel something has gone wrong in relation to the service, care or treatment they have received. Residents of Staffordshire and Stoke-on-Trent access healthcare services from a range of providers, including local hospitals, primary care services, health centres and services in their own homes. They can choose who they make their complaint to. Complaints can be raised directly to the provider of their care, or to the commissioner, in this case the ICB.

For primary care services, formal complaints are received by the ICB, but the process is managed by the West Midlands Regional Complaints Hub on our behalf. Response letters are reviewed and signed off within the ICB before being shared with the complainants by the regional team.

Number of contacts received – 2024/25

Contact type	Q1	Q2	Q3	Q4	Total
Complaint	242	183	167	158	750
MP letter	23	21	56	59	159
PALS	709	541	437	480	2,167
Compliment	7	1	2	1	11
Total	981	746	662	698	3,087

Themes and trends

These services had the largest volume of feedback during the year:

- **General practice (364)** – including overall clinical care and treatment, difficulty accessing the practice and appointments, attitude of staff, issues with referrals, medication and prescriptions, and concerns regarding Shared Care Agreements.
- **UHNM (106)** – including issues around overall clinical care and treatment, waiting times for assessment appointments and for treatment, and attitude of staff.
- **Dental services (71)** – including difficulty accessing NHS dental services, and concerns relating to both the treatment provided and charges for treatment.
- **Continuing Healthcare (50)** – including withdrawal of funding and dissatisfaction with the outcome of reviews, and regarding attitude and communication issues.
- **Wheelchair services (45)** – predominantly relating to unacceptable delays in the provision of equipment.

Complaint outcomes

When a case is closed, the outcome is recorded. The table below shows this information for all complaints closed during 2024/25.

Complaint outcomes – 2024/25

Outcome	Q1	Q2	Q3	Q4	Total
Already investigated elsewhere	18	22	18	10	68
Complaint not upheld	11	20	8	22	61
Complaint partially upheld	14	13	20	16	63
Complaint upheld	9	4	3	7	23
Information provided	3	5	1	6	15
No consent to continue	4	3	3	12	22
No further contact	21	57	46	38	162
Passed to provider	31	20	15	29	95
Passed to West Midlands Regional Complaints Hub	38	38	30	26	132
Closed by enquirer/withdrawn	29	29	3	3	64
Resolved	5	7	4	4	20
Out of area	0	0	0	0	0
Legacy NHS England complaint received for sign-off only	18	6	4	0	28
Out of scope	2	3	0	0	5
Total	203	227	155	173	758

Parliamentary and Health Service Ombudsman

When a complainant remains unhappy following our attempts to resolve the issues raised through the formal complaints process, the second (and final) stage of the NHS Complaint Regulations allows them to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO).

In such instances, the PHSO will contact us to ascertain that a full and final response has been provided and may initially request a copy of the final response for review. Where complaints referred to the PHSO meet their criteria for further investigation, we will be asked to provide all relevant complaint documentation (which may include copies of clinical/medical records) to enable an independent investigation to take place. On completion of this review, the PHSO will declare whether the complaint is upheld and will make recommendations to us which will need to be completed to conclude the case. In some cases, the PHSO can request that we make a financial payment to the complainant.

During 2024/25, we have not been made aware of any cases which the PHSO intends to fully investigate. This year, two long-standing complaints have been closed by the PHSO as we have now complied with all recommendations within the PHSO report. Redress and ex-gratia payments were required to be made to the complainant following this review.

Lessons learned from complaints and PALS

We view complaints positively as they provide an opportunity to review and improve services and processes to ensure the needs of our patient population continue to be met. Complaint responses provide details of improvements and changes made and lessons learned as a direct outcome of concerns being raised.

The following highlight some of the learning from cases we have responded to during the past year:

Complainant believes there was unnecessary use of syringe driver, and as a result, the patient's death was unnatural.

Since the death of the patient, the service has developed the information available to families to help inform and support them when a relative is undergoing palliative care and reaching the end of their life.

Complainant raised concern regarding poor communication during Continuing Healthcare review process.

The Continuing Healthcare team advised it was currently reviewing the local dispute process with the aim of streamlining it to improve resolution timescales and ensure clear communication throughout the process.

Patient was provided with a profiling cot that was not fit for purpose.

Apologies were offered by the provider who advised that its process for the issue of aids had been reviewed, and an additional final check implemented for recycling equipment to ensure similar issues do not reoccur.

Patient reported that her Vitamin B12 injection appointment had been cancelled and a new appointment arranged for four weeks' time. Patient was already feeling unwell and did not feel she could wait the requested length of time.

With consent, the Patient Services team offered to contact the GP practice to attempt to resolve this. The practice advised that a cancellation meant an appointment was now available for the next day, which was offered to the patient who gratefully accepted.

Continuing Healthcare funding was stopped following review without family or care home being notified.

The process has been updated and funding now ceases 28 days after the multi-disciplinary team's recommendation is verified by the ICB panel.

A number of issues were raised following the transfer of care between child and adolescent mental health service (CAMHS) providers.

A review of the duty system risk management process was undertaken. A review of the duty system admin approach clarified who is being contacted and when, and how this is managed when the allocated worker is on leave.

The team was reminded of the need for transparency in explaining waiting lists to families and what to do if a situation escalates. The issue was raised with the Ethics Committee to establish a plan of work to define conflicts of interest and when transfers or changes to care should be considered.

Working with people and communities

Our Working with People and Communities Strategy supports the ICB in delivering its statutory duty to involve people and communities in the planning, development and delivery of NHS services. We draw on the 2022 statutory guidance for working with people and communities, which supports effective partnership working to improve services while also meeting our public involvement legal duties.

To meet the public involvement duty, ICBs must 'make arrangements' to ensure that people who use the services currently or may use them in the future, and their carers or representatives, are involved when commissioning services for NHS patients.

This duty is set out in section 14Z45 of the NHS Act 2006 (as amended by the Health and Care Act 2022), and the arrangements must provide opportunities for the public to be involved in:

- the planning of services
- the development and consideration of proposals for changes which, if implemented, would have an impact on what services are provided and how they are delivered
- decisions which, when implemented, would have such an impact.

The legislation covers engagement activity with the public through to a full public consultation. We also have a duty to comply with the 2018 NHS guidance 'Planning, assuring and delivering service change for patients' (PADS), which:

- provides a clear path for commissioners and providers to follow from inception to implementation, including effective public involvement
- sets out how new proposals for change are tested through independent review and assurance by NHS England, considering the framework of Procurement, Patient Choice and Competition Regulations

- includes key considerations for commissioners and their partners in designing service change, including reconfiguration.

Further guidance was published by NHS England in 2022 – 'Major Service Change: an interactive handbook' – which charts the course and requirements of a service change programme, and includes a list of key resources including the PADS guidance and the guide for an eight-month process for planning, preparing, delivering and reporting on a public consultation.

Since January 2024, ICBs are required to notify the Secretary of State of 'notifiable reconfigurations' or proposed changes that would trigger a formal consultation. Anyone concerned about the adequacy of the process that has been undertaken, or who feels that a decision has not been made in the best interest of the health service in the area, can ask the Secretary of State to intervene if they can demonstrate they have first tried to resolve their concerns locally.

['Working in partnership with people and communities'](#) is new statutory guidance for ICBs. It supports them in meeting their public involvement legal duties and the new 'triple aim' of better health and wellbeing, improved quality of services, and the sustainable use of resources. The guidance sets out how working with people and communities supports the wider objectives of integration, and helps commissioners of health services build meaningful partnerships that start with people and focus on what matters to our communities.

We recognise the benefits of partnership working. It means better decision making about service changes and how money is spent and invested, it reduces risks of legal challenges, and it promotes improvements to safety, experience and performance.

It also helps address health inequalities by understanding communities' needs and developing solutions for them.

This year, we have worked with our partners to develop an approach to work through place-based partnerships, including through the Integrated Care Partnerships (ICP), Healthwatch Stoke-on-Trent and Healthwatch Staffordshire, and the voluntary, community and social enterprise sector to put localities and neighbourhoods at the heart of community involvement activity and to address health inequalities for under-served communities.

This work will continue through 2025/26 and inform how involvement activity is delivered.

How we have discharged our duty in relation to public involvement

We have discharged our duty to make arrangements for people who use services, or could use them in the future, to be involved in engagement about a range of health services during 2024/25.

This has built on previous involvement activity which has been used to shape services, and has also shaped new conversations about health services.

Primary care

We have been supporting primary care colleagues to hear from patients and the public following changes in the way some Primary Care Networks and GPs provide services. This work has helped the ICB, as commissioner, understand the challenges faced by communities and the impacts of unplanned and unexpected service change.

We continue to support primary care colleagues through periods of change as services are delivered.

Developing strategies

Our clinical and commissioning leads have been working with system partners to develop strategies to support the delivery of health services spanning a number of portfolios including mental health, primary care, improving population health, respiratory, palliative and end of life care, and pharmacy and medicines optimisation.

This work has included engagement activity to involve stakeholders within the Integrated Care Partnership as well as members of the public and patients who access the services, or support people who do.

The involvement activity has taken place over the last 12 months, and in some cases builds on the work of previous years. It will help to shape the delivery framework which will underpin the strategies.

The strategies are at different stages of development and progressing through the governance process and will be published for information.



Urgent and emergency care

To assess the public's understanding and use of our urgent and emergency care services, and identify potential improvements, we engaged with patients and communities across Staffordshire and Stoke-on-Trent in 2024/25.

This followed on from earlier involvement activity in 2019 and 2021 to understand how people access services, why they access services and how services could be shaped in future.

The 2024/25 engagement will help inform ongoing work by transformation and urgent and emergency care service colleagues to introduce and designate nationally mandated urgent treatment centres (UTCs).

Between July and October 2024, we received more than 1,500 responses from members of the public to our main engagement survey, easy read survey, bespoke discussion sessions hosted at NHS sites and community venues, and drop-in opportunities held at existing interest and neighbourhood groups.

Additional care was taken to reach out to people who were less likely to actively choose to engage with us, or who may not ordinarily be aware of these opportunities to give feedback. This helped ensure we received a range of views and information across the full variety of service users we support.

We partnered with NHS providers, local authority colleagues and the voluntary sector to share key messaging and drive take-up in the engagement so their vital insights could be used in helping to shape future service planning.

A Report of Findings is being developed for publication to share the analysis of the information received.

Urgent treatment centres

We're setting up UTCs in Staffordshire and Stoke-on-Trent as part of a national programme.

What are the benefits of UTCs?

Current services have different names and opening times, and do not all offer the same services. UTCs will help us provide consistent urgent care services that offer treatment quickly and are easier for people to understand.

Our local UTCs will:

- treat patients of all ages
- treat minor illnesses as well as injuries
- have access to your up-to-date electronic patient records
- have arrival times bookable through NHS 111.

What treatment can I get there?

UTCs will treat many of the common injuries and illnesses that people go to emergency departments for, including:

- sprains and strains
- suspected broken bones
- minor head and eye injuries
- minor burns and scalds
- cuts that need stitches
- abdominal (tummy) pain
- high temperature in children and adults
- skin infections and rashes
- urinary tract infections (UTIs).

Booked arrival times: We'll encourage everyone to book these through NHS 111 – helping to cut waiting times.

More X-ray services: X-ray will be available during the full opening hours. UTCs will be able to do a wider range than some existing units.

Making every contact count: Where appropriate, UTCs will give advice on health and wellbeing and let you know about other services that might be helpful to you.

Taking pressure off emergency departments: By making access to urgent treatment easier and quicker, UTCs should help relieve pressure on EDs – improving patient care and experience there as well.

How we have prepared for setting up UTCs

UTCs need to meet a set of standards. This is to make sure they can be run safely and effectively.

When thinking about where our UTCs should be, we looked in detail at:

- what demand has been like at existing urgent units
- our buildings and facilities – for example, layout and access
- whether our current services meet national UTC standards
- if we would need to recruit and train more staff.

For our local UTCs, we are proposing that:

- some sites will be 'standalone' UTCs – this could be as part of a community hospital
- some UTCs will be alongside a hospital ED
- not all the existing walk-in centres or minor injuries units would be replaced with a UTC. Where this is the case, we will speak to and involve local people as part of NHS England's process for changing services.

These remain as proposals – no final decisions have yet been made.

Providing opportunities to be involved

We are committed to meeting our obligations to involve patients and the public when considering changing the way health services are designed and delivered, and when health services have to change as a result of external influences, such as a government decision or the way local health service providers deliver their services.

The way we involve people is informed by the services under discussion, who we need to hear from, and understanding how we can reach them to provide as many opportunities as possible to be involved and engage in discussions. We have two core channels which we use to hear from people – the [People's Panel](#) and the [People and Communities Assembly](#). We also provide regular opportunities to be involved with discussions about health and care services throughout the year, using a range of channels and methods to ensure everybody has the opportunity to be involved and be heard when they engage with the involvement activity.

We review how we provide involvement opportunities for patients and the public regularly and when we are designing the approach for involvement activity. We also work closely with system partners to ensure we are involving people with lived experience.

We are continually reviewing how we engage patients and the public, and how effective that activity is to ensure the opportunities we provide are promoted through the appropriate channels, through the relationships we have developed with health, local authority and VCSE partners, and through open discussions with anyone interested in health services and helping to shape how they are delivered.

Over the last 12 months, ICBs have been tasked with developing 'place' and 'neighbourhood' thinking around how health services are designed and delivered, with a focus on how this

approach can help to tackle health inequalities for those who experience barriers in accessing health services.

This will build on the integrated working which has been enhanced through the creation of ICSs and Integrated Care Partnerships.

This approach extends to the ICB's approach for involving people and communities, and supports our assurance of how we are discharging our legal duty.

Reporting the approach to involvement and the impact of involvement by people and communities

Involvement activity is planned at the earliest stages to ensure that the opportunities are open and promoted to those affected or likely to be affected, with communications and engagement plans developed to clearly set out actions, milestones, channels and timescales.

These are supported by extensive stakeholder mapping as well as demographic mapping to ensure we not only know who we should be hearing from, but have a greater understanding of where they spend their time in Staffordshire and Stoke-on-Trent as well as how we can reach them through the support of our system partners spanning the health, local authority and VCSE sectors.

This work also helps us to understand any barriers to participating in involvement activity which may exist, and allows us to mitigate that impact to ensure everyone has the same opportunity to be involved. Our approach is reported through a transparent process to internal and public-facing meetings; this assures scrutiny and oversight by partners such as the city and county councils, district and borough councils, clinical senate and ICB committees.

Reporting on involvement activity occurs at several stages, proportionate to the work being delivered, but can include a mid-point review to understand who has participated in the activity

since it launched, where any gaps are and how those gaps can be closed.

An end-point review will similarly review who participated throughout the activity period, how gaps were planned to be closed, if gaps were closed and how the participation changed, if at all, following those interventions. These are typically internal reviews, and will inform any decisions to reopen the activity or provide bespoke opportunities to specific groups or communities where voices have been less heard or not heard at all.

Full reports of findings, along with summary versions, are created to provide the quantitative and qualitative outputs from the involvement activity; these are used to inform the decision-making process as well as shape presentations to internal and external boards and meetings as part of the governance process. These reports are discussed during public ICB Board meetings, which are also live-streamed and minuted so the public can see what was presented, considered and discussed, and how the decision was reached.

All information, from the planning to the reporting of involvement activity, is accessible to ensure equity for anyone interested in the materials produced, with easy read and language translation versions available on request.

How we assure ourselves we are meeting our legal duty

Assurance about how we are meeting our legal duty to involve people and communities, including carers and representatives of people who receive health services, is provided to the ICB Board through relevant committees, including the Quality and Safety Committee.

Our work to involve patients and the public is monitored by the People and Communities Assembly, which acts as an advisory board to the ICB, and which is chaired by our Non-Executive Chair. The Assembly holds us to account on our statutory duty to engage.

Through its membership representation, the Assembly also helps us to meet the requirements of the Public Sector Equality Duty to eliminate discrimination, advance equality of opportunity and foster good relations between different people. The Assembly meets regularly, as part of a robust schedule of internal meetings, to monitor and measure the discharge of our duties, and we regularly attend external meetings organised and facilitated by system partners, including district and borough, city and county councils, to demonstrate our compliance with our duties.

External oversight, monitoring and management are achieved through frequent and planned meetings with NHS England.

Emergency Preparedness, Resilience and Response (EPRR)

NHS organisations and providers of NHS-funded care are required to plan for a wide range of incidents and emergencies that could affect health or patient care, and to have arrangements in place to maintain services to patients while an incident is responded to.

Legislation includes the Civil Contingencies Act (CCA) 2004, NHS Act 2006, Health and Care Act 2022, and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework 2022.

Achieving core standards

We are defined as a Category 1 responder under the CCA 2004, and are required to discharge the relevant duties as set out in the Act. These duties, among others, are assessed within the NHS England core standards for EPRR annual assurance process.

