NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Annual Report 2025/26

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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 annual report for 2025/26. This past year has been significantly challenging for the NHS in Staffordshire and Stoke-on-Trent and across the country. Against a backdrop of organisational change, colleagues in our health and care system have worked exceptionally hard to continue improving outcomes for the population we serve. The performance overview in this report offers detailed insight into our achievements during this period.

In March 2025, the UK government announced far-reaching changes to the NHS in England. As part of the reset, the government asked all integrated care boards (ICBs) in England to reduce running costs by an average of 50%.

To meet these requirements, Staffordshire and Stoke-on-Trent ICB agreed to 'cluster' with Shropshire, Telford and Wrekin ICB. This arrangement enables the two organisations to work closely, share best practice and develop joint strategies to improve healthcare for our residents.

For now, both ICBs remain separate statutory bodies, but will increasingly operate under a single management structure.

Having served as Chief Executive Officer (CEO) of Shropshire, Telford and Wrekin ICB since 2022, I was appointed CEO of the new ICB cluster in October 2025.

Since taking up the role, I've been grateful for the warm welcome offered by colleagues in the ICB and the wider Staffordshire and Stoke-on-Trent system. I've been deeply impressed, too, by their dedication and ability to deliver high-quality work while navigating the uncertainties that accompany a major change programme.

I would like to acknowledge the work that has continued over the last year to strengthen relationships between Staffordshire and Stoke-on-Trent partners – including NHS organisations, local authorities and groups from the voluntary, community and social enterprise sector.

These robust relationships allow us to tackle challenges collaboratively and provide the broader perspectives that help keep the needs of our residents at the centre of our improvement work. Thousands of people have been engaged in shaping improvements including mental health services, healthy ageing, cancer care, primary care and community services.

This report is also a testament to the real achievements made in 2025/26:

- More same-day appointments in primary care, with strong access performance and also growing use of the NHS App.
- Improved patient flow thanks to extended urgent treatment centre opening hours, additional acute bed capacity, and enhanced frailty and Same Day Emergency Care services.
- Huge progress in prevention through blood pressure checks, community diagnostic tests, lung health checks and community eye care.

- NHS England recognised Staffordshire and Stoke-on-Trent ICB as an exemplar for work in the Transforming Care Programme, Annual Health Checks and reducing inequalities.

Looking ahead, one of our key priorities will be to develop the neighbourhood model of care. Shifting appropriate care from hospitals into communities is a core ambition of the NHS 10 Year Plan, and we will focus on delivering integrated neighbourhood services that are more personalised, accessible and closer to home. This will help ensure hospital services can concentrate on providing expert specialist care where it is most needed.

We will continue to strengthen our relationships with providers to drive improvements in areas such as urgent and emergency care and elective waiting times. Investment and support for mental health services for all ages will remain a priority, recognising the crucial role these services play in supporting wellbeing and tackling health inequalities.

Despite the challenges we face, I believe the future holds exciting opportunities for our ICB cluster. Existing links – such as those between the University Hospitals of North Midlands and the Shrewsbury and Telford Hospital NHS Trusts, and the work of Midlands Partnership University NHS Foundation Trust, which operates in both regions – provide a strong platform to build on.

We can look forward to exploring new ways to collaborate, share our expertise, and tackle health inequalities in our communities, by improving the services offered and the integration and connectivity of those services.

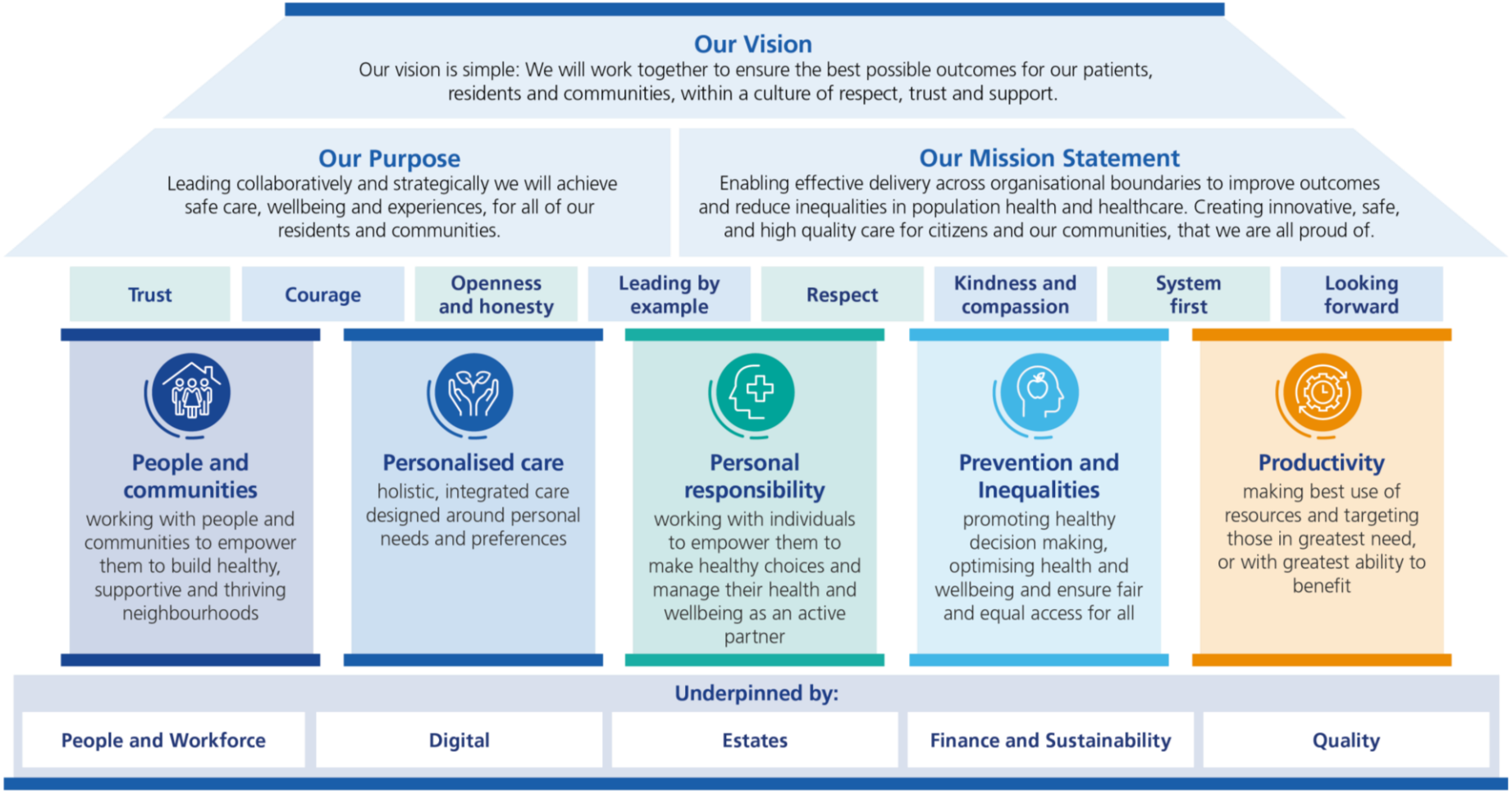
Finally, I would like to thank staff across the ICB for their unwavering commitment during a time of considerable change, and the clinicians and professionals who deliver amazing care, day in, day out, to the residents of Staffordshire and Stoke-on-Trent.

Simon Whitehouse
Accountable Officer

17 June 2026

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 square miles. We plan and buy a wide range of health and care services for the whole of Staffordshire and Stoke-on-Trent. These include general practice and primary care services such as optometry, pharmacy, and dentistry, hospital care, community healthcare and mental health services.

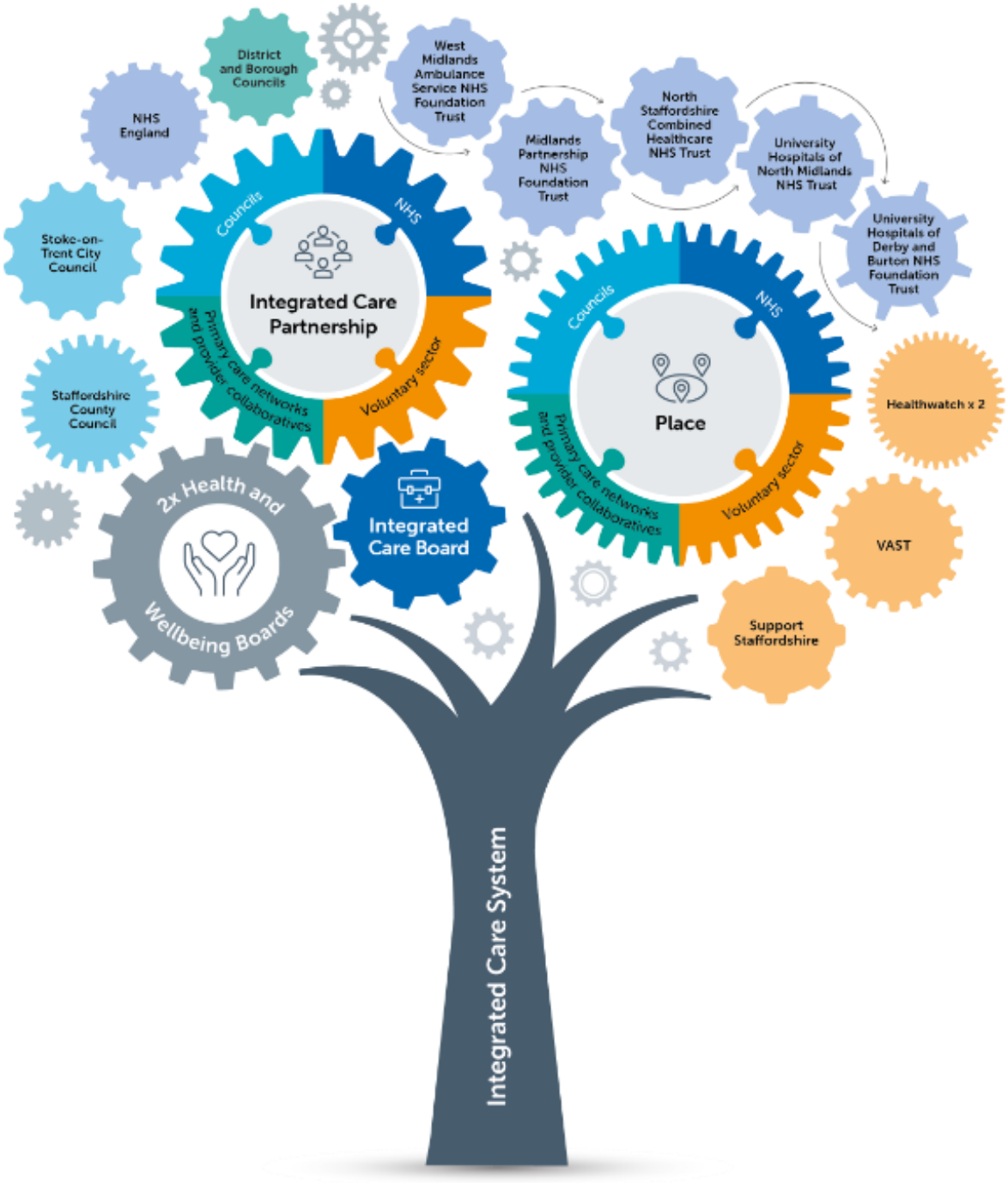


Staffordshire and Stoke-on-Trent Integrated Care System (ICS)

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

Integrated Care Boards (ICBs) are statutory NHS organisations responsible for planning health services, managing NHS budgets and improving population health across their area. Working alongside local authorities and wider partners through the Integrated Care Partnership (ICP), they form part of the Integrated Care System (ICS), which brings organisations together to deliver more joined-up health and care services for local people.



The Integrated Care Partnership (ICP) has representation from all the system partners. Our ICP Strategy sets the long-term vision for improving health and wellbeing across the whole system.

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
- 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

Health and care services across Staffordshire and Stoke-on-Trent are generally safe and well led, thanks to the dedication, skill and commitment of our workforce. However, we recognise that significant challenges remain, and we must continue to adapt to ensure we can deliver high-quality, sustainable care for our population in the years ahead.

Demand for services continues to grow as our population increases, people live longer with complex health conditions and more people require support for long-term physical and mental health needs. These pressures continue to impact waiting times for planned care and place additional strain on services across the system. Supporting people to stay well and independent for longer is therefore a key priority. Strengthening community and neighbourhood-based services, alongside initiatives such as virtual wards and rapid response teams, will help provide more care closer to home and reduce avoidable hospital 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.

Our workforce challenges are similar to those faced at a national level. Growth has not always kept pace with demand, and nationally there is a workforce supply-demand gap. There are shortages of care workers, midwives, physiotherapists, occupational therapists 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 also significant inequalities in health across Staffordshire and Stoke-on-Trent. Some communities experience much higher levels of deprivation, which can lead to poorer health outcomes and barriers to accessing care. While many of the underlying causes of these inequalities extend beyond health services alone, we remain committed to working with partners across the system to reduce these differences and ensure that everyone has the opportunity to live a healthier life.

Characteristics of our system include:

Staffordshire has a much higherproportion **(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 22% by 2035**.

Our local population experiences stark social inequality with **more than half (53%) of the population of Stoke-on-Trent**[1] living in the **most deprived 20% of areas in England**.

While **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 **palliative care patients** in the ICB compared to England.

Also we have higher proportion of people with:

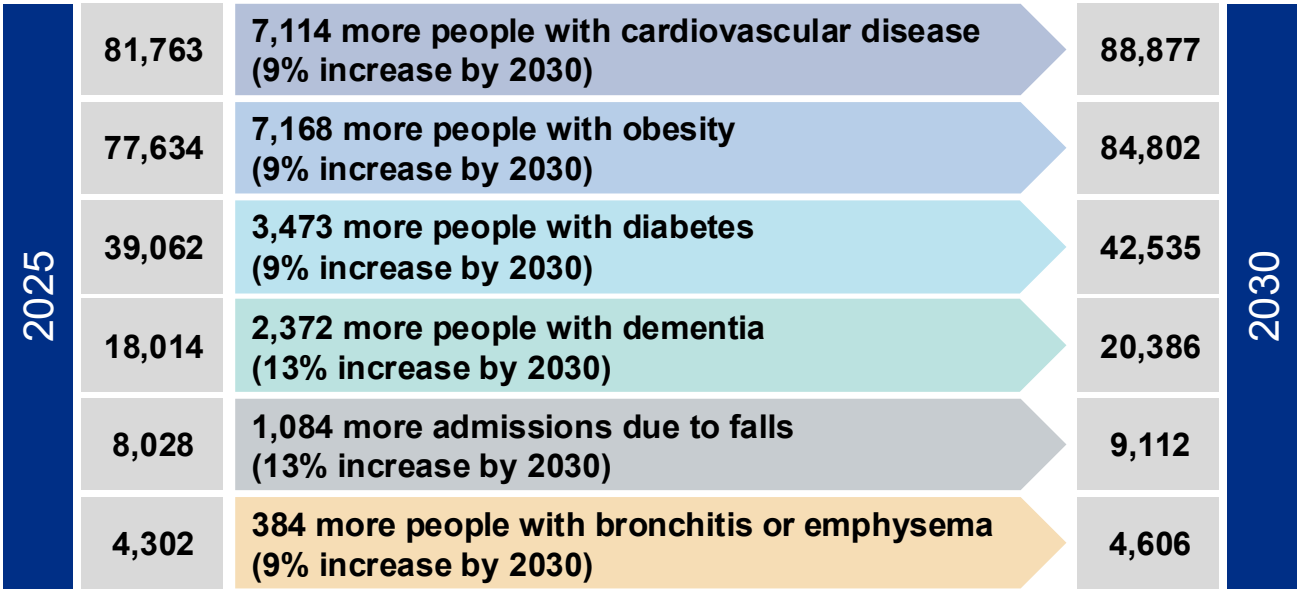
- hypertension (high blood pressure)
- cancer
- Epilepsy
- Rheumatoid arthritis.

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

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 2025 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.

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. The ICB also has some of the highest rates for infant mortality and premature births in England.

Joint Forward Plan

We published our first Joint Forward Plan (JFP) on the Staffordshire and Stoke-on-Trent website on 30 June 2023, setting out our shared strategic priorities and ambitions. While it was always expected that systems would review and refresh their plans annually, further guidance was issued by NHS England in December 2023 and January 2024. In response, we published an updated Joint Forward Plan on 8 April 2024. As our core priorities remain unchanged, this update was designed as a companion document to the original Plan, focusing on progress to date, developments since publication, and alignment with new national guidance.

The JFP sets out the medium-term strategic priorities and intended use of resources across the system, providing the basis against which commissioning decisions and operational plans are developed. The delivery described is a direct expression of how the ICB is exercising its functions in accordance with its forward plan duty, with the appendices providing clear linkage to specific statutory requirements at the time.

NHS Government Reset Programme

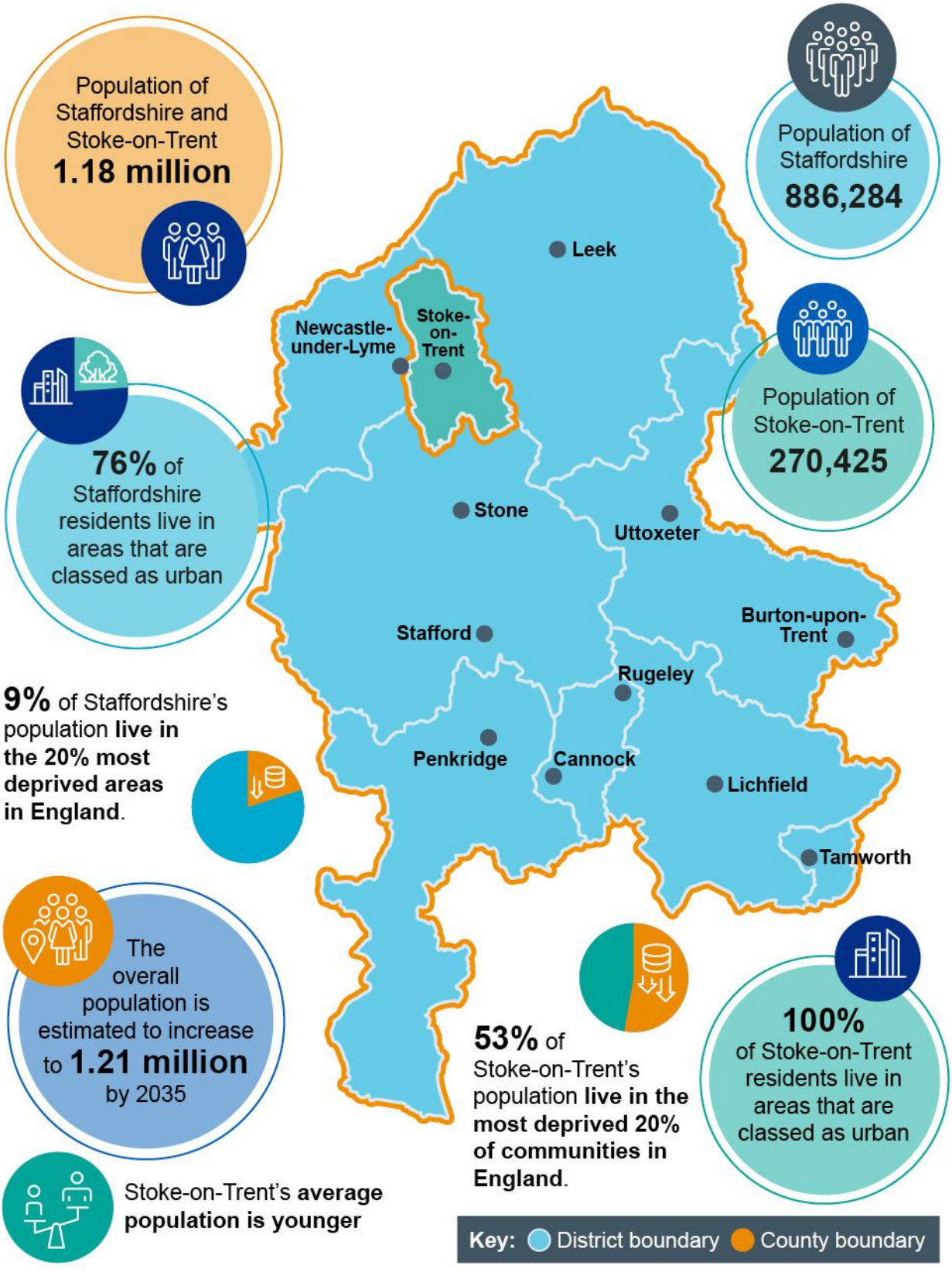
The Government NHS Reset Programme continues to progress as planned, supported by strengthened governance arrangements across both NHS Shropshire, Telford and Wrekin (STW) and NHS Staffordshire and Stoke-on-Trent (SSOT) Integrated Care Boards (ICBs).

During the year, the Management of Change (MOC) consultations for senior leadership and clinical roles were completed, and consultation commenced with the wider workforce.

The organisation continues to navigate a complex period of change in a structured and well-managed way, with a strong emphasis on supporting colleagues and maintaining long-term organisational stability.

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.



Performance Report

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 wider Staffordshire ICS have delivered a solid financial performance in 2025/26, reflecting the sustained effort and focus of teams across the system following a particularly challenging prior year.

Building on the improvement trajectory established in the second half of 2024/25, the ICB has delivered a surplus of £0.74n for the year. This is a significant turnaround from the £14.9m deficit position reported in 2024/25 and is a testament to the commitment and determination of staff, clinical leaders and partner organisations across the system.

The overall Staffordshire and Stoke-on-Trent ICS position is equally positive, with the system recording a £6.5m surplus for 2025/26. This represents a strong collective achievement and underlines the progress made across partner organisations in strengthening financial discipline whilst continuing to maintain the quality of patient care.

It is important to note that the ICS financial position has been achieved with the support of £90m of Deficit Support Funding, which is released by NHS England predicated on the system achieving its agreed financial plan. The delivery of that plan is therefore not only a financial imperative but a condition of accessing the support that underpins the system's overall position. This underscores the significance of the performance achieved and the importance of maintaining the financial discipline that has made it possible.

The ICB's improved position has been driven by three principal areas. First, continued progress within Continuing Healthcare (CHC), building on the clinically-led transformation programme that began during 2024/25 — focused on improved governance, decision-making and delivering better value from 1:1 care packages. Second, a sustained focus on prescribing expenditure, which had been a significant pressure in the prior year. Third, a thorough review of the ICB's contract portfolio, enabling more effective value for money to be achieved through targeted re-procurement and contract management, whilst preserving and maintaining patient care standards throughout.

During 2024/25, following a period of significant and sustained financial pressure, NHS England issued Staffordshire and Stoke-on-Trent ICB with Legal Undertakings. These formal undertakings were issued in response to the system's delivery of its agreed financial plan, against a backdrop of an unmitigated financial risk of £90m and an underlying system deficit of approximately £280m. The undertakings required the ICB to take a series of defined actions covering financial grip and control, governance, programme management, efficiency delivery and accountability — and to report regularly to NHS England on progress. In response, the ICB invested significantly in its recovery infrastructure, including the appointment of an independent Financial Recovery Director, engagement

of external advisors through the national Investigation and Intervention regime, and the establishment of enhanced governance and reporting arrangements at Board and Committee level. The progress made against the undertakings has been substantial, and the ICB submitted a formal report to NHS England in March 2026 requesting that the undertakings be lifted, evidenced by the delivery of financial balance in 2025/26 and a material reduction in the underlying deficit.

In summary, 2025/26 represents a year of genuine financial recovery and a platform from which the ICB and the wider ICS can continue to develop a sustainable financial footing for the future.

Financial position

Total resources of £3,386.75m were available for the 2025/26 financial year, comprising income of £40.53m and allocations from the Department of Health and Social Care. The ICB committed expenditure totalling £3,386.01m, leaving the ICB with a surplus of £0.74m. Further details can be found in the Annual Accounts section of this report.

The ICB's positive financial outturn in 2025/26 reflects the impact of sustained and targeted improvement work undertaken throughout the year. Significant progress within Continuing Healthcare, Prescribing and the ICB's wider contract portfolio has enabled the organisation to deliver a surplus whilst maintaining its commitments to patients and partner organisations across the system. This performance represents a substantial improvement on the prior year and demonstrates the effectiveness of the financial recovery work embedded across the ICB during 2024/25. The focus on value for money and financial discipline will continue to underpin the ICB's approach as it looks to build on this platform in the year ahead.

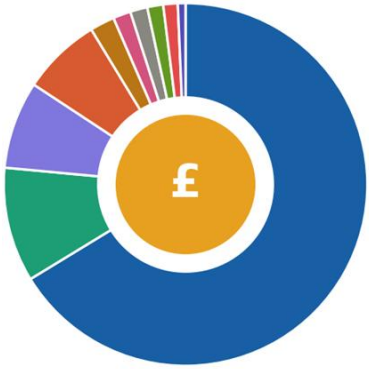
Gross Operating Costs by Category of Expenditure

Category of expenditure	2025/26 £'m
Services from NHS trusts	2,243.9
Services from NHS foundation trusts	346.0
Purchase of healthcare from non-NHS bodies	264.2
Primary care	238.3
Prescribing	74.2
Other	53.3
Dental services	51.8
Pharmaceutical services	47.8
Purchase of social care	43.5
Staff	23.1
Total	**3,386.0**

Category of expenditure as a proportion of gross operating costs

Chart 1 % Category of Expenditure as a proportion of Gross Operating Costs

Services from NHS Trusts/NHS Foundation Trusts	66.3%
Purchase of healthcare from non-NHS bodies	10.2%
Primary Care	7.8%
Prescribing	7.0%
Dental Services	2.2%
Pharmaceutical Services	1.6%
Other	1.5%
Staff	1.4%
Purchase of Social Care	1.3%
Ophthalmic Services	0.7%



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 2025/26 was £271.0m, the ICB has spent £271.1m and therefore, subject to audit, has achieved the standard for 2025/26.

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 2025/26 the proportion of Mental Health expenditure by the ICB of the overall resource allocation ringfenced for Patient Services was 10%.

Mental Health Investment Standard as a proportion of overall Patient Services expenditure

Financial years	2025/26 £'m
Mental Health Spend	271.04
ICB Programme Allocation	2,620.96
Mental Health Spend as a proportion of ICB Programme Allocation	10%

Statement of financial position

Also called the Balance Sheet, this statement provides a snapshot of the ICB's finances at a specific point in time. It sets out the organisation's assets (what it owns), its liabilities (what it owes), and the balance of public funds used to deliver services for local people.

At 31 March 2026, the ICB reported net liabilities of £166.9 million (2024/25: £155.8 million). This largely reflects the timing difference between when services are commissioned and paid for, and when funding is received, rather than an underlying cash shortfall.

Total assets reduced to £21.9 million, mainly due to the planned depreciation of assets and improved settlement of amounts owed to the ICB during the year. Trade and other receivables decreased as a result of clearing prior-year balances.

Total liabilities increased to £188.8 million, mainly reflecting the timing of payments to NHS providers for services delivered late in the financial year, with associated amounts anticipated to settled shortly after financial year end. Provisions also increased, primarily due to Continuing Healthcare claims and the recognition of a provision relating to a potential VAT recovery issue. Lease liabilities reduced following the repayment and surrender of right-of-use leases.

The movement in net liabilities is reflected in taxpayers' equity and is expected to reverse as funding is received in the following financial year.

Statement of Financial Position

Category	31 March 2026 £'000	31 March 2025 £'000
Non-current assets		
Property, plant and equipment	115	144
Right of use assets	111	332
Intangible assets	161	210
Total non-current assets	**386**	**686**
-	-	-
Current assets		
Trade and other receivables	20,918	24,125
Cash and cash equivalents	597	1,253
Total current assets	**21,515**	**25,378**
Total assets	**21,901**	**26,063**
Current liabilities	-	-
Trade and other payables	(178,752)	(174,880)
Lease liabilities	(32)	(208)
Provisions	(10,000)	(6,749)

Total current liabilities	**(188,784)**	**(181,838)**
Total assets less current liabilities	**(166,883)**	**(155,774)**
Total assets less total liabilities	**(166,883)**	**(155,774)**
Financed by taxpayers' equity and other reserves		
General Fund	(166,883)	(155,774)
Total equity	**(166,883)**	**(155,774)**

Going concern

NHS Staffordshire and Stoke-on-Trent ICB's accounts have been prepared on a going concern basis. In the year ended 31 March 2026 the ICB has reported a favourable position again plan reporting a £6.5m surplus in the year ended 31 March 2026 post deficit support funding, within this the ICB reported a £741k surplus.

At the end of the financial period, it was judged that the going concern status of the organisation remained unchanged on the following basis:

- NHS Staffordshire and Stoke-on-Trent ICB has taken steps to maintain business continuity for the finance function throughout the period in order that payments and collection of debt are not materially impacted. These steps include continuing with secure remote access to financial systems for all finance staff and budget holders and working with our third-party provider (Shared Business Services), to ensure transactional processing is not adversely affected. This is evidenced in the low value of NHS Staffordshire and Stoke-on-Trent ICB's aged debt and its continued high achievement against the Better Payment Practice Code.
- There is a presumption that Integrated Care Boards are deemed to be a going concern because there is a statutory requirement to perform the commissioning function by a public body – and this determines the requirement to apply the going concern principle – not whether the specific Integrated Care Board will be doing the function in future.

The Governing Body, having made appropriate enquiries, have reasonable expectations that NHS Staffordshire and Stoke-on-Trent ICB will have adequate resources to continue in operational existence for the foreseeable future.

Further, NHS Staffordshire and Stoke-on-Trent ICB submitted its 2026/27 financial plan covering the 12-month period for the organisation on the 12th February 2026 and again on the 18th March 2026, both submissions are compliant with the Revenue Financial Plan Resource Limit and Capital Depreciation Expenditure Limit. This plan was based on the allocations notified by NHS England for the full financial year of 2026/27. On the 7th April 2026 the ICB received an official plan close down letter from NHS England to confirm compliance with conditions related to performance trajectories.

NHS Staffordshire and Stoke-on-Trent ICB has therefore adopted the going concern basis for preparing the financial statements and has not included any adjustments that would result if it was unable to continue as a going concern

Duty to develop a joint capital resource use plan

As part of the Health and Care Act 2022 (the 2006 Act), Integrated Care Boards, partner NHS trusts and NHS foundation trusts are required to prepare joint capital resource use plans. The plans are intended to ensure there is transparency for local residents, patients, NHS health workers and other NHS stakeholders on how the capital funding provided to Integrated Care Boards is being prioritised and spent to achieve the Integrated Care Board's strategic aims. This aligns with Integrated Care

Board's financial duty to ensure that their allocated capital is not overspent and their obligation to report annually on their use of resources.

In 2025/26 the ICB set a Joint Capital Resource Use Plan with system partners compliant with capital expenditure depreciation limits (CDEL) for operational capital and included funding confirmed for national capital programmes such as the Hospital Transformation Programme and Estates Safety. A Staffordshire and Stoke-on-Trent System Capital Group oversaw monitoring of the system capital programme against the capital envelope, gained assurance that the estates and digital plans are built into system financial plans and to ensure effective oversight of future prioritisation and capital funding bids.

The Joint Capital Resource Use Plan can be viewed on our website Joint Resource Capital Plans - NHS Staffordshire and Stoke-on-Trent ICB (staffsstoke.icb.nhs.uk).

Performance analysis

Children and young people

The Children and Young People (CYP) portfolio strives to ensure that infants and children experience the best start to life – setting them on a course of improved life-long health and wellbeing, enabling them to thrive into adulthood, and supporting their physical, mental and social development.

Our aim is that children in Staffordshire and Stoke-on-Trent grow up healthy and happy, with their families and friends. They are able to look after their own wellbeing – while knowing they will get exceptional care and treatment when they need it. The outcomes we have identified for children and young people are overseen at a system level by the ICS CYP Programme Board.

The Board's strategic priorities are to:

- Improve the survival of babies and young children to reduce infant mortality
- Increase the number of children and young people to achieve and sustain a healthy weight
- Support children and young people to achieve their potential by enjoying good emotional wellbeing and positive mental health
- Support children with complex needs with the help they need so that they can fulfil their potential
- Effectively manage long-term conditions to reduce avoidable admissions in relation to asthma, epilepsy, and diabetes.

Working in conjunction with clinicians within the system, we successfully secured a business case to implement a dedicated tongue-tie service at University Hospitals of North Midlands NHS Trust. This service aims to improve the experience for mums and babies, offer breastfeeding support, and reduce waiting times for babies that need an intervention.

In February 2026, we launched the Staffordshire SEND and Alternative Provision Strategy, which sets out how we will work with the local authority to support children and young people with Special Educational Needs and Disabilities (SEND) and those who access alternative provision. Children, young people and their families were able to play a genuine role in shaping and contributing to its development.

In April 2025, we published the Staffordshire SEND Joint Strategic Needs Assessment, which sets out the strategic health and care needs for our population to inform strategy, commissioning, and local decision-making. We continue to work with Stoke-on-Trent City Council to support new ways of working and strengthen how we work with and engage schools on SEND and inclusion.

Getting It Right First Time (GIRFT) is a national programme to improve treatment and care by reviewing health services. Our children and young adult (CYA) system-wide diabetes services were reviewed in March 2025. The outcome report highlighted areas of good practice locally including improvements in HbA1c (blood glucose) outcomes, the implementation of hybrid closed-loop system (automated insulin management), high uptake of DigiBete (resources, tools and education for people living with type 1 diabetes), and collecting regular patient feedback on experiences of transitioning to adult services.

In October 2025, we were approved for providing psychological support for children and young people diagnosed with epilepsy. This will ensure that anyone identified as requiring additional support with their mental health and wellbeing is seen and supported to manage their mental health care.

Asthma rates continue to fall

Through the development of local pathways and resources, we continue to improve how we support children with long-term conditions.

- The rate of ICB patients with an asthma diagnosis attending A&E continues to decline. The under-18s rate fell by 11.2% from 22.4 per 100,000 in January 2025 to 19.9 per 100,000 in December 2025.
- There has also been a downward trend in emergency admissions of ICB patients with an asthma diagnosis. The under-18s rate fell by 57.8% from 8.0 per 100,000 in January 2025 to 3.4 per 100,000 in December 2025.

In conjunction with local authorities, we are maintaining our engagement activities to promote the Asthma Friendly Schools Programme.

We have developed resources to support schools, which are available on the ICS asthma and respiratory webpage.

Safeguarding, Child Deaths and Children in Care

Safeguarding children, young people and adults at risk is everyone's business – and a fundamental obligation for everyone who works in the NHS and its partner agencies.

The ICB Safeguarding team continue to ensure robust partner arrangements are in place to deliver safe, high-quality care and enable the earliest possible intervention. They also support the implementation of multi-agency reforms and comply with the Children Act (1989, 2004), Working Together to Safeguard Children (2023) and the Care Act (2026).

Strong leadership, partnership and contracts help maintain the required statutory duties, monitoring compliance and competence. The Health Safeguarding Collaborative Group is a forum for peer review and for monitoring training compliance and joint health work. Provider organisations maintain their own governance routes, and the group reports to the Strategic Oversight Group and ICB Quality and Safety Committee. The ICB is represented on Staffordshire and Stoke-on-Trent Safeguarding Adult and Children Partnership Boards and subsequent sub-groups and workstreams.

Our priorities over the past year:

- Engaging with, and supporting, the delivery of Staffordshire and Stoke-on-Trent Safeguarding Children Partnership multi-agency safeguarding arrangements, in accordance with Working Together to Safeguard Children (2026), ensuring accountability through the Lead Safeguarding Partners (one being the ICB CEO) and delegated responsibilities via the Delegated Safeguarding Partners (one being the ICB Chief Nursing Officer).
- Representing the ICB in statutory safeguarding review processes. These include Serious Incident Notification decision discussions, Rapid Reviews, Child Safeguarding Practice Reviews, Child Death Overview Panels, Child Death Reviews, and Domestic Abuse Related Death Reviews, and Safeguarding Adult Reviews (SARs). We have seen a substantial increase in SARs and SAR referrals compared to previous years. All published reports have been shared with ICB staff, with any health-related actions or recommendations monitored through the Health Safeguarding Collaborative Group and the relevant sub-groups.
- Supporting Continuing Healthcare with complex cases which include safeguarding concerns.
- No safeguarding disclosures requiring escalation through the ICB safeguarding governance process were recorded during 2025/26. It is important to note provider services work directly with our wider population therefore majority of this activity will be undertaken by the provider teams.
- Coordinating, influencing, developing, and delivering a mandatory Child Protection Information Sharing system (CPIS2) for the whole health system. With the support of the ICB Safeguarding team, most providers are compliant with NHS England's timescales. Delays with system integration have impacted primary care and dentistry, but a development plan is now in place to address this, with ongoing support and scrutiny.
- Integrating safeguarding responses in line with the Children's Wellbeing and Schools Bill (2024) which focuses on prevention and early intervention.
- Leading on various audit workstreams, including improving staff knowledge and awareness of domestic abuse and mental capacity assessments.
- Contributing to a multi-agency case study audit for safeguarding adults.
- Developing and reporting on the Safeguarding Accountability and Assurance Framework in accordance with national guidance.
- Continuing to support GP practices to engage with statutory review processes and helping to shape recommendations for statutory reviews as panel members.
- Supporting safeguarding practice improvements across the primary care workforce, using data from the Joint

Safeguarding Self-Assurance Tool (JSSAT) to inform training and development planning – such as implementing safeguarding processes and policy within GP365.
- Influencing the embedding of the Domestic Abuse Strategy and the Serious Violence Strategy to ensure the health economy is fully engaged with action planning and delivery.
- Co-commissioning and supporting the newly appointed Health Lead role for violence reduction to implement the evidence-based Navigator (Catch 22) programme for East Staffordshire residents accessing Queen's Hospital Burton.
- Representing the health economy on both Prevent Boards and updating provider organisations on the current threat levels and risks. Ensuring all health providers contribute to Channel Panel and all health staff receive Prevent training. Encouraging health providers to contribute to relevant task and finish groups or discussions of any actions and recommendations from Prevent Boards.

Prevention and early intervention

A multi-agency approach has been key to implementing the Families First Partnership Programme across Staffordshire and Stoke-on-Trent. We are key partners in delivering early help, supporting health engagement with family hubs, a newly implemented Integrated Front Door model for safeguarding concerns, and designing multi-agency child protection teams (MACPT).

Child Death Overview Panel (CDOP)

The ICB and the local authorities are jointly responsible for reviewing the death of all children up to the age of 18, regardless of circumstances. CDOP data is reported into the National Child Mortality Database (NCMD).

It has been a challenging year for CDOP, partly due to changes in chairing arrangements. A review will take place following the expected new guidance – which is an opportunity to refresh and strengthen joint working towards the quality of child death reviews.

The NCMD data release published in December 2025 (child deaths 2019–2025) showed neonatal, infant and child mortality in Staffordshire and Stoke-on-Trent to be above the England average, particularly for deaths of babies under one year. The Infant Mortality Steering Group is looking at the factors influencing this and how to address them.

As of February 2026, there appears to be a reduction in the number of deaths by suicide and sudden infant deaths relating to unsafe sleeping practices. This could demonstrate the effectiveness of the training and awareness work done around safer sleep, sharing of thematic review and trends in suicide, and suicide prevention. However, due to the small numbers of deaths reported, caution is advised at understanding the significance of this.

Health and wellbeing of Looked After Children

The post of Designated Nurse for Looked After Children is currently vacant. Interim arrangements are in place for colleagues in Shropshire, Telford and Wrekin to undertake this statutory role.

Maternity and neonatal services

We are part of the Local Maternity and Neonatal System (LMNS) Partnership, which brings together commissioners, providers, clinicians, and service users to improve maternity and neonatal care. The primary role is to deliver safer, more personalised, and equitable care by implementing national, and local recommendations in all aspects of maternity quality and safety for women/birthing people in Staffordshire and Stoke-on-Trent.

Perinatal assurance processes have been maintained through the Quality and Safety Oversight Forum, which includes monthly data submissions from the perinatal quality oversight pack. This including oversight and implementation of the National Saving Babies' Lives care bundle V3.2 and Year 7 of the Maternity Incentive Scheme Standards.

The LMNS 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. This includes infant mortality groups, child death overview panels, the development of safety initiatives such as Infant CPR and Safe Sleep, and system-wide standardised postnatal care guidance.

Equity and equality

Our commitment to reduce inequalities in maternity and neonatal services across our system has been strengthened over the past year. This is in line with the Core20PLUS5 framework and our local five-year Equity and Equality action plan.

In collaboration with our Maternity and Neonatal Voice Partnership (MNVP) and the Equality Diversity Inclusion (EDI) lead at UHNM, we have facilitated listening events to better understand barriers to access of care, cultural needs, and experiences of discrimination.

Collaborative support has strengthened continuity of carer pathways for women at higher risk of poorer outcomes – prioritising those from deprived communities and ethnic minority groups. Health inequality data monitoring has identified outcome gaps in areas such as access to antenatal care and preterm birth.

Bookings by 10 weeks' gestation is proven to reduce maternal mortality risk, improve screening uptake, enhances safeguarding and contributes to better outcomes. UHNM has identified this as a quality-improvement priority, and demonstrated measurable improvement in this area. This has been supported by active involvement from the maternity workforce and Family Hub leads.

Nationally, racism and discrimination in maternity and neonatal services are having a profound impact on experience and outcomes for Black and Asian women, and women from marginalised communities. An immediate action for perinatal services – in line with the medium-term planning framework (2025) – were for providers across the system to attend the perinatal equity and anti-discrimination programme. Our main provider is part of the first intake, and we look forward to this positive impact for our local families and workforce.

Engagement with service users

Our MNVP works hard to ensure that the voices of service users are heard and responded to, and continue to work with providers and service users to develop response actions. This work includes coordination of all MNVP activities such as the 15 steps toolkit and inclusivity visits.

In the latter part of 2025/26, we appointed a Neonatal Voices Lead to work directly with families on the neonatal unit. This has provided the opportunity to gain valuable insights into their experiences, which neonatal services are then able to respond to through improving services.

Maternity and Neonatal Independent Senior Advocate (MNISA)

Our MNISA has provided support and advocacy to 18 families as they navigated a range of investigation pathways following an unexpected health complication, harm event, stillbirth or the death of a baby and/or mother.

The families provided rich feedback, focussed on recognition of deterioration, escalation, compassionate communication, the need for robust psychological support following loss, grief and bereavement, transparency and duty of candour. They highlighted that the length and complexity of the investigation processes caused them to need to relive their trauma over and over again, and that this compounded the harm that they had already experienced.

Many families described how this had affected all aspects of their lives, having an impact on relationships, finances and long term physical and psychological health. One family described feeling ‘lost in the middle of a rough sea’, but that the MNISA role offered the opportunity to ‘put down their oars and just float for a while’.

Families valued the independence that the role brought alongside the seniority to challenge and to make recommendations to ensure that poor experiences are not repeated. In an independent evaluation of the role, 100% of families interviewed concluded that the role had been valuable, helped them to feel heard and supported a national roll out.

While the role is due to end in March 2026, it has given a unique insight into the experience of harmed families which can be used for transparency, care and service.

Quality and patient safety assurance, and improvement

High-quality care is only possible when partners work together. We recognise the vital role that all organisations – NHS providers, councils, regulators, voluntary sector partners and local communities –play in maintaining high standards and fostering a culture of openness, learning and continuous improvement. Our System Quality Group brings these partners together, including the Care Quality Commission, Healthwatch organisations and NHS England. This provides a trusted forum for sharing intelligence, discussing quality concerns, learning from incidents, and driving improvement.

Quality Impact Assessments (QIA) form a routine part of our commissioning processes supporting informed decision making, proactive risk assessment, and ongoing accountability. In 2025, NHS England undertook an independent Quality Assurance Review of the ICB's QIA process and concluded there was Significant Assurance, confirming strong evidence that the Staffordshire and Stoke-on-Trent QIA process is robust and sustainable. The QIA policy has since been updated to reflect the National Quality Board guidance published in June 2025 and NHS England's areas for consideration issued in July 2025. These arrangements will be further strengthened through our clustering partnership model.

Improving mental health support

In 2024/25, we took part in an NHS England pilot looking at how care is provided for people staying in mental health rehabilitation hospitals.

As part of this work, an assessment tool was developed to help understand the quality and consistency of care across the region. In 2025/26, after putting this tool into practice, we completed a Quality Improvement Plan. This showed that the ICB already had strong oversight in place for independent mental health rehabilitation hospitals in our local area.

We then focused on strengthening how we monitor and support people who are placed in mental health units outside Staffordshire and Stoke-on-Trent but who still rely on us for their ongoing care. We worked closely with both NHS mental health trusts in our area to ensure regular monitoring of care, strong oversight of placements, and a clear focus on helping people move closer to home whenever possible. This strengthened way of working is now fully embedded as part of our routine business.

Reducing waiting times for wheelchair services

Over the past three years, people using our wheelchair service have experienced long waits for assessment and equipment. This led to an increase in feedback from service users, particularly about delays and communication. Throughout 2025/26, we have made significant progress in reducing these waiting times. The overall number of people waiting has reduced substantially. At the end of March 2026 there were 29 service users waiting more than 18 weeks, and the longest wait was 31 weeks, the lowest level recorded since June 2023.

Alongside reducing waiting times, we have worked closely with the service provider to strengthen quality and safety. This has included updating triage processes, improving how we review clinical risk, and sharing best practice from across the NHS. We have also introduced regular multidisciplinary meetings with referrers to improve communication and ensure people are prioritised appropriately. Feedback from referrers has been positive, highlighting the value of these meetings and the improvements in information sharing.

Strengthening support for care home residents

Across Staffordshire and Stoke-on-Trent, we have been working to strengthen the support available for residents living in care homes – particularly around recognising when someone's health may be starting to deteriorate.

Over the past year, we have led a full update of the care home resource pack, working closely with partners across the system and with the Deteriorating Patient Network (DPN). The DPN focuses on spotting early changes in a person's condition – often first noticed by the people who know them best, such as relatives or care home staff. These early or 'soft' signs, like a person being quieter than usual or eating and drinking less, can help staff identify when someone may be becoming unwell. Acting on these signs early can prevent health from worsening and can help people stay well in their home environment.

The updated pack includes practical tools to support care home staff, such as the SBARD communication framework, which helps staff clearly raise concerns with clinicians. Community teams, including the Community Rapid Intervention Service, can often provide treatment directly in the care home when it is safe to do so – helping to avoid unnecessary hospital admissions and reducing risks such as dehydration or hospital-acquired infections.

To further support this work, we are developing a training programme to help care home staff build confidence in recognising early signs of deterioration and in preventing illnesses – for example, through encouraging vaccinations. Care homes have been active partners throughout this process. They helped shape the updated resource pack and are already using the tools to improve communication and handovers.

At the ICB's Patient Safety Conference, care homes shared their experiences with a system-wide audience, showing how these tools are improving resident safety and supporting more consistent care across the area.

Mental health

We are committed to collaborating with partners across the system to ensure mental health is given the same priority as physical health. This approach ensures that mental health support is provided in accordance with the 'three main shifts' in NHS England's 10 Year Plan and delivered in our neighbourhoods in the appropriate way, at the right time, and in the right place.

Our achievements

- As of November 2025, our specialist perinatal mental health service had supported 1,350 women – on course to achieve our access target for 2025/26.
- The refreshed Local Transformation Plan for Children and Young People's Mental Health set out the strategic and delivery framework for 2025/26 and builds on progress and learning from 2024/25. The plan supports a coordinated approach to planning, commissioning and service delivery, with a strong emphasis on local population need and place-based delivery.
- As of November 2025, our child and adolescent mental health service (CAMHS) saw 17,620 children and young people (CYP). We were also on course to achieve our targets for supporting CYP in the community for 2025/26.
- In April 2025, we launched the jointly-commissioned Staywell emotional health and wellbeing service – providing a comprehensive offer for earlier intervention.
- Our Mental Health Support Team (MHST) offer was enhanced by the launch of a further team in January 2026. We are ahead of other areas nationally for our coverage of schools, with plans to achieve 100% by 2029/30.
- 17,085 individuals began Talking Therapies treatment as of December 2025. Of those who completed a course of treatment, 71.5% showed reliable improvement. Having secured System Development Funding from the Autumn Statement, we will be offering supervision and management to the expanding clinical workforce and further enhance the offer to patients.
- Dementia diagnosis rates have continued to remain above target this year, and we are on course to be the highest performer across the Midlands. Diagnostic waiting time performance remains positive, with only 3% waiting more than 18 weeks – the second highest performance across the Midlands.
- System partners came together during 2025/26 with the ambition of completing the Dementia 100 assessment tool. The requirement was to produce a completed assessment at place level, one for Staffordshire and one for Stoke-on-Trent. Both assessments have now been completed, and a report has been produced to summarise the findings and outline the next steps. Delivery plans have been developed, and task and finish groups will now be established to drive forward the actions during 2026/27. While most actions are consistent across both areas, there are some local variations.

Centre for Mental Health

We have worked with the Centre for Mental Health to develop a shared vision for local mental health, learning disability and neurodivergence services over the next five to 10 years.

Focusing on the individual, multi-disciplinary working, and awareness of neurodiversity and offering reasonable adjustments were identified as significant strengths and successes to build upon and enhance further.

Areas for improvement were also identified, and an Action Plan was devised with shared vision and accountability. The actions focus on a needs-led approach to care, innovative use of resources, enhanced data intelligence, and embedding training and awareness.

Learning disabilities and autism

The rights of people with a learning disability and/or autism and Down's syndrome are protected by statutory duties, legislation and policy (Human Rights Act 1998 and Equality Act 2010) to ensure they receive the interventions they need. There is also a legal duty to make reasonable adjustments so that mainstream services and support are accessible to all.

Despite this, significant and widespread health inequalities persist. Adults with a learning disability die nearly 20 years younger than the general population. People from ethnic minority groups who have a learning disability die even younger – at just 34 years old, on average. Compared to 21.6% for the general population, 38.8% of deaths were considered 'avoidable' (deaths from conditions that should have been preventable or treatable).

Autistic people have poorer health outcomes than the general population – particularly around mental health. Autism is a common neurodevelopmental condition, affecting approximately one million people in the UK. About 40% of these also have ADHD, and up to 30% have a learning disability. An estimated 70% have at least one mental health condition, but access to mental health services is often difficult if services are not adapted. Autistic people are around seven times more likely to die by suicide than non-autistic people.

We strategically tackle the inequality issues in partnership with health, social care, education, and voluntary sector partners.

Performance success in 2025/26

- There are 193 more people on the Learning Disabilities Register
- 191 more people had an Annual Health Check
- 100% compliance for LeDeR reviews (learning from the lives and deaths of people with a learning disability and/or autism) that help inform our work
- On average, waiting times for autism assessments in North Staffordshire were maintained despite a 17.5% increase in caseload. In South Staffordshire, average waiting times reduced despite a 7% increase in caseload.
- Oliver McGowan mandatory training was delivered to more than 11,500 health and social care staff
- 84 people are working with our Down's Syndrome Forum to improve outcomes
- There is now only one young person in an inpatient setting (reduced from five). There are still 27 adults in an inpatient setting, which is one of the lowest figures per head of population in the Midlands.

Our key aims for 2026/27 are to:

- Move away from hospital care to community-based care in neighbourhoods
- Make reasonable adjustments everyone's business to further improve accessibility to services and support
- Offer more help through the Dynamic Support Register and keyworkers to prevent hospital admissions
- Reduce the number of people with long lengths of stay as inpatients.

Planned care (includes elective, cancer and diagnostics)

Throughout 2025, the ICB has worked closely with hospitals, community services, local councils and patient representatives to shape a new Elective Care Strategy for 2025–2030. This strategy sets out how we will improve planned care over the next five years and ensures all partners are working towards the same goals.

The strategy reflects the ambitions of the NHS Long Term Plan and focuses on five key areas:

1. Supporting people to stay well and prevent illness
2. Expanding digital and modern ways of working
3. Shifting care closer to home
4. Improving productivity and making the best use of resources
5. Building a resilient and sustainable health and care system

Reducing long waits for planned care has remained a major priority. Total patients waiting for treatment has continued to decrease and the patients waiting the longest have been prioritised, along with clinically urgent patients. UHNM were recognised nationally for their progress, achieving the eighth-largest improvement in referral-to-treatment times of all acute trusts in England between April and September 2025.

MSK problems (such as back, joint and muscle issues) affect around 21% of local residents, placing us in the highest quartile group nationally. Because of this, MSK has been a key area of focus and partners across the system came together to map the entire MSK pathway. This work has:

- Identified where services can be improved
- Tackled inconsistencies across the area
- Identified community pain management as an area of focus.

Two procurements have helped to improve access, choice and consistency for patients in the community:

- Two consultant-led providers have been appointed to deliver high-quality community Ear, Nose and Throat (ENT) services across Staffordshire and Stoke-on-Trent
- Two consultant-led providers have been appointed to deliver minor hand surgery procedures.

Diagnostics

Community Diagnostic Centre's (CDCs) provide patients with a co-ordinated set of diagnostic tests in the community and in as few visits as possible, enabling an accurate and fast diagnosis on a range of clinical pathways.

Across Staffordshire and Stoke-on-Trent we will have three Community Diagnostic Centres. Two CDCs opened in 2025/26 and the third one will open in Quarter 1 2026/27.

- Cannock Chase Community Hospital – open
- Sir Robert Peel Community Hospital in Tamworth - open
- Stoke-on-Trent CDC is located at the old Sainsbury's site, in Hanley – due to open Q1 2026/27.