In 2024, we were confirmed as being substantially compliant against these standards, maintaining this position held in 2023.

We will submit our 2025 assurance self-assessment report at the end of August, the results of which will be reported in the 2026 Annual Report following a confirm and challenge assessment with NHS England.

We have a robust EPRR work programme and well tested plans in place to maintain our compliance. We continue to build resilience across our ICS working closely with EPRR teams across the NHS, local authorities, and the Local Resilience Forum to tackle our common themes and planning priorities.

Throughout 2024/25, our on-call teams participated in numerous training sessions and incident scenario exercises to ensure we are in a good position to respond to any incident, regardless of its nature and scale. We will continue to build this across 2025/26 and have already planned some great exercises with our partners.

We continue to grow our resilience across our business continuity management to ensure we can flex and adapt to any unplanned disruption and continue our services during such events.

Over the last year, we have responded to numerous incidents and emergencies of varying scale and nature, demonstrating our ability to respond to these while continuing to deliver our EPRR portfolio to a substantially compliant level. As ever, learning from incidents is key, and this process is embedded throughout our EPRR structures to enable arrangements to be adapted as necessary.

Sharing in our collaborative approach to our EPRR work programmes and priorities across the system, the EPRR teams will come together in spring 2025 for a working day to share expertise, learning, and identify joint working opportunities to explore our EPRR priorities and continue to build a system approach to our arrangements.

We remain an active partner in system and local resilience forum EPRR activities, leading the health input to multi-agency arrangements, and working closely with partners to ensure robust and resilient arrangements are in place.

Accountability Report

Peter Axon

Chief Executive Officer
Staffordshire and Stoke-on-Trent ICB
19 June 2025

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

- The **Corporate Governance** Report sets out how we have governed the organisation during the period from 1 April 2024 to 31 March 2025, including membership and organisation of our governance structures and how they supported the achievement of our objectives.
- The **Remuneration and Staff Report** describes our remuneration policies for executive and non-executive members (NEMs), including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.
- The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

During 2024/25, the population's health has been at the forefront of all the ICB's commissioning decisions, ensuring high-quality services for its patients. We have continued to work to ensure that there were sufficient structures and processes in place for the ICB to operate.

Our role as an ICB is to help bring partners together to integrate our approach to improving health and care services for our local population. We have made positive strides towards this goal during the last year, with much more still to do.

During 2024/25 we have worked together with our partners across the system to bring a joined-up approach for our population. Working with our partners has enabled us to develop our Operational Plan, and this work will continue into the next financial year.

Corporate Governance Report

The Corporate Governance Report explains the composition and organisation of our governance structures and how they support our achievements.

Scope of responsibility

As Chief Executive Officer, I have responsibility for maintaining a sound system of internal control that supports the policies, aims and objectives of Staffordshire and Stoke-on-Trent ICB.

I am also responsible for safeguarding the public funds and assets in accordance with the ICB's Constitution and regulations assigned to me.

I am responsible for ensuring that public money is spent prudently and in the best interest of the population of Staffordshire and Stoke-on-Trent.

System of internal control

The system of internal control is designed to manage risk to a reasonable level, although the ICB recognises that not all risk can be eliminated.

It also provides assurance to the Audit Committee that although risks cannot always be eliminated, they are being managed efficiently. The system of internal control is an ongoing process and aligns to the aims and objectives of the ICB.

Capacity to handle risk

The Board has established the following governance arrangements for risk management:

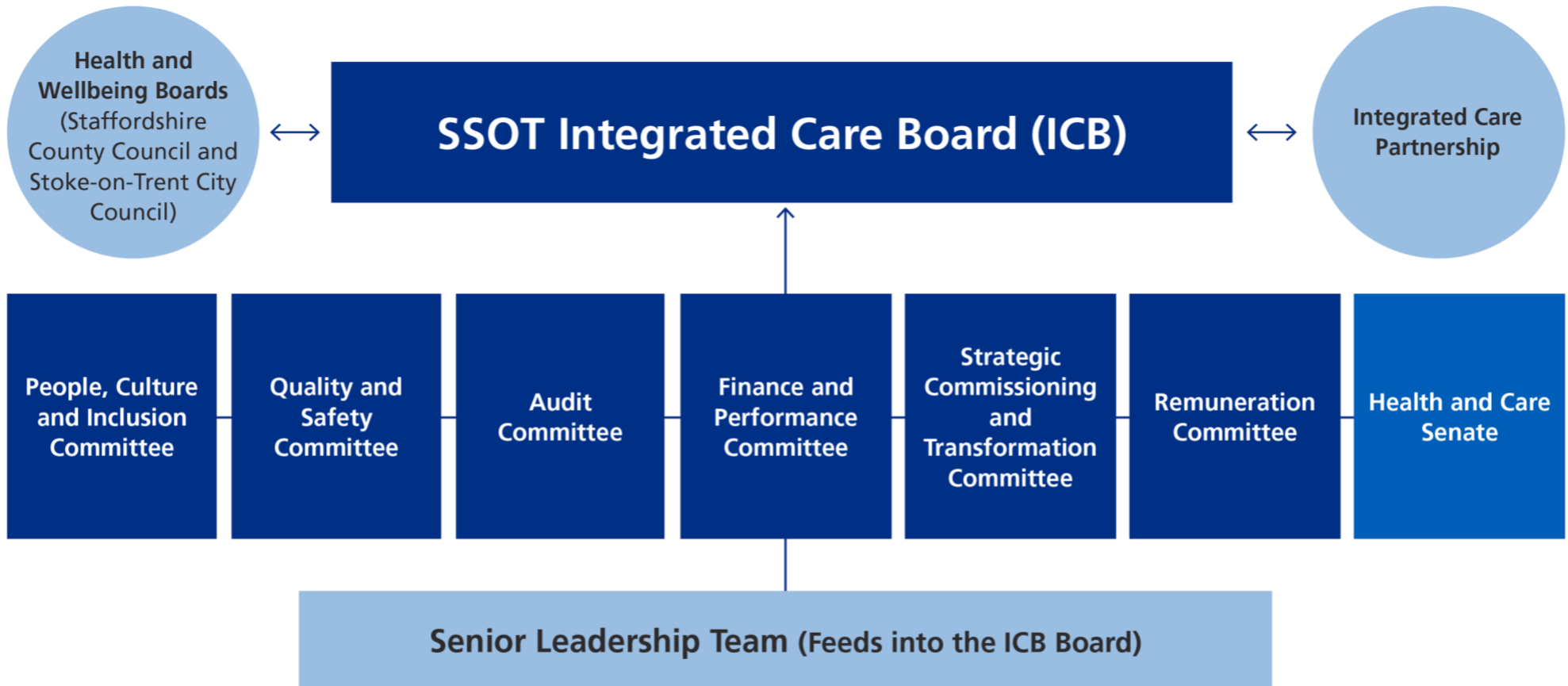
Chief Executive: The Accountable Officer takes Board-level responsibility for governance, including risk management, and has overall responsibility for maintaining an effective risk management system and for meeting all statutory requirements.

Together with the Board members, the Accountable Officer has responsibility for setting the following committees:

- **Audit Committee** – monitors the effectiveness of the risk management arrangements (operational, non-clinical and financial) on behalf of the Board
- **Remuneration and Terms of Service Committee** – accountable for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB
- **Quality and Safety Committee** – a sub-committee of the Board responsible for managing, mitigating and monitoring risks in relation to quality and safety
- **Finance and Performance Committee** – a key meeting for providing accountability on quality, operational performance, workforce and finance from the directorates. It ensures that quality and governance and financial and operational performance are effectively managed and controlled
- **Strategic Commissioning and Transformation Committee** – a newly formed sub-committee of the Board, accountable for supporting the development of collaborative commissioning arrangements, supporting system (ICB–ICS) portfolios, place and provider collaboratives and helping to broker ICB commissioning decisions
- **People, Culture and Inclusion Committee** – oversees the delivery of the ICS People Plan and underpinning delivery plans. It aims to ensure we act in the best interests of patients by providing innovative strategic solutions to build a sustainable workforce and health and care system.

We have set up six committees through which we delegate our function and responsibilities – shown in the diagram below.

ICB Committee structure for Board assurance



- ICB Board Governance (Assurance)
- ICB Board Governance (Non-Assurance)
- ICB/S Synergistic Governance

Composition of Integrated Care Board

Name	Position
David Pearson	Chair
Peter Axon	Chief Executive Officer
Paul Brown	Chief Finance Officer
Phil Smith	Chief Delivery Officer
Dr Paul Edmondson-Jones	Chief Medical Officer
Heather Johnstone	Chief Nursing and Therapies Officer
* Chris Bird	Chief Transformation Officer
* Elizabeth Disney	Chief Transformation Officer
Julie Houlder	Non-Executive Member
* Megan Nurse	Non-Executive Member
Josephine Spencer	Non-Executive Member
Shokat Lal	Non-Executive Member
* Mike Lawton	Non-Executive Member
Jon Rouse	Urban Local Authority Services Partner Member
Patrick Flaherty	Rural Local Authority Services Partner Member
Dr Jack Aw	Primary Medical Services Partner Member
* Simon Constable	Physical Health Services Partner Member
* Tracy Bullock	Physical Health Services Partner Member
Neil Carr	Community Physical Health Services Partner Member
Dr Buki Adeyemo	Mental Health Services Partner Member

There are other 'Participant Members' of the Board from our partner organisations. As per our Constitution, we have only disclosed those who are members.

* Chris Bird left the ICB in May 2024 and Elizabeth Disney replaced Chris in September 2024.

* Megan Nurse will be leaving the ICB at the end of March 2025. We would like to thank Megan and acknowledge the work she has contributed to, in particular her leadership of the Finance and Performance Committee.

* Mike Lawton joined the ICB in February 2025.

* Simon Constable joined the Board in September 2024.

* Tracy Bullock left the Board in June 2024.

You can meet our Integrated Care Board, including our partner members, on our website: [Board members – Staffordshire and Stoke-on-Trent Integrated Care Board](#).

ICB Board

Our Board is made up of ICB executive directors and key executives from our partner organisations across the system. This gives all partners a voice and allows key decisions to be made as a collective.

Our Constitution sets out the arrangements for election and re-election of members of the Board.

Our Board meets monthly and has held 11 meetings in public and one Extraordinary Board meeting in September 2024. The full membership of the Board is detailed within the Governance Statement.

The Board discussed the following topics throughout 2024/25:

- Financial Recovery Plan
- System OD Plan
- Freedom to Speak Up updates
- Medium Term Plan
- System Recovery Plan
- System Board Assurance Framework quarterly reviews
- Reports received from its sub-committees.

The Board also held three development sessions where they discussed:

- The Darzi Review
- 2024/25 Governance Review
- Cyber training for NHS Boards assured by the National Cyber Security Centre
- Counter Fraud and Bribery
- Governance partnerships
- Establishment of the System Board Assurance Framework and agreeing 2024/25 Strategic Objectives.

A number of committees support the Board – meeting on a regular basis throughout the year to review and assess our activities and responsibilities.

The remit and terms of reference of these committees were reviewed during the year to ensure robust governance and assurance. Each of these committees reports into the Board through particular mechanisms, which may include submission of Committee Chairs' highlight and escalation reports and any additional reports by exception.

Portfolios and leads

Portfolio	Senior Responsible Officer (SRO)	Executive Lead
Primary care	Dr Paul Edmondson-Jones	Dr Paul Edmondson-Jones
Improving population health	Dr Paul Edmondson-Jones	Dr Paul Edmondson-Jones
Planned care and cancer	Helen Ashley (UHNM)	Phil Smith
Urgent and emergency care	Matthew Lewis (UHNM)	Phil Smith
Community transformation, including end of life, long-term conditions and frailty	Elizabeth Disney	Elizabeth Disney
Children and young people (CYP) and maternity	Elizabeth Disney – CYP Heather Johnstone – Maternity	Elizabeth Disney – CYP Heather Johnstone – Maternity
Mental health, learning disabilities and autism	Ben Richards (NSCHT)	Elizabeth Disney
Contracts – CSU, Legal and HR	N/A	Tracey Shewan
Other contracts	N/A	Paul Brown

During 2024/25, we have also commissioned services from NHS Midlands and Lancashire Commissioning Support Unit (CSU):

- Primary Care Digital
- Data Quality Facilitation
- Registration Authority
- Funded Care
- Regional Capacity Management Team
- Design and Media
- Information Governance
- Procurement
- Data Processing
- Human Resources support
- Employment Services
- Digital Leadership and Management support
- Chief Technology Officer support
- Digital Transformation.

The ICB Board and its sub-committees have met regularly throughout the year. A summary of business discussed at these is provided in the following paragraphs, but full details can be found on our website.

Membership of the Board Committees

Audit Committee

Members	Meetings held in 2024/25	Business discussed
<ul style="list-style-type: none"> • Julie Houlder, Non-Executive Member • Megan Nurse, Non-Executive Member 	<p>Five meetings and one extraordinary meeting. All meetings were quorate.</p>	<ul style="list-style-type: none"> • External audit services contract award • Risk management, including SBAF • Review of committee effectiveness • EPRR annual assurance compliance • Losses and special payments • Single Tender Waivers for single contracts • Anti-fraud and bribery • Freedom of Information requests • Gifts and hospitality

Remuneration and Terms of Service Committee

The Remuneration Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. This is to confirm our Pay Policy, including adoption of any pay frameworks for all employees including senior managers/directors (including Board members) and non-executive members (NEMs) of the Board excluding the Chair.

Members	Meetings held in 2024/25	Business discussed
<ul style="list-style-type: none"> • Megan Nurse, Non-Executive Member • Julie Houlder, Non-Executive Member • Shokat Lal, Non-Executive Member / Chair • Josephine Spencer, Non-Executive Member • Tracey Shewan, Director of Corporate Governance • Mish Irvine, Chief People Officer 	<p>Four meetings and four extraordinary meetings. All meetings were quorate.</p>	<ul style="list-style-type: none"> • Retire and return • Terms of Reference review • Director recruitment • Appraisals for Chair, CEO, NEMs and directors • Fit and Proper Person Test (FPPT) • VSM pay • NEM recruitment

Quality and Safety Committee

Members	Meetings held in 2024/25	Business discussed
<ul style="list-style-type: none"> Josephine Spencer, Non-Executive Member / Chair Megan Nurse, Non-Executive Member / Vice Chair Heather Johnstone, Chief Nursing and Therapies Officer Paul Brown, Chief Finance Officer * Elizabeth Disney, Chief Transformation Officer Dr Paul Edmondson-Jones, Chief Medical Officer Phil Smith, Chief Delivery Officer Lynn Tolley, Assistant Chief Nursing and Therapies Officer Tracey Shewan, Director of Corporate Governance Becky Scullion, Director of Nursing Paul Winter, Associate Director of Corporate Governance Vasileia Pitarokoili, Head of Governance 	11 meetings – all meetings were quorate.	<ul style="list-style-type: none"> System Board Assurance Framework and Risk (SBAF) Urgent and emergency care Looked After Children Transforming care Maternity and neonatal Transforming mental health inpatient services Review of committee effectiveness All-Age Continuing Healthcare Safeguarding

* Elizabeth joined the committee in September 2024.

Note: There are other 'Participant Members' of the Committee as per their clinical speciality from our partner organisations. We have only disclosed those who are members.

Finance and Performance Committee

Members	Meetings held in 2024/25	Business discussed
<ul style="list-style-type: none"> Megan Nurse, Non-Executive Member / Chair Josephine Spencer, Non-Executive Member / Vice Chair Paul Brown, Chief Finance Officer Phil Smith, Chief Delivery Officer * Chris Bird, Chief Transformation Officer * Elizabeth Disney, Chief Transformation Officer Dr Paul Edmondson-Jones, Chief Medical Officer Heather Johnstone, Chief Nursing and Therapies Officer Tracey Shewan, Director of Corporate Governance * Stuart Diggles, Recovery Director 	12 meetings – all meetings were quorate.	<ul style="list-style-type: none"> Financial position System Recovery Programme System Delivery Operating Plan Winter planning Risk management and SBAF Review of committee effectiveness Efficiency performance Elective Care/Elective Recovery Plan Green Plan Transformation and service change

* Chris Bird left the ICB in May 2024 and Elizabeth Disney was appointed to the role in September 2024.

* Stuart Diggles was appointed in August 2024.

Note: There are other 'Participant Members' of the Committee as per their financial portfolios from our partner organisations. We have only disclosed those who are members.

People, Culture and Inclusion Committee

Members	Meetings held in 2024/25	Business discussed
<ul style="list-style-type: none"> Shokat Lal, Non-Executive Member / Chair Julie Houlder, Non-Executive Director Member / Vice Chair Mish Irvine, Chief People Officer Tracey Shewan, Director of Corporate Governance Dr Paul Edmondson-Jones, Chief Medical Officer Heather Johnstone, Chief Nursing and Therapies Officer Paul Brown, Chief Finance Officer Tracey Cox, Associate Director of Primary Care 	Six meetings – all meetings were quorate.	<ul style="list-style-type: none"> Risk management, including the SBAF Workforce Equality, diversity and inclusion Review of committee effectiveness Recovery Plan Freedom to Speak Up Domestic abuse and sexual violence update

Note: There are other ‘Participant Members’ of the Committee as per their financial portfolios from our partner organisations. We have only disclosed those who are members.