CDCs have six aims:

1. Improve health outcomes by reaching patients earlier and providing accurate diagnoses of health conditions.
2. Increase the availability of tests and scans.
3. Quicker access to tests and scans.

4. Reduce health inequalities by reducing variation in referrals, access, uptake, experience, and outcomes of diagnostic provision.
5. Deliver better and more personalised patient experience.
6. Support the integration of diagnostic pathways across primary, community and acute hospital care.

CDCs are designed to provide an easier and altogether better patient experience. To improve the patient experience for people that are living with dementia, the ICB sought funding from NHS England. This funded the Alzheimer's Society to work with the three CDCs across our care system to support environmental enhancements for patients living with dementia. Service users have also been involved in advising on recommendations which will make patient experience when attending diagnostic tests much better.

This involvement has led to design amendments at the Stoke Diagnostic Centre including changing of the speckled flooring to plain which will help patients who may have cognitive difficulties or are visually impaired. The funding also supports NHS staff to participate in dementia training which has increased confidence and knowledge of dementia symptoms and how to support patients. Overall, the project will help make access to diagnostic services easier for people living with dementia as well as those with learning disabilities and/or autism.

Cancer Awareness and Early Diagnosis Campaigns programme

Building on from our previous cancer campaigns approach we opted to take on the challenge of identifying "how could we shift from general awareness as being just information," to "awareness that genuinely changes behaviour, reduces inequalities and supports earlier diagnosis".

We did this by designing and delivering a system-wide cancer awareness and early diagnosis programme that moved beyond one-off campaigns and instead embedded prevention, symptom recognition and screening engagement into communities across the year. We focused on:

Data-led targeting

We used PCN-level data, deprivation indices, screening uptake data and referral patterns to identify *who* we were missing and *where* we needed to be. This ensured resources were focused on communities with the greatest need, not just the loudest demand.

A tiered campaign model

To ensure focus, consistency and impact, we introduced a tiered cancer campaigns model that aligned local delivery with national priorities and population need.

- **Tier 1 campaigns** focused on the highest-impact cancers and priorities, delivered at scale across the system with sustained investment and visibility.
- **Tier 2 campaigns** targeted cancers or population groups where data showed emerging need, variation or opportunity for improvement.
- **Tier 3 campaigns** provided flexible, responsive capacity to address niche, local or time-limited needs, particularly within underserved communities.

This model enabled the system to balance strategic consistency with local responsiveness, ensuring resources were used where they would deliver the greatest health benefit.

Community-first delivery

Rather than expecting people to come to healthcare settings, we took cancer conversations into trusted, familiar spaces: town centres, faith venues, prisons, football stadiums and community hubs. This removed both physical and psychological barriers to engagement.

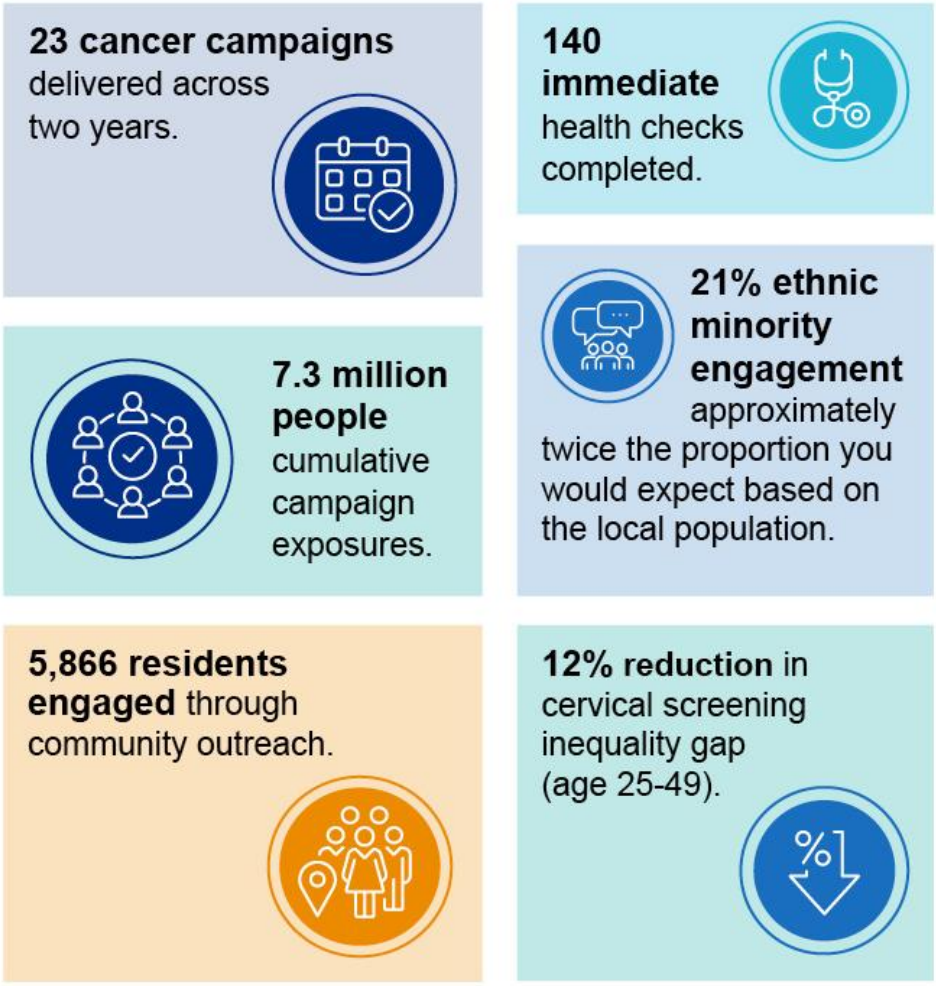
Blended campaign model

We combined targeted digital and radio campaigns with in-person engagement, ensuring consistent messaging while adapting tone, language and imagery for different audiences.

Continuous learning and improvement

Each campaign and outreach activity was evaluated, with learning fed into subsequent delivery. Community feedback shaped messaging, formats and locations, allowing the programme to evolve responsively.

Programme Impact at a Glance



Community transformation (includes end of life, long-term condition and frailty)

Partnership working and professional and public engagement shapes our approach to effecting tangible transformation to the community services that we commission and which serve our population. The Community Transformation directorate covers commissioning and transformation of long-term conditions (including diabetes, respiratory, cardiac and stroke services), end of life care and palliative care, and neighbourhood health.

Neighbourhood health

We want more people to receive the care they need at home or in their community, so they don't have to go to hospital unless necessary. This means building stronger neighbourhood teams, improving urgent community response, offering more care at home through virtual wards, and ensuring that people with long-term conditions, frailty or palliative care needs receive earlier support.

This year, we have been working to establish the neighbourhood health and care programme to support achieving this ambition. Delivering neighbourhood health and care requires co-ordination across multiple portfolios and system partners so health and care is more local, more joined up and easier to use.

We have held system-wide workshops to bring together primary care, community services, social care, voluntary sector partners, and wider healthcare providers to understand neighbourhood working and jointly agree our aims, vision and priorities.

Our local strategy was aligned to the national neighbourhood health guidelines with our Neighbourhood Health and Care Strategic Group covering all six core components and key enablers that are described within the national guideline. Building on this initial work, we established pilot sites for integrated neighbourhood teams (INTs) and the learning from these is being used to refine the model and shape a phased rollout to additional neighbourhoods over the coming years.

The portfolio has taken a population health management approach to reviewing cost and activity information through the Pathfinder tool to review differences in activity for people with long-term conditions, this information alongside patient feedback undertaken through strategy development has supported the development of our transformation programme for 2026/27.

Palliative care and end of life care

These services play a vital role in supporting individuals, their families, and carers, while also acting as a key enabler for wider NHS priorities by improving patient outcomes, enhancing experience, and promoting equity across all sectors. We continue to work closely with partners across Staffordshire and Stoke-on-Trent, in particular with the local hospice providers to take forward work in this key area.

The PC&EoLC programme is continuing to work with partners to drive implementation of the Staffordshire and Stoke-on-Trent Palliative and End of Life Care Strategy 2025–28. The strategy was published during Dying Matters Awareness Week in May 2025.

Implementation of the strategy is led by the Clinical Improvement Group and focuses on delivering compassionate, high-quality, and equitable care for all residents, regardless of background or circumstance. It seeks to strengthen partnerships, optimise resources across sectors, and embed collaborative approaches across healthcare, social care, and community organisations.

As part of the launch, we hosted a Death Café, which was attended by members of the ICB Executive Team and other senior health and care leaders. Death Cafés are part of helping individuals and organisations to normalise conversations around death, dying, and bereavement. In addition, an online portal is in development for professionals and the public to provide a range of resources for patients and their carers, alongside training materials and links to a variety of useful resources.

24/7 palliative care advice line

We have commissioned a 24/7 advice line for healthcare professionals, patients, and carers. The service provides specialist clinical support to aid decision-making about palliative and end-of-life care. The service is funded by the ICB and delivered collaboratively by three local adult hospices.

Digital development

There has been continued work with digital colleagues on a digital system that enables health and care professionals to record and securely share key information about a person's end-of-life wishes and preferences. The Electronic Palliative Care Coordination System (EPaCCS) ensures that care is coordinated and aligned with what matters most to each individual.

The EPaCCS form has now been deployed to the live One Health and Care environment – the shared care record for Staffordshire and Stoke-on-Trent patients. Early adopters include four GP practices and three of the local adult hospices. Clinicians in these organisations can now create and edit EPaCCS forms on the system.

Over half of the GP practices in our area have signed up so far. They are using the digital ReSPECT tool to digitally record important information regarding a person's care and their preferences and clinical recommendations.

Long-term conditions

Diabetes

The National Diabetes Prevention Programme identifies people at risk of developing Type 2 diabetes and refers them onto a nine-month, evidence-based lifestyle change programme. Between April 2024 and December 2025, Staffordshire and Stoke-on-Trent referred 11,880 people, and 6,790 went onto start the programme. This is a conversion rate of 57% for the ICB, which exceeds expectations.

The Path to Remission Programme is based on research showing that a three-month, specially-formulated diet (total diet replacement products including soups and shakes) followed by healthy lifestyle support helped people living with Type 2 diabetes and obesity or overweight to lose over 10kg in weight. It also improves their blood sugar levels, reduces diabetes-related medication and, in almost half of participants, puts their Type 2 diabetes into remission. We have continued to commission this programme with good results.

One local patient said: “The programme has completely transformed my life. I look and feel better than I ever have, and I have so much more confidence in managing my diabetes through diet and exercise. I’m proud to be making healthier choices every day.”

Respiratory

Respiratory Champion, Victoria Campbell continues in post until May 2026. Victoria’s post is sponsored by Asthma and Lung UK, and targets areas of high need for change. Her focus remains on asthma and chronic obstructive pulmonary disease (COPD) by supporting health care professionals in primary care.

The Sentinel programme continues to recruit practices to deliver asthma guidelines and is looking to expand this to COPD care.

Adult asthma treatment guidelines

Our Medicines Optimisation team has been working with local specialists to develop new guidelines for the management of adult asthma – using the latest NICE guidance. A comprehensive suite of resources is now available to support patients in the following areas:

- **Pharmacological management and review:** Detailed information on medication options, treatment regimens, and how to review current treatment plans.
- **Transition to MART regimen for uncontrolled asthma (12+ years):** Guidance on transitioning patients aged 12 and above to the Maintenance and Reliever Therapy (MART) regimen where applicable.
- **Lifestyle advice:** Advice and signposting to various resources to support patients in managing their asthma.

For links to these guidelines, see our Formulary webpage.

COPD guidance

In collaboration with local specialists, our Medicines Optimisation team have updated the treatment guidelines for patients with COPD. These updates align with the guidance for the West Midlands, which is also supported across other local ICBs, ensuring consistency and best practice regionally.

For links to these guidelines, see our Formulary webpage.

All Age Respiratory Strategy 2025-30

The publication of this ICS-wide strategy in 2025 was a significant milestone in the collective commitment to improving respiratory care for people of all ages from our communities. As the NHS Long Term Plan identifies respiratory disease as a key clinical priority for better care, this strategy outlines our shared vision across the ICS to enable high-quality, patient-centred respiratory care.

Cardiovascular disease

We have supported the continuation of the BEAT heart health events, delivering a coordinated, multi-agency community outreach model aimed at earlier identification of heart failure and cardiovascular risk across Staffordshire and Stoke-on-Trent. The programme provides on-site screening, including blood pressure and pulse checks, atrial fibrillation identification and NT-proBNP protein testing, alongside a comprehensive heart health wellbeing marketplace.

The events have so far resulted inidentification of new atrial fibrillation cases, previously undetected hypertension and raised blood pressure levels. More events are planned throughout 2026.

Frailty and falls

Targeted work to provide more proactive and preventative care and interventions to frail residents has continued, with the commissioning of and implementation of the Steady on Your Feet digital falls prevention platform. The platform delivers evidence-based tools to support early identification of falls risk, personalised prevention plans and improved coordination across community and clinical pathways.

Alongside implementation of improvement work and the commissioning of Steady on Your Feet, we are continuing to work with partners to deliver the Staying Well service. This is a specialist team providing support to adults within their own home who have been identified as having mild to moderate frailty. By taking a preventative approach, the aim is to help individuals to stay well, live well, and age well.

Wheelchair service

The Staffordshire and Stoke-on-Trent wheelchair service serves adults, and children and young people who are registered with a GP in Staffordshire and Stoke-on-Trent. We have worked hard to improve performance over the last 12 months.

Delivery of equipment has seen notable and sustained improvements, with reductions in waiting times and improved patient experience reported. These improvements and hard work have been recognised and sighted within the Stoke-on-Trent Wheelchair User representation group report to the Adult Social Care, Health Integration and Wellbeing Overview and Scrutiny Committee.

Urgent and emergency care

Urgent and emergency care (UEC) covers services such as acute hospital emergency departments (EDs), NHS 111, West Midlands Ambulance Service University NHS Foundation Trust (WMAS), urgent community response (UCR), virtual wards, and hospital discharge services.

Our role within the Integrated Care Board (ICB) is to ensure people can access timely and safe UEC care, while reducing pressure on hospitals and improving outcomes across the whole system. We work closely with a wide range of partners, including the University Hospitals of North Midlands (UHNM), West Midlands Ambulance Service (WMAS), Midlands Partnership Foundation Trust (MPFT), University Hospitals of Derby & Burton (UHDB), Local Authorities and Voluntary sector partners.

During 2025/26 our work focused on delivering the national priorities set by NHS England National Urgent & Emergency Care Plan 2025/26, published in June 2025. These priorities centred on improving Emergency Department (ED) waiting times, reducing ambulance response times, strengthening alternatives to hospital admission, and improving patient flow to support timely discharge.

Despite sustained and increasing demand – with activity at UHNM increasing by 4.1% - the system continued to make progress through coordinated actions across Acute and Community Services.

During 2025/26 performance against key metrics was:

- A&E four-hour performance in March 2026 performance increased by 1.13% to 66.73% when compared to March 2025, however across the year performance declined slightly, from 67.9% in 2024/25 to 66.7% in 2025/26.
- Ambulance handover times showed marginal improvement, reducing from an average of 1 hour 19 minutes 32 seconds to 1 hour 18 minutes 45 seconds (using locally validated data including County Hospital) across the year.
- 12-hour waits (Type 1 and 2) increased marginally, from 15.29% in 2024/25 to 15.33% in 2025/26.
- Category 2 ambulance response times 2025/26 were 31minutes, 13 seconds, a 4 minute 28 second minute improvement on 2024/25.

Our UEC Improvement Plan was structured around three key areas:

- Alternative Pathways,
- In-Hospital Pathways, and
- Post-Hospital/Discharge Support.

Alternative Pathways

A key priority for the system has been supporting more people to receive care outside of hospital. The ICB has continued to invest in alternative pathways through the Integrated Care Coordination (ICC) Service, which acts as the system's 24/7 single point of access for health and social care professionals.

During 25/26, the ICC continued to expand and now manages over 4,000 referrals per month. Since transferring to MPFT in June 2024, the ICC has developed over 30 referral pathways, helping professionals access timely community-based support and reducing

avoidable hospital admissions. This work continues to expand through MPFT's internal transformation programme. The service out of hours is provided by a separate provider, PHL Group, and continuation of the 24/7 model has been continued throughout 25/26.

Urgent Community Response (UCR) and Virtual Wards is delivered through the Acute Care at Home (ACAH) collaborative involving UHNM, MPFT, UHDB and Royal Wolverhampton Trust (RWT) and continued to grow throughout the year. The UCR service consistently exceeded its planned capacity and met the national standard of responding to 70% of referrals within two hours.

Virtual Wards expanded capacity and supported around 150-200 patients every two weeks, providing hospital-level care safely in people's usual residence. To support continuous improvement, the ICB led a system-wide multi-disciplinary forum to identify opportunities to improve pathways and further increase care closer to home. Learning from this work is being embedded into future system plans and commissioning intentions.

Urgent Treatment Centres (UTCs)

During 25/26, progress continued regarding the designation of UTCs across SSOT. UTCs provide an alternative for patients who need urgent, same-day care but do not require an emergency department. Following extensive public engagement in 24/25, proposal for both co-located and standalone UTC sites progressed through initial governance processes, ahead of formal designation planned for early 26/27.

Post-Hospital and discharge support

Supporting people to return home safely and promptly remained a key priority. Integrated Discharge Hubs, jointly funded with both local authorities, continued to commission voluntary, community and social enterprise (VCSE) organisations to provide practical and emotional support to people leaving hospital.

The system has also been supporting a system-wide review of Discharge to Assess services. The review focused on strengthening home-based pathways and will inform planning for 2026/27 and beyond.

Winter Planning and System resilience

Throughout winter 2025/26, the ICB led system-wide winter planning to ensure partners were aligned and prepared for periods of increased pressure. The Winter Plan was delivered using a 'pillared' approach and approved through statutory board meetings, alongside engagement with both Health Overview and Scrutiny Committees.

This work was underpinned by the refreshed System Escalation Plan, which continues to emphasise shared responsibility, learning and continuous improvement. A winter "lessons learned" event is planned for spring 2026 and will help shape the system's approach to winter planning for 2026/27.

Primary care

Primary care is usually the first place people go for help with their health. This includes GP practices, pharmacies, dentists, and opticians. These services provide everyday care, help prevent illness, manage long-term conditions and guide people to specialist support when needed.

As an ICB, we are responsible for planning and funding local primary care services under the Health and Care Act 2022. Our role is to make sure services are high quality, easy to access and meet the needs of our communities. We work with local health and care partners to improve services, support staff and make sure our population can get the care they need.

Since launching our five-year GP Strategy in April 2023, we've continued to improve access to high-quality, sustainable general practice services and improve patient experience. Our focus for 2025/26 remained on:

Reducing inequalities and tackling unwarranted variation

- Delivering 494,478 COVID-19 and flu vaccinations as part of the 2025 autumn/winter campaign, of which 280,213 were given by general practices and PCNs (56.7%) and delivered 13,554 Respiratory Syncytial Virus (RSV) vaccinations to protect serious respiratory tract infections.
- More than 5,380 (83.6%) people with a learning disability have received an annual health check this year (182 more than last year).
- More than 4,300 (60%) of people with severe mental health conditions expected to receive an annual health check.

Ensuring patients receive timely, consistent, reliable care

- Working towards a better experience for patients when phoning their GP practice through improved digital telephony.
- Implementing simple methods for online requests – More than 550,000 online consultations delivered (April to November 2025) and 52% of patients had downloaded the NHS App by November 2025 to manage their healthcare using a phone, tablet or computer.
- Training 110 staff in Care Navigation and advanced customer service skills – This provides faster navigation, assessment, and response for patients to receive the right support at the right time with the right professional to manage their needs. Pharmacy First training was attended by 13 staff to navigate patients to community pharmacy services.
- Supporting more than 30 practices to take part in the NHS Support Level Framework – The programme helps practices look at how they work and find ways to improve, so patients can get appointments more easily, receive help more quicky and experience more consistent, reliable care.

- Demonstrating our commitment to recruiting and retaining our valuable workforce – This year's Long Service Awards recognised the dedication and sustained commitment of general practice staff with 25–50 years of service to general practice and the wider NHS – more than 1,655 years of service in total.

Primary care nursing recognition

Gill Boast – Practice Nurse Facilitator and General Practice Nursing Foundation School Training Programme Lead for the Staffordshire Training Hub – has been awarded an MBE in the King's New Year Honours List for services to primary care nursing. Gill has worked in nursing for 47 years, including 27 years in general practice, and has played a key role in developing the General Practice Nursing Foundation School to support practice-based learning for nurses in GP practices across Staffordshire.

She continues to balance patient care with education and leadership work and has previously received the Queen's Nurse title and a national Chief Nursing Officer Silver Award. Read more about Gill's award.

Improving contract oversight

- **GP practices** – This year, the Care Quality Commission (CQC) rated 132 (93.6%) of our GP practices as Good or Outstanding (as of 1 March 2026) and action plans are closely monitored to demonstrate improvements in those practices rated below Good.
- **Dental** – 16,190 additional urgent care activity has been commissioned. 51,594 activity has also been commissioned into targeted areas with the poorest dental health to help improve access for patients.
- **Community pharmacy** – Increased use of schemes like Pharmacy First for seven common minor ailments (more than 55,000 patient consultations from April to December 2025 – more than 16,000 on previous year).
- **Optometry** – Local optometry services provided to ensure accessible routine eye care for patients. 100% of opticians have been onboarded to the Electronic Eyecare Referral Service (EeRS), enabling streamlined, secure, and efficient referral pathways between primary and secondary care services.

Commissioning services closer to home

- Breathing tests (spirometry and FeNO) are now available at GP practices and local health hubs. This means people can be tested for asthma and COPD closer to home, helping to diagnose these conditions more quickly and start the right treatment sooner
- Mounjaro is now available through GP practices to support weight loss for people who meet the first set of national eligibility criteria. This means patients who qualify can access this treatment locally, as part of their overall weight management care.

Supporting transformation and development

- We have been working with all 25 of our PCNs to look at how buildings can be better used. This involves exploring opportunities for future improvements and major developments to support better patient care and accommodate new models of care and future demand.

Donating laptops to community projects

Our Digital Team partnered with local charities to donate 189 laptops that were no longer suitable for NHS use due to age and security requirements, giving them a new purpose to improve digital literacy and accessibility across the region.

They were distributed equitably to VAST, YMCA, Free IT Stafford, and Donate IT. These laptops have been given a new lease of life and been put to use in a variety of ways:

- Enabled young people in the YMCA's Youth Employment and Skills (YES) programme to access training, build confidence, and prepare for employment – many owning a laptop for the first time
- Enabled young people to complete online learning and work experience placements
- Enabled individuals to prepare for their Construction Skills Certification Scheme (CSCS) tests

- Provided digital access for children outside mainstream education
- Provided internet access for cadets to attend training
- Community outreach to help individuals experiencing housing and benefit claiming
- Providing internet and Zoom access to reducing elderly social isolation.

These donations have made a significant impact that would not have been possible without this initiative.

Partnership working, integration, and neighbourhood-level activity

Primary care has continued to work collaboratively with system partners, to integrate services and have started to develop early implementor sites to pilot neighbourhood working.

PCNs have worked to improve access to services and health outcomes, particularly for people with learning disabilities, ethnic minority communities, and older or frail residents. They have partnered with local councils and community teams to create more joined-up neighbourhood services.

Community events and 'winter-ready' sessions have encouraged people to proactively get vaccinations that protect against serious illnesses. These events have also promoted cancer screening programmes and helped people learn about the different roles within the wider primary care team. They highlighted the support available from local services such as Pharmacy First and encouraged the use of the NHS App to help people stay healthy during colder months and manage their conditions.

- **6,196,590** total appointments from April 2025 to Feb 2026. This is an increase of 131,141 appointments (2.2% difference) compared to the total appointments from April 2024 to Feb 2025
- **46,154** additional urgent/same day appointments available at PCN hubs to support high demand during winter to further support access to primary care.
- **91.1%** seen within 2 weeks (appointments mapped to the 8 National Categories from April 2025 to Feb 2026)
- **66.6%** face to face appointments (from April 2025 to Feb 2026)
- **10.2%** video consultations (from April 2025 to Feb 2026).

Medicines optimisation

Our Medicines Optimisation team works behind the scenes to make sure every patient gets the safest, most effective, and most appropriate medicines for their needs. This work helps improve health outcomes, reduce harm, and ensure NHS medicines are used wisely.

During 2025, the ICB spent £241.7 million on medicines prescribed in primary care. The three highest areas of spend were for the endocrine system (treatments for diabetes and other hormone-dependent conditions), central nervous system (treatments for pain, depression, and other mental health conditions), and respiratory system (treatments for asthma, chronic obstructive pulmonary disease, and other lung conditions).

For 2025/26, we estimate a £44 million spend on complex and high-cost medicines used in hospitals. The three highest areas of spend were for severe rheumatoid arthritis, macular degeneration (a common disease affecting eyesight), and Crohn's disease.

Endocrine system treatments: for diabetes and other hormone-dependent conditions.
Central nervous system treatments: for pain, depression, and other mental health conditions.
Respiratory system treatments: for asthma, chronic obstructive pulmonary disease, and other lung conditions.
Macular degeneration: a common disease affecting eyesight.

Antimicrobial stewardship

Antimicrobial stewardship is a national priority ensuring antibiotics are used appropriately, in order to get the best patient outcomes, reduce resistance, and minimise side effects. Our work across the system has included developing localised prescribing guidelines for primary care and campaign materials for World Antimicrobial Resistance Awareness Week aimed at patients and clinicians. We also established a system-wide working group to support delivery against the national plans.

Reducing falls through reviewing medication

We have introduced a more focused approach in GP practices to review patients who are taking medicines that may increase their risk of falling. This involves reducing unnecessary medicines for older adults, and providing additional support for patients recently discharged from hospital after treatment for heart disease.

From April to December 2025, a total of 5,444 reviews had been recorded.

Reducing harm from inappropriate opioid prescribing

Reducing reliance on opioids (strong painkillers which can be very addictive) remains a national priority, the harms of long-term use have been proven to outweigh the benefits for most patients. We have continued to lead on a comprehensive programme to reduce harm from inappropriate opioid prescribing for chronic, non-cancer pain.

By working with pain specialists across primary and secondary care, substance misuse services, local authorities, and patient representatives, the team has developed resources and raised awareness of safe and effective opioid prescribing.

Between July 2025 and January 2026, GP practices reviewed 1,341 patients on opioid medication. Where appropriate and clinically safe, they supported 41% to taper (gradually reduce) their dose and signposted 34% to resources to self-manage their pain. Practices also collected information about motivators and barriers to opioid tapering, which suggest that patients were more likely to agree to tapering if they reported side effects or felt that opioids affected their ability to do what is important to them.

Community pharmacy

We commission 234 community pharmacies to deliver vital NHS services across Staffordshire and Stoke-on-Trent. Alongside dispensing prescriptions and advising patients on the safe and effective use of medicines, pharmacies now provide a wide range of clinical services within local communities.

Through the Pharmacy First scheme, patients can access advice and treatment from their pharmacy for minor illnesses and seven specified clinical conditions such as a sore throat, earache, and impetigo. In 2025 alone, local pharmacies delivered care to more than 95,000 patients through this service – helping to improve access and ease pressure on GP practices.

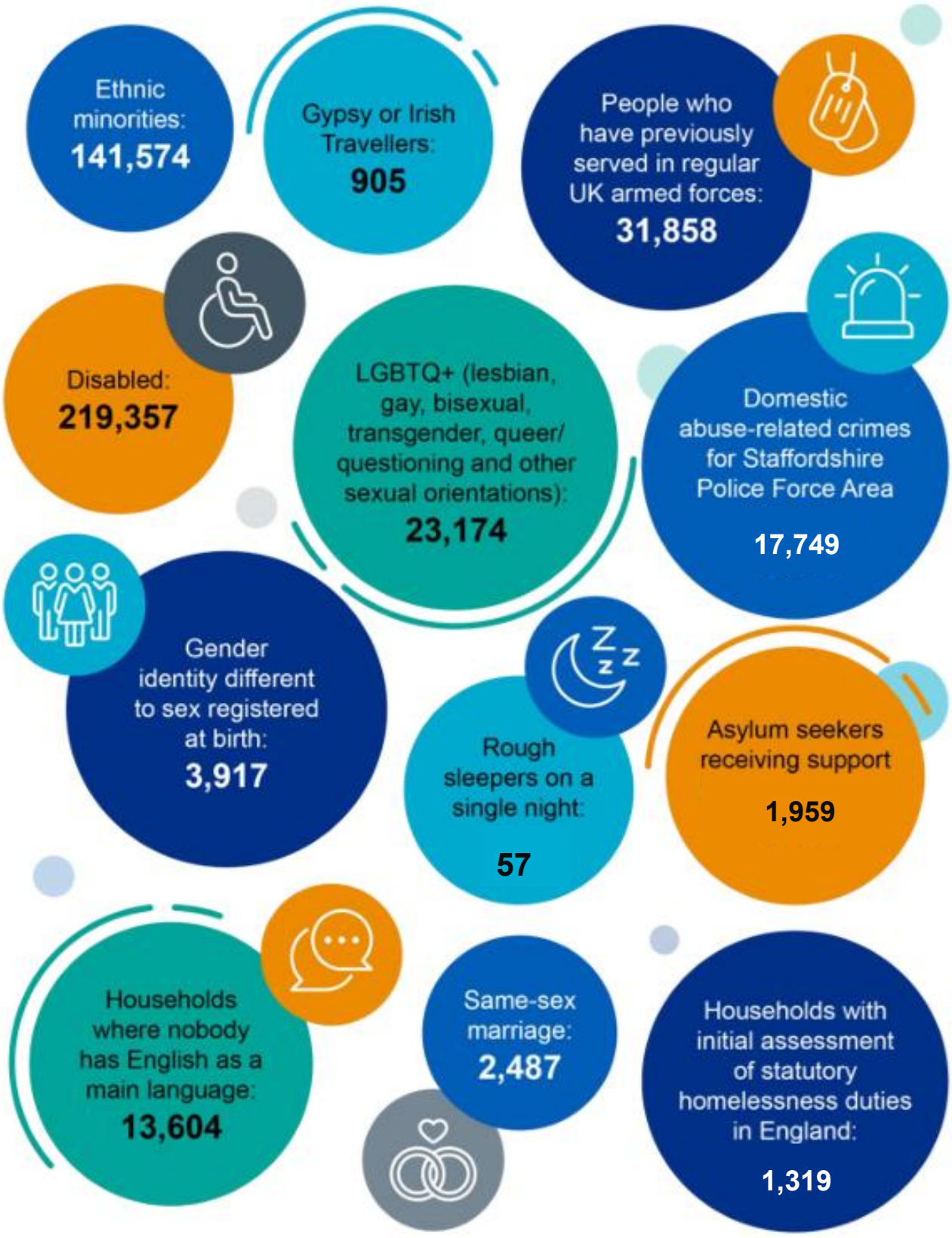
Community pharmacies can offer contraceptive advice, initiate oral contraceptives, or provide repeat supplies where appropriate. More than 28,000 patients benefited from these services in 2025, and since October 2025, emergency contraception (known as ‘the morning-after pill’) has also been available from many pharmacies.

All newly qualified pharmacists will become independent prescribers from September 2026. In preparation, five local pharmacies participated in a national pathfinder programme to explore this expanding role. Areas of focus include safer prescribing of anticoagulants (blood thinners), antidepressants, treatment for blood pressure, and treatment for common conditions.

From January to December 2025, a total of 5,012 patients had consultations with an independent prescribing pharmacist in their local pharmacy – helping to shape the future of community pharmacy services.

Improving Population Health

The demographic profile of Staffordshire and Stoke-on-Trent:



Reducing health inequalities

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 publish a separate report on health inequalities. This provides 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. His is updated on an annual basis at Q2 given data time lags. The current Health Inequalities Report can be seen here.

BEAT Heart Health Events

The 2024/25 BEAT Heart Health events delivered a coordinated, multi-agency community outreach model aimed at earlier identification of heart failure and cardiovascular risk across Staffordshire and Stoke-on-Trent. The programme integrated NHS clinical teams, Local Authorities, Primary Care Networks and VCSE partners to provide on-site screening, including blood pressure and pulse checks, atrial fibrillation identification, and NT-proBNP testing, alongside a comprehensive heart health wellbeing marketplace. Across BEAT events, large numbers of residents engaged with heart health assessments, resulting in the identification of new atrial fibrillation cases, previously undetected hypertension, and raised NT-proBNP levels, generating timely GP follow-up and diagnostics. These events strengthened prevention, supported neighbourhood-level inequalities work, and aimed to evidence the value of assertive outreach models.

Forward Plan for 2026

In line with the programme's 2026 objective to expand community awareness and targeted cardiovascular prevention, plans include delivering BEAT events in high-risk localities, enhancing data capture to inform local prevalence, and refining operational models through structured evaluation. The programme will also aim to strengthen PCN insights through coding and follow-up processes, integrate citizen voice more systematically. These developments support the ICB's strategic priorities around lived experience voice, prevention, early detection, and reducing health inequalities.

Locality Improvement Framework

Through our Locality Improvement Framework, each of our 12 local areas have designed and will deliver targeted projects to reduce health inequalities, focusing support on those who need it most over the next three years. These projects will be implemented and evaluated over the next one to three years, with an expectation of measurable improvements - particularly for groups identified through the Core20PLUS5 approach - underpinned by robust population health data and analysis.

To enable this work, we are strengthening cross-sector collaboration and embedding a systematic, population-health-driven method for delivering improved outcomes.

We have:

- Continued to strengthen cross sector collaboration and deliver systematic, demonstrate measurable improvement in health outcomes for local populations through a targeted Core20plus5 approach.
- Fund each locality of up to £100,000 in Staffordshire and £125,000 in Stoke-on-Trent annually for a rolling 3 years, informed by Population Health Management.

Ambition: Our ambition is to work together with people, families and communities in Staffordshire and Stoke-on-Trent to ensure everyone has the opportunity to have healthy, safe and prosperous lives with fair access, improved experience and better outcomes for all.

Aim: To improve health outcomes across Staffordshire and Stoke-on-Trent through the prevention of ill health and by tackling health inequalities.

Approach: Using a population health management approach, we have created the environment for measurable, systematic, at scale change.

This funding opportunity represents a significant investment in tackling health inequalities across Staffordshire and Stoke-on-Trent:

- Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) ring-fenced £1.7 million in recurrent funding over three years from the Health Inequalities budget.
- This funding presents a unique opportunity for the 8 localities in Staffordshire and 4 in Stoke-on-Trent to submit proposals aligned with their local Core20 priorities. Each locality can access up to £100,000 in Staffordshire and £125,000 in Stoke-on-Trent annually for a rolling 3 years.
- To be eligible, localities had to demonstrate a new way of working by collaborating with at least three partners from different sectors. Proposals aim to strengthen cross-sector collaboration and deliver systematic, measurable improvements in health outcomes for local communities.
- Additionally, a portion of the funding supports a micro-grant scheme for small, grassroots organisations, ensuring community-led initiatives are empowered to make a difference.
- Each locality has developed its own Core20PLUS5 based on the NHSE model defining five priority areas and inclusion groups. All localities will work to the following PHM led lifecycle:
- Identify & Define Core20PLUS 5
- Identification: Identify a selection of key local priority indicators most impacted by health inequalities and poorer performance compared to national and regional benchmarks.
- Definition: Each locality will use the insights to create their own Core20PLUS5 Framework.
- Cohort definition & Current State
- Segmentation: Segment and Risk Stratify the Core20PLUS5 Population into a cohort of interest.
- Identification & Collaboration: Map out existing resources and opportunities for enhanced collaboration.
- Define Objectives & Key Results
- Set Objectives: Establish clear, measurable goals for the programme of work (e.g., reducing hospital readmissions, improving chronic disease management, etc).
- Define Results: Determine the key performance indicators (KPIs) and outcomes that will be used to measure success
- Design and Implement Interventions
- Develop Interventions: Create & roll-out tailored interventions to address identified needs of the population.
- Monitor Progress: Track the implementation process to ensure adherence to the care plans and adjust as needed.
- Evaluate Results and Improve
- Evaluate Outcomes: Assess the effectiveness of the interventions by analysing health outcomes, patient satisfaction, and cost savings.
- Continuous Improvement: Use the evaluation data to refine and improve the PHM strategies, ensuring ongoing optimization and better health outcomes.

Worklessness

WorkWell sits alongside locally-led interventions such as Get Britain Working, Connect to Work and Trailblazers. It is expected that most people who will benefit from WorkWell are those whose work is at risk due to health barriers and those recently unemployed with health conditions.

Over the next 1–3 years, WorkWell will:

- Sit at the heart of the local work and health system
- Integrate with programmes such as Get Britain Working, Connect to Work and Trailblazers

- Target people whose employment is at risk due to health barriers, and those recently unemployed with health conditions
- Provide holistic, personalised, biopsychosocial support via MDTs.

Helping disabled people and people with health conditions to get into and get on in work is also a crucial part of driving economic success, improving community well-being, and reducing health inequalities. This in turn creates the conditions for a more inclusive, healthier and more productive society. This aligns with the government's ambition to increase the overall employment rate to 80%, recognising that achieving this requires focused support for groups currently underrepresented in the labour market. Driving change in this area will require a joined-up approach right across government, the NHS, employment services, local areas, and employers to ensure a seamless integration of work, health and skills support offer for people who need it.

The health system has the opportunity to provide a unique contribution to preventing economic inactivity with its ability to spot at-risk people early. The Fit for the Future: 10 Year Health Plan for England recognises the important role of employment and good work in supporting people's health as set out in the recent consensus statement: Good Work is a Health Outcome. The plan emphasises the importance of joining up work, health and skills support as critical to delivering on the three shifts: community-led support, digitalisation, and focusing on proactive and preventative measures, all of which can be advanced by WorkWell's locally-led, early-intervention approach. It also introduces a commitment for all ICBs to have a specific and measurable outcome target for reducing economic inactivity and unemployment, as well as recognising the NHS' own role as an anchor institution and employer. WorkWell is a practical mechanism to demonstrate action on inactivity and unemployment whilst bolstering the join-up and system-change needed to realise the ambition of employment advice within every neighbourhood health hub.

WorkWell now sits alongside locally-led interventions such as Connect to Work and Trailblazers, it becomes increasingly critical that programmes are delivered holistically and in an integrated way through joined-up governance between ICBs, MSAs, LAs, and other system partners.

This builds on the ambition set out in the Get Britain Working White Paper which provides over £240 million to tackle economic inactivity caused by ill health by supporting disabled people and people with health conditions get back into or get on at work. Schemes such as the Health and Growth Accelerators, delivered in three ICBs are an important part of this ambition; insights from both this scheme and the WorkWell pilot can be used to support local service development.

WorkWell empowers areas to design services that intervene at the earliest possible point, as evidence shows this is the most effective way of helping people to stay in work or go back to work. As a result, it is expected that the majority of people who will benefit from WorkWell are those whose work is at risk due to health barriers and those recently unemployed with health conditions. The service will also, crucially, sit at the heart of the local work and health system, connecting the wider support and services available to meet participants' needs.

This programme provides ICBs the opportunity to support the ambition of helping disabled people and people with health conditions across England by enabling:

- An early-intervention work and health assessment service with a focus on prevention, which includes holistic support for their health-related barriers to employment;
- A joined-up view and gateway into the services that are available locally to tackle their specific needs. This could include healthcare professionals, community sector services, health promotion programmes, more intensive employment support, skills support and much more.

WorkWell is centred on holistic biopsychosocial support. There is good evidence that we can support faster returns to work through interventions that take a holistic view of the barriers an individual experiences through their physical health, their psychological situation and their social situation – often referred to as biopsychosocial interventions.
WorkWell services are based on the principles of personalised care and delivered by a multi-disciplinary team (MDT). The overall composition of the MDT for each ICB will be determined by individual Local Partnerships.

It is recognised that people with health and disability-related barriers to employment need a variety of support. WorkWell funding is intended to support a holistic, early-intervention, work, health and skills service. It will provide participants with a personalised assessment of their barriers to employment and holistic support. WorkWell services will also provide a joined-up view and pathway into the services that are available locally to tackle their specific needs.

The service will be available to anyone of working age with a disability or health condition for whom the ICB has responsibility in its area:

- who needs support to remain in work; or
- who needs support managing a health condition to return to work from sickness absence; or
- who needs support to start work; and for whom a low-intensity support offer is the most suitable provision.

The core WorkWell offer will be available for all eligible cohorts across the ICB. ICBs are encouraged to use their local knowledge to design services that reflect community needs. The form this takes can be locally determined such as promoting WorkWell to marginalised communities or working with specific employers.

Warmer Homes

The ICB is investing in Staffordshire and Stoke-on-Trent's Upper Tier Local Authorities (UTLAs) and all 12 local communities to help reduce health inequalities and improve people's health. We know that poor quality housing can have a major impact on the physical and mental wellbeing of both adults and children, so part of this investment focuses on supporting residents living in cold, damp or unsafe homes to create healthier living conditions.

We have used the available investment on a phased approach targeting the homes of vulnerable residents in Staffordshire and Stoke-on-Trent with low incomes and health conditions exacerbated by cold conditions and poor housing.

The Integrated Care Board (ICB) has invested in Staffordshire and Stoke-on-Trent UTLA's and its 12 localities to reduce health inequalities and improve health outcomes.

Tackling health inequalities and improving health for the groups who typically experience the worst outcomes requires a consistent and coherent focus on population health at a local, regional and national level, as well as targeted action to support change.

Our vision for population health is based on action across four interconnecting pillars:

- the wider determinants of health
- healthy behaviours and lifestyles
- the places and communities we live in
- the support of an integrated health system.

Delivering this kind of approach requires collective action from many systems, places, sectors and organisations. However, as a key partner in our health system, the ICB has a central role to play in delivering care equitably and working collaboratively with others to tackle health inequalities.

Alongside the moral case for action on tackling inequalities and the worst health outcomes, there is an economic case: a more equitable NHS is likely to be more efficient. Reducing the barriers to accessing services will prevent ill health, while tackling racism and discrimination will help to recruit and retain staff in the NHS. This will also support the government's aim of helping more people out of long-term sick leave and bolstering economic activity.

Living in inadequate housing is a major contributor to poor physical and mental health and wellbeing outcomes for both adults and children.
Investment will be used on a phased approach having risk stratified the population to target the homes of residents with specific health criteria and poor housing.

Target population for the intervention: Vulnerable residents in Stoke-on-Trent with low incomes and health conditions exacerbated by cold conditions.

Eligibility criteria: The core criteria that residents will be assessed against are health conditions – to include a member of the household with one or more of the following conditions:

- Immunosuppressed
- Cardiovascular
- Limited mobility
- Respiratory

Exclusion criteria:

- Residents who are living in private rented accommodation or social housing.
- Residents who have owned their home for less than one year.
- Where the property the application is for is not the address the vulnerable resident is living at.
- Non-residential property.
- Any other resident who does not meet the above eligibility criteria.

Vaccinations, Immunisations and Screening

Joint working across the system with key partners across ICB, Provider organisations, Local Authorities and the voluntary sector are essential to address the requirements for vaccinations, immunisation and screening programmes. As part of this approach, we will:

- Improve uptake of vaccination and immunisation through the use of convenient local places for ease of access and offering multiple vaccinations for individuals / wider family at the same time, supplemented with targeted outreach to support individuals in underserved populations.
- Maximise digital capabilities of the national programmes
- Commission responsibly for vaccinations and immunisations together with screening once responsibility transfers from NHS England to ICBs from April 2027.
- Review and develop screening services that improve uptake by ensuring capacity is delivered in the most appropriate locations and increases accessibility for all eligible individuals.
- Establish system programme governance structures by April 2027 for immunisation and screening programmes
- Take part in a regional review of how TB is managed
- Undertake a local review of latent TB services
- Develop local plans by December 2026 to reduce TB incidence through consistent latent TB testing.

Migrant health services

Delivery of migrant health services within community and neighbourhood capacity is key to establishing effective support for this population group. To achieve this, we will:

- Develop robust and consistent services to support migrants from initial health check, through to management of long-term conditions by March 2027.

Pause

Pause Stoke delivers intensive, life-changing support to women who have had children removed from their care. Since 2023, Pause has worked with 24 women who have had 89 children removed. 13 have successfully completed the programme and 11 women are progressing through the final elements.

Transformational impact

- The women have made significant and lasting improvements across multiple areas, including mental and physical health, housing stability, employment, and relationships with their children.
- 1 woman who has completed the programme has been reunified with her youngest child.

Wider benefits

- Part of city-wide forums and voluntary sector groups, in order to raise awareness, contribute information and learning, and ensure women's voice is fed into local strategic priorities and service development.
- Contributing to the NSPCC working group on CSA and pregnant women to help the developing service support and break generational cycles of sexual abuse.

Financial impact

- Reducing the number of children in care has resulted in significant cost savings. By the end of 26/27, the investment of £929,777 will deliver an estimated net cost avoidance of £1.3m — equivalent to £2.41 saved for every £1 spent. Savings will be much higher if the service is sustained beyond 26/27.
- The additional benefit of one child returning to their mother's care, has resulted in an estimated saving of £66,300 in a single year – depending on the age of the reunified child, these savings could be far higher over time.

Looking ahead

- Pause Stoke is committed to building on these strong outcomes and collaborating further with local agencies

Health and wellbeing strategy

We are a member of both Staffordshire and Stoke-on-Trent's Health and Wellbeing Boards (HWBs), which bring together local organisations to improve health and wellbeing and ensure fair access to good-quality health and care services.

The HWBs meet to understand local needs, agree priorities and promote joint working between the NHS, Local Authorities and other partners, including commissioning services where possible. The 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 for each Place.

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 HWBs in 2025/26. 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 JSNAs inform 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, Primary Care Network). This allows end users to self-serve their own data, with the dashboard built to automatically draw through new data whenever it is updated. There is ambition to align the Staffordshire and Stoke-on-Trent approaches to JSNA during 2026/27.

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 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.

Implementation of the Staffordshire and Stoke-on-Trent Health and Wellbeing Strategies has not been a single programme but a set of coordinated system-wide actions, led by the Health and Wellbeing Boards (HWBs) and delivered jointly with the ICB, local authorities, NHS providers and voluntary sector partners.

The Staffordshire and Stoke-on-Trent (SSOT) Integrated Care System (ICS) Joint Forward Plan (JFP) is the main mechanism for implementing HWB strategies, converting HWB priorities into portfolio programmes and delivery plans, annual operational plans and resource decisions. This has ensured that priorities such as prevention, mental health, and healthy ageing are embedded in commissioning and service redesign, not just strategic documents.

Implementation emphasises preventing illness and supporting people earlier, reflecting HWB priorities like healthy weight, early life and mental wellbeing. The SSOT ICS has adopted a system-wide prevention approach which supports people to stay well at home, expands community-based care and addresses wider determinants of health, e.g. smoking cessation programmes and pharmacy-based support, working together to reduce obesity and improve physical activity, and through early years interventions to reduce infant mortality.

Our dedicated Tackling Health Inequalities Strategy (2024–2029) underpins implementation; targeting groups at highest risk through Core20PLUS5, improving access to preventative services and using population data to direct resources. The SSOT JFP also puts inequalities and prevention at the centre of all programmes.

Implementation is deliberately “place-based”, working through Staffordshire County Council and Stoke-on-Trent City Council. HWB priorities are delivered locally by Local Authorities, Primary Care Networks and Community and Voluntary Sector organisations, including designing services around neighbourhoods, integrating health, social care, housing and community support reflecting the principle that delivery happens closest to communities, not just at system level.

A “community approach” has been key throughout 2025/26; working with voluntary, community and social enterprise (VCSE) partners, co-producing initiatives with residents and using community insight to shape services, and in practice programmes targeting local priorities and grassroots support for behaviour change.

Both Staffordshire and Stoke-in-Trent HWB strategies explicitly address social determinants and the ICP strategy reinforces that delivery must go beyond healthcare alone. The strategies are described as “live documents” and are regularly refreshed based on new evidence, policy changes and performance and outcomes. Annual updates to the JFP track progress and adjust delivery actions, such as supporting people into work, linking economic wellbeing with health outcomes and coordinating work with housing and local infrastructure partners.

Environmental matters

Aligned with the NHS Long Term Plan and wider system priorities across local areas, the Staffordshire and Stoke-on-Trent ICS Green Plan 2025-28 was published in July 2025.

It is a high-level strategic document that is intended as a 'living' document, with the key aims of:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development.

We want to enable collaborative working across the system to meet the needs of patients and residents. Delivering joined-up, sustainable, person-centred care close to home is central to our updated plan. There is greater emphasis on managing resources, performance and delivery to transform how health and care services are provided.

The plan recognises and reinforces the positive impacts of reducing greenhouse gas emissions and improving health outcomes. Sustainability will continue to run as a 'green thread' through all areas of planning, delivery, and transformation. Our Action Plan for 2025-28 can be found in Appendix 3 of our Green Plan.

Progress to date

Workforce and leadership

Leading the way in embedding climate and sustainability actions, Staffordshire and Stoke-on-Trent ICS was the first NHS body to receive One Planet Standard certification last year, and Support Staffordshire has since achieved bronze accreditation. In July 2025, the Sustainability Programme Lead joined the panel at the Good Governance Institute's 'Net Zero – hold firm or fold?' webinar. This was an opportunity to share the practicalities of achieving this accreditation, and advocating for embedding climate considerations into decision-making.

We continue to build awareness of our net zero targets and obligations through educating and training our workforce. As of November 2025, 94% of all ICB staff have completed the 'Building a Net Zero NHS' training, which has been made mandatory.

Medicines

Reducing nitrous oxide (N_2O) and inhaler emissions continues to be a priority, and reductions have been achieved by replacing manifolds, transitioning to N_2O canisters, and educating patients on correct inhaler usage. As of December 2025, the system achieved an 20% reduction in pure nitrous oxide, a 14.6% reduction in mixed nitrous oxide, and 11.6% reduction in inhaler emissions compared to 2024/25 performance.

Supply Chain and procurement

The system manages the inclusion of the minimum of 10% on Net Zero and Social Value in every tender, and continues to follow the NHS Supply Chain's recommendations. Climate change and social value is factored into the commissioning and procurement of several key, high-value contracts within the ICB.

Travel and transport

Both local authorities have updated their Local Transport Plan, supplemented by strategies to promote active travel (Local Cycling and Walking Infrastructure Plan) and public transport (Bus Service Improvement Plan). These themes are key priorities for both the NHS and local authority.

Percentage of fleet vehicles meeting emission standards

Vehicle category	Percentage meeting standard 2024/25	Target
Zero emission vehicles (ZEV)	14%	>11%
Ultra-low emission vehicles (ULEV)	16%	>11%
Low emission vehicles (LEV)	96%	>90%

Zero emission vehicles are available to our workforce alongside non-electric options through salary sacrifice schemes across our system providers. We also offer a salary sacrifice cycle to work scheme, and staff webpages promote these schemes alongside other sustainable travel options.

Estates and facilities

A heat decarbonisation plan is in place at one of our provider organisations, and is in development at a second provider – with the help of Midlands Net Zero Hub. All trusts in the system are actively pursuing suitable funding opportunities which are highlighted and shared by NHS England and the ICB.

Clinical transformation

We have identified and successfully promoted an opportunity for primary care support through the Business Energy Advice Service funding and energy efficiency surveys being offered by West Midlands Combined Authority.

Food

The system continues to make progress on food waste reduction. Food waste is monitored across all provider trusts, and food waste collections have been introduced as part of the government's simpler recycling legislation. Trusts have also introduced a digital meal ordering system to reduce waste.

Adaptation

We collaborated with students at Keele University's School of Environment and Sustainability to establish key threats to primary care resulting from climate change impacts including flooding, wildfires, extreme heat, cold spells and storm events. Using literature and data searches, climate risk assessments were completed to identify which GP practices were at risk of severe weather events and extreme conditions.

These have been mapped to reveal the level of risk, and adaptation measures have been suggested. Our Emergency Preparedness Resilience and Response (EPRR) team and our system-wide ICS Strategic Estates Group are using this to inform appropriate measures and preparations required to mitigate risks.

Digital

We are continuing to identify and report on carbon savings across key focus areas – aligned with the shift from analogue to digital as outlined in the NHS 10 Year Plan. A digital-first service will empower patients to manage their care and give clinicians a comprehensive view of a patient's history – reducing the need for repeated information.

Taskforce on Climate-related Financial Disclosures (TCFD)

The Department of Health and Social Care General Accounting Manual (DHSC GAM) set out a phased approach to incorporating the recommended TCFD, as part of sustainability annual reporting requirements for NHS bodies, stemming 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 gas emissions under TCFD requirements as these are computed nationally, by NHS England.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD-aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to 2025/26. The phased approach incorporates the disclosure requirements of the following 'pillars' – Governance, Strategy, Risk management, and Metrics and targets.

Governance

Describe the board's oversight of climate-related issues

Please refer to the Staffordshire and Stoke-on-Trent ICS Green Plan 2025-28 – Leadership (page 15) and Governance and Accountability (pages 41-42).

The ongoing ICB Reform process has led to a new executive lead being appointed who has senior responsibility for the Green Agenda within SSOT ICS.

Describe management's role in assessing and managing climate-related issues

Our Green Plan was agreed by board and executives and launched in July 2025. It will support cohesive collaborative working across the system to deliver the needs of patients and residents, while recognising and reinforcing the beneficial impacts of greenhouse gas emission reduction and health improvement throughout the system as a green thread.