Strategic Commissioning and Transformation Committee

This new committee was formed in January 2025, when it discussed the committee’s proposed terms of reference and the Community Transformation Programme.

Members	Meetings held in 2024/25	Business discussed
<ul style="list-style-type: none"> Mike Lawton, Non-Executive Member / Chair Julie Houlder, Non-Executive Member / Vice Chair David Pearson, Interim Chair / Vice Chair Elizabeth Disney, Chief Transformation Officer Phil Smith, Chief Delivery Officer Dr Paul Edmondson-Jones, Chief Medical Officer Heather Johnstone, Chief Nursing and Therapies Officer Paul Brown, Chief Finance Officer Tracey Shewan, Director of Corporate Governance Mish Irvine, Chief People Officer Helen Ashley, Exec Director, UHNM Colin Anderson, Associate Director of Strategy and Commercial Development, MPFT James Venables, Deputy Director of Service Development and Business Planning, MPFT Liz Mellor, Exec Director, NSCHT Dr Richard Harling, Director of Public Health, Staffordshire County Council Andrew Jepps, Assistant Director, Care Commissioning, Staffordshire County Council Peter Tomlin, Corporate Director, Adult Social Care, Stoke-on-Trent City Council Garry Jones / Lisa Healings, VCSE Reps: VAST / Support Staffordshire 	Three meetings – all meetings were quorate.	<ul style="list-style-type: none"> Commissioning Transformation Programme SBAF and risk Service transformation and service charge Specialised commissioning Primary Care Forum Report Paediatric psychology 2025/26 planning process Wheelchair service

Health and Care Senate

The Board delegated decision-making powers to the Health and Care Senate in April 2024, allowing them to approve business in accordance with their field of clinical matters. They held their first meeting as an approvals board on 13 June 2024.

Members	Meetings held in 2024/25	Business discussed
<ul style="list-style-type: none"> • Rachel Gallyot, Deputy Chief Medical Officer, SSOT ICB / Co-chair • Abid Khan, Medical Director, MPFT • Ananth Viswanath, Deputy Chief Medical Officer, RWT • Anwar Tufail, Secretary, North Staffordshire Local Medical Committee • Arne Rose, Deputy Medical Director QHB Site / SSOT ICS, UHDB • Dennis Okolo, Medical Director, NSCHT • Jack Aw, Place Based Partnership PCN CD Lead (North) • James Eccersley, Clinical Director and Consultant General Surgeon, UHDB • Jayanth Srinivas, Deputy Medical Director, MPFT • Joanna Chan, Place Based Partnership PCN CD Lead (South-West) • Karthik Bhat, Vice Chair, North Staffordshire Local Medical Committee • Lee Calvert, Assistant Director of Adult Social Care, Stoke-on-Trent City Council • Liz Lockett, Director of Quality and Clinical Performance, MPFT • Mark Poulson, Deputy Chief Medical Officer (Performance), UHNM • Matthew Lewis, Executive Medical Director, UHNM *(has now left) • Matthew Nixon, Adult Social Care, Stoke-on-Trent City Council • Rachel McKeown, Director of Allied Health Professionals, MPFT • Susan Thomson, Clinical Director of Pharmacy and Medicines, UHNM • Tilo Scheel, Secretary Local Medical Committee South and GP • Usha Tiguti, Treasurer, North Staffordshire Local Medical Committee • Zafar Iqbal, Associate Medical Director Public Health, MPFT • Zia Din, Deputy Medical Director, UHNM *(has now left) 	<p>10 meetings – all meetings were quorate.</p>	<ul style="list-style-type: none"> • System-wide approach to malnutrition policy • Asthma improvement projects • Vitamin D testing and prescribing guidance • Staffordshire and Stoke-on-Trent Advice and Guidance Standards • Integrated Medicines Optimisation Group approvals • Healthy Ageing and Frailty Strategy • All-Age Respiratory Strategy • Development of diagnostic pathways – liver, lower GI, upper GI and breathlessness • Lower back pain guidance • Medium Term Plan – mitigated modelling • Demand Management System collaborative

Note: There are other ‘Participant Members’ of the Committee from our partner organisations. We have only disclosed those who are voting members.

Register of Interests

Details of company directorships and other significant interests held by members of the ICB that may conflict with their management responsibilities are available on our [Publications and policies](#) webpage, along with information on how these conflicts can be managed.

Modern Slavery Act

We fully support the government's objectives to eradicate modern slavery and human trafficking. Our [Slavery and Human Trafficking Statement](#) is published on our website.

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each ICB to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Staffordshire and Stoke-on-Trent ICB and of its income and expenditure, statement of financial position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts
- prepare the accounts on a going concern basis

- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each ICB shall have an Accountable Officer and that Officer shall be appointed by NHS England. NHS England has appointed Mr Peter Axon to be the Accountable Officer of Staffordshire and Stoke-on-Trent ICB.

The responsibilities of an Accountable Officer are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by HM Treasury.

These include responsibilities for:

- the propriety and regularity of the public finances for which the Accountable Officer is answerable
- keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the ICB and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- safeguarding Staffordshire and Stoke-on-Trent ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Staffordshire and Stoke-on-Trent ICB's auditors are aware of that information.

So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Peter Axon

Chief Executive Officer
Staffordshire and Stoke-on-Trent ICB
19 June 2025

Governance statement

Staffordshire and Stoke-on-Trent ICB is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Under the National Health Service Act 2006 ('the NHS Act 2006'), as amended by the Health and Care Act 2022 ('the 2022 Act'), NHS England has statutory accountability for oversight of ICBs.

NHS England exercises its related enforcement powers for ICBs via separate Enforcement Guidance, published further to NHS England's accountability duties.

Between 1 April 2024 and 31 March 2025, the ICB was placed by NHS England into the 'Undertakings' part of this Enforcement Guidance regime, because of reasonable grounds to suspect potential failure and concerns about the risk of failing to discharge financial planning functions.

Our ICB is also currently part of the 'Investigation and Intervention' regime, in which Integrated Care Systems have to appoint outside advisers to find rapid ways of making savings. Our ICS commissioned Deloitte to help with the necessary work (as covered in more detail within the next section) for the mandatory aspects of this part of the enforcement intervention process.

Scope of responsibility

As Chief Executive Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, while safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money.

I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Delivering a deficit financial position will be a failure to discharge one of the ICB's statutory duties and therefore will result in the ICB's external auditors issuing a referral to the Secretary of State for Health under section 30(a) of the Local Audit and Accountability Act 2014.

In order to mitigate the financial deficit, we have implemented a number of processes in conjunction with our NHS partners within Staffordshire and Stoke-on-Trent:

- Employed an **external Recovery Director** with a sole focus to deliver the in-year financial position, challenging the performance of the recovery programme and identifying new opportunities as they arise.
- Employed an **external supplier (Deloitte)** for a 12-week period to review all areas of expenditure across the ICS – including NHS providers – in order to reduce the expenditure run rate this financial year and beyond.
- Designed a **holistic efficiency programme in respect of Continuing Healthcare** – which is acknowledged as a national outlier in terms of expenditure. The programme seeks to ensure eligibility criteria are rigorously applied, that the main NHS provider within the system is heavily involved in improving the commissioned service, that the market is sufficiently stimulated to help bring down average bed day costs, and that all patients in receipt of CHC are reviewed on a regular basis to ensure care is appropriate and cost effective.
- Adopted **prescribing schemes** which focus on moving patients onto non-patented, less expensive drugs, greater use of the clinical decision support tool OptimiseRx to support the prescribing of appropriate medicines, among other aims.

Corporate schemes have involved the retendering/contracting in respect of external/internal audit, Local Counter Fraud, rationalisation of the corporate estate, better use of capital funds to support the IT infrastructure, and a line-by-line review of all discretionary expenditure.

- Introduced a **vacancy control panel process** for all new/replacement posts even where a source of funding has been identified to help ensure that the overall headcount does not increase.
- Instigated a programme to **reduce the level of agency expenditure** predominantly at the local acute trust.

- Introduced the **'triple lock' business case process** where any request that would result in the ICS moving further away from its financial target necessitates approval from all four NHS organisations within the system.
- Implemented a range of **Cost Improvement Programme schemes** across the system to deliver efficiencies unencumbered by organisational biases. These schemes are owned by the Local Collaborative Boards.



Governance arrangements and effectiveness

The main function of the Board is to ensure that the organisation has established appropriate arrangements to carry out its functions effectively, efficiently and economically while adhering to relevant principles of good governance.

The role of the Board, the types of decisions taken by the Board or delegated to committees or Executive Officers are detailed in the Scheme of Reservation and Delegation.

This has been achieved by the following:

Key features of the ICB's constitution for governance

We promote good governance and proper stewardship of public resources in pursuance of our goals and in meeting our statutory duties. The principles of good governance are established in our [Constitution](#).

At all times, we will observe these generally accepted principles in the way we conduct our business. These include:

- The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business.
- The Good Governance Standard for Public Services.
- The standards of behaviour published by the Committee on Standards in Public Life (1995), known as the 'Nolan Principles'.
- The seven key principles of the NHS Constitution.
- The Equality Act 2010.



Committee effectiveness

The committees undertake an annual review of the effectiveness of their performance by inviting each committee member to rate and provide comment on how the committee operates. Each member has the opportunity to help shape the committee by giving their views on how it could be improved.

In 2024/25, the following committees carried out a survey to judge how the committees were carrying out their statutory obligations. The key messages are listed below.

Audit Committee

- Effective functioning
- Structured agenda
- Good attendance of key executives and managers
- Briefing on key risks and assurance gaps
- Expertise and proactive approach
- Regulatory and compliance awareness
- Need for increased attendance from other committee chairs
- Better alignment with other committees.

Quality and Safety Committee

- Well-established and patient-focused committee
- Effective leadership and meeting management
- Linking assurance with improvement goals
- Tracking progress on quality, performance, and finance
- Annual objectives and aligned business cycle
- Strong engagement but gaps in representation
- Need for cross-team collaboration and broader understanding
- Shift focus from process reassurance to evidencing improvement.

People, Culture and Inclusion Committee

- Effective decision-making
- Effective chairing and engagement
- Strong representation
- Open discussion culture
- Balanced experience, knowledge, and skills
- Structured agenda covering key areas
- Limited cross-discipline representation among executives
- Improved collaboration and systems thinking approach
- Overemphasis on assurance and hard metrics.

Finance and Performance Committee

- Effective chairing
- Ongoing time pressures
- Heavy agenda despite high-quality reports
- Lack of strategic focus and cross-function triangulation
- Potential need to streamline committee's scope
- Broad committee attendance requiring review.

All committees have discussed the key findings and suggestions for improvement which will be part of their individual annual plan for 2025/26 as required.

Since the Strategic Commissioning and Transformation Committee and the Health and Care Senate have only recently been established, they have not conducted a self-assessment for 2024/25. This will be scheduled for a future review period once the committees have had sufficient time to operate and assess their performance effectively.

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our Corporate Governance arrangements by drawing on the Good Governance Institute best practice.

Freedom to Speak Up

We continue to promote an open culture where employees are aware of how to speak up and who to speak to.

Protecting people from retaliation when they report in good faith any suspected acts of corruption or other wrongdoing is integral to efforts to protect patients and staff and to combat corruption, safeguard integrity, and enhance accountability.

Our Freedom to Speak Up Guardians work proactively to deliver our aims and promote the Freedom to Speak Up work. Our Guardians are required to undertake mandatory training and have to register with the National Guardian's Office (NGO).

The Guardians meet with our Executive Director and Chief Executive Officer to keep them apprised of any issues that may be raised with them.

The People, Culture and Inclusion Committee receives regular updates from the Guardians, informing them of any concerns raised. The Guardians also make a submission to the NGO on the number of concerns that have been raised.

The Board receives high-level information about all concerns raised by our staff and what we are doing to address them.

In February 2024, we were approached by a neighbouring ICB for one of our Guardians to take on the role for them on an interim basis. This ended in May 2024 when they appointed a substantive member for the role.

Freedom to Speak Up month

During October 2024, the Freedom to Speak Up Guardians promoted Speak Up month, where the topic was 'The Art of Listening'.

A series of communications went out to staff encouraging them to get involved in activities regarding speaking up.

Staff were encouraged to nominate colleagues who they thought were good at listening and who had helped them.

We can report that low numbers of concerns have been raised, and those that have been raised have been addressed through the HR process. Staff welfare is a priority.

One of our Guardians also supports local GP practices – giving practice staff a way to raise any concerns they may have about their working conditions or patient safety. A low number of concerns were raised this year, and these have been addressed through primary care and HR providers.

Discharge of Statutory Functions

We have reviewed all of the statutory duties and powers conferred on the ICB by the NHS Act 2006 (as amended) and other associated legislation and regulations.

As a result, I can confirm that as an ICB we are clear about the legislative requirements associated with each of the statutory functions for which we are responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of our statutory duties.

Risk management arrangements and effectiveness

We actively encourage risk awareness, with a culture that is open and supportive, while also ensuring robust accountability. We expect all our staff and leaders to adhere to our Leadership Compact and to behave appropriately.

The key mechanisms through which risk management is captured are:

- System Board Assurance Framework (SBAF)
- Organisation-wide Risk Register
- Oversight through our committees
- Risk Governance Network meeting.

Our system of internal control is the set of processes and procedures in place to ensure we deliver our aims and objectives. It is designed to ensure that risks are evaluated to identify the likelihood of those risks being realised and their potential impact.

The system of internal control allows risks to be managed to a level within our risk tolerance as we recognise that not all risks can be eliminated.






The SBAF sets out our objectives and identified risks that would derail our objectives. All risks on our Risk Register are aligned with our SBAF objectives.

All our risks are aligned to a lead committee, and each committee receives a Risk Report and Register bi-monthly. All risks scoring 12 and above are presented to the committees for assurance and discussion.

Our executives embody the Leadership Compact behaviours, which play a vital role in the development of openness and transparency, as highlighted by the Francis Report's Inquiry 2013. It is important that we promote and embed a culture of transparency, openness and honesty throughout the ICB in all that we do, to ensure risks are properly identified, evaluated, documented and managed.

NHS England has acknowledged that we have made good progress in developing our approach to governance and leadership and recognises the hard work we have done along with our system partners.

ICS Partnership Leadership Compact

Area	We will:
Trust 	<ul style="list-style-type: none"> • Be dependable – we will do what we say we will do and when we can't, we will explain to others why not • Act with integrity and consistency, working in the interests of the population that we serve • Be willing to take a leap of faith because we trust that partners will support us when we are in a more exposed position.
Respect 	<ul style="list-style-type: none"> • Be inclusive and encourage all partners to contribute and express their opinions • Listen actively to others, without jumping to conclusions based on assumptions • Take the time to understand others' points of view and empathise with their position • Respect and uphold collective decisions made.
Courage 	<ul style="list-style-type: none"> • Be ambitious and willing to do something different to improve health and care for the local population • Be willing to make difficult decisions and take proportionate risks for the benefit of the population • Be open to changing course if required • Speak out about inappropriate behaviour that goes against our compact.
Kindness and compassion 	<ul style="list-style-type: none"> • Show kindness, empathy and understanding towards others • Speak kindly of each other • Support each other and seek to solve problems collectively • Challenge each other constructively and with compassion.
Openness and honesty 	<ul style="list-style-type: none"> • Be open and honest about what we can and cannot do • Create a psychologically safe environment where people feel that they can raise thoughts and concerns without fear of negative consequences • Be prepared to concede a little to reach a consensus where there is disagreement.
System first 	<ul style="list-style-type: none"> • Put organisational loyalty and imperatives to one side for the benefit of the population we serve • Spend the Staffordshire and Stoke-on-Trent pound together and once • Develop, agree and uphold a collective and consistent narrative • Present a united front to regulators.
Leading by example 	<ul style="list-style-type: none"> • Lead with conviction and be ambassadors of our shared ICS vision • Be committed to playing our part in delivering the ICS vision • Live our shared values and agreed leadership behaviours • Positively promote collaborative working across our organisation.
Looking forward 	<ul style="list-style-type: none"> • Focus on what is possible, and not allow the past to dictate the future • Be open-minded and willing to consider new ideas and suggestions • Show a willingness to change the status quo and demonstrate a positive 'can do' attitude • Be open to conflict resolution.

Capacity to handle risk

The ICB's Board is responsible for the organisation's systems for internal control, including risk management.

We recognise that not all risks can be eliminated and that there are a number of 'enduring' risks which will remain on the Register. These will continue to be monitored, although they may not be mitigated against. This is accepted as being within our risk appetite.