The plan links into all portfolios and enables key decision makers to make evidence-based decisions that ensure future generations are not put at risk. It also contributes to the local, regional and national delivery of net zero targets and the UK Government's net zero pledge.

We will be introducing a Sustainability Impact Assessment (SIA) for Staffordshire and Stoke-on-Trent ICB in the new financial year 2026/27. The SIA has been developed by the Greener NHS team in conjunction with ICB Sustainability Leads in the West Midlands as a tool which may be used in:

- decision-making
- business cases
- internal and external policies
- procuring goods and services
- the services they provide
- service transformation
- recruitment, promotion, and performance management of employees.

Its aim is to inform decision makers of any sustainability risks and benefits associated with projects and proposals (including business cases, service development and improvement, transformation, procurement), and to provide a means to mitigate these risks. SIAs contribute to the assurance that we are meeting the legal duties around sustainability, including the TCFD and the Health and Care Act 2022.

Green interdependencies – Emergency Preparedness Resilience and Response (EPRR)

- Set out actions to prepare for severe weather events and improve climate resilience of local sites and services, including digital services
- In partnership with emergency response colleagues and others, identify interdependencies between services and the necessary mutual aid requirements to prevent service disruptions

- Share findings with resilience partners (for example – local resilience forums and directors of public health) to ensure critical information is integrated into broader emergency planning and climate adaptation planning practices.

Strategy

Describe the climate-related risks and opportunities the organisation has identified over the short, medium and long term

The Staffordshire and Stoke-on-Trent Community Risk Register (April 2025) sets out risks and impact associated with climate change. It also details the appropriate measures on how these risks will be responded to as part of a multi-agency response.

Figures show global average temperature levels rising by 2 and 4 degrees relative to 1982-2000 levels. To better understand health impacts and the changing risk to the county of Staffordshire as a result of the projected changes in climate, Staffordshire County Council has created an adaptation risk assessment which includes health, wellbeing and safety. This document was informed by the UK Climate Change Risk Assessment (CCRA) and the Sustainability West Midlands (SWM) risk assessment and adaptation plan for the West Midlands. NHS, local authorities and UK Health Security Agency (UKHSA) are committed to working together on this agenda. Please see Staffordshire County Council Climate Change Action Plan 2025-30 – Health, wellbeing and safety risk assessment (pages 34-35).

As mentioned above under the Adaptation heading, we have worked with Keele University students to map the level of risk GP practices have to increasing frequency of extreme weather conditions linked to rising global temperature. This project produced a number of suggested adaptation measures to help impacted practices prepare for these events.

Describe the impact of climate-related risks and opportunities on the organisation's operations, strategy and financial planning and how these may materialise over the short, medium and long term, when considered against a global warming pathway of 2°C or lower

- Excess deaths or heat-related illness – especially impacting vulnerable people during heatwaves.
- Extreme cold, damp and mould and associated illness or death – especially impacting people living in fuel poverty. Potential benefits to health from reduced frequency of cold weather. Risks and opportunities from summer and winter household energy demand.
- Mental health issues from climate-related impacts (flood, storm damage, extreme heat etc) and potential risk to life. Potential benefit to mental health from warmer weather and greater opportunities to be outdoors.
- High temperatures and more frequent exposure to heat will increase risk of heat stress and ultraviolet (UV) exposure – particularly impacting outdoor and mobile workers.
- Higher temperatures affecting food safety and food borne disease cases. Changing climate could impact food security (local and global supplies).

Overall, the threats associated with a global warming pathway of 2°C or lower far outweigh any opportunities. Any reduction in demand for NHS service as a result of warmer winters will be minimal compared to the anticipated increased demand for mental health services resulting from increased flooding, spread of waterborne diseases, staff shortages due to infrastructure failures and injuries sustained from physical hazards, and potential social disorder.

Global warming is undermining the peace, security and wellbeing of millions of people worldwide. As well as driving demands for more effective state action, these developments will have a growing impact on many aspects of people's lives and livelihoods – including the potential for unrest. Please refer to the College of Policing: Policing in England and Wales Future Operating Environment 2040 which identifies the potential climate change, environmental decline and competition for resources.

Please refer to the Staffordshire and Stoke-on-Trent ICS Green Plan 2025-28 – Adaptation (pages 39-40). We will also be adopting the approach outlined in The Green Book – UK Government Guidance on Appraisal – Climate change resilience (pages 66-67).

Risk management

Describe the organisation's processes for identifying and assessing climate-related risks

The EPRR team will work to support the Greener NHS agenda through the consideration of climate change and adaptation within plans as appropriate. As the Sustainability portfolio sits within that of the Chief Transformation Officer, the EPRR team will work with portfolio leads to give due consideration to this within EPRR plans and policies as appropriate.

See the Staffordshire and Stoke-on-Trent (SSOT) ICB EPRR Policy 2025 on the SSOT ICB website.

Describe the organisation's processes for managing climate-related risks

Although we do not currently have dedicated climate change risks logged on our corporate risk register, these have been raised as part of the planning and commissioning intentions process as part of the Five Year Medium Term Plan.

In addition, there are significant mitigations in place for the severe weather impacts that the modelling from the Climate Change Risk Assessment 3 has identified. These are included within the Local Resilience Forum – Community Risk Register and EPRR Adverse Weather and Health Action Card.

ICB Adverse Weather and Health Action Card

The EPRR team will support, advise and coordinate adaptation arrangements locally to support a system-wide strategic approach to protect the health of the population, patients, clients and workforce during adverse weather events, alongside NHS England and UK Health Security Agency (UKHSA).

All areas will consider heat health as part of business-as-usual conversations and planning activities around the following areas:

- Service delivery
- Capacity building
- Organisational arrangements
- Communication
- Risk management
- Research and data analysis
- Quality assurance.

We will use the Joint Emergency Services Interoperability Principles (JESIP) as a decision-making model all year round, and consider application as part of the Green Agenda and climate change adaptation principles.

Furthermore, the 'Building a net zero NHS' module is mandatory for all Staffordshire and Stoke-on-Trent ICB staff. This training will help ensure all staff are aware of the risks associated with climate change over the short, medium and long term future.

Describe how processes for identifying, assessing and managing climate-related risks are integrated into the organisation's overall risk management approach

Please refer to previous responses on EPRR and Local Resilience Forum – Community Risk Register.

Metrics and targets

Disclose the metrics used by the organisation to assess climate-related risks and opportunities in line with its strategy and risk management process

In addition to metrics and data provided by the Greener NHS team, the local actions agreed within our Green Plan also contain specific metrics to measure progress. Please refer to the Staffordshire and Stoke-on-Trent ICS Green Plan 2025-28 – Action Plan (pages 60-65).

Describe the targets used by the organisation to manage climate-related risks and opportunities and performance against targets

Please refer to the Staffordshire and Stoke-on-Trent ICS Green Plan 2025-28 – Foreword (page 3).

NHS bodies will not be required to disclose or develop processes to disclose scope 1, scope 2 and scope 3 emissions as part of the metrics and target pillar. Emissions estimates for the NHS in England will be provided by the Greener NHS team.

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 services or patient care. Robust arrangements must be in place to maintain essential services while responding to incidents.

We continue to strengthen organisational resilience to ensure we can respond effectively to any unplanned disruption while maintaining services for patients. A comprehensive EPRR work programme and well-tested plans are in place to comply with national requirements (including the Civil Contingencies Act 2004, NHS Act 2006, Health and Care Act 2022, and the NHS England EPRR Framework 2022).

We are also working collaboratively across the cluster to share best practice and support the development of joint arrangements.

Responding to incidents

Throughout 2025/26, our incident response teams participated in a range of 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 2026/27 within the cluster and have already some great exercises opportunities in development with our partners. This work will continue into 2026/27, with several joint exercises already being developed with system partners.

We have responded to numerous incidents and emergencies of varying scale and nature this year – demonstrating our ability to manage operational pressures while maintaining delivery of our EPRR responsibilities at a substantially compliant level. Learning from incidents remains central to our approach, and this is embedded within our EPRR governance structures to ensure plans and arrangements are continuously reviewed and strengthened.

Within Staffordshire and Stoke-on-Trent we continue to build resilience across our ICS EPRR strategy and partnerships, working closely with EPRR teams across the NHS, local authorities, and the Local Resilience Forum to tackle our common themes and planning priorities. In February 2026, EPRR teams from across the system came together to share learning, expertise and identify opportunities for joint working. This collaborative approach supports the development of a more integrated system-wide response as we move towards new ways of working.

We remain an active partner in system and Local Resilience Forum activities, leading the NHS contribution to multi-agency planning and ensuring robust and coordinated arrangements are in place.

Achieving core standards

As a Category 1 responder, we are required to discharge the relevant duties as set out in the Civil Contingencies Act 2004. In 2025, we were confirmed as being substantially compliant against these standards, maintaining this position held since 2023. Our 2026 assurance self-assessment will be submitted in August 2026. The results will be subject to confirm and challenge by NHS England, and reported in the 2026/27 Annual Report.

Patient experience and complaints

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.

Complaints, Patient Advice and Liaison Service (PALS) contacts and MP enquiries offer wider insights into patient experience to help identify themes and trends. This helps to ensure that complaints directly drive system-wide learning and support continuous improvement in the quality and safety of commissioned services. Complaints are treated as a vital source of intelligence to improve patient care, rather than merely a process to be managed.

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). The Ombudsman makes final decisions on complaints that have not been resolved by the NHS, government departments and other public organisations.

The table below show a breakdown of complaints received 2025/26:

Service	Number of complaints
GP practice	259
Continuing Healthcare	57
Hospital	97
Mental health services	76
Dental	38
Pharmacy	21
Referral Management	28
NHS 111	20
Transport services	10
Medicines Management	4
Out of hours	8
Commissioning finance	35
Prescription Ordering Department	14
Multiagency	35
Individual funding request	3
Private nursing / care home	0
Emergency response	3
Other	126
Total	**834**

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

Partnership working enables better decision making about service changes and how money is spent and invested. It reduces risks of legal challenges, and 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 continued to work 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 (VCSE) 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 2026/27 and inform how involvement activity is delivered. We are also working closely with our colleagues in Shropshire, Telford and Wrekin ICB as part of the clustered system to align involvement opportunities for diverse populations.

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 2025/26. 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 PCNs and GPs provide services. This work has helped us to 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, particularly following the approval of weight management medications.

Maternity

We have been reviewing the provision of maternity services since the COVID-19 pandemic, which resulted in the temporary closure of midwife-led birthing units at County Hospital, Stafford, and Samuel Johnson Community Hospital in Lichfield. While birthing services have remained closed,

antenatal and postnatal care has continued at both sites, with the exception that glucose tolerance testing (GTT) and Anti-D injections have not been offered at Samuel Johnson since the pandemic.

Following periods of involvement opportunity since 2021, we launched a formal consultation, setting out the proposal to make permanent the temporary closures. The consultation strategy was designed to ensure opportunities for involvement were provided in communities and neighbourhoods, such as family hubs and children's centres, and in hospital settings where maternity services are provided.

The formal, 12-week consultation ran from 12 May to 3 August 2025, with more than 1,400 responses from our main survey, easy read survey, bespoke discussion sessions hosted at NHS sites and community venues, and during drop-in sessions at neighbourhood groups. We also hosted online discussion events at various times to provide as many opportunities as possible for people to attend and contribute to the decision-making process.

We partnered with NHS providers, the local Maternity and Neonatal Voices Partnership (MNVP) local authority colleagues and the voluntary sector, as well as our formal involvement channels – the People and Communities Assembly, and the People's Panel – to share messaging and drive participation in the consultation so their valuable insights could be considered and used to help shape future services.

As a result of the responses received during the consultation, we launched an additional four-week engagement to gather views on antenatal care. In particular, we wanted to understand any potential impact of the current arrangements for GTT and Anti-D injections and identify potential mitigations.

A report of findings is being prepared for publication to share the analysis of the information received.

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, we have continued our work to develop '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 involve 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, which 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.

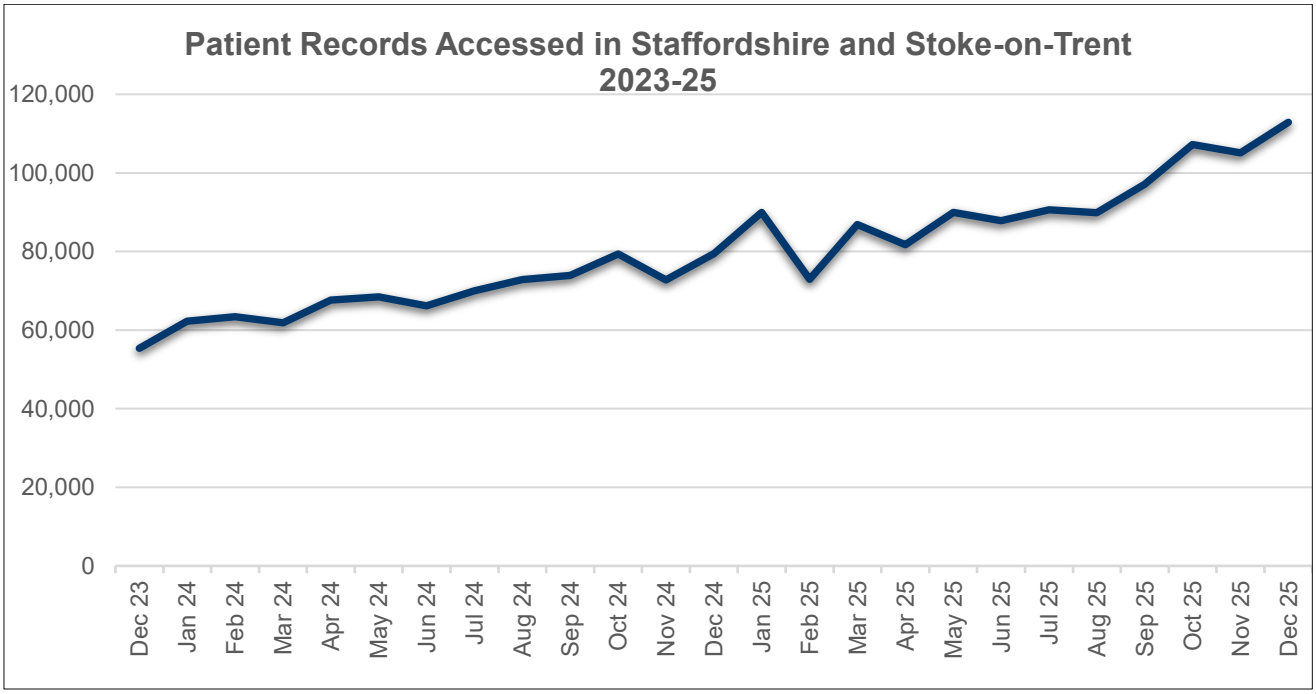
Our work to involve patients and the public is monitored by the People and Communities Assembly, which acts as an advisory board to the ICB, and which is chaired by our Non-Executive Chair. The Assembly holds us to account on our statutory duty to engage. Through its membership representation, the Assembly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

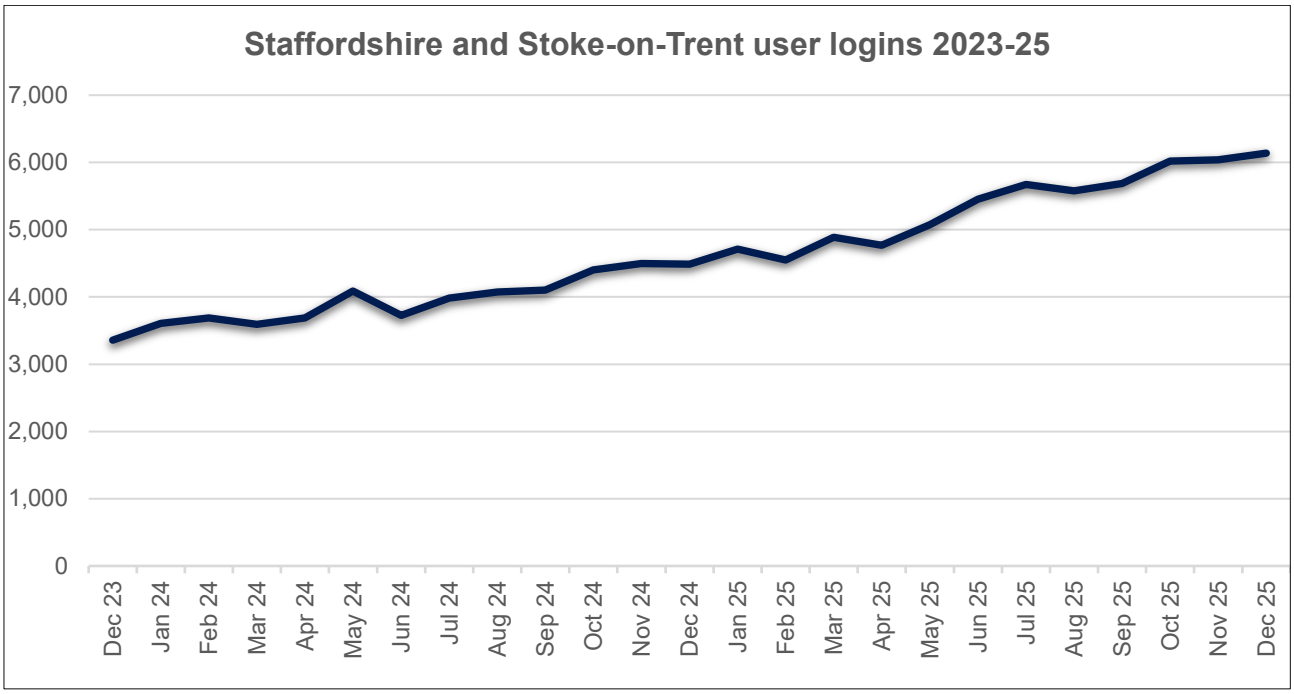
Digital

One Health and Care (OHC)

Our shared care record is continually developing to enhance collaboration and patient outcomes across healthcare services. The recent inclusion of Katharine House Hospice and the user interface upgrade to version 4 have improved usability, while integration with West Midlands Ambulance Service allows real-time emergency data sharing. A new feedback button enables users to shape future improvements with their valuable suggestions and feedback. Upcoming plans include integrating Docman for better clinical correspondence sharing, working closely with NHS national team towards single patient record and improving system connectivity for greater interoperability. Furthermore, other data enhancements have incorporated social care datasets for both adults and children, as well as MPFT community and mental health data. We remain committed to delivering a robust, user-focused shared care record for better community care.



The graph above shows a **103.9%** increase in utilisation of OHC with 112,881 patient records accessed in Dec 2025 compared to 55,261 records accessed in Dec 2023.



The graph above shows an **82%** increase in user logins in last 2 years. In Dec 2025 6138 users logged in to OHC compared to 3357 users in Dec 2023.

Analytics

Exploratory use cases:

- **Penicillin allergy** : Analysis focused on gaining a clear understanding of the OHC data available to support the National Patient Safety Alert on the risks associated with incorrect recording of penicillin allergy status.
- **Opioid-related harm**: A comprehensive exploratory analysis into opioid-related harm was successfully delivered, establishing a robust dual-code method to identify potential opioid-linked admissions and related adverse outcomes such as overdose, falls, constipation and mental-health complications. This work produced clear, clinically meaningful cohorts by tracing harm both from opioid exposure forward and from side-effect codes backward, ensuring no gaps in case-finding. The exploratory findings set out a replicable approach to support safer prescribing, targeted reviews, and improved visibility of opioid-related risk across the system.
- **Maternity Risk Assessment:** Maternity-risk extract, aiming to identify clinically relevant information—particularly from GP records and selected non-maternity specialties—that could inform complex pregnancy risk assessments. Several maternal history and clinical factors are associated with an increased risk of preterm birth such as previous preterm birth or mid-trimester pregnancy loss, cervical cone biopsy, trachelectomy and uterine infections.
- **Flu admissions**: Flu admissions and vaccination data validation work, beginning with clarifying and refining the data specification for identifying patients admitted with influenza and linking this to GP vaccination status and eligibility.
- **OHC Dashboard Utilisation**: Overall usage of the OHC dashboards shows a steady and diverse engagement pattern, with several reports being accessed consistently across months. The utilisation of key dashboards such as the Diabetes Report, Utilisation Trend Report, Frailty Dashboard, and Access Reports are actively used and continue to provide value to their intended user groups.

Digital Care Plans

Digital ReSPECT

Digital ReSPECT is the electronic version of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form, available on OHC enabling clinicians to record and access emergency care and treatment recommendations across organisations. Moving to digital improves accessibility in urgent situations, reduces reliance on paper forms and ensures a patient's wishes and clinical recommendations are visible across care settings when they are most needed.

Across Staffordshire and Stoke-on-Trent, **6,440** Digital ReSPECT forms have been created.

Digital ReSPECT is live across:

- **81** GP practices,
- University Hospitals of North Midlands (UHNM),
- University Hospitals of Derby and Burton (UHDB),
- **Three** hospices.

Ongoing engagement is being carried out to support rollout to additional partners, including Midlands Partnership University NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT).

Electronic Palliative Care Coordination System (EPaCCS)

The Electronic Palliative Care Coordination System (EPaCCS) has been configured within One Health & Care to improve end of life care by recording and sharing key information about people's needs and preferences with clinicians involved in an individual's care.

Staffordshire and Stoke-on-Trent EPaCCS Task & Finish Group has finalised the Standard Operating Procedures (SOP) and workflows, with three hospices and 5 GP practices will be early adopters. Training has been delivered to early adopter sites with go-live planned for February 2026, followed by a phased rollout across Staffordshire and Stoke-on-Trent.

Accountability Report

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 1 April 2025 to 31 March 2026 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 polices 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.

In March 2025, NHS England announced that ICBs must reduce running and programme costs by 50% by December 2025.

To deliver the mandated reductions in running costs for 2025/26, the majority of ICBs nationally are adopting clustering arrangements. Under this model, two or more ICBs work together across a larger geographical footprint while retaining their status as separate legal entities. Reflecting this national direction, the Staffordshire and Stoke-on-Trent ICB has formally entered into a Cluster arrangement with Shropshire, Telford and Wrekin ICB.

Through this arrangement, both organisations now operate with a shared Executive leadership team. Senior posts are aligned across the two ICBs to streamline decision-making, reduce duplication, and enhance cross-system working. Alongside the establishment of the shared leadership model, both ICBs are undertaking a comprehensive review of their organisational structures to ensure they can continue to discharge their statutory duties effectively while achieving the required reductions in running costs.

The Cluster model provides a number of benefits that directly support improved efficiency, strengthened governance, and greater system integration:

- **Stronger strategic alignment –** Clustering enables a more cohesive approach to planning, performance oversight and transformation activity across neighbouring systems. It supports more consistent decision-making, closer alignment of strategic priorities and a shared understanding of delivery challenges.
- **Improved efficiency and reduced duplication –** By consolidating corporate functions, governance processes and specialist capacity, Clustered ICBs can streamline operations, reduce duplication of effort, and contribute directly to meeting national running cost targets.
- **Enhanced resilience and organisational capacity –** Shared leadership and pooled resources strengthen organisational resilience, ensuring that statutory functions continue to be delivered effectively despite reductions in workforce numbers. The combined approach offers greater stability and mitigates operational risk.
- **Accelerated learning and adoption of best practice –** Cluster arrangements promote the rapid spread of innovation, shared problem solving, and alignment of approaches. This supports improved quality, greater consistency and more efficient use of specialist expertise.
- **More coherent engagement with system partners –** Working with a combined voice enables more effective engagement with NHS England, local authorities, NHS providers, primary care, and wider Integrated Care System (ICS) partners. This supports more joined-up planning, clearer communication and more coordinated delivery.
- **A managed pathway towards potential future merger –** While both organisations remain legally distinct, Cluster working provides a structured platform from which future merger proposals could be explored. It supports early alignment of governance, culture, processes and workforce arrangements ahead of any statutory change.

As key partners within the Staffordshire and Stoke-on-Trent ICS, both ICBs continue to work closely with NHS trusts, local authorities, primary care providers, voluntary and community sector organisations, and other system partners. These relationships are supported by robust governance arrangements that enable effective shared planning, joint decision-making and collaborative delivery.

This integrated approach has been essential in shaping the 2025/26 Operational Plan and supporting system-wide transformation programmes. It ensures that priorities are aligned, resources are deployed effectively, and collective efforts are focused on improving health outcomes and reducing inequalities for local populations.

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:

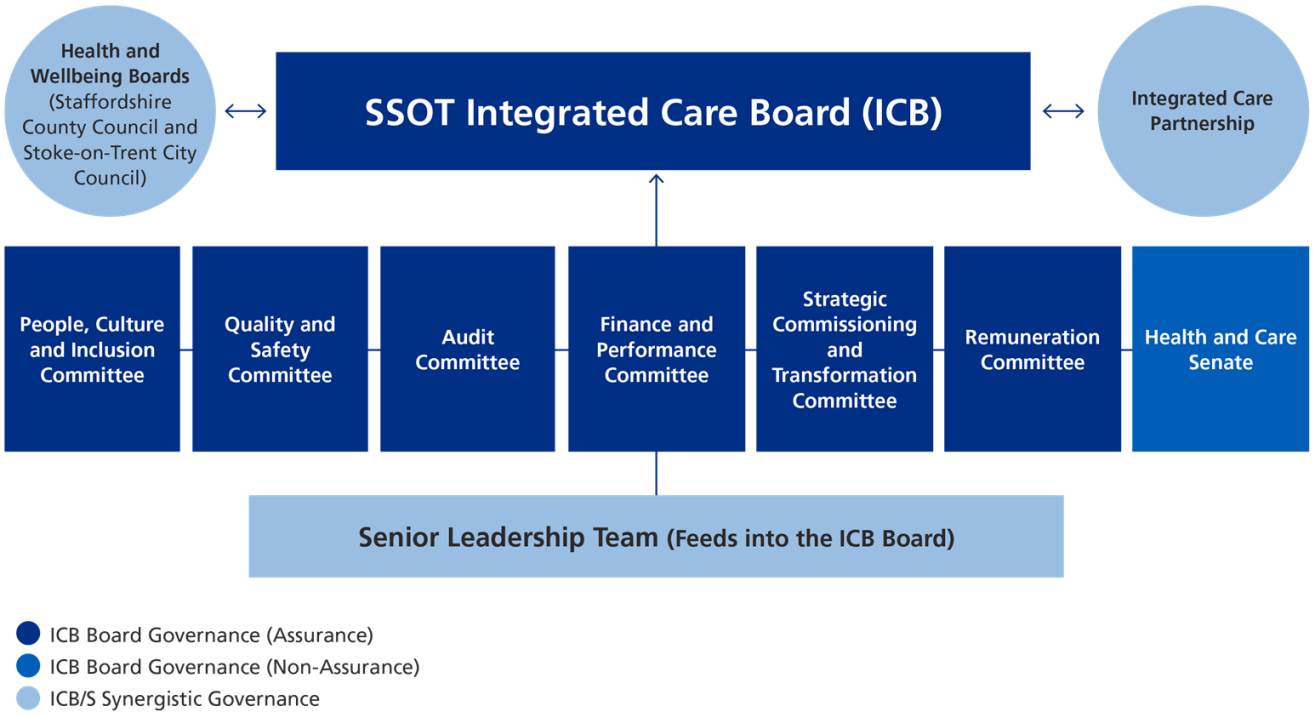
- **Audit Committee** – monitors the effectiveness of the risk management arrangements, operational, non-clinical and financial) on behalf of the Board.
- **Remuneration Committee** – accountable for matters relating to remuneration, fees and other allowances, including pension schemes, for employees 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** – 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.
- **Health and Care Senate** – expanded in 2025/26, bringing multidisciplinary clinical leadership together to shape clinical strategy and provide advice to the Board.

Risks are identified, assessed, and monitored consistently through agreed processes, with clear mechanisms in place for escalation and oversight. Committees receive regular updates on the risks aligned to their areas of responsibility, ensuring that risk management remains a core element of their assurance role.

Each committee is accountable for overseeing the risks relevant to its functions, while the Audit Committee retains overarching responsibility for the effectiveness of the risk management framework as a whole. To support this, Risk Reports are presented to committees on a bi-monthly basis. The Governance team highlights key areas requiring attention and provides recommendations or proposed escalations, ensuring that emerging or significant risks receive timely scrutiny and appropriate action.

This coordinated approach enables the organisation to maintain alignment between operational delivery, strategic objectives, and risk exposure, ensuring that risks are managed proportionately and transparently throughout the year.

ICB Committee structure for Board assurance



Composition of the ICB

Name	Position	Date of leaving	Date of joining
David Pearson	Chair	31/10/2025	
Peter Axon	Chief Executive Officer	14/07/2025	
Paul Brown	Chief Finance Officer	30/06/2025	
Phil Smith	Chief Officer: System Development and Integration		
Dr Paul Edmondson-Jones	Transformation Director		
Heather Johnstone	Chief Nursing Officer (Interim)		
Ian Green OBE	Chair		01/11/2025
Simon Whitehouse	Chief Executive Officer		01/10/2025
Elizabeth Disney	Chief Transformation Officer	28/02/2025	
Dr Lorna Clarson	Chief Officer, Strategy and Improving Outcomes		01/12/2025
Dr Rachel Gallyot	Chief Medical Officer (Interim)		01/08/2025
Mish Irvine	Chief People Officer		01/04/2025
Julie Houlder	Non-Executive Member	31/01/2026	
Josephine Spencer	Non-Executive Member	31/10/2025	
Shokat Lal	Non-Executive Member		
Mike Lawton	Non-Executive Member		
Siobhan Heafield	Non-Executive Member	31/03/2026	01/07/2025
Cheryl Etches	Non-Executive Member		12/02/2025
Trevor McMillan	Non-Executive Member		12/02/2025
Roger Dunshea	Non-Executive Member		12/02/2025
Claire Finn	Chief Finance Officer (Interim)	01/06/2025	15/03/2026
Claire Skidmore	Cluster Finance Officer		01/12/2025
Jon Rouse	Chief Executive, City of Stoke-on-Trent Council		
Patrick Flaherty	Chief Executive, Staffordshire County Council		
Dr Jack Aw	Primary Medical Services Partner Member		
Simon Constable	Chief Executive, University Hospitals of North Midlands		
Neil Carr	Chief Executive, Midlands Partnership NHS Foundation		
Dr Buki Adeyemo	Chief Executive, North Staffordshire Combined Healthcare		

There are other ‘participant members’ of the Board from our partner organisations. As per our Constitution, we have only disclosed those who are members. You can meet our ICB, including our partner members, on the Board members page of our website.

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 has held six meetings in public, four OD sessions 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 2025/26:

- System Board Assurance Framework (SBAF) and Risk Management
- Highlight reports from the Board's sub-committees
- Local Dental Plan
- National planning submissions
- Intensive and Assertive Community Mental Health Care
- 10 Year Plan
- System Winter/Surge Plan.

The Board also held four organisational development (OD) sessions where they discussed:

- SBAF
- Board Assurance and Annual Plan
- Board Assurance and Fraud
- Seminar – Oliver McGowan training / Patient Review.

There was also one extraordinary board meeting held in private.

A number of committees provide regular support to the Board, meeting throughout the year to oversee, review and scrutinise the organisation's activities and statutory responsibilities. During 2025/26, the remit and terms of reference for each committee were reviewed to ensure they continued to provide robust governance and effective assurance.

Each committee reports to the Board through established mechanisms, including the submission of Chair's highlight and escalation reports, alongside any additional assurance or exception reports as required.

Portfolios and leads

Portfolio	Senior Responsible Officer (SRO)	Executive Lead
Primary care	Dr Rachel Gallyot	Dr Rachel Gallyot
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	Phil Smith	Neil Carr Phil Smith
Children and young people and maternity	Phil Smith (CYP) Heather Johnstone (Maternity)	Phil Smith (CYP) Heather Johnstone (Maternity)
Mental health, learning disabilities and autism	Ben Richards (NSCHT)	Phil Smith
Contracts – CSU, Legal and HR	N/A	Mish Irvine
Other contracts	N/A	Claire Skidmore

During 2025/26, we have also commissioned services from NHS Midlands and Lancashire Commissioning Support Unit (MLCSU):

- 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.

Following the directive to form a Cluster with Shropshire, Telford and Wrekin ICB, several committees – including the Audit Committee, Remuneration Committee, Finance and Performance Committee, and Strategic Commissioning and Transformation Committee – began holding meetings in common. This approach strengthened cross-ICB governance by supporting aligned assurance processes, enabling joint consideration of shared risks and audit findings, and reducing duplication. Operating in common improved transparency and consistency while ensuring that each ICB continued to meet its statutory responsibilities as a separate legal entity.

Membership of the Board Committees

Audit Committee

Members	Meetings held in 2025/26	Business discussed
• Roger Dunshea, Non-Executive Member • Julie Houlder, Non-Executive Member* • Mike Lawton, Non-Executive Member • Shokat Lal, Non-Executive Member • Trevor McMillan, Non-Executive Member • Cheryl Etches, Non-Executive Director	Five meetings including, two held in common with Shropshire Telford and Wrekin ICB and one extraordinary meeting. Four OD meetings.	• External audit services contract award • Risk management, including SBAF • Review of committee effectiveness • EPRR annual assurance compliance • Gordon Street (extraordinary meeting) • Losses and special payments • Single Tender Waivers for single contracts • Anti-fraud and bribery • Freedom of Information and Subject Access requests • Gifts and hospitality • Board Assurance and Annual Plan • Fraud • Oliver McGowan training • AP Review

*** The following members left the committee during the financial year 2025/26: Julie Houlder – 31/01/2025**

Remuneration and Terms of Service Committee

Members	Meetings held in 2025/26	Business discussed
Shropshire, Telford and Wrekin: • Cheryl Etches, Non-Executive Member** • Ian Green, Chair** • Trevor McMillan, Non-Executive Member* • Niti Pall, Non-Executive Member** Staffordshire and Stoke-on-Trent: • Shokat Lal, Non-Executive Member • Ian Green, Non-Executive Member • Siobhan Heafield, Non-Executive Member • Julie Houlder, Non-Executive Member* • Shokat Lal, Non-Executive Member • Mike Lawton, Non-Executive Member	Six meetings and two joint meetings with Shropshire Telford and Wrekin ICB.	• Interim CFO recruitment • Appointment to vacant NEM position • Interim CEO, CMO and Deputy CEO arrangements • VSM Pay Strategy • Chief Nurse and Therapies arrangements • Appointment to Cluster CEO • Fixed-term contract redundancies • VSM Pay recommendations • Voluntary redundancy (VR) scheme and applications

*** The following members left the committee during the financial year 2025/26: Julie Houlder – 31/01/2025**
**** The following members joined the committee during the financial year 2025/26: Ian Green – 01/11/2025, Simon Whitehouse – 01/10/2025, Trevor McMillan – 01/02/2026, Niti Pall – 01/02/2026**

Quality and Safety Committee

Members	Meetings held in 2025/26	Business discussed
• Josephine Spencer, Non-Executive Member / Chair* • Siobhan Heafield, Non-Executive Member / Chair** • Heather Johnstone, Chief Nursing and Therapies Officer • Paul Brown, Chief Finance Officer* • Elizabeth Disney, Chief Transformation Officer* • Dr Rachel Gallyot, Chief Medical Officer (Interim)** • 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 • Vasileia Pitarokoili, Head of Governance	Seven meetings and six Deep Dive meetings were held.	• SBAF and Risk Report • All-Age Continuing Healthcare • Perinatal services • Paediatric Hearing services • Patient Safety Incident Response Plan • Looked After Children • Safeguarding • Special Education Needs and Disability • Children and Young People Complex funding • UHDB Gynaecology Review • ICB Reset • Infection, Prevention and Control • Committee effectiveness

*** The following members left the committee during the financial year 2025/26: Josephine Spencer – 31/01/2025, Paul Brown – 30/06/2025, Elizabeth Disney – 28/02/2026, Dr Paul Edmondson-Jones – 09/07/2025**
**** The following members joined the committee during the financial year 2025/26: Siobhan Heafield – 09/07/2025, Dr Rachel Gallyot – 20/08/2025**

Finance and Performance Committee

Members	Meetings held in 2025/26	Business discussed
• Josephine Spencer, Non-Executive Member / Chair • Mike Lawton, Non-Executive Member / Vice Chair • Paul Brown, Chief Finance Officer* • Claire Finn, Interim Chief Finance Officer** • Phil Smith, Chief Delivery 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* • Mish Irvine, Chief of Staff • Chris Ibell, Chief Digital Information Officer • Stuart Diggles, Recovery Director*	12 meetings were held, including meetings in Common with Shropshire Telford and Wrekin.	• Financial position • System Recovery Programme • System Delivery Operating Plan • System Workforce • Review of committee effectiveness • Winter planning • Risk management and SBAF • ICB Undertakings • Digital Strategy • Maternity Birth Rate • Efficiency Report

*** The following members left the committee during the financial year 2025/26: Paul Brown – 30/06/2025, Elizabeth Disney – 28/02/2026, Tracey Shewan – 26/11/2025, Claire Finn – 06/01/2026**

**** The following members joined the committee during the financial year 2025/26: Claire Finn – 03/06/2025, Claire Skidmore – 06/01/2026**

Strategic Commissioning and Transformation Committee

Members	Meetings held in 2025/26	Business discussed
• 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	13 meetings were held, one being an extraordinary meeting held in private.	• SBAF and Risk Report • 2025/26 Planning Process • Wheelchairs • NHS Reform • Dental Plan • Maternity consultation survey • Diabetes Prevention • Regional Specialised Services Commissioning • GP Action Plan • CYP access issues • Draft terms of reference meeting in common • Wheelchair contract award (extraordinary meeting)

*** The following members left the committee during the financial year 2025/26: Julie Houlder – 31/01/2026, David Pearson – 31/10/2025, Paul Brown – 30/06/2025, Elizabeth Disney – 28/02/2026, Tracey Shewan – 26/11/2025**
**** The following members joined the committee during the financial year 2025/26: Claire Skidmore – 06/01/2026, Dr Lorna Clarson – 01/12/2025**

People, Culture and Inclusion Committee

Members	Meetings held in 2025/26	Business discussed
• Shokat Lal, Non-Executive Member / Chair • Julie Houlder, Non-Executive* Director Member / Vice Chair • Siobhan Heafield** • 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	13 meetings were held, one being an extraordinary meeting.	• SBAF and Risk Report • 2025/26 planning process • Wheelchairs • NHS Reform • Dental Plan • Maternity consultation survey • Diabetes Prevention • Gordon Street procurement • Regional Specialised Services Commissioning • GP Action Plan • CYP access issues • Draft terms of reference meeting in common • Wheelchair contract award (extraordinary meeting)

*** The following members left the committee during the financial year 2025/26: Julie Houlder – 31/01/2026, Paul Brown – 30/06/2025, Tracey Shewan – 26/11/2025**
**** The following members joined the committee during the financial year 2025/26: Siobhan Heafield – August 2026, Claire Skidmore – 06/01/2026**

Health and Care Senate

Members	Meetings held in 2025/26	Business discussed
• 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 Hohensee (Rose), Deputy Medical Director QHB Site / SSOT ICS, UHDB • Dennis Okolo, Medical Director, NSCHT • Fiona Bevan, Clinical Director of Pharmacy and Medicines, UHNM • 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	Nine meetings were held.	• SBAF and ICB Risk Report • Integrated Medicines Optimisation Group approvals • Ear Wax Removal Policy 2025 • Individual Funding Request Policy V.3.0. • Staffordshire and Stoke-on-Trent Alcohol Strategy • Community Ear, Nose and Throat Service Specification • Primary Care Weight Management • SSOT ICS Diagnostic Strategy and Diagnostic Strategy Delivery Plan • Value-based healthcare steering group terms of reference • System Mortality Forum • Excluded Restricted Policy clinical area updates • Staffordshire and Stoke-on-Trent infertility pathway and prior approval process • System Winter Surge Plan 2025/26

- 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
- Muhammad Gill, Medical Director for CDCS, UHDB
- Muhammad Gul, Associate Medical Director, MPFT
- Rachel McKeown, Director of Allied Health Professionals, MPFT
- Susan Thomson, Clinical Director of Pharmacy and Medicines, UHNM *(has now left)
- 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

- Individual Funding Request Annual Report 2024/25
- Minor hand surgery procurement service specification
- Locality Improvement Framework (LIF)
- Management of dry eye in primary care – guidance for clinicians
- System Elective Strategy
- Pneumonia management pathways
- Excluded and Restricted Procedures Policy including Evidence-based interventions
- Assisted Conception for Infertility Policy – scheduled review update
- Antimicrobial resistance and stewardship

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 ICB members during 2025/26 – where these may give rise to potential conflicts with their management responsibilities – are published on our Publications and policies webpage, together with information on how any such conflicts are identified, managed and mitigated.

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 NHS Act 2006 (as amended), NHS England has directed each Integrated Care Board 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 NHS 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 NHS Act 2006 (as amended) requires each ICB to have an Accountable Officer, appointed by NHS England. Following the directive from NHS England for ICBs to cluster, NHSE has appointed Mr Simon Whitehouse as the Accountable Officer for Staffordshire and Stoke-on-Trent ICB.

The responsibilities of an Accountable Officer are set out in the Appointment Letter, the NHS Act 2006 (as amended), and in 'Managing Public Money' (HM Treasury). These include responsibility for:

- the propriety and regularity of the public finances for which the Accountable Officer is answerable
- keeping proper accounting records that disclose, with reasonable accuracy at any time, the ICB's financial position and enable compliance with the Accounts Direction
- safeguarding the ICB's assets, including taking reasonable steps for the prevention and detection of fraud and other irregularities.

As 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 ensure that the Staffordshire and Stoke-on-Trent ICB's external auditors are aware of that information.

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

Simon Whitehouse

Accountable Officer

17 June 2026

Governance statement

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

The ICB's statutory functions are set out under the NHS 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 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 acknowledge my responsibilities as set out in the NHS 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 used efficiently and effectively, safeguarding financial propriety and regularity. I am also responsible for reviewing the effectiveness of the system of internal control within the ICB, as described in this Governance Statement.

Failure to deliver a balanced financial position constitutes a breach of the ICB's statutory duties and would result in the external auditors issuing a referral to the Secretary of State for Health under section 30(a) of the Local Audit and Accountability Act 2014.

To support the mitigation of the financial deficit, we have implemented a series of measures in collaboration with our NHS partners across Staffordshire and Stoke-on-Trent. These include:

- The establishment of a Cluster arrangement with Shropshire, Telford and Wrekin ICB, enabling shared leadership, streamlined decision-making and greater operational efficiency.
- A structured management of change programme to deliver the nationally mandated 50% reduction in running costs by December 2025.
- The implementation of a recruitment freeze, applied across non-essential roles, to support tighter financial control and reduce cost growth while ensuring that critical functions and statutory duties continue to be appropriately resourced.
- The introduction of a shared Senior Executive Management model across the Cluster, strengthening strategic alignment and ensuring consistent oversight of financial, operational and governance responsibilities.

Governance arrangements and effectiveness

The primary role of the Board is to ensure that the organisation has appropriate arrangements in place to discharge its functions effectively, efficiently and economically, while upholding the principles of good governance. The roles and responsibilities of the Board, including the types of decisions reserved to the Board or delegated to its committees or Executive Officers, are set out within the Scheme of Reservation and Delegation.

Key features of the ICB's constitution for governance

The ICB is committed to promoting good governance and the proper stewardship of public resources in delivering its objectives and meeting its statutory duties. The principles that underpin our governance arrangements are set out in our Constitution and include:

- The highest standards of propriety, including impartiality, integrity and objectivity in relation to the stewardship of public funds, organisational management and the conduct of business.
- The Good Governance Standard for Public Services.
- The standards of behaviour defined by the Committee on Standards in Public Life (1995), known as the Nolan Principles.
- The seven key principles of the NHS Constitution.
- The requirements of the Equality Act 2010.

These principles continue to guide how we operate, make decisions and provide assurance to the public that we are managing public resources appropriately.

Committee effectiveness

To support strong and coordinated governance, the Board is supported by a network of committees, each with clearly defined Terms of Reference. In 2025/26, the following committees operated on behalf of the Board:

- Each committee operated within its Terms of Reference and provided regular assurance reports to the Board.
- 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 2025/26, 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

- The meeting was well led.
- Engagement from members was strong.
- Members expressed support for operating as a Committee in Common.
- Agendas were clear and well structured.
- Members felt able to speak openly.
- Papers could be more succinct, with key issues highlighted more clearly to support focused discussion.

People Culture and Inclusion Committee

- Meetings were chaired effectively.
- Committee papers were of good quality.
- Members expressed support for progressing the Committee in Common approach.
- The committee experienced challenges regarding meeting regularity.
- Members identified the need for clearer definition of the committee's role in relation to the Finance and Performance Committee and the Strategic Commissioning and Transformation Committee.

Quality and Safety Committee

- The experienced Non-Executive Member Chair facilitated constructive and robust discussion.
- Members were supportive of further developing the Committee in Common approach.
- Attendance from some partner organisations, including CQC and certain providers, was limited.
- At times, meetings felt compressed due to the volume of business.
- The bi-monthly Deep Dive sessions were regarded as helpful in providing additional assurance.
- Reporting processes were clear and well structured.

Finance and Performance Committee

- Members are supportive of a Committee in Common.
- Detailed areas of concern, i.e. Finance, Operational and Performance.
- Excellent attendance.
- No real engagement from providers.
- Members identified the need for clarity regarding the committee's role and membership.

Strategic Commissioning and Transformation Committee

- Meetings were well chaired and focused.
- Members were supportive of moving to a Committee in Common.
- Members highlighted the need for clearer understanding of commissioning functions across both ICBs.
- Discussions were open and constructive.
- Meetings were sometimes dominated by process.
- Members acknowledged that not all committees may need to continue under future arrangements.
- A stronger focus on transformation was encouraged.
- Some overlap with the Finance and Performance Committee was noted.

Health and Care Senate

- The Chair has a positive impact on the performance of the Senate.
- Members were supportive of a Committee in Common.
- More involvement from partner organisations.
- The Senate has a clear focus on its purpose.
- Quality of papers allows members to perform their roles effectively.

All Committees were provided with the results of the surveys and discussed the suggestions for improvement which will be part of their individual annual plan for 2026/27 as required.

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

The ICB remains committed to fostering an open and supportive culture where colleagues feel safe, confident and encouraged to raise concerns. Promoting transparency, learning and psychological safety is essential to delivering high quality care and ensuring that our statutory responsibilities are met. Freedom to Speak Up continues to play a central role in supporting this culture.

Our Freedom to Speak Up Guardians provide an independent, confidential route for staff to raise concerns relating to patient safety, workforce issues or organisational practices. Guardians meet regularly with the Chief Executive Officer and the Executive Director with responsibility for Freedom to Speak Up to ensure that themes, issues and learning are visible at the highest levels of the organisation. The People, Culture and Inclusion Committee receives routine updates on the number and nature of concerns raised, actions taken, and any emerging risks or trends.

During 2025/26, the number of concerns raised remained low. All issues brought forward were managed appropriately and in accordance with our established HR and governance processes. No cases resulted in formal escalation beyond the organisation, and there were no instances where individuals reported detriment as a result of speaking up.

The Guardians continued to promote awareness of the Freedom to Speak Up process across the organisation, including promoting the service during National Speak Up Month and engagement with staff networks, directorates and leadership teams.

One of our Freedom to Speak Up Guardians also provides support to general practice colleagues across the Staffordshire and Stoke on Trent area, offering an independent and confidential route for primary care staff to raise concerns. The Guardian has engaged with Practice Manager forums to promote the service and ensure colleagues are aware of how to access support. No concerns were raised via this route during the reporting year.

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
- Review and alignment of risks across the Cluster.

Our system of internal control comprises the processes and procedures established to ensure the effective delivery of our aims and objectives. It provides a structured approach for the identification, evaluation and management of risk, assessing both the likelihood of risks materialising and the potential impact on the organisation.

The System Board Assurance Framework (SBAF) articulates our strategic objectives and the principal risks that could compromise their achievement. All risks recorded on the ICB's Risk Register continue to be aligned to the relevant SBAF objectives, ensuring a clear and consistent line of sight from operational risk to strategic ambition.

Each risk is assigned to a lead committee with responsibility for oversight. Committees receive a bi-monthly Risk Report and Risk Register, enabling timely scrutiny and assurance. In line with our Risk Management Framework, all risks scoring 12 or above are escalated to the relevant committee for detailed consideration, assurance and, where required, action.

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.

Leadership compact

The leadership compacts for Staffordshire and Stoke-on-Trent ICB and Shropshire, Telford and Wrekin ICB have been reviewed and aligned to establish a single, unified compact across the Cluster, ensuring consistency in leadership expectations and behaviours.

Cluster leadership compact – Shropshire, Telford and Wrekin ICB and Staffordshire and Stoke-on-Trent ICB

As system leaders, we commit to working as partners first, placing the needs of our communities above organisational boundaries. We will lead in ways that strengthen trust, collaboration and shared purpose across our two Integrated Care Systems (ICS).

Trust and integrity

- We will act as **trusted partners**, doing what we say we will do and explaining openly when we cannot.
- We will act with **integrity, transparency and consistency** across organisational lines.
- We will **build trust** by sharing information openly and **supporting each other** when decisions place partners in exposed or challenging positions.

Courage, ambition and shared risk-taking

- We will be **ambitious** and willing to take forward new ideas that **improve outcomes** for our populations.
- We will **make difficult decisions together**, taking proportionate risks as partners rather than in isolation.
- We will be **open to changing course** collectively when the **evidence**, people and community **voice** or outcomes require it.

Openness, honesty and psychological safety

- We will be **open and honest** about what we can deliver individually and collectively.
- We will **foster psychological safety** between partners, enabling constructive challenge, open dialogue and new thinking.
- We will **share knowledge, insight and expertise** freely to enable system wide understanding and improvement.

Respect, inclusion and compassion

- We will **value all partners equally**, recognising the strengths each brings.
- We will **listen actively** and seek to understand different organisational, professional and community perspectives.
- We will treat one another with **kindness, empathy and respect**.

Collaboration and system-first leadership

- We will prioritise system **outcomes and population needs** above organisational interests or historical boundaries.
- We will **use system resources responsibly** and collectively, recognising that decisions in one part of a system affects the whole.
- We will present a **united approach** to communities, partners and regulators.

Consistency, accountability and shared stewardship

- We will apply **shared standards, processes and behaviours** fairly and consistently across our systems.
- We will **hold ourselves and one another to account** for agreed actions and delivery.
- We will maintain a **constructive, solutions focused attitude**, supporting each other to overcome barriers and deliver priorities.

Leading by example

- We will demonstrate the behaviours and values expected across our systems and **model collaborative leadership**.
- We will champion **integrated working** and strengthen relationships across organisations, sectors and communities.
- We will encourage, develop and empower colleagues and partners to contribute to **shared goals**.

Forward focus, innovation and constructive challenge

- We will **focus on what is possible** and avoid allowing past difficulties or organisational histories to limit future progress.
- We will stay optimistic, **open to new ideas** and committed to **continuous improvement**.
- We will **challenge each other** constructively, resolve conflict openly, and remain committed to **shared solutions** that benefit our populations.

Capacity to handle risk

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.

The Board is responsible for ensuring that the ICB has effective systems of internal control in place, including arrangements for managing risk across the organisation. We recognise that not all risks can be eliminated and that a number of enduring risks will remain on the Risk Register. These risks continue to be monitored and reviewed, in line with the organisation's agreed risk appetite.

To support robust risk management, the Board has established the following governance arrangements:

- **Chief Executive Officer –** holds overall responsibility for ensuring that appropriate systems of internal control are in place, covering governance, financial and risk management, as well as emergency preparedness. Day-to-day responsibility for coordinating and maintaining risk management processes is delegated to the Director of Corporate Governance.
- **Executive Management Team –** provides oversight of the System Board Assurance Framework (SBAF) and the overarching Risk Register. Executive Directors are responsible for validating and managing the risks within their respective portfolios. Risks are reviewed monthly to provide assurance to both committees and the Board that risks are being actively monitored and managed.
- **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

During 2025/26, all risks recorded on the System Board Assurance Framework (SBAF) and the ICB Risk Register continued to be owned by the relevant Executive Director. Each Director remained accountable for ensuring that risks within their portfolio were appropriately monitored and managed. Action owners were assigned to each risk to support the implementation of mitigation activities and to maintain regular review processes.

Where mitigating actions required time to embed before influencing the overall risk score, the review frequency for certain risks was adjusted to a bi-monthly or quarterly cycle to reflect their nature and trajectory.