The Board has established the following governance arrangements for risk management:

Chief Executive Officer

The Chief Executive Officer has overall responsibility to ensure appropriate systems of internal control are in place for all aspects of governance, including financial and risk management as well as plans for dealing with emergencies that may impact on the ICB.

Day-to-day management of risk management processes is delegated to the Director of Corporate Governance.

Executive Management Team

The role of the Executive Management Team is to have oversight of the SBAF and the encompassing Risk Register for all risks.

Executive directors are responsible for validating and managing risks within their designated remit of work and these are reviewed by the team monthly to enable assurance to the committees and boards that risk is being considered and managed appropriately.

Audit Committee

The Audit Committee ensures that we maintain effective systems of integrated governance, risk management and internal control. It has oversight of the full Risk Register and SBAF.

Our sub-committees are responsible for overseeing the risks relating to their workstreams.

Risk assessment

Risk owners

In 2023/24, it was agreed that all risks on the SBAF and Risk Register would be owned by the director of the relevant directorate, and each director would assign action owners to be responsible for ensuring the risks are managed on a monthly basis.

The director has overall responsibility to ensure that the risks within their designation are appropriately managed. The directors are listed below.

Risk owners for each area of work

Executive leads	Area of work
Chief Finance Officer	Finance, Financial Governance, Senior Information Risk Owner
Chief Nursing and Therapies Officer	Quality, Safety, Safeguarding, Caldicott Guardian
Director of Corporate Governance	Corporate Governance, Communication and Engagement
Chief Medical Officer	Primary Care and Medicines Optimisation, Mental Health, Continuing Healthcare
Chief Delivery Officer	Performance, Information, Planning and Strategy, as well as formal processes for Incident Coordination Centre (ICC) incident response
Chief People Officer	Human Resources, Organisational Development, Equalities
Chief Digital Officer	Digital and Cyber Security

Our strategic ambitions

Number	Description
SA1	Improve health and wellbeing outcomes
SA2	Address inequalities in access, experience and outcomes from health and social care services
SA3	Achieve a sustainable and resilient Integrated Care System
SA4	Working in partnership with communities to achieve social, economic and environmental community development

The key risks to the delivery of our Corporate Objectives during 2024/25 are as follows:

SBAF 1: Responsive patient care – urgent and emergency care

Key risks	Key mitigations
Ambulance handover delays	Bi-weekly meetings with West Midlands Ambulance Service (WMAS) are ongoing. We are monitoring spikes in demand. WMAS continue to mitigate with increased crews to support demand.
A&E four-hour performance – Urgent treatment centres	NHSE assurance visits to standalone sites.
Delivering timely patient care	The system continues to achieve well above our target set by NHSE. Reporting on Secondary Uses Service has improved and the Planned Care Portfolio continue to work with providers to ensure reporting remains consistent.

SBAF 2: Responsive patient care – elective care, cancer and diagnostics

Key risks	Key mitigations
UHNM Electronic Patient Record (EPR)	Options appraisal considered as short and mid-terms for risk mitigation, particularly at UHNM. The funding gap poses significant risks for all ICS partners.
System surge capacity	The System Surge Plan received ratification at ICB Board in November, post assessment and approval at full range of governance forums (including public partner organisation Boards and ICB committees). The system continues to work with NHSE to provide assurance regarding surge plans and capacity and to address areas identified for improvement at the NHSE winter assurance visit to Royal Stoke University Hospital in October.

SBAF 3: Proactive planning and delivery of integrated locality based community services

Key risks	Key mitigations
UHNM EPR	As for SBAF 2 above.
System surge capacity	As for SBAF 2 above.

SBAF 4: Reducing health inequalities

Key risks	Key mitigations
Patient Safety Incident Response Framework (PSIRF)	Providers are to confirm they are reporting all relevant serious level harms on the Strategic Executive Information System (STEIS) as per arrangement with NHSE, although concern remains that incidents requiring STEIS reporting are not always being notified.
Access to dental services due to capacity and workforce pressures	The Dental Local Delivery Plan has been developed – focusing on improving dental access, oral health, and supporting dental workforce.
Some GPs are not prescribing medications in pregnancy	Providers are escalating any issues through internal governance. The maternity team are supporting providers with shared learning and best practice ideas to support changes in midwifery practice.

SBAF 5: High quality, safe care outcomes

Strategic objectives	Key mitigations
Paediatric audiology	A 'Look-back' exercise is underway at UHNM to help determine any actual harm. Burton site issue is being addressed.
Children and young people delayed discharges from Tier 4 hospitals	Monthly meetings established with the provider collaborative and Associate Director for Safeguarding to ensure timely discharge. Agreement reached about sharing information re CYP who are indicated for autism assessment given the late referrals to the Transforming Care Programme.
Urgent care sepsis management	The performance on sepsis antibiotic prescribing has improved slightly for Q3 2024/25. Monthly progress on screening is shown as consistent for the last eight months and risk has been reduced. However, monthly reviews will be needed to ensure improvement is continued.

SBAF 6: Sustainable finances

Strategic objectives	Key mitigations
Incomplete delivery of the 2024/25 ICB Efficiency Programme	The efficiency programme is one of the key drivers behind the ICB's risk position of £48.0 million. The Recovery Director, alongside the Efficiency Oversight Group, has been working at pace to enact recovery actions to mitigate. However, the forecast still suggests a £28.1 million adverse variance to the £102.2 million efficiency target.
Delivery of the 2024/25 System Financial Plan	The system forecast at Month 9 has reported a surplus of £1.2 million at NSCHT in line with their continuing run rate and efficiency delivery. This has been offset by a corresponding deficit in the ICB to maintain a nil net balance for the system.
Continuing Healthcare (CHC) cost pressure	The CHC efficiency workstream continues to be a risk to the ICB financial position. The Recovery Director conducted an urgent review to assess best/worst and most likely delivery of the efficiency savings in 2024/25.

SBAF 7: Improving efficiency and productivity

Strategic objectives	Key mitigations
System productivity	A workstream on productivity is proposed as part of the development of the Medium Term Plan. The system is in Level 4 and subject to the Investigation and Intervention Regime, with Deloitte appointed as partners to undertake this work.
Delivering timely patient care, reducing elective backlogs and achievement of Elective Recovery Fund	See SBAF 1 above.
Digital cyber security	Work progressing system-wide – specifically around incident response and working with Emergency Preparedness colleagues.



SBAF 8: Sustainable workforce

Strategic objectives	Key mitigations
Care home and home care workforce capacity	Mitigation in place via local authorities, Skills for Care and People Function team activities including People Hub, Social Care Hub and Retention programme.
Employee health, wellbeing and retention	A Health and Wellbeing Strategy is being developed across the system, reviewing staff experience. Deep dive into sickness rates, considering stress, anxiety and depression.
Neonatal and obstetric workforce	Medical recruitment is ongoing. UHNM have reduced their risk, and the ICB will align as required.

Risk reporting

We have introduced an intelligent three-bell approach to reporting on risk, which highlights those risks that have not been reviewed in line with our Risk Management Framework. This approach has had a positive impact on our risk reporting, encouraging committees to discuss those risks in more detail.

Three-bell approach to risk reporting

Colour	Description
 Red	Risk score has not improved towards target in six months
 Blue	Risk does not have future actions identified
 Orange	Risk has not been reviewed in line with policy

Closing risks

In 2024/25, we closed **49 risks**, compared to 11 in 2023/24.

All risks have a lead committee to receive assurance on the management of risk. The increase in closed risks is a result of our three-bell approach and enhanced risk reporting, which provides committees with better insights into areas of concern.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures we have in place to ensure we deliver our policies, aims and objectives. It is designed to:

- identify and prioritise risks
- evaluate the likelihood of those risks being realised, and the impact if they are realised
- manage them efficiently, effectively and economically.

This allows risk to be managed to a reasonable level rather than eliminating all risk – it can therefore only provide reasonable and not absolute assurance of effectiveness.

We have a Risk Management Framework which staff should adhere to when writing risks. The Framework is available within our [Risk Management Strategy](#).

Executive directors are the responsible risk owners, with members of the directorate being action owners and responsible for managing the risks. All risks are reviewed by the Executive Management Team on a monthly basis.

The SBAF is reviewed and updated on a quarterly basis, with submission to the Board and its sub-committees. This enables the ICB to ensure an effective level of internal control, safety and quality.

The Audit Committee receives reports which provide assurance of our risk management.

All committee Chairs agreed that risk reporting should move to bi-monthly reporting and only open risks scoring 12 and above would be presented to enable the committee to focus on the high-scoring risks. Our risk management process is also reviewed and audited by our internal auditors, RSM.

Examples of what the risks are related to include Continuing Healthcare, finances, cyber security and ambulance handover delays. All of our risks have been managed and mitigated in line with our Risk Management Strategy.

A full copy of our Risk Register can be made available on request.

Annual audit of conflicts of interest management

We follow the requirements set out in the 2022 Health and Care Act to maintain robust systems of governance around conflicts of interest, including maintenance of registers of staff and committee meetings' declarations, and managing decision-making processes in those.

We continue to publish our [Declarations of Interest Register](#) on our website.

Data quality

The Board agrees that the data, information and intelligence brought to its attention – and that of the committees – are fully acceptable and fit for purpose.

Data collection and reliability are kept under review. If issues are identified with the data, we would take steps to rectify the situation.

Section 251 of the NHS Act (2016) relates to the confidentiality of patient information. On 27 February 2024, we received notification from the Confidentiality Advisory Group (CAG) that we had met the conditions of support and are registered for 's251' fully supported.

Information Governance (IG)

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information.

The framework is supported by an IG Toolkit, and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust IG systems and processes in place to help protect patient and corporate information. We have established an IG Management Framework and have developed processes and procedures in line with the IG Toolkit.

We have ensured all staff undertake annual IG training and have implemented a staff IG Handbook to ensure staff are aware of their roles and responsibilities.

The final submission of the Data Security and Protection Toolkit (DSPT) will be made by 30 June 2025. The DSPT for 2024/25 has made changes to align to the Cyber Assurance Framework (CAF) during this submission year. The interim submission date was also moved forward from 28 February 2025 to 31 December 2024. The ICB completed and submitted the interim submission by this date.

Following further changes, the 10 National Data Guardian standards are no longer used and have been replaced with five CAF objectives. The evidence for these objectives are known as outcomes.

The ICB shall provide evidence for **46** mandatory outcomes. The objectives are:

- A. Managing risk
- B. Protecting against cyber attack and data breaches
- C. Detecting cyber security events
- D. Minimising the impact of incidents
- E. Using and sharing information appropriately.

At the point of the ICB interim submission, the ICB reported that **15** outcomes had been achieved to the indicators of Good Practice recommendations. As we have not yet reached our final submission date, there are **31** outcomes to meet.

There are processes in place for incident reporting and investigation of serious incidents. Serious incidents are reported on our electronic reporting system, and our IG, Data & Digital Committee undertakes reviews or investigations as appropriate.

Personal data-related incidents

There have not been any personal data breaches during 2024/25.

Freedom of Information (FOI) requests

In 2024/25, we received a total of **473** Freedom of Information requests, in comparison with 453 requests in 2023/24. We have noted more interest from members of the public, who are using the FOI facility more and more.

We have applied the following exemptions during 2024/25:

Exemption / clause	Description	Number recorded
Exemption 21	Information reasonably accessible by other means i.e. ICB website	Three – Relating to patient choice, structures and primary care networks
Exemption 40.(1) (2)	Information deemed personal data	Six – Structure (names of staff not in the public domain)
Exemption 43.2	Information deemed commercially sensitive	One – Service (disclosure would likely prejudice the commercial interests of any legal person)

Under our Publication Scheme, redacted responses to the requests we have received are published on our website: [Our publications and policies](#).

The Audit Committee receives a report on our management of FOIs, and are advised of any breaches where deadlines have not been met. Five requests have breached the 20 days deadline – the delays were as a result of receiving information late and staff absences. All requests have been acknowledged within the three-day response timeline.

Subject Access Requests (SARs)

As an ICB, we do not receive patient medical records or hospital notes, and so we cannot provide this information under Subject Access. Instead, these must be obtained from the relevant hospital trust or GP practice.

We are able to provide information relating to Continuing Healthcare (CHC), Personal Health Budget (PHB) funding and/or individual funding requests (IFR).

SARs

We received **235** requests in 2024/25, compared with 71 in 2023/24 (seven of which were withdrawn).

Most of the requests have been for medical records or birth notes. We believe the increase in birth records relates to concerns over maternity services as reported on in the media.

All requests have been handled within timescales, with no breaches reported.

Business critical models

In line with the best practice recommendations of the 2013 MacPherson Review into the quality assurance of analytical models, we confirm that an appropriate framework and environment are in place to provide quality assurance of business-critical analytics and modelling.

Third party assurances

We commission our back-office support from NHS Midlands and Lancashire Commissioning Support Unit (ML). Monthly performance reviews are scheduled with ML.

ML's Internal Audit support is provided by Deloitte. We are awaiting the outcome of the ML's Service Auditor Reports and will include any identified weaknesses in controls within the final submission.

Control issues

No material issues requiring reporting beyond the underlying financial position were identified via the Month 9 Governance Statement return to NHS England.

The financial framework for 2024/25 is one of a population-based funding method. The system's [Operational Plan](#) in respect of 2024/25 has been published on the ICB website. It outlines our plans for 2024/25, aligned to the national objectives and our five operational priorities and our two key aims. It also sets out the scope and ambition of each of the five system collaboratives, including the level of savings that we expect each of the collaboratives to deliver.

The accompanying Financial Plan is based on the latest system allocations and is currently showing that the system will have a financial deficit in 2024/25, the sum total of which has been agreed with NHS England.

At the time of writing, the external audit opinion on the financial statements is expected to be unqualified – therefore, delivery of the standards expected of the Accountable Officer are not deemed to be at risk.

Review of economy, efficiency and effectiveness of the use of resources

Financial planning and in-year performance monitoring are covered in the Performance Report section.

Central management costs are provided in the Financial Performance Targets note in the Accounts section. Our Governing Body and the Finance and Performance Committee and Audit Committees have been kept fully abreast of the ICB's financial position and have provided both support and challenge as would be expected.

Business processes have been restructured to enable the Finance and Performance Committee to scrutinise and lead the financial agenda while carefully separating its work into two parts – one to focus on the performance of the unitary entity that is the ICB, and one concerning itself with the wider ICS.

Delegation of functions

The key financial systems (general ledger, accounts payable, accounts receivable) are operated by Shared Business Services under contract to NHS England. The Payroll service is provided by ML.

These systems undergo a separate regime of Audit assessment. Their Service Auditor Reports are published twice a year, presented to the Audit Committee and reviewed by our external auditors in terms of informing the overall audit opinion.

Counter fraud arrangements

We have an accredited Local Counter Fraud Specialist (LCFS) in place to undertake counter fraud work proportionate to identified risks. This service is currently provided by RSM UK.

We continue to ensure that a comprehensive counter fraud and anti-bribery culture exists throughout the ICB as detailed in the Counter Fraud and Bribery Policy and through the work undertaken by the LCFS.

All policy and procedures are subject to review by the LCFS to ensure all our documentation is maintained in accordance with Service Condition 24 (SC24) of the NHS Standard Contract 2021/22 and the NHS Requirements to meet Government Functional Standard 013: Counter Fraud.

The Chief Finance Officer and Counter Fraud Champions work with the LCFS to support a proactive work plan to address identified risks.

This year, we held fraud awareness campaigns and RSM hosted webinars for staff to attend which have focused on raising awareness of the different types of fraud. Staff are required to complete mandatory training for fraud awareness, and there have been briefing sessions as part of the Team Briefs.

Gifts and hospitality

It is important that we are made aware of any gifts and hospitality offered to staff to ensure transparency and openness and to ensure there is no conflict of interest for any of our decision-making staff.

We keep a register of all and any gifts and hospitality offered to our staff. All ICB staff are required to declare any gifts and hospitality offered to them. This is published in the [Publications and policies](#) section of our website. We have reviewed our Declaration of Interests, including Gifts and Hospitality policy to ensure that all aspects of the policy are current and relevant.



Head of Internal Audit Opinion

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's Annual Governance Statement.

This section provides RSM's annual internal audit opinion for 2024/25. As at June 2025, the Head of Internal Audit Opinion for Staffordshire and Stoke-on-Trent ICB is as follows:

The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

The following audits have been undertaken during the year:

Assignment	Executive lead	Status / Opinion issued
Emergency Preparedness, Resilience and Response (EPRR)	Phil Smith, Chief Delivery Officer	Reasonable Assurance
Population Health Management	Chris Bird, Chief Transformation Officer	Advisory
Personal Health Budgets (PHBs)	Dr Paul Edmondson-Jones, Chief Medical Officer	Advisory
Green Plan	Paul Brown, Chief Finance Officer	Reasonable Assurance
Financial Efficiency Programme	Paul Brown, Chief Finance Officer	Reasonable Assurance
Key Financial Controls	Paul Brown, Chief Finance Officer	Substantial Assurance
System Board Assurance Framework	Tracy Shewan, Director of Corporate Governance / Paul Winter, Deputy Director of Corporate Services and Governance	Reasonable Assurance
Data Security Protection Toolkit (DSPT)	Paul Brown, Chief Finance Officer / Paul Winter, Deputy Director of Corporate Services and Governance	Medium

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Board
- The Audit Committee
- Board Assurance Committees
- Internal Audit.