Executive leads	Area of work
Claire Skidmore, Chief Finance Officer/ Deputy CEO	Finance, Financial Governance, Senior Information Risk Owner
Heather Johnstone / Vanessa Whateley, Interim Chief Nursing and Therapies Officer	Quality, Safety, Safeguarding, Caldicott Guardian
Rachel Gallyot, Interim Chief Medical Officer	Primary Care and Medicines Optimisation, Mental Health, Continuing Healthcare
Phil Smith, Chief Officer System Development and Integration	Performance, Information, System Development, as well as formal processes for Incident Coordination Centre (ICC) incident response
Dr Lorna Clarson, Chief Officer Strategy & Improving Outcomes	Planning and Strategy
Mish Irvine, Chief of Staff	Human Resources, Organisational Development, Equalities and Governance

Strategic objectives		Key mitigations
SBAF 1: Responsive Patient Care – urgent and emergency care	If the Urgent and Emergency Care (UEC) system does not have sufficient and appropriate capacity across the entire system pathway to meet demand and support flow, then should demand outstrip capacity, there will be pressure points within the UEC system, resulting in poor outcomes and experience for patients, increased pressure for our workforce and consequently poor performance and non-delivery of operational planning targets.	The UEC system continued to face high pressure throughout 2025/26, with demand exceeding capacity and impacting flow, ambulance handovers and ED performance. The risk remained High, though was mitigated through delivery of the UEC Improvement Plan, System Winter and System Escalation Plans, real-time oversight via the System Co-ordination Centre & twice daily system calls to drive improvements across the UEC system. The ICB's Finance & Performance Committee and System Performance Group were tasked with being assured on delivery and decision-making processes. These measures supported stabilisation during peak pressures, but ongoing gaps in capacity and workforce resilience mean the risk continues to require focused attention by all stakeholders.
SBAF 2: Responsive Patient Care – non-UEC care (e.g. elective, cancer diagnostics, community / mental health /primary care)	If the system fails to deliver on the specific expectations set out in the 2025/26 (and earlier) planning guidance relating to improvements of all aspects of health and care services, then services will not improve in line with national expectations, resulting in potential patient harm and reputational damage to the ICS.	Performance across elective, cancer, diagnostics, community, mental health and primary care remained under significant pressure during 2025/26, with the risk scoring remaining High throughout the year. Progress was made on reducing long waiters and improving cancer pathway capacity – however, winter pressures and high referral volumes continued to impact recovery trajectories. Mitigations included targeted backlog reduction initiatives, clinical symptomatic pathways developed, Getting It Right First Time (GIRFT) productivity work, system Capacity & Demand reviews, increased delivery of activity and continued reduction of long wait patients through Indicative Activity Plans supporting Elective Recovery. While improvements are emerging, sustained pressure on core services means this risk requires continued system focus.
SBAF 3: Proactive Planning and Delivery of integrated, locality-based Community Services	If we do not deliver integrated community services based on population need, then services will remain reactive and generic and not sensitive to the needs of the population, leading to increasing demand, rising acuity and worsening outcomes for the population.	The risk remained High across all quarters, reflecting system-wide challenges in shifting from reactive service models to proactive, population-based community care. Community Transformation is aligned to the NHS neighbourhood health model, focusing on whole-person, community-based care for people. Progress included mental health crisis pathway developments, launch of the Crisis Assessment Centre, neighbourhood health model maturation, improvements in community equipment sustainability, and ongoing review / realignment of the Better Care Fund (BCF) ensuring that resources are strategically deployed to meet population needs and strengthen system resilience through integrated care home support and frailty pathways. System-wide planning structures and PHM-supported data insight

		have advanced, but gaps remain in governance alignment, provider collaborative development and achieving fully integrated locality models.
SBAF 4: Reducing Health Inequalities	If the system does not prioritise and co-ordinate targeted action and resource allocation to reduce health inequalities, then avoidable differences in access, experience and outcomes will persist or worsen, resulting in poorer health outcomes and increased demand and cost pressures across the system.	This remained a High-rated strategic risk throughout the year due to its long-term nature and system-wide scope. Targets for progress to reduce health inequalities are set against the agreement of Integrated Care Partnership Strategy, delivery of the Health Inequalities Strategy, Locality Improvement Framework investment, Population Health Management expansion across 101 GP practices, and multi-agency engagement. National partners commended the depth of local work, including digital inclusion initiatives, community outreach and data-driven elective care inequality tools. However, sustained stakeholder engagement, long-term impact demonstration and alignment across partner organisations remain ongoing challenges.
SBAF 5: High Quality, Safe Care Outcomes	If we cannot ensure high-quality, equitable and safe patient care, then we will be unable to achieve high standards of quality and safety, resulting in actual or potential harm to patients, loss of reputation, intervention from regulators, failure to deliver our statutory quality duties and increased costs associated with poor standards of care.	This risk remained High, driven by pressures across UEC, maternity, paediatric services, and community pathways. Mitigations included strengthened quality governance, system learning approaches for UEC harms, progress on maternity improvement plans, reduction of wheelchair assessment backlogs, improvements in Initial Health Assessment (IHA)/Review Health Assessment (RHA) timeliness, and continued oversight through Quality and Safety Committee and System Quality Group. Although positive progress was recorded – including national “Significant Assurance” of the QIA process – sustained operational pressures and pockets of long waiting times require ongoing quality oversight.
SBAF 6: Sustainable Finances	If financial cost pressures are not controlled and recurrent efficiency and productivity improvements are not delivered, then the system will fail to achieve its statutory financial duties, resulting in long term financial instability, financial intervention, reduced local decision-making and adverse impacts on services and waiting times.	High in-year financial risk reduced to Low by Q4 following successful system-wide mitigation, despite early-year deficits. Strong oversight, efficiency delivery, and Deficit Support Funding (DSF) support improved the year-end position, with the system forecasting a breakeven outcome. Mitigations included enhanced CIP monitoring, strengthened CFO collaboration, system-wide efficiency oversight, and revised recovery plans at UHNM supported by Deloitte. While the system made significant progress, ongoing efficiency requirements and cost pressures remain areas for continued monitoring.
SBAF 7: System Enablement (Collaboration and Digital)	If the system fails to sustain effective collaboration, partnership working and develop digital and data capabilities, then informed decision-making,integrated service delivery and monitoring of outcomes will be	This risk remained High throughout the year, as sustaining a culture of strategic collaboration and partnership working through the progression of provider collaborative and partnership work programmes continued to require significant focus. Priority remained on establishing appropriate resourcing, infrastructure and reporting arrangements for the Collaborative. Since the approval of the ICS Digital Strategy in March 2024, significant progress has

	limited, resulting in inefficiencies and poorer health and care outcomes for our local population.	been made to address the underlying risks associated with digital and data capacity. Other key developments include: a re-organised Digital Portfolio; delivery of mandated national requirements and maintaining system compliance; systemwide visibility of high impact programmes including Shared Care Record; increased engagement with providers and local authorities to embed digital thinking; identifying challenges and opportunities to support annual work plans.
SBAF 8: Sustainable Workforce	If ICB reform, significant reductions in ICB staffing capacity, and ongoing financial constraints across the ICS limit the ICB's ability to lead, plan, and coordinate the system workforce agenda, then system-wide recruitment, retention, workforce development, and pipeline planning activity may reduce or become fragmented, resulting in the inability to meet the requirements of the NHS Long Term Workforce Plan, deterioration of employee health, wellbeing and retention, with actual or potential impact on service delivery and quality of care.	High in-year financial risk reduced to Low by Q4 reflecting the financial challenges and challenging landscape, meaning the overarching focus continues to be addressed via focused programmes of work, interventions and targeted collaborative work at System / organisational level with evidence of an improved position in several areas including retention, wellbeing and strengthening the future pipeline. The ICB/ICS People Delivery Plan for 2025/26 remained a delivery focus, although was reviewed in line with the change in roles and responsibilities of ICB and Providers.
SBAF 9: Patient and Public Involvement	If the ICB fails to meet its statutory duty to involve patients, the public, marginalised groups and to consider the 9 'Protected Characteristics' in planning & commissioning arrangements, and in the development of proposals to change or cease existing services, then services will not be tailored to local people's health & care needs, resulting in potential judicial review, discrimination, not meeting the population's health needs, increasing health inequalities and leading to poorer health outcomes.	This risk was developed across the ICB Cluster midway through the year, and its risk status remained High throughout. Communications & Engagement Teams in STW and SSOT ICBs are now working under the same Cluster management structure. Both teams continue to share ways of working and shared approaches where appropriate; maximising capacity, experience and knowledge. Membership of the People's Network will need ongoing focus to ensure diversity to enable engagement on a regular basis with a wide range of citizens. A refresh of ICB Involvement Strategies to consider the implications of the ICB Model Blueprint was undertaken.

Risk reporting

Our high-scoring risks 12+

Risk number	Risk description	Lead committee
1619	Ambulance Handover Delays	Finance and Performance
1219	UHNM Electronic Patient Record (EPR)	Finance and Performance
1444	Demand for Paediatric dietetic services continues to outstrip current capacity across the system. Coupled by inequity of service offer both from a community / inpatient perspective	Strategic Commissioning and Transformation
1551	System Surge Capacity	Finance and Performance
1176	Digital Cyber Security	Audit
1191	Employee Health, Wellbeing and Experience	People, Culture and Inclusion
1430	Inadequate provision of Epilepsy Nurse Specialists to meet quality requirements across system for children	Quality and Safety
1457	Gaps in Allied Health Professional (AHP) workforce on UHNM neonatal unit	Quality and Safety
1511	Ability to deliver the 2025/26 Operational Workforce Plan	People, Culture and Inclusion
1513	Impact of focussing on and implementing NHS Reform, ICB redesign and clustering on Staffordshire and Stoke-on-Trent ICB and system work	People, Culture and Inclusion
1515	Impact on culture, behaviour and leadership of uncertain and significantly financially challenged environment	People, Culture and Inclusion
1526	Planned care national and local performance standards not achieved	Finance and Performance
1197	Discharge to Assess (D2A) Capacity	Finance and Performance
1528	Delivery of the 2025/26 System Financial Plan	Finance and Performance
1239	Neonatal Consultant workforce	Quality and Safety
1514	Ability to deliver the workforce transformation and change required within 10 Year Plan and Provider Collaborative	People, Culture and Inclusion
1578	ICB 50% workforce / headcount reduction	Finance and Performance
1609	Infant and neonatal mortality	Quality and Safety
1613	Essential Shared Care Agreements (ESCAs) being declined by GP practices	Strategic Commissioning and Transformation
1206	A&E four-hour performance – Urgent Treatment Centres (UTC) designation	Finance and Performance

Associated SBAF risks 12+

SBAF 1	Risk title	Risk score
1197	D2A capacity	**15**
1199	Ambulance handover delays	**25**
1206	A&E four-hour performance	**12**
1526	Planned care national and local performance standards not achieved	**16**
1541	Relocation of GP out of hours face-to-face locations from Royal Stoke and County Hospital	**16**

1551	System surge capacity	**20**

SBAF 2	Risk title	Risk score
1219	UHNM Electronic Patient Record (EPR)	**20**
1551	System surge capacity	**20**

SBAF 3	Risk title	Risk score
1219	UHNM Electronic Patient Records (EPR)	**20**

At the end of the financial year, no risks aligned to SBAF 4 met the threshold for high-scoring status.

SBAF 5	Risk title	Risk score
1239	Neonatal consultant workforce	**12**
1430	Inadequate provision of Epilepsy Nurse Specialists	**16**
1444	Demand for paediatric dietetic services	**20**
1551	System surge capacity	**20**

SBAF 6	Risk title	Risk score
1523	Planned care savings targets not achieved	**20**
1528	Delivery of the 2025/26 System Financial Plan	**20**
1551	System surge capacity	**20**

SBAF 7	Risk title	Risk score
1176	Digital Cyber security	**16**
1526	Planned care national and local performance standards not achieved	**16**

SBAF 8	Risk title	Risk score
1191	Employee health, wellbeing and experience	**16**
1239	Neonatal consultant workforce	**12**
1444	Demand for paediatric dietetic services	**20**
1511	Ability to deliver the 2025/26 Operational Workforce Plan	**16**
1512	Ability to deliver required ICB and NHS infrastructure reductions	**16**
1513	Impact of focussing on and implementing NHS Reform	**16**
1514	Ability to deliver the workforce transformation and change	**16**
1515	Impact on culture behaviour and leadership of uncertain and significantly financially challenged environment	**16**
1551	System surge capacity	**20**

Closing risks

In 2025/26, we closed 27 risks, compared to 49 in 2024/25.

Other sources of assurance

Internal Control Framework

A system of internal control comprises the processes and procedures that enable the ICB to deliver its policies, aims and objectives. This system is designed to:

- identify and prioritise risks
- assess the likelihood of those risks materialising and the potential impact
- ensure risks are managed efficiently, effectively and economically.

This approach allows risk to be managed to a reasonable level – it cannot eliminate all risk and therefore provides reasonable, rather than absolute, assurance of effectiveness.

The ICB operates within a defined Risk Management Framework, which sets out the standards and methodology for assessing, recording and managing risks. All staff are expected to follow this Framework when developing or updating risks, and the full Framework is available within the ICB's Risk Management Strategy.

Executive Directors act as the accountable owners for the risks within their respective portfolios Directorate team members are assigned as action owners and are responsible for implementing mitigation and monitoring progress. All risks are reviewed by the Executive Management Team, ensuring consistent oversight, timely escalation and alignment with the System Board Assurance Framework (SBAF).

The SBAF is reviewed and updated on a quarterly basis and submitted to the Board and its sub-committees. This process ensures that the ICB maintains effective oversight of internal control, safety and quality throughout the year.

The Audit Committee has continued to receive regular reports providing assurance over the effectiveness of the ICB's risk management arrangements. During 2025/26, all open risks scoring 12 and above are presented. This enables committees to focus their scrutiny on the highest-scoring and most significant risks. Our risk management processes are also subject to independent review and audit by our internal auditors, MIAA.

Key areas of risk during the year included Continuing Healthcare, financial pressures, cyber security, and ambulance handover delays. All identified risks have been managed and mitigated in accordance with the ICB's Risk Management Strategy. A full copy of the Risk Register can be provided 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 12 November 20245, 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

The NHS Information Governance (IG) 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 2026.

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 they were working towards the 46 outcomes to ensure the indicators of Good Practice recommendations are met. As we have not yet reached our final submission date, there are 46 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 and Digital Committee undertakes reviews or investigations as appropriate.

Personal data-related incidents

No personal data breaches were identified during 2025/26, and there were no incidents requiring notification to, or investigation by, the Information Commissioner's Office.

Freedom of Information (FOI) requests

In 2025/26, we received a total of 421 Freedom of Information requests, in comparison with 453 requests in 2024/25. 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 2025/26:

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 FOI requests are published on the Our publications and policies page of the ICB website. The Audit Committee receives regular reports on the management of FOI requests and is notified of any instances where statutory deadlines have not been met.

During 2025/26, three requests exceeded the 20-day statutory response deadline, with delays arising from late receipt of information and staff absences. All FOI requests, however, continued to be acknowledged within the required three-day timeframe.

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).

We received 120 SARs to 10 March 2026, compared with 230 at 31 March 2025.

The ICB received:

- 30 CHC requests.
- Three requests from members of staff requesting access to their HR file – two have been completed and one remains active.

All requests have been handled within timescales, with no breaches reported, however two requests have had an extension applied due to the volume of information requested.

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 (MLCSU). Monthly performance reviews are scheduled with MLCSU.

MLCSU'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 were identified via the Month 9 Governance Statement return to NHS England.

The ICB's Five Year Strategic Commissioning Plan, published in April 2026, sets out our commissioning intentions for 2026/27 to 2030/31, replacing the previous Joint Forward Plan. It outlines our plans aligned to national objectives and our five major system shifts - Hospital to Community, Analogue to Digital, Sickness to Prevention, Improving Access, and Value and Productivity alongside our two key aims of delivering safe, timely and sustainable care and meeting the capacity challenge.

The Medium-Term Financial Plan sets out a credible route to breakeven by the end of the five-year planning horizon, with the system working towards a minimum annual improvement target of 2% efficiency and 2% productivity. The system's financial position continues to reflect a deficit, the sum total of which has been agreed with NHS England, alongside significant and longstanding financial pressures driven by rising demand, inflationary costs and increasing acuity.

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 structured 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.

Commissioning of delegated services (primary care services and specialised services)

NHS Staffordshire and Stoke-on-Trent ICB has signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025/26 reporting period.

To the best of the ICB leadership’s knowledge, all delegated services were commissioned in accordance with 2025/26 delegation agreements and national service specifications.

The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated function is operating (either directly or via multi-ICB working arrangements) should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of ICB functions

The key financial systems (general ledger, accounts payable, accounts receivable) are operated by Shared Business Services under contract to NHS England and a new Financial Ledger was implemented from 1st October 2025. The Payroll service is provided by Midlands and Lancashire Commissioning Support Unit.

These systems undergo a separate regime of Audit assessment. Their Service Auditor Reports are published annually, presented to the Audit Committee and reviewed by our external auditors in terms of informing the overall audit opinion.

Counter fraud arrangements

The ICB continues to promote a comprehensive counter-fraud and anti-bribery culture, as set out in the Counter Fraud and Bribery Policy and through work undertaken by the Local Counter Fraud Specialist (LCFS). All policies and procedures are subject to review by the LCFS to ensure ongoing compliance with Service Condition 24 (SC24) of the NHS Standard Contract, the Government Functional Standard 013: Counter Fraud, and relevant updates issued during 2025/26 to national counter-fraud guidance and assurance frameworks.

During the year, the ICB implemented process updates to reflect national changes, including alignment to the updated Cyber Assurance Framework (CAF) objectives within the Data Security and Protection Toolkit submission, which now form part of wider counter-fraud and organisational assurance expectations. The LCFS continues to advise on the impact of any legislative or regulatory changes on local systems, ensuring that internal arrangements remain compliant and fit for purpose.

The Chief Finance Officer and the Counter Fraud Champion worked closely with the LCFS to deliver a proactive work plan aimed at addressing identified fraud risks and strengthening organisational resilience. This included reviewing control processes, responding to emerging NHS England guidance, and ensuring the organisation maintained its obligations under the NHS Standard Contract, Government Counter Fraud Standards and wider statutory responsibilities.

During 2025/26, the ICB continued to raise staff awareness of fraud risks through targeted fraud-awareness campaigns, including webinars delivered by MIAA. Staff are required to complete mandatory fraud-awareness training, and key messages have been reinforced through regular briefing sessions as part of the ICB's internal communications. The programme of education and awareness was updated to reflect any changes in national fraud-related legislation, NHS England guidance and standards.

Annual counter fraud assurances

Annual Counter Fraud assurances have been received from the ICB's Counter Fraud Specialists, reporting routinely to Audit Committee. The overall position is positive with "Assure / Understand & Prevent / Respond" counter fraud activities all progressing as planned and compliant. The Counter Fraud Specialists have issued over 30 Fraud Prevention Checks (FPCs), alerting the ICB to new phishing emails and mandate frauds. No issues or concerns have been reported back from the ICB in respect of these. A total of five referrals have been received in the year and four Intelligence Reports were created (cases about Continuing Health Care, non-clinical supplier invoicing, Personal Health Budget payments and a case about an employee working elsewhere whilst on sickness absence from the ICB). All of these have been managed and closed in the year. No actions were outstanding at the end of the year.

Gifts and hospitality

The ICB is committed to ensuring full transparency in relation to gifts and hospitality to safeguard against any actual or perceived conflicts of interest. All staff are required to declare any gifts or hospitality offered to them, and a central register is maintained and published within the Our publications and policies section of our website.

During 2025/26, the ICB reviewed its Declaration of Interests, including the Gifts and Hospitality Policy, to ensure continued compliance with national guidance and to confirm that the policy remains up to date, proportionate and fit for purpose.

The ICB received eight declarations from members of staff. The register can be viewed on our Registers and declarations webpage.

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.

An interim Head of Internal Audit Opinion was provided in March 2026 in line with NHS England submission requirements. Due to the timing of this submission, no overall audit opinion was issued at the interim stage. The final opinion will be provided on completion of all internal audit work for 2025/26.

Internal audit activity undertaken to date indicates that the ICB has generally sound systems of internal control, with all completed audits receiving Substantial Assurance. These included reviews of key financial controls, Continuing Healthcare, health inequalities monitoring, quality of commissioned services, and workforce key controls.

Internal audit has reported good progress in the implementation of agreed recommendations. The reviews of the Assurance Framework and Risk Management Core Controls are scheduled for completion in Q4 and will inform the final year-end opinion.

MIAA has confirmed its independence and continued compliance with the Global Internal Audit Standards and the Internal Audit Charter.

Audits undertaken during 2025/26

Assignment	Executive Lead	Status / opinion issued
Assurance Framework	Mish Irvine, Chief of Staff/Paul Winter, Associate Director of Corporate Governance	Draft report issued
Risk Management – Core Controls	Mish Irvine, Chief of Staff/Paul Winter, Associate Director of Corporate Governance	Draft report issued
Key Financial Transactional Processing Controls	Claire Skidmore, Deputy CEO and Chief Finance Officer	Substantial Assurance
Continuing Healthcare	Heather Johnstone, Interim Chief Nurse and Therapies Officer	Substantial Assurance
Health Inequalities	Dr Rachel Gallyot, Interim Chief Medical Officer	Substantial Assurance
Quality of Commissioned Services	Heather Johnstone, Interim Chief Nurse and Therapies Officer	Substantial Assurance
Workforce Key Controls	Mish Irvine, Chief of Staff	Substantial Assurance
Data Security and Protection Toolkit	Claire Skidmore, Deputy CEO and Chief Finance Officer/Paul Winter, Associate Director of Corporate Governance	Phased for Q1 2026/27 to align with Shropshire, Telford and Wrekin ICB DSPT audit

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

The governance arrangements for Staffordshire and Stoke-on-Trent ICB remained robust, effective and fully compliant with statutory and regulatory requirements throughout 2025/26. Oversight provided by the Board and its committees, supported by established systems of internal control, ensured that the organisation continued to operate safely, efficiently and transparently during the reporting period.

Based on the assurances received, I am satisfied that the ICB has appropriate governance, risk-management and internal-control arrangements in place to support the effective discharge of its functions and responsibilities.

Simon Whitehouse

Accountable Officer

17 June 2026

Remuneration and Staff Report

Remuneration committee

Remuneration Committee members:

Name	Position	Date joining the committee	Date leaving the committee
David Pearson	ICB Chair	01/07/2022	31/10/2025
Shokat Lal	ICB Non-Executive Member	01/07/2022	
Josephine Spencer	ICB Non-Executive Member	01/07/2022	31/10/2025
Julie Houlder	ICB Non-Executive Member	01/07/2022	31/01/2026
Mike Lawton	ICB Non-Executive Member	01/02/2025	
Siobhan Heafield	ICB Non-Executive Member	08/07/2025	31/03/2026

Policy on the remuneration of senior managers

The following posts were remunerated in accordance with the Very Senior Manager (VSM) pay framework from 1 April to 30 November 2025:

- 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.

Note: The Chief Digital Officer and Director of Corporate Governance posts ceased to form part of the executive structure from 1 December 2025. However, the post-holders remained in employment beyond this date to complete their contractual notice periods.

Following the implementation of a new executive structure on 1 December 2025, the following posts were remunerated in accordance with the VSM pay framework:

- Chief Executive Officer
- Chief Finance Officer
- Chief of Staff
- Chief Nursing Officer
- Chief Medical Officer
- Chief of Strategy and Improving Outcomes
- Chief of System Development and Improvement

VSM pay is based on 'NHS England Integrated Care Board Chief Executive and Executive Director Pay Ranges and Guidance' – publication reference PPR1479_ii.

In June 2025, 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 3.25% pay award for Very Senior Managers – '2025/26 Annual Pay Increase Recommendations for Very Senior Managers employed by Integrated Care Boards, NHS Trusts and Foundation Trusts' – publication reference PRN02027.

This was considered by the Remuneration Committee on 30 September 2025 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.

Remuneration Committee

From November 2025 the Shropshire Telford and Wrekin ICB Remuneration Committee has been meeting in common with Staffordshire and Stoke-on-Trent ICB Remuneration Committee. The meeting in common has taken place on three occasions between November 2025 and March 2026.

Percentage change in remuneration of highest paid director (subject to audit)

These figures are based on total remuneration paid to the Highest Paid Director versus the total gross remuneration paid to all remaining employees.

	2024-25 Salary (£)	2025/26 Salary (£)	Change (%)
Highest paid director	215,759	181,070	-16%
Median pay of employees	56,454	54,710	-3%

The reduction in the remuneration of the highest-paid director during 2025/26 reflects a change in the organisation's leadership arrangements. During the previous year, the highest-paid director was the Chief Executive Officer, whose remuneration was reported within the £215,000–£220,000 band. Following the departure of the substantive Chief Executive Officer, the organisation entered into a cluster leadership arrangement whereby Chief Executive responsibilities were undertaken by a senior officer employed by a neighbouring NHS organisation. Consequently, the highest-paid director reported during 2025/26 was another Executive Director, with remuneration in the £180,000–£185,000 band. The year-on-year reduction therefore reflects a change in organisational arrangements rather than a reduction in remuneration levels for equivalent roles.

The reduction in the median remuneration of employees during 2025/26 primarily reflects changes in the composition of the workforce during the year. As a result, the median remuneration point reduced by 3% compared to the previous year. The change in median pay therefore reflects a shift in workforce profile rather than changes to pay rates or terms and conditions. This movement has contributed to the change in the reported pay multiple between the highest-paid director and the median employee remuneration.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in the organisation in the financial year 2025/26 was £180,000 - £185,000 (2024-25 £215,000 - £220,000).

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2025/26	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	39,217	54,710	68,631
Salary component of total remuneration (£)	39,217	54,710	68,631
Pay ratio information	4.65	3.34	2.66

2024/25	25th percentile	Median pay ratio	75th percentile pay ratio
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

Note: Salary movement for all pay scales reflects incremental movement only.

In 2025/26, 0 employees received remuneration in excess of the highest-paid director / member (2024-25: 0).

Remuneration ranged from £14,763 to £181,070 (2024-25 £12,514 to £215,759)

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 2025/26.