The role and conclusions of each were captured in the reports of the assurance committees to the Board.

Based on the work we have undertaken to date on the ICB's system of internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS).

The ICB may wish to consider whether any other issues have arisen as well as recognising the challenging environment within which we are operating, including the results of any external reviews, when determining whether anything should be highlighted within the AGS.

Conclusion

No significant internal control issues have been identified.

Remuneration and Staff Report



Remuneration Report

Remuneration Committee

Remuneration Committee members

Name	Position	Date joining the committee	Date leaving the committee
David Pearson	ICB Chair	01/07/2022	
Shokat Lal	ICB Non-Executive Member	01/07/2022	
Josephine Spencer	ICB Non-Executive Member	01/07/2022	
Julie Houlder	ICB Non-Executive Member	01/07/2022	
Megan Nurse	ICB Non-Executive Member	01/07/2022	31/03/2025
Mike Lawton	ICB Non-Executive Member	01/02/2025	

Policy on the remuneration of senior managers

The following posts were paid on the Very Senior Manager (VSM) pay scale:

- Chief Executive Officer
- Chief Finance Officer
- Chief Medical Officer
- Chief Nursing and Therapies Officer
- Chief Transformation Officer
- Chief Delivery Officer
- Chief People Officer
- Chief Digital Officer
- Director of Corporate Governance.

VSM pay is based on 'NHS England Integrated Care Board Chief Executive and Executive Director Pay Ranges and Guidance' – publication reference PPR1479_ii.

On 18 September 2024, ICB Chairs and Chief Executive Officers received a letter from Dr Navina Evans, Chief Workforce, Training and Education Officer of NHS England, outlining a recommendation for a 5% pay award for Very Senior Managers – '2024/25 Annual Pay Increase Recommendations for Very Senior Managers employed by Integrated Care Boards, NHS Trusts and Foundation Trusts' – publication reference PRN01526. This was considered by the Remuneration Committee on 17 October 2024 and approved for implementation.

All pay, terms and conditions and recruitment matters relating to Very Senior Managers are subject to approval by the Remuneration Committee.

Percentage change in remuneration of highest-paid director

These figures are based on total remuneration paid to the highest-paid director versus the total gross remuneration paid to all remaining employees.

Role	2023/24 salary (£)	2024/25 salary (£)	Change (%)
Highest-paid director	205,485	215,759	5.00%
Median pay of employees	50,952	56,454	11.00%

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director or member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest-paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest-paid director or member in the organisation in the financial year 2024/25 was £215,000 to £220,000 (2023/24: £205,000 to £210,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2024/25	25th percentile	Median salary ratio	75th percentile
Total remuneration (£)	39,405	56,454	74,290
Salary component of total remuneration (£)	39,405	56,454	74,290
Pay ratio information	5.52	3.85	2.93

2023/24	25th percentile	Median salary ratio	75th percentile
Total remuneration (£)	37,350	50,952	70,417
Salary component of total remuneration (£)	37,350	50,952	70,417
Pay ratio information	5.56	4.07	2.95

Note: Salary movement for all pay scales reflects incremental movement only.

In 2024/25, 0 employees received remuneration in excess of the highest-paid director or member (2023/24: 0). Remuneration ranged from £12,514 to £215,759 (2023/24: £22,383 to £205,485). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Agenda for change

The majority of our other employees are employed and paid in line with the NHS Terms and Conditions of Service (TCS) for Agenda for Change. A small number of employees are employed under our Local Clinical and Professional Leadership Terms and Conditions and Pay Framework, and national Medical and Dental Terms and Conditions and Pay.

Remuneration of Very Senior Managers

Non-Executive Member remuneration is in line with 'NHS England Integrated Care Board Chairs and Non-Executive Member Pay and Guidance' – publication reference B1479_i.

No senior managers have been paid through a performance-related pay mechanism in 2024/25.

Senior manager remuneration (including salary and pension entitlements) (subject to audit)

1 April 2024 to 31 March 2025	(a) Salary (bands of £5,000)	(b) Expense payments (Taxable to nearest £100)	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term performance pay and bonuses (bands of £5,000)	(e) All pension- related benefits (bands of £2,500)	Total a-e (bands of £5,000)
	£000	£000	£000	£000	£000	£000
David Pearson – Chair	55 - 60	0	0 - 0	0 - 0	0 - 0	55 - 60
Peter Axon – Chief Executive Officer	210 - 215	0	0 - 0	0 - 0	0 - 0	210 - 215
Dr Paul Edmondson-Jones – Chief Medical Officer	170 - 175	0	0 - 0	0 - 0	15.0 -17.5	190 - 195
Phil Smith – Chief Delivery Officer	140 - 145	0	0 - 0	0 - 0	40.0 - 42.5	180 - 185
Paul Brown – Chief Finance Officer	160 - 165	0	0 - 0	0 - 0	42.5 - 45.0	205 - 210
Heather Johnstone – Chief Nursing and Therapies Officer	100 - 105	0	0 - 0	0 - 0	0 - 0	100 - 105
Chris Bird – Chief Transformation Officer	60 - 65	0	0 - 0	0 - 0	0 - 0	60 - 65
Elizabeth Disney – Chief Transformation Officer	85 - 90	0	0 - 0	0 - 0	45.0 - 47.5	130 - 135
Julie Houlder – NED, Chair of Audit Committee	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Megan Nurse – NED, Chair of Finance and Performance Committee	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Josie Spencer – NED, Chair of Quality and Safety Committee	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Shokat Lal – NED, Chair of People, Culture and Inclusion Committee	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Mike Lawton – NED and Chair of Strategic Commissioning and Transformation Committee	0 - 5	0	0 - 0	0 - 0	0 - 0	0 - 5

****Notes: Taxable expenses and benefits in kind are expressed to the nearest £100.**

- **Chris Bird – Chief Transformation Officer | Left 19 August 2024**
- **Elizabeth Disney – Chief Transformation Officer | Joined 1 September 2024**
- **Megan Nurse – NED and Chair of Finance and Performance Committee | Left 31 March 2025**
- **Mike Lawton – NED and Chair of Strategic Commissioning and Transformation Committee | Joined 1 February 2025**
- **Chief People Officers and Chief Digital Officer have been excluded from 24/25 table because they are not voting members of the board**

1 April 2023 to 31 March 2024	(a) Salary (bands of £5,000)	(b) Expense payments (Taxable to nearest £100)	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term performance pay and bonuses (bands of £5,000)	(e) All pension- related benefits (bands of £2,500)	Total a-e (bands of £5,000)
	£000	£000	£000	£000	£000	£000
David Pearson – Chair	55 - 60	0	0 - 0	0 - 0	0 - 0	55 - 60
Peter Axon – Chief Executive Officer	205 - 210	0	0 - 0	0 - 0	0 - 0	205 - 210
Dr Paul Edmondson-Jones – Chief Medical Officer	170 - 175	0	0 - 0	0 - 0	62.5 - 65.0	235 - 240
Phil Smith – Chief Delivery Officer	130 - 135	0	0 - 0	0 - 0	35.0 - 37.5	170 - 175
Paul Brown – Chief Finance Officer	150 - 155	0	0 - 0	0 - 0	0 - 0	150 - 155
Heather Johnstone – Chief Nursing and Therapies Officer	140 - 145	0	0 - 0	0 - 0	42.5 - 45.0	185 - 190
Chris Bird – Chief Transformation Officer	130 - 135	0	0 - 0	0 - 0	0 - 0	130 - 135
Alex Brett – Chief People Officer	30 - 35	0	0 - 0	0 - 0	0 - 0	30 - 35
Mish Irvine – Chief People Officer	25 - 30	0	0 - 0	0 - 0	150.0 - 152.5	180 - 185
Chris Ibell – Chief Digital Officer	65 - 70	0	0 - 0	0 - 0	0 - 0	65 - 70
Julie Houlder – NED, Chair of Audit Committee	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Megan Nurse – NED, Chair of Finance and Performance Committee	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Josie Spencer – NED, Chair of Quality and Safety Committee	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Shokat Lal – NED, Chair of People, Culture and Inclusion Committee	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20

****Note: Taxable expenses and benefits in kind are expressed to the nearest £100.**

Further information:

- **Peter Axon – Interim CEO (seconded from NSCHT at 1 WTE) | Joined permanently 1 January 2024**
- **Alex Brett – Chief People Officer (seconded from MPFT at 0.5 WTE) | Annual salary £151k | Left 31 August 2023**
- **Mish Irvine – Chief People Officer (seconded from MPFT at 0.5 WTE) | Annual salary £111k | Joined 1 October 2023**
- **Chris Ibell – Chief Digital Officer (seconded from MPFT at 0.5 WTE) | Annual salary £113k | Joined permanently 1 December 2023.**

Pension benefits (subject to audit)

1 April 2024 to 31 March 2025	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31/03/25 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31/03/25 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 01/04/2024	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31/03/25	(h) Employer's Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Peter Axon – Interim CEO	0 - 0	0 - 0	5 - 10	0 - 0	1,530	0	135	0
Dr Paul Edmondson-Jones – Chief Medical Officer	0 - 2.5	0 - 0	5 - 10	0 - 0	0	0	13	0
Phil Smith – Chief Delivery Officer	2.5 - 5	0 - 0	25 - 30	0 - 0	274	22	332	0
Paul Brown – Chief Finance Officer	2.5 - 5	0 - 0	20 - 25	0 - 0	269	39	346	0
Heather Johnstone – Chief Nursing and Therapies Officer	0 - 0	0 - 0	5 - 10	0 - 0	1,199	0	121	0
Chris Bird – Chief Transformation Officer	0 – 0.25	0 - 0	60 - 65	0 - 0	907	7	991	0
Elizabeth Disney – Chief Transformation Officer	2.5 - 5	0 - 0	15 - 20	5 - 10	199	26	249	0

1 April 2023 to 31 March 2024	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31/03/24 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31/03/24 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 01/04/2023	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31/03/24	(h) Employer's Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Peter Axon – Interim CEO	0 - 0	45 - 47.5	70 - 75	185 - 190	1,106	284	1,530	0
Dr Paul Edmondson-Jones – Chief Medical Officer	2.5 - 5	0 - 0	5 - 10	0 - 0	0	0	0	0
Phil Smith – Chief Delivery Officer	2.5 - 5	0 - 0	20 - 25	0 - 0	174	63	274	0
Paul Brown – Chief Finance Officer	0 - 0	0 - 0	15 - 20	0 - 0	878	0	269	0
Heather Johnstone – Chief Nursing and Therapies Officer	0 - 2.5	40 - 42.5	50 - 55	130 - 135	856	237	1,199	0
Chris Bird – Chief Transformation Officer	0 - 2.5	0 - 0	55 - 60	0 - 0	679	141	907	0

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouses' (or other allowable beneficiaries) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement for loss of office

No payments have been made in respect of compensation on early retirement. Payments paid or payable in respect of loss of office are summarised within the notes relating to Exit Packages.

Payments to past directors

There were no payments made in relation to past directors during 2024/25.

Staff Report

Number of senior managers

A senior manager is defined by NHS Business Services Authority as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS organisation. For the purposes of this report, we believe those persons in Band 8a and above are senior managers.

Senior staff analysis by Band (based on staffing at 31 March 2025)

Pay Band	Headcount
Ad-hoc / Local	0
Apprentice	2
Band 1	0
Band 2	6
Band 3	5
Band 4	34
Band 5	23
Band 6	36
Band 7	45
Band 8 – Range A	58
Band 8 – Range B	46
Band 8 – Range C	25
Band 8 – Range D	15
Band 9	11
Medical	20
VSM	16
Board (off payroll)	0
Grand total	342

Staff numbers and costs (subject to audit)

The table below shows the average number of people employed in 2024/25 in NHS Staffordshire and Stoke-on-Trent ICB.

Average number of people employed

Average number of people employed	Permanently employed	Other	Total
Administration and estates	224.11	9.37	233.48
Medical and dental	7.38	0.97	8.35
Nursing, midwifery and health visiting staff	20.71	3.77	24.48
Other	1.36	0.00	1.36
Scientific, therapeutic and technical staff	24.43	0.25	24.68
Total	277.99	14.36	292.35

The table below shows the associated staff costs for NHS Staffordshire and Stoke-on-Trent ICB. Prior year comparator financials can be found in note 4 of the accounts.

Staff costs

Staff costs	Permanently employed £000	Other £000	Total £000
Salaries and wages	£16,569	£1,871	£18,440
Social security costs	£1,898	£0	£1,898
Employer contributions to NHS pension scheme	£3,640	£0	£3,640
Apprenticeship levy	£68	£0	£68
Total	£22,175	£1,871	£24,046

Staff composition

Headcount by gender (based on staffing at 31 March 2025)

Staff grouping	Female	Male	Totals
Board member	7	7	14
Other senior management (Band 8C+)	44	29	73
All other employees	208	47	255
Grand total	259	83	342

Percentage by gender (based on staffing at 31 March 2025)

Staff grouping	Female	Male
Board member	50.0%	50.0%
Other senior management (Band 8C+)	60.3%	39.7%
All other employees	81.6%	18.4%
Grand total	75.73%	24.27%

Sickness absence data

Staff sickness absence

Staff sickness absence 2024	2024 number
Total days lost	2,419.83
Total staff years	277.53
Average working days lost	8.72

The sickness absence data for the ICB in 2024 was whole time equivalent (WTE) days available of 62,443.21 and WTE days lost to sickness absence of 2,419.83. Average working days lost per employee was 8.72 which was managed through the Absence Management Policy.

Staff turnover percentages

ICB staff turnover 2024/25

ICB staff turnover 2024/25	2024/25 number
Average full-time equivalent (FTE) employed 2024/25	282.58
Total FTE leavers 2024/25	18.03
Turnover rate	6.38%

The ICB staff turnover rate for 2024/25 has been calculated by dividing the total FTE leavers in-year by the average FTE staff in post during the year. The ICB's total FTE leavers in year was 18.03. The ICB's average FTE staff in post during the year was 282.58. The ICB staff turnover rate for the year was 6.38%.

Staff policies

As part of our approach to support our individual and organisational performance, we continue to build a values-based organisational culture.

In summer 2024, every directorate attended an **Organisational Development (OD) Away Day** – structured around strategic direction, stakeholders, shared values and behaviours, styles of leadership and skills, and tailored to their particular requirements. The outcomes of these sessions shaped the development of our Learning and Development Plan.

Supporting staff during the riots of summer 2024

During the Islamophobic-fuelled riots and civil unrest experienced across the country last summer, we worked closely with our staff networks, Governance, Communications and Engagement and Executive Team colleagues to ensure that we provided the support our colleagues said they wanted.

This included providing clarity of messaging about our zero tolerance stance to racism, as well as clarity on how individuals and line managers should act and what support was available in a range of scenarios.

We worked with system Chief People Officer colleagues on a shared, consistent approach. Three drop-in sessions were chaired by our EDI Business Partner and a Chair of the Ethnic Diverse Group.

When a colleague expressed discomfort performing Salat in a previously-used area, a senior manager promptly created a plan to identify safe, private, appropriate spaces for prayer across all three ICB sites. Suitable signage and dynamic notices are in place to ensure privacy, and the spaces can be booked in advance.

In autumn 2024, we launched a new **Learning and Development offer** that focused on the learning needs identified from the OD Away Days. It included business skills sessions on topics such as project management, leadership and successful people management, as well as apprenticeships, coaching and mentoring and key people management topics. More than 70 colleagues attended the sessions, and 30 staff are benefiting from coaching or mentoring support.

We have brought a renewed emphasis to **apprenticeships** during the year, and the number of colleagues completing apprenticeships as part of their development and upskilling has increased from zero at the start of 2024/25 to eight at year-end, with more apprenticeships starting in 2025/26.

Our People policies

In 2024/25, we introduced new HR policies based on NHS England's simplified and user-friendly format. Examples include the Flexible Working Policy and the Pregnancy and Baby Loss Policy which have been well received.

As part of our Policy Renewal Plan, a number of HR policies have been reviewed this year to reflect legislative changes, including:

- Attendance Policy
- Bullying and Harassment Policy
- Employee Expenses Policy
- Lone Working Policy
- Management of Change Policy
- Performance Management Policy
- Retirement Policy
- Working Time Policy.

We have continued to work with the Staff Engagement Group (SEG), staff networks and support groups, and Staff Side representatives to align and review all HR policies. All our policies are also accessibility checked.

Colleagues can easily access HR policies and documents by using the intranet, 'Information and News', known by us all as IAN.

Our Trade Union Facility Time Reporting Requirements

We have regional representatives for the ICB in Staffordshire and Stoke-on-Trent. As we continue to work across the system, we have been using local representatives as well as continuing to engage and consult with regional representatives from various trade unions.

Health and safety

All staff are asked annually to undertake a display screen equipment (DSE) assessment for their home office set up, and this was sent to the HR team for inclusion in their personnel records.

There were no health and safety-related incidents reported to the ICB Safety and Security Officer, and no Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents.

Other employee matters

Celebrating long service

We recognised and celebrated **22** colleagues who reached long service milestones during 2024/25.

Our health and wellbeing

We aim to create a culture where we all feel heard and valued, and in which diversity is respected.

We understand our health and wellbeing can be affected by all kinds of factors at work – workload, capacity, relationships with colleagues and the physical working environment can all have an impact. Likewise, factors outside work, including lack of sleep, financial worries, health conditions, caring responsibilities and other personal circumstances can have an impact – especially if they have changed recently.

We are proud of our health and wellbeing support. We have a range of staff support groups, specialist partners and personalised support available which was reviewed during 2024/25 to ensure it meets the needs of our staff.

Our offer includes:

- **My Wellbeing Plan** – developed and launched during summer 2024, this one-page plan, based on NHS England's template, empowers us all to take ownership of our health and wellbeing and to assess the support we may need
- **Wellbeing Guardian** – we value the input of our Wellbeing Guardian in seeking assurance, independently challenging, and holding the senior leadership team of our organisation to account, to ensure that we are all cared for and enabled to deliver high-quality care to patients and service users. Our Wellbeing Guardian is one of our experienced non-executive members, who also chairs our People, Culture and Inclusion Committee
- Menopause Champions
- Mental Health First Aiders
- Domestic Abuse Ambassadors
- Invisible Disability Representatives
- Staff Equality Networks
- Employee Assistance Programme
- Staff Psychological and Wellbeing Hub
- **Workshops** – including full body stretching, back care, chair yoga, workplace loneliness, work-life balance and relaxation.

Whistleblowing

For our corporate whistleblowing obligations, we have a dedicated policy in place. We have appointed Freedom to Speak Up Guardians, and all our staff are assured that they can speak up freely to raise any concerns they may have.

Staff Engagement Group

Our Staff Engagement Group includes core members and various volunteers from all directorates. The primary purpose of the group is to facilitate communication, collaboration and feedback on behalf of everyone to continuously improve working conditions in the ICB.

Employee voice – Staff Survey

The Staff Survey ran during October and November 2024. There was an excellent response rate of **78%** which is above average for similar organisations.

Feedback from the 2024 Staff Survey has been reviewed by the ICB Executive Team and shared with all colleagues to recognise achievements, investigate areas of improvement and seek new opportunities to support us in building the organisational culture we all aspire to.

We will ensure actions emerging from the Staff Survey align with the seven elements of the NHS People Promise:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team.

Workforce diversity profile and recruitment reporting

The report provides a profile of ICB staff in post as at 30 September 2023, which at that point totalled 329. It provides an overview of our workforce as a whole and by directorate, along with an average applicant's journey through the recruitment process, disaggregated by protected characteristics.

During an audit of our EDI webpages by the Equality and Human Rights Commission (EHRC) in 2024 to assess compliance with the Public Sector Equality Duty, we were praised for the level of detail published. The EHRC plans to use some of this information to share with other ICBs as good practice.

Employee voice – People Pulse

This year, we joined the NHS People Pulse programme to deliver regular 'temperature checks' throughout the year, in between the annual NHS Staff Survey points.

These quarterly surveys are an important part of how we measure our health and wellbeing – giving staff the opportunity to voice our thoughts, feelings, and concerns about our work environment, workload, and wellbeing, and helping us all to stay focused on what matters to us.

2024/25 Public Sector Equality Duty Annual Report

We produce an Annual Report to evidence through several mechanisms and functions how we are meeting a range of NHS equality statutory and mandated requirements, all of which demonstrate how we are meeting the Equality Acts and Public Sector Equality Duty (PSED) and publishing requirements under its specific duties.

We continue to advance and evidence equality, diversity and inclusion (EDI) through a range of statutory and mandated instruments and mechanisms, along with good practice initiatives – all of which are reported and published on our dedicated [Equality, diversity, inclusion and human rights](#) webpage.

[View our Public Sector Equality Duty Annual Report 2024/25.](#)

The table below provides a summary of the key findings.

Protected characteristic	Narrative
Age	Currently 2.4% of our workforce are aged 16 to 25, compared to the Staffordshire and Stoke-on-Trent combined figure of 10.5% (ONS). However, there has been a year-on-year increase for this age group.
Disability	People with disabilities are underrepresented in our workforce compared to the working-age population of Staffordshire and Stoke-on-Trent, which is around 19.5%. Overall, the number of staff who declare a disability has increased year-on-year, although some pay bands have higher disclosure rates than others.
Race	The non-white population in Staffordshire and Stoke-on-Trent is about 8.69%, and non-white staff are proportionately represented in our workforce. Asian staff are positively represented across all pay bands including the higher non-Agenda for Change (AfC) pay band. Black staff are positively represented in bands 1-4 (2.4%) and 8a-9 (1.4%). Mixed heritage staff are positively represented in bands 1-4.
Sex (female and male)	When we compare the NHS national workforce figure of 76.7% female and 23.3% male, it is closely representative at pay band levels 8a-9. When looking at the most senior (non-AfC) roles, male staff are overrepresented as a proportion of our workforce. While male staff are underrepresented at both pay band groupings 1-4 (11.9%) and 5-7 (13.2%) respectively, their representation at band 1-4 has increased year-on-year.
Sexual orientation	Staff who identified as lesbian, gay or bisexual are represented in the middle broad pay band ranges: 5-7 (1.9%) and 8a-9 (2.0%). 67.8% of staff identified as heterosexual or straight. 30.7% were asked but declined to provide their sexual orientation status. 63.4% of non-AfC pay band staff did not state or chose not to declare this information.

Race Equality Code (REC)

As part of our commitment to addressing race equality, we adopted the REC – an accredited leadership-focused programme – in 2022. As a result of the assessment process, we have been implementing 31 actions over a three-year period. Other national equality reporting tools and mechanisms used to evidence compliance with the PSED include the NHS Accessible Information Standard and Modern Slavery Act.

Gender Pay Gap (GPG)

The table below provides our GPG reporting data for 2023 and 2024 and shows the average and median hourly rates between male and female staff, expressed as both monetary and percentage difference (pay gap). We are pleased to report a significant reduction in the gender pay gap compared to the previous reporting period. [View the full Workforce Diversity Profile Report for 2024.](#)

Gender	2024 average hourly rate	2024 median hourly rate	2023 average hourly rate	2023 median hourly rate
Male	£38.72	£31.79	£40.67	£33.38
Female	£28.00	£25.60	£26.70	£24.38
Difference	£10.73	£6.19	£13.97	£9.00
Pay gap %	27.71%	19.46%	34.34%	26.96%

ICB EDI equality objectives

In meeting our equality obligations under the Equality Act 2010, we will produce new equality objectives for 2025. Our equality objectives will align with the ICS's Organisational Development Strategy, which includes system-wide EDI aims and objectives along with the ICB's EDI responsibilities as a lead strategic commissioner.

The objectives will also reflect feedback we received from the Equality and Human Rights Commission (EHRC) that there needs to be a focus on publishing patient information around their access, experiences and outcomes; and that this information should be disaggregated by protected characteristics.

Executive EDI objectives

Individual EDI objectives for our Executive team have been produced and are aligned to their specific directorates, roles and responsibilities.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

ICBs are not mandated to produce Workforce Race Equality Standard (WRES) or Workforce Disability Equality Standard (WDES) reports – these requirements primarily apply to NHS trusts and foundation trusts. However, we are encouraged to adopt the principles of these standards and apply them as much as possible to our own workforce. This will be reflected in our Workforce Diversity Profile and Public Sector Equality Duty reports.

Equality and Health Inequalities Impact Assessments (EHIA)

EHIAs continue to be a well-established and embedded tool in the ICB. This tried-and-tested tool helps to ensure our decisions, practices, and policies are fair and do not discriminate against any protected or vulnerable/excluded group.

Data collection and analysis regarding patient and staff access, experiences and outcomes is vitally important – as is engagement.

During this reporting period, a total of 38 assessments were completed and approved, with seven paused or in the process of being completed. The assessments include ICB policies, services, and day-to-day functions.

ICB staff can access one-to-one training and support to complete Equality Health Impact Assessments.

ICB staff networks

During 2024/25, staff networks and support groups were active and provided a platform for staff to support, express and voice a range of experiences. Information and feedback from these network groups progress through the governance process with the aim of influencing ICB policies, procedures, and day-to-day functions.

Colleague engagement and involvement

We keep ourselves engaged and informed through a range of activities, including:

- **Team Brief** – usually held via Microsoft Teams fortnightly on a Monday. If an urgent communication is needed, we will arrange a special Team Brief
- **Mid-Week Message** – for sharing key messages about process, policy and system updates
- **Friday Message** – a message directly from the Chief Executive Officer, Peter Axon. These are stored on the intranet – Information and News (IAN)
- **Staff Engagement Group (SEG)** – monthly meetings with staff representatives for the sharing of feedback and organisation updates.

Our learning and development

In spring 2024/25 we developed and launched our new learning and development offer which includes:

- **Apprenticeships** ranging from Level 2 to Level 7, in a diverse range of professions including accountancy and management
- **Nationally-recognised accredited courses**, in a range of subjects including PRINCE2 Project Management, Managing Successful Programmes, ILM Level 5 Effective Coaching and Mentoring, and Neuro-Linguistics Programming. More than 10 colleagues have accessed these courses during the year
- **Coaching and Management courses** – more than 40 colleagues have attended the Manager as Coach and Stepping into Management Programmes during 2024/25
- **Statutory and mandatory e-learning courses** – these include Equality, Diversity and Human Rights, Preventing Radicalisation and Display Screen Equipment, with which, at the end of February 2025, 95% of us were compliant
- **Mandated training courses** including the Oliver McGowan Mandatory Training on Learning Disability and Autism, Unconscious Bias and Invisible Disability Training Programmes
- Health and Wellbeing Sessions
- NHS England's Leadership Academy
- Carbon Literacy Accreditation
- Healthcare Financial Management Association.

As at 31 March 2025, **95.7%** of our staff had completed their mandatory Equality, Diversity and Human Rights training.

Staff coaching and mentoring

Coaching is a key part of our organisational culture, supporting ourselves to be as good as we can be at work.

We have **18** qualified coaches and mentors, three of whom successfully achieved their ILM Level 5 Coaching and Mentoring qualification during autumn 2024/25.

We also have **11** in-training coaches and mentors who are due to complete during 2025/26. When qualified, this will equate to almost 10% of our workforce being qualified coaches and mentors.

We are part of the Staffordshire and Stoke-on-Trent ICS Coaching and Mentoring consortium, which meets monthly to share coaching and mentoring resources and best practices.

More than 30 of our staff – which is almost 10% of our workforce – are actively working with a qualified coach or mentor to support their professional and personal development.

ICS people, culture and inclusion






Staffordshire and Stoke-on-Trent ICS has navigated a series of significant challenges during 2024/25. In particular these concerned financial pressures and surging demand for services, notably in acute services, including urgent and emergency care. These challenges have tested the resilience of our workforce and the system as a whole.

The ICS People, Culture and Inclusion Annual Report 2024/25 serves as a testament to the hard work and dedication of our exceptional people, and as a roadmap for the future of health and social care in Staffordshire and Stoke-on-Trent.

Looking forward to 2025/26, we will be focusing on working together to achieve financial balance for the system, develop and deliver our Medium Term Plan, continue to prioritise our equality, diversity and inclusion work, and support the health and wellbeing of our staff.

Working together, we look forward to driving this journey of transformation and collaboration, with a shared commitment to improving health outcomes, reducing inequalities and building a workforce that is supported, empowered, and equipped to meet the challenges ahead.

People, culture and inclusion achievements 2024/25

Area	Description
T-Levels 	Placement provision has continued to grow from 81 placements in 2023/24 to 126 in 2024/25
People Hub 	More than 17,500 hours worked by People Hub staff on 'any day, any hour' basis
Occupational Health contract 	Second year delivery of joint NHS occupational health contract. More than 6,600 referrals have been received since April 2024
Health and Wellbeing Hub 	1,964 referrals to the Health and Wellbeing Hub, with an extension of the contract until February 2026
High Potential Scheme 	27 participants graduated in January 2025

Expenditure on consultancy

The ICB expensed £1,635k for 2024/25 (2023/24: £426k). Expenditure classified as consultancy relates to the provision to management of objective advice and assistance relating to strategy, structure, management, or operations of an organisation in pursuit of its purposes and objectives.

The increase of £1,209k in 2024/25, when compared to the previous year, is a result of NHS England expressing significant concerns about the ICB delivering against its agreed expenditure control limit.

NHS England formally requested that the ICB, together with its system partners, engage external support to drive interventions, with the aim of supporting the system to deliver against the agreed in-year control total and identifying opportunity to enhance financial sustainability moving forward.

Off-payroll engagements (subject to audit)

A £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The ICB did not have any highly paid off-payroll engagements during 2024/25.

Off-payroll board members/senior official engagements

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025.

Off-payroll board members/senior official engagements	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	13

Exit packages, including special (non-contractual) payments (subject to audit)

There were no payments made in relation to exit packages during 2024/25.

Analysis of other departures

The ICB agreed no departures where special payments have been made during the reporting period.

Parliamentary Accountability and Audit Report

Staffordshire and Stoke-on-Trent ICB is not required to produce a Parliamentary Accountability and Audit Report.

Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this Annual Report between pages 149-151 of the Annual Accounts.

An audit report is also included in this Annual Report between pages 1-7 of the following Independent Auditor's Report.

Peter Axon

Chief Executive Officer

Staffordshire and Stoke-on-Trent ICB

19 June 2025

Independent auditor's report to the members of the Governing Body of NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Staffordshire and Stoke-on-Trent Integrated Care Board (the 'ICB') for the year ended 31 March 2025, which comprise the statement of comprehensive net expenditure, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cash flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2025 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion.

Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The ICB reported expenditure of £3,230.64 million against income of £3,215.36 million in its financial statements for the year ended 31 March 2025. The ICB thereby breached its duty under section 223GC (1) of the National Health Service Act 2006, as amended, to ensure that expenditure it incurred in a financial year does not exceed the sums received by it in that year. Under sections 223GB and 272(7) and (8) of the National Health Service Act 2006, as amended, NHS England directed that revenue resource use for the ICB in 2024-25 should not exceed £3,176.96 million. The ICB's revenue resource use for 2024-25 was £3,191.85 million, thereby breaching the direction given to it by NHS England.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 6 May 2025 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to the ICB's breach of its breakeven duty and revenue resource limit for the year ending 31 March 2025.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and

using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the audit committee, concerning the ICB's policies and procedures relating to:
 - the identification, evaluation and compliance with laws and regulations;
 - the detection and response to the risks of fraud; and
 - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
 - journals with a specific focus on those which altered the financial performance of the ICB for the year
 - significant accounting estimates in relation to accruals.
- Our audit procedures involved:
 - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
 - journal entry testing, with a focus on:
 - journals posted by senior finance officers
 - large value journals
 - journals posted in March and post period-end that might relate to advance payments

- challenging assumptions and judgements made by management in its significant accounting estimates in relation to accruals;
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates in relation to accruals. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
 - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
 - knowledge of the health sector and economy in which the ICB operates
 - understanding of the legal and regulatory requirements specific to the ICB including:
 - the provisions of the applicable legislation
 - NHS England's rules and related guidance
 - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
 - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
 - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter except on 20 June 2024 we identified a significant weakness in the ICB's arrangements for financial sustainability for the year ended 31 March 2024. This was in relation to delivering a balanced financial position. We reported that the ICB delivered a deficit against its breakeven plan, despite in-year recovery and this continues to be the case for the

year ended 31 March 2025. The scale and complexity of efficiency savings represent a significant risk to the delivery of the ICB's 2025-26 financial plan and detailed plans for medium term financial sustainability are not yet finalised. Therefore, the significant weakness remains in place for the year ended 31 March 2025. We recommend that the ICB should finalise a realistic, achievable and robust medium term financial plan to bring the system back into financial balance in the short to medium term.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Staffordshire And Stoke-on-Trent Integrated Care Board for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the members of the Governing Body of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Governing Body of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Avtar Sohal

Avtar Sohal, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

19 June 2025

Annual Accounts

NHS Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)

Accounts for the period 1 April 2024 to 31 March 2025

Foreword to the accounts

These accounts have been prepared in accordance with International Financial Reporting Standards (IFRS) as adopted in HM Treasury's 'Financial Reporting Manual' (FReM), subject to any agreed divergences for the DHSC group, or through subordination to the Companies Act 2006.

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

Statement of Comprehensive Net Expenditure	Note	2024/25 £'000	2023/24 £'000
Income from sale of goods and services	2	(38,629)	(39,106)
Other operating income	2	(160)	(226)
Total operating income	-	(38,789)	(39,332)
Staff costs	4	24,046	19,741
Purchase of goods and services	5	3,201,409	2,692,791
Depreciation and impairment charges	5	280	293
Provision expense	5	2,806	1,476
Other operating expenditure	5	2,097	2,192
Total operating expenditure	-	3,230,638	2,716,493
Net operating expenditure	-	3,191,849	2,677,161
Finance expense	7	5	8
Net expenditure for the year	-	3,191,854	2,677,169

The notes on pages 152 to 160 form part of this statement.

Statement of Financial Position as at 31 March 2025

Statement of Financial Position	Note	2024/25 £'000	2023/24 £'000
Non-current assets:	-		
Property, plant and equipment	8	144	-
Right-of-use assets	9	332	643
Intangible assets	10	210	-
Total non-current assets	-	686	643
Current assets:	-		
Trade and other receivables	11	24,125	38,082
Cash and cash equivalents	12	1,253	1,424
Total current assets	-	25,378	39,506
Total assets	-	26,064	40,149
Current liabilities	-		
Trade and other payables	13	(174,880)	(175,236)
Lease liabilities	9	(209)	(330)
Provisions	14	(6,749)	(4,779)
Total current liabilities	-	(181,838)	(180,345)
Non-current Assets less net current assets/liabilities	-	(155,774)	(140,196)
Non-current liabilities	-		
Lease liabilities	9	-	(293)
Total non-current liabilities	-	-	(293)
Assets less Liabilities	-	(155,774)	(140,489)
Financed by taxpayers' equity	-		
General fund	-	(155,774)	(140,489)
Total taxpayers' equity:	-	(155,774)	(140,489)

The notes on pages 152 to 160 form part of this statement.

The financial statements on pages 148 to 151 were approved by the Governing Body on 19 June 2025 and signed on its behalf by:

Peter Axon

Chief Accountable Officer
19 June 2025

Statement of Changes in Taxpayers Equity for the year ended 31 March 2025

Changes in taxpayers' equity for 2024/25	General fund £'000	Total reserves £'000
Balance at 01 April 2024	(140,489)	(140,489)
Changes in NHS ICB taxpayers' equity		
Net operating expenditure for the financial year	(3,191,854)	(3,191,854)
Net Recognised NHS ICB Expenditure	(3,191,854)	(3,191,854)
Net funding	3,176,569	3,176,569
Balance at 31 March 2025	(155,774)	(155,774)

Changes in taxpayers' equity for 2023/24	General fund £'000	Total reserves £'000
Balance at 01 April 2023	(135,668)	(135,668)
Changes in NHS ICB taxpayers' equity		
Net operating costs for the financial year	(2,677,169)	(2,677,169)
Net Recognised NHS ICB Expenditure	(2,677,169)	(2,677,169)
Net funding	2,672,348	2,672,348
Balance at 31 March 2024	(140,489)	(140,489)

The notes on pages 152 to 160 form part of this statement

Statement of Cash Flows for the year ended 31 March 2025

Statement of Cash Flows	Note	2024/25 £'000	2023/24 £'000
Cash flows from operating activities	-		
Net operating expenditure for the financial year	-	(3,191,849)	(2,677,162)
Depreciation and amortisation	5	280	293
(Increase) / decrease in trade and other receivables	11	13,957	(26,522)
Increase / (decrease) in trade and other payables	13	(355)	31,511
Provisions utilised	14	(836)	(1,240)
Increase / (decrease) in provisions	14	2,806	1,476
Net cash outflow from operating activities	-	(3,175,997)	(2,671,644)
Cash flows from investing activities	-		
Payments for property, plant and equipment	-	(144)	-
Payments for intangible assets	-	(210)	-
Net cash outflow from investing activities	-	(354)	-
Net cash outflow before financing	-	(3,176,351)	(2,671,644)
Cash flows from financing activities	-		
Grant in aid funding received	-	3,176,569	2,672,348
Repayment of lease liabilities	-	(389)	(311)
Net cash inflow from financing activities	-	3,176,180	2,672,037
Net increase / (decrease) in cash and cash equivalents	12	(171)	393
Cash and cash equivalents at the beginning of the financial year	-	1,424	1,031
Cash and cash equivalents at the end of the financial year	-	1,253	1,424

The notes on pages 152 to 160 form part of this statement.

Notes to the financial statements

Note 1. Accounting policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the circumstances of the ICB for the purpose of giving a true and fair view has been selected. The policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1 Going concern

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

Note 1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.3 Movement of assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of modified absorption accounting. Modified absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the resulting gain or loss is recognised within reserves.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

Note 1.4 Joint arrangement

The ICB has entered into a joint arrangement with both Staffordshire County Council and Stoke-on-Trent City Council, in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled in order to provide healthcare benefits to the people of its region and note 19 provides details of the income and expenditure.

The two separate joint arrangements are hosted by the Councils named above. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Notes to the financial statements (continued)

Note 1.5 Operating segments

Income and expenditure are analysed in the operating segments note and are reported in line with management information used within the ICB. Both internally and externally, management report the entity as one single operating segment, that being the commissioning of healthcare services.

Note 1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England and is distinct from revenue. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Note 1.7 Employee benefits

Note 1.7.1 Short term employee benefits

Salaries, wages, and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Note 1.7.2 Retirement benefits costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the

contributions payable to that scheme for the accounting period. For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme.

Notes to the financial statements (continued)

The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Note 1.8 Other expenditure

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Note 1.9 Grants payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accrual's basis.

Note 1.10 Property, Plant and Equipment

Note 1.10.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB
- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably AND
- The item has a cost of at least £5,000 OR
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control OR
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.10.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use AND

- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

Notes to the financial statements (continued)

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

Note 1.10.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Note 1.11 Intangible assets

Note 11.11.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB
- Where the cost of the asset can be measured reliably AND
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use
- The intention to complete the intangible asset and use it
- The ability to sell or use the intangible asset
- How the intangible asset will generate probable future economic benefits or service potential
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it AND
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

Notes to the financial statements (continued)

Note 1.11.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

Note 1.11.3 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Note 1.12 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The ICB assesses whether a contract is or contains a lease, at inception of the contract.

Note 1.12.1 The ICB as a lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments

made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

Notes to the financial statements (continued)

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

Note 1.13 Cash

Cash relates to cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

Note 1.14 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

Note 1.15 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

Notes to the financial statements (continued)

Note 1.16 Contingent assets and liabilities

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Note 1.17 Financial assets

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Note 1.17.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Note 1.17.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

Note 1.17.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Notes to the financial statements (continued)

Note 1.17.4 Impairments

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Note 1.18 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Note 1.18.1 Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Note 1.18.2 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Note 1.19 Value added tax

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Notes to the financial statements (continued)

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accrual's basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

Note 1.21 Critical accounting judgements and key sources of estimation uncertainty

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions.

Note 1.21.1 Critical accounting judgements in applying accounting policies

Management has made no critical accounting judgements, apart from those involving estimations, in the process of applying the clinical ICB's accounting policies.

Note 1.21.2 Sources of estimation uncertainty

There are no sources of estimation uncertainty that are likely to have a material effect on the amounts recognised in the ICB's financial statements. Estimations have been made in respect of a number of accruals; these accruals have been calculated based on the best available information when preparing the financial statements, and on historic experience, principally in respect of certain elements of GP prescribing and the Continuing Healthcare service.

Note 1.22 Adoption of new standards

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.
- IFRS 18 Presentation and Disclosure in Financial Statements – The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.
- IFRS 19 Subsidiaries without Public Accountability: Disclosures – The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

Note 2. Other operating income

Other operating income	2024/25 Total £'000	2023/24 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	1,880	2,360
Non-patient care services to other bodies	-	754
Prescription fees and charges	15,932	15,194
Dental fees and charges	18,210	18,052
Other contract income	2,607	2,746
Total income from sale of goods and services	38,629	39,106
Other operating income		
Other non contract revenue	160	226
Total other operating income	160	226
Total operating Income	38,789	39,332

Note 3.1 Disaggregation of income - income from sale of good and services (contracts)

Source of revenue	Education, training and research £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
NHS	1,880	-	-	-
Non NHS	-	15,932	18,210	2,607
Total	1,880	15,932	18,210	2,607

Timing of revenue	Education, training and research £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Point in time	1,880	15,932	18,210	2,607
Over time	-	-	-	-
Total	1,880	15,932	18,210	2,607

Note 3.2 Transaction price to remaining contract performance obligations

The ICB did not have any contract revenue during the reporting period expected to be recognised in future periods, related to contract performance obligations not yet completed at the reporting date.

Note 4. Employee benefits and staff numbers

Note 4.1 Employee benefits

Employee benefits 2024/25	Total Permanent Employees £'000	Total Other £'000	2024/25 Total £'000
Salaries and wages	16,569	1,871	18,440
Social security costs	1,898	-	1,898
Employer contributions to NHS pension scheme	3,640	-	3,640
Apprenticeship levy	68	-	68
Gross employee benefits expenditure	22,175	1,871	24,046

Employee benefits 2023/24	Total Permanent Employees £'000	Total Other £'000	2023/24 Total £'000
Salaries and wages	14,179	1,170	15,349
Social security costs	1,631	-	1,631
Employer contributions to NHS pension scheme	2,699	-	2,699
Apprenticeship levy	62	-	62
Gross employee benefits expenditure	18,571	1,170	19,742

Note 4.2 Average number of people employed

Average number of people employed	2024/25 Permanently employed Number	2024/25 Other Number	2024/25 Total Number	2023/24 Permanently employed Number	2023/24 Other Number	2023/24 Total Number
Total	277.14	14.36	291.50	253.08	10.40	263.48

Note 4.3 Exit packages agreed during the reporting period

There was no exit packages agreed during the 2024/25 reporting period. The table below provides information relating to 2023/24 for comparator purposes.

Exit packages	2024/25 Compulsory redundancies Number	2024/25 Compulsory redundancies £	2023/24 Total Number	2023/24 Total £
Less than £10,000	5	29,600	5	29,600
£10,001 to £25,000	4	51,933	4	51,933
£25,001 to £50,000	3	118,667	3	118,667
Total	12	200,200	12	200,200

Note 4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 5. Operating expenditure

Operating expenditure	2024/25 Total £'000	2023/24 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	13,387	13,743
Services from foundation trusts *	823,357	686,191
Services from other NHS trusts *	1,240,878	960,948
Services from other WGA bodies	2	2
Purchase of healthcare from non-NHS bodies	406,794	355,154
Purchase of social care	44,679	42,006
General dental services and personal dental services	71,098	58,004
Prescribing costs	240,178	238,860
Pharmaceutical services	47,768	44,355
General ophthalmic services	25,367	26,958
GPMS/APMS and PCTMS	246,681	234,241
Supplies and services – clinical	601	564
Supplies and services – general	16,661	8,545
Consultancy services	1,635	426
Establishment	5,611	4,973
Transport	9,852	9,553
Premises	4,770	6,360
Audit fees **	270	270
Other non-statutory audit expenditure		
• Internal audit services	132	141
• Other services	37	62
Other professional fees	142	426
Legal fees	944	741
Education, training and conferences	565	268
Total purchase of goods and services	3,201,409	2,692,791
Depreciation charges		
Depreciation	280	293
Total depreciation charges	280	293
Provision expense		
Provisions	2,806	1,476
Total provision expense	2,806	1,476
Other operating expenditure		
Chair and non-executive members	143	140
Research and development (excluding staff costs)	1,855	2,360
Expected credit loss on receivables	-	(311)
Other expenditure	99	3
Total other operating expenditure	2,097	2,192
Total operating expenditure	3,206,592	2,696,752

* During 2024/25 NHS England delegated responsibility for specialised commissioning services to the ICB as part of a test cohort which also included the other 10 ICBs in the Midlands region. NHS England have been working towards more integrated commissioning of specialised services for some time, and with the establishment of ICBs, has been able to take practical steps to put this on a more formal footing.

These changes aim to improve patient care and outcomes by enabling the joined-up planning and commissioning of services at a population level across whole pathways of care, i.e. across specialised and non-specialised services.

** The external audit fee is inclusive of VAT.

The auditor's liability for external audit work carried out throughout the period is limited to £2 million.

Note 6. Better payment practice code

Non-NHS payables	2024/25 Number	2024/25 £'000	2023/24 Number	2023/24 £'000
Total non-NHS trade invoices paid in the year	54,130	789,349	49,074	728,323
Total non-NHS trade invoices paid within target	53,630	774,818	48,722	723,738
Percentage of non-NHS trade invoices paid within target	99.08%	98.16%	99.28%	99.37%

NHS payables	2024/25 Number	2024/25 £'000	2023/24 Number	2023/24 £'000
Total NHS trade invoices paid in the year	2,832	2,101,830	2,107	1,670,282
Total NHS trade invoices paid within target	2,822	2,101,432	2,081	1,669,674
Percentage of NHS trade invoices paid within target	99.65%	99.98%	98.77%	99.96%

Note 7. Finance Costs

Interest	2024/25 £'000	2023/24 £'000
Interest on lease liabilities	5	8
Total finance costs	5	8

Note 8.1 Property, plant and equipment

Property, plant and equipment	Information technology £'000	Total £'000
Cost or valuation at 01 April 2024	-	-
Additions purchased	144	144
Cost/Valuation at 31 March 2025	144	144
Depreciation 01 April 2024	-	-
Depreciation at 31 March 2025	-	-
Net book value at 31 March 2025	144	144
Purchased	144	144
Total at 31 March 2025	144	144

Note 8.2 Economic lives of property, plant and equipment

Economic lives of property, plant and equipment	Minimum life (years)	Maximum life (years)
Information technology	0	5

Note 9.1 Right-of-use assets

Right-of-use assets	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2024	1,229	1,229
Lease remeasurement	(31)	(31)
Cost/Valuation at 31 March 2025	1,198	1,198
Depreciation 01 April 2024	586	586
Charged during the year	280	280
Depreciation at 31 March 2025	866	866
Net book value at 31 March 2025	332	332

The net book value at 31 March 2025 relates to a non-clinical building leased from Stoke-on-Trent City Council with the initial lease term running until October 2026. The lease contains an option to extend into a secondary lease term if required.

Note 9.2 Lease liabilities

Lease liabilities	2024/25 £'000	2023/24 £'000
Lease liabilities at 01 April 2024	(623)	(926)
Interest expense relating to lease liabilities	(5)	(8)
Repayment of lease liabilities (including interest)	389	311
Other	31	-
Lease liabilities at 31 March 2025	(208)	(623)

Note 9.3 Lease liabilities – maturity analysis of undiscounted future lease payments

Lease liabilities – maturity analysis of undiscounted future lease payments	2024/25 £'000	2023/24 £'000
Within one year	(208)	(330)
Between one and five years	-	(293)
After five years	-	-
Balance at 31 March 2025	(208)	(623)

Note 9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

Amounts recognised in Statement of Comprehensive Net Expenditure	2024/25 £'000	2023/24 £'000
Depreciation expense on right-of-use assets	280	293
Interest expense on lease liabilities	5	8

Note 9.5 Amounts recognised in Statement of Cash Flows

Amounts recognised in Statement of Cash Flows	2024/25 £'000	2023/24 £'000
Total cash outflow on leases under IFRS 16	389	311

Note 10.1 Intangible non-current assets

Intangible non-current assets	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2024	-	-
Additions purchased	210	210
Cost / Valuation at 31 March 2025	210	210
Amortisation 01 April 2024	-	-
Amortisation at 31 March 2025	-	-
Net book value at 31 March 2025	210	210

Note 10.2 Economic lives of intangible assets

Economic lives of intangible assets	Minimum life (years)	Maximum life (years)
Computer software: purchased	-	5

Note 11. Receivables

Note 11.1 Trade and other receivables

Trade and other receivables	Current 2024/25 £'000	Current 2023/24 £'000
NHS receivables: revenue	2,531	681
NHS accrued income	4,448	12,840
Non-NHS and other WGA receivables: revenue	8,486	11,173
Non-NHS and other WGA prepayments	665	786
Non-NHS and other WGA accrued income	1,780	1,439
Non-NHS and other WGA contract receivable not yet invoiced/non-invoice	5,774	11,071
Expected credit loss allowance-receivables	(239)	(239)
VAT	676	327
Other receivables and accruals	4	4
Total trade and other receivables	24,125	38,082

As at 31 March 2025 there were no non-current trade and other receivables.

Note 11.2 Receivables past their due dates but not impaired

Receivables past their due dates but not impaired	2024/25 DHSC Group Bodies £'000	2024/25 Non DHSC Group Bodies £'000	2023/24 DHSC Group Bodies £'000	2023/24 Non DHSC Group Bodies £'000
By up to three months	2,110	2,712	224	1,289
By three to six months	6	1,417	-	1,040
By more than six months	-	4,085	-	2,942
Total	2,116	8,214	224	5,271

Note 11.3 Loss allowance on asset classes

Loss allowance on asset classes	Trade and other receivables – Non DHSC Group Bodies £'000	Total £'000
Balance at 01 April 2024	(239)	(239)
Total	(239)	(239)

Note 12. Cash and cash equivalents

Cash and cash equivalents	2024/25 £'000	2023/24 £'000
Balance at 01 April 2024	1,424	1,031
Net change in year	(170)	393
Balance at 31 March 2025	1,253	1,424
Made up of:		
• Cash with the Government Banking Service	1,253	1,424
Cash and cash equivalents as in Statement of Financial Position	1,253	1,424

Note 13. Trade and other payables

Trade and other payables	Current 2024/25 £'000	Current 2023/24 £'000
NHS payables: revenue	9,073	3,398
NHS accruals	2,947	26,103
Non-NHS and other WGA payables: revenue	19,010	20,601
Non-NHS and other WGA accruals	123,703	102,453
Social security costs	243	224
Tax	276	229
Other payables and accruals *	19,628	22,228
Total trade and other payables	174,880	175,236

As at 31 March 2025 there were no non-current trade and other payables.

There are no liabilities included in the above for any person due in future years under arrangements to buy out the liability for early retirement over five years.

* Other payables include £1.808 million outstanding pension contributions as at 31 March 2025 (2023/24: £1.503 million).

Note 14. Provisions

Provisions	Current 2024/25 £'000	Current 2023/24 £'000
Continuing care	2,618	2,876
Other *	4,131	1,903
Total	6,749	4,779

* Other provisions:

- GP premises rent reviews – covering any premises that have not been reviewed externally to ascertain their current market rental value within the last three years which would result in a future cash outflow for the entity.
- In housing of admin services – during 2024/25 discussions have accelerated regarding the in-housing of services currently outsourced to other organisations, such as Continuing Health Care, Payroll, HR and Information Governance.

Provisions	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2024	2,876	1,903	4,779
Arising during the year	2,641	2,968	5,609
Utilised during the year	(444)	(393)	(837)
Reversed unused	(2,455)	(347)	(2,802)
Balance at 31 March 2025	2,618	4,131	6,749
Expected timing of cash flows:			
Within one year	2,618	4,131	6,749
Balance at 31 March 2025	2,618	4,131	6,749

Note 15. Contingencies

Contingent assets	2024/25 £'000	2023/24 £'000
VAT recovery from HMRC	-	900
Net value of contingent assets	-	900

The ICB had an ongoing claim outstanding with HMRC regarding the recovery of VAT on expenses incurred in prior periods, this claim was settled in 2024/25.

There are no contingent liabilities to report at 31 March 2025.

Note 16. Other financial commitments

The Staffordshire and Stoke-on-Trent ICB has entered into one non-cancellable contract (which is not a lease, private finance initiative contracts or other service concession arrangements) which expires as follows:

Other financial commitments	2024/25 £'000	2023/24 £'000
In not more than one year	1,284	1,233
In more than one year but not more than five years	5,136	4,778
In more than five years	8,454	8,361
Total	14,874	14,372

NHS Staffordshire and Stoke-on-Trent ICB has a long-term contractual arrangement running until 2037 with an Intermediate care provider in the local area, which is the cause of the large commitments value identified above.

Note 17. Financial instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

Note 17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within organisations standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by internal auditors.

Note 17.1.1 Currency risk

The Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations and therefore has low exposure to currency rate fluctuations.

Note 17.1.2 Credit risk

Because the majority of the organisation's revenue comes parliamentary funding, it has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

Note 17.1.3 Liquidity risk

The Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Integrated Care Board draws down cash to cover expenditure, as the need arises. The Integrated Care Board is not, therefore, exposed to significant liquidity risks.

Note 17.2 Financial assets

Financial assets	Measured at amortised cost 2024/25 £'000	Total 2024/25 £'000
Trade and other receivables with NHSE bodies	1,928	1,928
Trade and other receivables with other DHSC group bodies	5,357	5,357
Trade and other receivables with external bodies	15,737	15,737
Cash and cash equivalents	1,253	1,253
Total at 31 March 2025	24,275	24,275

Note 17.3 Financial liabilities

Financial liabilities	Measured at amortised cost 2024/25 £'000	Total 2024/25 £'000
Trade and other payables with NHSE bodies	2,056	2,056
Trade and other payables with other DHSC group bodies	9,790	9,790
Trade and other payables with external bodies	162,516	162,516
Private Finance Initiative and finance lease obligations	208	208
Total at 31 March 2025	174,570	174,570

Note 18. Operating segments

The ICB considers that it has only one operating segment: commissioning of healthcare services.

Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
3,230,643	(38,789)	3,191,854	26,063	(181,838)	(155,774)
3,230,643	(38,789)	3,191,854	26,063	(181,838)	(155,774)

Note 19. Pooled budgets

The ICB has entered into pooled budget arrangements with both Staffordshire County Council and Stoke-on-Trent City Council. The pools are hosted by either the ICB or the councils named above. Under the arrangement, funds are pooled under Section 75 of the NHS Act 2006 for the Better Care Fund.

The contributions made by NHS Staffordshire and Stoke-on-Trent ICB during the reporting period are as follows:

Name of arrangement	Parties to the arrangement	Description of principal activities	2024/25 Expenditure £'000
Better Care Fund	Staffordshire County Council	Adult Social Care	23,649
Better Care Fund	Staffordshire County Council	Implementation of the Care Act	2,590
Better Care Fund	Staffordshire County Council	Carers Hub	788
Better Care Fund	Staffordshire County Council	Health Tasks	2,286
Better Care Fund	Staffordshire County Council	Step Across	2,742
Better Care Fund	Stoke-on-Trent City Council	Adult Social Care	13,024
Better Care Fund	Stoke-on-Trent City Council	Partnership and Effectiveness	137
Better Care Fund	Stoke-on-Trent City Council	Health Tasks	646
-	-	-	45,865

Name of arrangement	Parties to the arrangement	Description of principal activities	2023/24 Expenditure £'000
Better Care Fund	Staffordshire County Council	Adult Social Care	22,382
Better Care Fund	Staffordshire County Council	Implementation of the Care Act	2,451
Better Care Fund	Staffordshire County Council	Carers Hub	746
Better Care Fund	Staffordshire County Council	Health Tasks	1,754
Better Care Fund	Stoke-on-Trent City Council	Adult Social Care	13,078
-	-	-	40,411

Note 20. Related parties

Individual ICB Board members, having significant influence over the management of the ICB, are considered to be related parties. Details of transactions between the ICB and ICB Board members are detailed in the Remuneration Report within the Annual Report.

Entities controlled by the ICB Board members, or a close family member, are also considered to be a related party as defined by IAS 24. There were no entities that fell within this definition in 2024/25.

The DHSC is regarded as a related party. During the year the organisation has had a significant number of material transactions with entities for which the Department is regarded as the parent. These entities are listed below and represent organisations where we have had greater than 1% of expenditure (£32 million):

- University Hospitals of North Midlands NHS Trust (ICS partner)
- Midlands Partnership University NHS Foundation Trust (ICS partner)
- North Staffordshire Combined Healthcare NHS Trust (ICS partner)
- University Hospitals of Derby and Burton NHS Foundation Trust
- The Royal Wolverhampton NHS Trust
- University Hospitals Birmingham NHS Foundation Trust
- West Midlands Ambulance Service University NHS Foundation Trust.

Note 21. Losses and special payments

Losses

The total number of losses cases and the total value incurred, was as follows:

Losses	Total number of cases 2024/25 Number	Total value of cases 2024/25 £'000	Total number of cases 2023/24 Number	Total value of cases 2023/24 £'000
Administrative write-offs	-	-	1	2,607
Total	-	-	1	2,607

Special Payments

The total number special payments cases and the total value incurred, was as follows:

Special payments	Total number of cases 2024/25 Number	Total value of cases 2024/25 £'000	Total number of cases 2023/24 Number	Total value of cases 2023/24 £'000
Compensation payments	-	-	1	3
Ex gratia payments	1	58	-	-
Total	1	58	1	3

Note 22. Financial performance target

Financial performance target	2024/25 Target	2024/25 Performance	2023/24 Target	2023/24 Performance
Revenue resource use does not exceed the amount specified in directions	3,176,960	3,191,854	2,585,603	2,677,169
Revenue administration resource use does not exceed the amount specified in directions	20,802	20,222	21,983	20,587

As can be seen from the position reported above, the ICB failed one of its two statutory duties to maintain costs within the revenue funding available. The ICB successfully managed to control its costs and finish the year within its admin resource available, however has failed on the overall financial control. Failing to stay within the revenue resource limit has resulted in a Section 30 letter being issued by external audit to the Secretary of State.

Note 23. Events after the reporting period

There are no adjusting events that would impact the income, expenditure, assets or liabilities recorded within the financial statements for the reporting period. However, in May 2025, NHS England published the Model Integrated Care Board (ICB) Blueprint. This blueprint outlines significant structural and operational changes for ICBs, which including a reduction in corporate costs by the end of Q3 2025/26, based on a revised cost envelope of £18.76 per head of population. The blueprint reaffirms the role of ICBs as strategic commissioners, with a shift in focus from delivery functions to system leadership, population health management, and commissioning.

These changes are expected to impact the organisation's future operating model, governance arrangements, and potentially the allocation of resources across the system. While the full financial and operational implications are still being assessed, the organisation is actively engaging in the planning and transition process in line with NHS England's expectations.

No adjustments have been made to the financial statements for the year ended 31 March 2025, as the impact of these changes relates to future periods.

Note 24. Impact of IFRS 17 – Insurance Contracts

IFRS 17 is applicable from 2025/26 and will be implemented retrospectively with a transition date of 1 April 2024 (restating comparatives). We are currently in the transition period and the table below provides an update on the current work undertaken as part of the accounting standard adoption.

IFRS 17 readiness questions	Answers
Has the Entity assessed existing contracts for the existence of insurance components within the scope of IFRS 17?	Yes – assessment started but not yet completed
If assessment is underway or complete, have you identified any contracts that contain an insurance component?	Not yet
If the answer to Q2 is 'yes' please briefly describe that nature of the contract(s) identified.	N/A
If the answer to Q2 is 'yes', have you calculated the value of the contract liability(/ies) at 1 April 2024 (transition date)?	N/A
If the answer to Q2 is 'yes' please enter the value of the calculated contract liability(/ies).	N/A

List of acronyms

A&E – Accident and emergency	ED – Emergency department
ACAH – Acute Care at Home	EDI – Equality, diversity and inclusion
ACP – Advanced Clinical Practitioner	EHRC – Equality and Human Rights Commission
AI – Artificial Intelligence	ENT – Ear, nose and throat
CAF – Cyber Assurance Framework	EPaCCS – Electronic Palliative Care Coordination Systems
CAFAG – Chell Area Family Action Group	EPR – Electronic Patient Record
CAG – Confidentiality Advisory Group	EPRR – Emergency Preparedness Resilience and Response
CAMHS – Child and Adolescent Mental Health Services	ERIC – Estates Returns Information Collection
CCA – Civil Contingencies Act	ERS – e-Referral service
CCC – Cancer Care Coordinator	FOI – Freedom of information
CDC – Community Diagnostic Centre	FMN – Family Matters Network
CDR – Child Death Review	FPPT – Fit and Proper Person Test
CDOP – Child Death Overview Panel	FReM – Financial Reporting Manual
CEO – Chief Executive Officer	FTE – Full-time equivalent
CETV – Cash Equivalent Transfer Value	GP – General Practitioner
CHC – Continuing healthcare	GPG – Gender Pay Gap
COPD – Chronic obstructive pulmonary disease	HR – Human Resources
COVID – Coronavirus disease	HSJ – Health Service Journal
CPR – Cardiopulmonary resuscitation	HWBB – Health and Wellbeing Board
CQC – Care Quality Commission	IAN – Information and News
CQI – Continuous Quality Improvement	ICB – Integrated Care Board
CRIS – Community Rapid Intervention Service	ICC – Incident Coordination Centre
CSPR – Child Safeguarding Practice Reviews	ICP – Integrated Care Partnership
CSU – Commissioning Support Unit	ICS – Integrated Care System
CUES – Community Urgent Eyecare Services	IDH – Integrated Discharge Hub
CVD – Cardiovascular disease	IFR – Individual Funding Request
CYP – Children and young people	IMD – Index of Multiple Deprivation
DARDR – Domestic Abuse Related Death Review	IMPACT – Improving Patient Care Together
DHSC – Department of Health and Social Care	ITQP – Inpatient Quality Transformation Programme
DMT – Disease modifying treatment	JFP – Joint Forward Plan
DSE – Display screen equipment	JSNA – Joint Strategic Needs Assessment
DSPT – Data Security and Protection Toolkit	LCFS – Local Counter Fraud Specialist
DMWS – Defence Medical Welfare Service	LD – Learning disability
EAPDR – Enhanced Assess Plan Do Review	

LeDeR – Learning from the lives and deaths of those with a learning disability and autism

LES – Local Enhanced Services

LGA – Local Government Association

LGBTQ+ – Lesbian, gay, bisexual, transgender, queer/questioning and other

LMNS – Local Maternity and Neonatal System

LNRS – Local Nature Recovery Strategy

LTP – Local Transformation Plan

MDT – Multi-disciplinary team

MHLDA – Mental health, learning disabilities and autism

MHRV – Mental Health Response Vehicles

MHST – Mental Health Support Team

MIU – Minor Injuries Unit

ML – Midlands and Lancashire Commissioning Support Unit

MMR – Measles, mumps and rubella

MNISA – Maternity and Neonatal Independent Senior Advocate

MNVP – Maternity and Neonatal Voices Partnership

MPFT – Midlands Partnership University NHS Foundation Trust

MSK – Musculoskeletal

NDPP – NHS Diabetes Prevention Programme

NEM – Non-executive member

NGO – National Guardian’s Office

NHS – National Health Service

NHSE – NHS England

NICE – National Institute for Health and Care Excellence

NSCHT – North Staffordshire Combined Healthcare NHS Trust

OD – Organisational Development

OHC – One Health and Care

OHID – Office for Health Improvement and Disparities

ONS – Office for National Statistics

OPEL – Operational Pressures Escalation Levels

OSC – Overview and Scrutiny Committee

PADS – Planning, assuring and delivering service change for patients

PALS – Patient Advice and Liaison Service

PCN – Primary Care Network

PHB – Personal Health Budget

PHM – Population Health Management

PHSO – Parliamentary and Health Service Ombudsman

PKB – Patient Knows Best

POPPI – Projecting Older People Population Information

PPHS – Perinatal Pelvic Health Services

PSED – Public Sector Equality Duty

PSIRF – Patient Safety Incident Response Framework

PSP – Patient Safety Partner

PSS – Patient Safety Specialist

QIA – Quality Impact Assessment

QHB – Queen’s Hospital, Burton

QOF – Quality and Outcomes Framework

RAS – Referral Assessment Service

RCRP – Right Care, Right Person

REC – Race Equality Code

ReSPECT – Recommended Summary Plan for Emergency Care and Treatment

RIDDOR – Reporting of Incidents, Diseases and Dangerous Occurrences Regulations

RSM – RSM UK (the ICB’s internal auditors)

RWT – The Royal Wolverhampton NHS Trust

SABLE – Staffordshire Lives for Black Lives Equality

SAR – Safeguarding Adult Review

SAR – Subject Access Request

SBAF – System Board Assurance Framework

SC24 – Service Condition 24

SCC – System Coordination Centre

SEG – Staff Engagement Group

SEND – Special educational needs and disabilities

SIA – Sustainability Impact Assessment

SIRO – Senior Information Risk Owner

SOC – Security Operations Centre
SRO – Senior Responsible Officer
SSOT – Staffordshire and Stoke-on-Trent
STEIS – Strategic Executive Information System
STW – Shropshire, Telford and Wrekin
tCO2e – Tonnes of carbon dioxide equivalent
TCFD – Taskforce on Climate-related Financial Disclosures
TCS – Terms and Conditions of Service
UCR – Urgent Community Response
UEC – Urgent and emergency care
UHDB – University Hospitals of Derby and Burton NHS Foundation Trust
UHNM – University Hospitals of North Midlands NHS Trust

ULEV – Ultra-low emission vehicle
UTC – Urgent Treatment Centre
VAST – Voluntary Action Stoke-on-Trent
VAT – Value Added Tax
VCSE – Voluntary, community and social enterprise
VSM – Very Senior Manager
WDES – Workforce Disability Equality Standard
WIC – Walk-in Centre
WMAS – West Midlands Ambulance Service University NHS Foundation Trust
WRES – Workforce Race Equality Standard
WTE – Whole-time equivalent
ZEV – Zero emission vehicle