Senior manager remuneration (including salary and pension entitlements) (subject to audit)

1 April 2025 to 31 March 2026

Name and title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100** £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
David Pearson - Chair	30 - 35	0	0 - 0	0 - 0	0 - 0	30 - 35
Peter Axon - Chief Executive Officer	60 - 65	0	0 - 0	0 - 0	77.5 - 80.0	140 - 145
Dr Paul Edmondson-Jones - Interim Chief Executive Officer	45 - 50	0	0 - 0	0 - 0	10.0 - 12.5	55 – 60
Dr Paul Edmondson-Jones - Chief Medical Officer	45 - 50	0	0 - 0	0 - 0	15.0 - 17.5	65 - 70
Rachel Gallyot - Chief Medical Officer	115 - 120	0	0 - 0	0 - 0	0 - 0	115 - 120
Phil Smith - Chief Delivery Officer	115 - 150	0	0 - 0	0 - 0	45.0 – 47.5	195 – 200
Paul Brown - Chief Finance Officer	40 - 45	0	0 - 0	0 - 0	32.5 - 35.0	75 - 80
Claire Finn - Interim Chief Finance Officer	80 - 85	0	0 - 0	0 - 0	110.0 - 112.5	190 - 195
Heather Johnstone - Chief Nursing & Therapies Officer	100 - 105	0	0 - 0	0 - 0	25.0 - 27.5	125 - 130
Elizabeth Disney - Chief Transformation Officer	100 - 105	0	0 - 0	0 - 0	40.0 - 42.5	140 - 145
Julie Houlder - NED	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Siobhan Heafield - NED	10 - 15	0	0 - 0	0 - 0	0 - 0	10 - 15
Josie Spencer - NED	10 - 15	0	0 - 0	0 - 0	0 - 0	10 - 15

Shokat Lal - NED	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Mike Lawton - NED	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Ian Green - Chair *	0 - 0	0	0 - 0	0 - 0	0 - 0	0 - 0
Simon Whitehouse - Chief Executive Officer *	0 - 0	0	0 - 0	0 - 0	0 - 0	0 - 0
Claire Skidmore - Chief Finance Officer and Deputy Chief Executive Officer *	0 - 0	0	0 - 0	0 - 0	0 - 0	0 - 0
Lorna Clarson - Chief Officer: Strategy and Improving Outcomes *	0 - 0	0	0 - 0	0 - 0	0 - 0	0 - 0

****Note: Taxable expenses and benefits in kind are expressed to the nearest £100.**

Further information

- David Pearson, Chair: left the ICB on 31 October 2025
- Peter Axon, Chief Executive Officer: left the ICB on 14 July 2025
- Paul Edmondson-Jones, Chief Medical Officer: vacated post on 14 July 2025
- Paul Edmondson-Jones, Interim Chief Executive Officer: appointed on 15 July 2025; vacated post on 30 September 2025
- Paul Edmondson-Jones | Combined Remuneration: Salary - £120-125k | Pension Related Benefits - £27.5-30.0k | Total £150-155k
- Rachel Gallyot | Chief Medical Officer | joined the ICB on 15th July 2025 | The pension-related benefits disclosed are £0 as the calculated real increase in pension value during the year was negative.
- Paul Brown, Chief Finance Officer: left the ICB on 30 June 2025
- Claire Finn, Interim Chief Finance Officer: joined the ICB on 1 June 2025; vacated post on 30 November 2025
- Elizabeth Disney, Chief Transformation Officer: left the ICB on 30 November 2025
- Julie Houlder, Non-Executive Director: left the ICB on 31 January 2026
- Siobhan Heafield, Non-Executive Director: joined the ICB on 7 July 2025; left the ICB on 31 March 2026
- Josie Spencer, Non-Executive Director: left the ICB on 31 October 2025.

*** The following Directors are employed by NHS Shropshire, Telford and Wrekin ICB and following their appointment to the Clustered organisation from 1st December 2025 all associated remuneration costs remain with that ICB, and are fully disclosed within their Annual Report. No recharge is made to NHS Staffordshire and Stoke on Trent ICB.**

- Ian Green | Chair | Salary - £45-50k | Pension Related Benefits - £0k | Total £45-50k
- Simon Whitehouse | Chief Executive Officer | Salary - £215-220k | Pension Related Benefits - £25-27.5k | Total - £240-245k

- Claire Skidmore | Chief Finance Officer and Deputy Chief Executive Officer |Salary - £175-180k | Pension Related Benefits - £37.5-40k | Total - £215-220k
- Lorna Clarson | Chief Officer: Strategy and Improving Outcomes | Salary - £155-160k | Pension Related Benefits - £0k | Total - £155-160k
- Cheryl Etches | Non-Executive Director | Salary £10 – 15k
- Trevor McMillan | Non-Executive Director | Salary £10-15k
- Roger Dunshea | Non-Executive Director | Salary 25-30k

1 April 2024 to 31 March 2025

Name and title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
David Pearson - Chair	55 - 60	0	0 - 0	0 - 0	0 - 0	55 - 60
Peter Axon - Chier 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 & 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	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Megan Nurse - NED	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20

Josie Spencer - NED	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Shokat Lal - NED	15 - 20	0	0 - 0	0 - 0	0 - 0	15 - 20
Mike Lawton - NED	0 - 5	0	0 - 0	0 - 0	0 - 0	0 - 5
David Pearson - Chair	55 - 60	0	0 - 0	0 - 0	0 - 0	55 - 60

****Note: Taxable expenses and benefits in kind are expressed to the nearest £100.**

Further information

- Chris Bird, Chief Transformation Officer: left the ICB on 19 August 2024
- Elizabeth Disney, Chief Transformation Officer: joined the ICB 1 September 2024
- Megan Nurse, NED, Chair of F&P Committee: left the ICB on 31 March 2025
- Mike Lawton, NED, Chair of Strategic Commissioning and Transformation Committee: joined the ICB on 1 February 2025.

Pension benefits (subject to audit)

1 April 2025 to 31 March 2026

Name and title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2026 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 31 March 2026 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2026 £000	(h) Employers Contribution to partnership pension £000
Peter Axon - Interim CEO	2.5 - 5	0 - 0	10 - 15	0 - 0	135	57	203	0
Dr Paul Edmondson-Jones - Chief Medical Officer	2.5 - 5	0 - 0	10 - 15	0 - 0	13	0	18	0
Phil Smith - Chief Delivery Officer	2.5 - 5	0 - 0	25 - 30	0 - 0	332	27	382	0
Paul Brown - Chief Finance Officer	0 - 2.5	0 - 0	20 - 25	0 - 0	346	34	391	0
Claire Finn - Interim Chief Finance Officer	7.5 - 10	17.5 - 20	40 - 45	105 - 110	687	166	880	0
Heather Johnstone - Chief Nursing & Therapies Officer	50 - 52.5	145 - 147.5	55 - 60	145 - 150	121	1,276	1,412	0
Elizabeth Disney - Chief Transformation Officer	2.5 - 5	0 - 0	20 - 25	5 - 10	249	21	293	0
Rachel Gallyot - Chief Medical Officer	0 - 0	0 - 0	25 - 30	45 - 50	613	0	563	0

1 April 2024 to 31 March 2025

Name and title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 31 March 2025 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2025 £000	(h) Employers Contribution to partnership pension £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 & Therapies Officer	0 - 0	0 - 0	5 - 10	0 - 0	1,199	0	121	0
Chris Bird - Chief Transformation Officer	0 - 2.5	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

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 member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) 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 or for loss of office (subject to audit)

During 2025/26, the Integrated Care Board agreed exit arrangements with two Executive Directors as part of organisational changes and leadership restructuring. The individuals concerned were the Chief Medical Officer and Chief Nursing & Therapies Officer.

No payments had been made by 31 March 2026. The associated costs have been included in the exit packages disclosure within the financial statements.

Payments to past directors (subject to audit)

There were no payments made in relation to past directors during the reporting period.

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 2026)

Pay Band	Headcount
Ad Hoc / Local	0
Apprentice	1
Band 1	0
Band 2	7
Band 3	19
Band 4	44
Band 5	37
Band 6	76
Band 7	61
Band 8 - Range A	67
Band 8 - Range B	50
Band 8 - Range C	26
Band 8 - Range D	16
Band 9	11
Medical	22
VSM	10
Board (off payroll)	8
Grand Total	**455**

Staff numbers and costs (subject to audit)

The table below shows the average number of people employed in 2025/26 in NHS Staffordshire and Stoke-on-Trent ICB.

Average number of people employed	Permanently employed	Other	Total
Administration and estates	292	8	300
Medical and dental	9	1	10
Nursing, midwifery and health visiting staff	67	3	70
Scientific, therapeutic and technical staff	27	0	27
Total	**395**	**12**	**407**

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	Permanently employed £000	Other £000	Total £000
Salaries and wages	22,993	2,704	25,697
Social security costs	3,082	13	3,095
Employer contributions to NHS pension scheme	5,105	17	5,123
Apprenticeship levy	98	0	98
Termination benefits	14,210	0	14,210
Recoveries in respect of employee benefits	(255)	(190)	(445)
Total	**45,233**	**2,545**	**47,778**

Staff composition

Headcount by gender (based on staffing at 31 March 2026)

Staff Grouping	Female	Male	Total
Board Member	7	7	**14**
Other Senior Management (Band 8C+)	49	30	**79**
All Other Employees	312	50	**362**
Grand Total	**368**	**87**	**455**

Percentage by gender (based on staffing at 31 March 2026)

Staff Grouping	Female	Male
Board Member	50.0%	50.0%
Other Senior Management (Band 8C+)	62.0%	38.0%
All Other Employees	86.2%	13.8%
Grand Total	**80.88%**	**19.12%**

Sickness absence data

Staff sickness absence	2025 number
Total days lost	3045.02
Total staff years	376.64
Average working day lost	8.08

The sickness absence data for the ICB in 2025 was whole time equivalent (WTE) days available of 84744.91 and WTE days lost to sickness absence of 3045.02 and average working days lost per employee was 8.08 which was managed through the absence management policy.

Staff turnover percentages

ICB staff turnover 2025/26	2025/26 number
Average full-time equivalent (FTE) employed 2025/26	399.99
Total FTE leavers 2025/26	59.97
Turnover rate	14.99%

The ICB Staff Turnover Rate for 2025/26 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 59.97. The ICB's Average FTE Staff in Post during the year was 399.99. The ICB Staff Turnover Rate for the year was 14.99%.

Staff policies

As part of our approach to support our individual and organisational performance, we continue to build a values-based organisational culture.

Supporting staff during the ICB Reform

A programme of support for staff was first launched in May 2025 and the fourth edition was shared with staff in January 2026. The range of support has included:

- 'Navigating change' and 'Leading through change' workshops
- CV and job application form sessions
- Interview preparation sessions
- 'Thriving in uncertain times' sessions
- Wellbeing support including counselling, wellbeing workshops, and a plethora of resources and support
- Coaching conversations
- Coaching and mentoring
- NHS Midlands regional offer with support such as entrepreneurial skills
- Redundancy and financial planning support
- Senior leadership support programme.

This support has been very well received with more than 500 staff delegates recorded (as of February 2026).

Our people policies

In 2025/26, we implemented more HR policies based on NHS England's simplified and user-friendly format. Examples include the Sexual Misconduct Policy which was introduced in line with the NHS Sexual Safety Charter and the Mandatory Learning Policy.

We reviewed a number of HR policies this year to reflect legislative changes, including the Retirement Policy, Family Leave Policy, Sexual Misconduct Policy, Recruitment and Selection Policy, and Mandatory Learning Policy.

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.

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
0	0

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	0
51%-99%	0
100%	0

Percentage of pay bill spent on facility time

Description	Figure
Total cost of facility time	0
Total pay bill	0
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0

Paid trade union activities

Description	Figure
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	0

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 35 colleagues who reached long service milestones during 2025/26.

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 continually reviewed during 2025/26 to ensure it meets the needs of our staff.

Our offer includes:

- Counselling support – new for 2025/26
- Health and wellbeing workshops – topics included men's health, back care, relaxation, self-acceptance, managing stress and burnout, building self-confidence, managing bereavement and grief, self-care, and introduction to sleep
- My Wellbeing Plan – 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
- Staff Psychological and Wellbeing Hub
- NHS Health Checks.

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. The group meets on a monthly basis.

Employee voice – Staff Survey

The Staff Survey ran from 6 October to 28 November 2025. There was an excellent response rate of 76% which is above average for similar organisations (66%).

Feedback 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.

Employee voice – People Pulse

We continue to participate in the NHS People Pulse which expertly facilitates regular staff 'temperature checks' throughout the year.

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.

Public Sector Equality Duty (PSED)

Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) remains fully committed to meeting our responsibilities under the Equality Act's Public Sector Equality Duty (PSED) and to being transparent about how we are advancing equality for our workforce and the populations we serve.

The PSED is supported by the Specific Duties Regulations, which require public bodies in England to publish information demonstrating compliance with the Equality Duty at least annually, and to publish equality objectives every four years. Many public organisations, including NHS bodies, publish their workforce and service-related equality information by the end of March each year to ensure compliance with the annual publication duty.

Integrated Care Boards across England are currently undergoing a period of significant change linked to the national ICB Blueprint, including organisational reform, new cluster arrangements and restructuring. As part of this transition, our annual PSED Workforce and Patient Equality Reports are progressing through updated internal governance routes, including review by our recently formed Executive and Senior Leadership Teams.

The ICB continues to undertake all required equality, diversity and inclusion duties in practice. When published, the full PSED Workforce and Patient Equality Reports can be found on our website: Equality, Diversity, Inclusion and Human Rights - SSOT (ICB).

The ICB remains committed to upholding our statutory duties, reducing inequalities, and ensuring our decision-making is fair and inclusive for our workforce and meets the needs of our diverse communities.

Workforce diversity profile and recruitment reporting

As of September 2025, the ICB employed 484 staff, following the TUPE transfer of the Continuing Healthcare (CHC) team. The workforce continues to be mid to late career, strongly female, with modest improvements in ethnic diversity and disability declaration. High nondisclosure rates and disparities in recruitment outcomes highlight key areas for strengthened Public Sector Equality Duty (PSED) and Equality, Diversity and Inclusion (EDI) action.

Progress includes improved senior ethnic representation, rising disability declaration, and enhanced female leadership. However:

- Recruitment outcomes for disabled and Black candidates require review.
- High nondisclosure at appointment stage limits PSED transparency.
- Early career underrepresentation persists, weakening long-term succession.
- Gender imbalance between Ageda for Change (AfC) and Non AfC roles remains.
- Directorate variation indicates the need for tailored EDI plans rather than a single ICB wide approach.

As ICB reform and cluster arrangements with Shropshire, Telford and Wrekin (STW) Integrated Care Board (ICB) continue, establishing a consistent cross ICB approach to workforce equality and PSED delivery will be crucial for accountability and improved outcomes.

Race Equality Code (REC)

As part of our ongoing commitment to advancing race equality through leadership, the Race Equality Code (REC) programme was paused during 2025/26. This reflects a strategic focus on delivering core Equality, Diversity and Inclusion (EDI) and Public Sector Equality Duty (PSED) responsibilities, while supporting leaders and staff through the Management of Change processes associated with the ICB restructure and clustering arrangements set out in the ICB Blueprint.

The programme will be reviewed and, if taken forward, will be realigned alongside the development of refreshed EDI and PSED strategies, aims, and objectives through the EDI framework.

Gender Pay Gap (GPG)

The table below provides our GPG reporting data for 2024 and 2025.

Gender	2025 average hourly rate	2025 median hourly rate	2024 average hourly rate	2024 median hourly rate
Male	£40.34	£33.87	£38.72	£31.79
Female	£30.84	£27.49	£28.00	£25.60
Difference	£9.49	£6.38	£10.73	£6.19
Pay gap %	**23.54%**	**18.85%**	**27.71%**	**19.46%**

This year's gender pay gap figures should be interpreted with caution due to the significant organisational changes currently taking place within the ICB. The workforce has grown significantly since the previous reporting period, and further substantial changes are expected as the new cluster structures and Management of Change processes are completed. Due to this shifting workforce profile, comparing this year's results with previous years would not provide a reliable or meaningful assessment of trends.

Any targeted actions based on this year's figures may also become quickly outdated as the new staffing structure is finalised. Once the new organisation design is fully embedded and workforce numbers stabilise, the ICB will be in a stronger position to undertake a more accurate analysis of the gender pay gap and implement actions that reflect the future workforce.

ICB Equality, Diversity and Inclusion (EDI) objectives

Both Staffordshire and Stoke-on-Trent ICB and Shropshire, Telford and Wrekin ICB have proposed an EDI framework which will be supported by both workforce and patient/population focused equality. Objectives will focus on aligning policies, data practices, leadership responsibilities, and cultural expectations across the cluster ICBs to create a coherent and collaborative Equality, Diversity and Inclusion (EDI) and Public Sector Equality Duty (PSED) agenda. The intention is to build a shared framework that supports inclusive employment practices, improves workforce experience, and ensures that both ICBs continue to meet their statutory duties while adapting to the evolving reform landscape. This work will require sustained engagement, careful change management and a continued emphasis on staff wellbeing and communication throughout the transition.

Executive EDI objectives

Individual EDI objectives for our Executive team will be produced and aligned to their specific directorates, roles and responsibilities.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

NHS Integrated Care Boards (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 is what we do and is reflected in the PSED workforce reports.

The ICB has also shared its WRES and WDES data with the wider Integrated Care System.

Equality and Health Inequalities Impact Assessments (EHIA)

During 2025–2026, the Integrated Care Board (ICB) continued to embed a comprehensive and systematic approach to Equality and Health Inequality Impact Assessments (EHIAs) across all major programmes, policies, service transformations and organisational functions. The EHIA Tracker shows strong and consistent engagement across multiple directorates, evidencing the ICB's commitment to meeting the Public Sector Equality Duty (PSED), reducing health inequalities, and ensuring inclusive decision making.

Overall, the breadth and depth of EHIAs completed in 2025–2026 highlight a mature, organisation wide approach to advancing equality, eliminating discrimination, and addressing health inequalities. The structured recording, follow up actions, and multi-directorate ownership provide a strong platform for ongoing compliance with the Public Sector Equality Duty and for driving equitable outcomes for both the workforce and local population.

ICB staff can access both one-to-one training and mandated EHIA training to support in the understanding and completing Equality Health Impact Assessments.

ICB staff networks

During 2025/26, 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 our colleagues 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, Simon Whitehouse.
- Staff Engagement Group (SEG) – monthly meetings with staff representatives for the sharing of feedback and organisation updates.
- IAN – our staff intranet site, where we host key updates and information, policies and procedures and opportunities.

Our learning and development

Our learning and development offer is continually revised throughout the year. Our offer for 2025/26 included:

- Apprenticeships as part of Workforce Development, ranging from Level 2 to Level 7
- Coaching and mentoring support
- More than 10 colleagues attended the Manager as Coach programme during 2025/26
- Communicating with impact workshops
- NHS Leadership Academy
- NHS Midlands (Regional) training and development
- Health and wellbeing training and workshops
- Microsoft/IT software workshops
- HR training on key topics such as absence management and performance
- Financial and pension advice
- Statutory and mandatory e-learning
- Mandated training including the Oliver McGowan mandatory training course on learning disability and autism
- Equality, diversity and inclusion (EDI) training – We launched our new EDI staff training package in June 2025. This mandatory training included Reasonable Adjustments training and Equality and Health Impact Assessment (EHIA) training. As of February 2026, 238 members of staff have attended these sessions to date.

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 25 qualified coaches and mentors, three of whom successfully achieved their ILM Level 5 Coaching and Mentoring qualification during 2025/26. Since 1 April 2025, our internal coaches and mentors have delivered almost 100 sessions (as of February 2026), which equates to almost 100 hours of personalised support.

In summer 2025, our coaches launched one-hour confidential ‘coaching conversations’ to support staff during the ICB Reform. Almost 20 members of staff have taken up this offer.

Alongside this, 48 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.

We are part of the Staffordshire and Stoke-on-Trent ICS Coaching and Mentoring Consortium, which meets on a monthly basis to share coaching and mentoring resources and best practices.

People, culture and inclusion

In a year marked by increasing financial pressures and the workforce implications of NHS Reform, the ICS has continued to deliver impactful initiatives that support the existing workforce and open new pathways for people aspiring to careers in health and social care.

The People, Culture and Inclusion Annual Report highlights these achievements and the collective effort behind them.

As we enter the next phase for our system and the Cluster ICB, we will work with People leads and stakeholders to define our future direction, aligned with the ICB Blueprint Model. Central to this will be our commitment to socio-economic development, our anchor employer role, and improving population health through employment and education.

Widening access and participation

- **The Careville® Primary School Engagement Strategy:** Developed in early 2025, this strategy supports reduced health inequalities and improved population health across Staffordshire and Stoke-on-Trent. Aligned to the CYP portfolio, it embeds prevention, wellbeing and early intervention through three themes – Healthy Me, Happy Me, and Future Me. Future Me includes a co-produced animation and six classroom resources.
- **Health and Care Careers Roadshow:** Two events were delivered in late 2025 at Newcastle College and the Stoke-on-Trent and Staffordshire Institute of Technology. They were attended by a total of 285 Year 10 and 11 students from 15 schools across the county. Three partners delivered 15 workshops between them, alongside 26 exhibition stands hosted by 11 partners.
- **Virtual Work Experience (VWEX):** Hosted by Springpod, the VWEX Careers Hub continued for a second year alongside the launch of a new digital careers programme – the system's first non-clinical offer. The programmes have engaged around 4,000 students, providing schools and colleges with a flexible, modern workplace experience that broadens access to health and care careers.
- **Outreach and inclusion:**
    - 13 young asylum seekers aged 18-21 participated in the successful Summer School seven-week programme – improving Maths, English and teaching employability skills.
    - We are one of five national pilot sites for the Care Leaver programme, and have supported 25 young adults into the sector.
    - We made contact with 817 people in 2025, and supported more than 100 into work, education, training or volunteering.

Education, training and development

- **T-Levels:** System partners have supported 106 students with placements across health and social care settings in Staffordshire and Stoke-on-Trent. We have released five episodes of our new T-Levels Mini Series podcast.
- **Future Leaders:** Four programmes took place with approximately 70 students from Derby, Keele and Staffordshire taking part. We launched 10 episodes of our podcast titled Clinical Education: The Placement Perspective.
- **Apprenticeships:** The long-running Healthcare Support Worker apprenticeship closed, having enrolled 62 apprentices with a retention rate of 72%. A further 11 apprentices have completed the Pharmacy Technician programme, with 79% remaining in employment across the pharmacy sector. Ten Physician Associate Apprentices are currently working within the system, and will complete their apprenticeship after sitting their exams in May 2026.

Employee experience, health and wellbeing

- **Free health checks:** Sourced for all system employees, aligned to the prevention agenda.
- **Mental Health First Aid Training:** 76 system employees trained so far.
- **Virtual health and wellbeing sessions (Optima Health):** 43 courses ran during 2025/26.
- **Sexual Safety Charter:** Implementation to include primary care and two Sexual Safety conferences, attracting more than 150 members of staff.
- **Social Care Staff Wellbeing Champions:** 80 champions recruited to date.
- **Joint NHS Occupational Health Contract:** Continued strategic oversight of the contract, working closely with partners to ensure optimum delivery of services and value for money for our people.

Resourcing

- **System redeployment:** Successfully redeployed 18 employees, retaining skills and talent in the system – and saving £178,000 in redundancy costs.
- **ICS People Hub:** After successfully providing a contingent flexible workforce for the system for more than five years, the ICS People Hub closed in May 2025.

Equality, diversity and inclusion

- **Staff resources:** Including the creation of an ICS staff network leadership collaborative group and MS Teams channel.
- **Network events:** Including an online ICS staff networks event in July 2025 and an in-person event in September 2025 – to support and develop the collaborative group.
- **Calendar of inclusion awareness events:** Shared across the system to ensure key inclusion events were observed.
- **WRES Champions:** Established ICS collaborative monthly meetings to drive sustainable change on shared priorities relating to key workforce race inclusion metrics.
- **Anti racism:** Launched an ICS toolkit and comprehensive support offer. Created six 'Lunch and Learn' programmes with more than 180 enrolments from colleagues across the ICS.

Expenditure on consultancy

The ICB expensed £1,927k for 2025/26 (2024/25: £1,635k). 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.

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 2025/26.

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2025 to 31 March 2026:

Description	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period (1)	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 reporting period. This figure should include both on payroll and off-payroll engagements (2)	14

Exit packages (subject to audit)

There are 210 agreed Exit packages in the financial year ended 31st March 2026. These arise following the Government Reset programme which was launched on 13th March 2025. There are a combination of voluntary, classified as other agreed departures in the table below and compulsory redundancies which have occurred or are scheduled to occur over the coming months. All Management of Change consultations have been launched – some have been completed whilst others remain in progress.

The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Redundancy and other departure costs have been paid in accordance with the provisions of NHS England guidance. Where the NHS Staffordshire & Stoke-on-Trent ICB has agreed early retirements, the additional costs are met by the NHS Staffordshire & Stoke-on-Trent ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included.

Note 4.3 Exit packages agreed during the reporting period

	2025-26 Compulsory redundancies		2025-26 Other agreed departures		2025-26 Total	
	Number	£	Number	£	Number	£
Less than £10,000	4	21,703	5	35,455	9	57,158
£10,001 to £25,000	22	407,832	20	350,234	42	758,066
£25,001 to £50,000	27	1,014,207	20	745,387	47	1,759,594
£50,001 to £100,000	19	1,186,790	27	1,931,134	46	3,117,924
£100,001 to £150,000	17	1,764,265	34	4,087,929	51	5,852,194
£150,001 to £200,000	2	343,666	12	2,111,968	14	2,455,634
Over £200,001	1	208,908	-	-	1	208,908
Total	**92**	**4,947,371**	**124**	**9,839,701**	**210**	**14,209,478**

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.

Simon Whitehouse
Accountable Officer
17 June 2026

Annual Accounts

NHS Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)

Please find a full copy of our annual accounts following this page.

Simon Whitehouse

Accountable Officer

17 June 2026

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 2026

Statement of Comprehensive Net Expenditure	Note	2025-26 £'000	2024-25 £'000
Income from sale of goods and services	2	(40,466)	(38,629)
Other operating income	2	(62)	(160)
Total operating income	-	**(40,528)**	**(38,789)**
Staff costs	4	47,778	24,046
Purchase of goods and services	5	3,331,336	3,201,409
Depreciation and impairment charges	5	299	280
Provision expense	5	4,535	2,806
Other operating expenditure	5	2,062	2,097
Total operating expenditure	-	**3,386,011**	**3,230,638**
Net Operating expenditure	-	**3,345,483**	**3,191,849**
Finance expense	7	2	5
Net expenditure for the Year	-	**3,345,485**	**3,191,854**

The notes on pages 130-157 form part of this statement.

Statement of Financial Position as at 31 March 2026

Statement of Financial Position	Note	2025-26 £'000	2024-25 £'000
Non-current assets:			
Property, plant and equipment	8	115	144
Right-of-use assets	9	111	332
Intangible assets	10	161	210
Total non-current assets	-	**386**	**686**
Current assets:			
Trade and other receivables	11	20,918	24,125
Cash and cash equivalents	12	597	1,253
Total current assets	-	**21,515**	**25,378**
Total assets	-	**21,901**	**26,063**
Current liabilities			
Trade and other payables	13	(178,752)	(174,880)
Lease liabilities	9	(32)	(208)
Provisions	14	(10,000)	(6,749)
Total current liabilities	-	**(188,784)**	**(181,838)**
Assets less Liabilities	-	**(166,883)**	**(155,774)**
Financed by Taxpayers' Equity			
General fund	-	(166,883)	(155,774)
Total taxpayers' equity:	-	**(166,883)**	**(155,774)**

The notes on pages 130-157 form part of this statement.

The financial statements on pages 126-129 were approved by the Governing Body on 17 June 2026 and signed on its behalf by:

Simon Whitehouse

Chief Accountable Officer

17 June 2026

Statement of Changes in Taxpayers Equity for the year ended 31 March 2026

Changes in tax payers' equity for 2025-26	General fund £'000	Total reserves £'000
Balance at 1 April 2025	**(155,774)**	**(155,774)**
Changes in NHS ICB taxpayers' equity for 2025-26		
Net expenditure for the financial year	(3,345,485)	(3,345,485)
Net Recognised NHS ICB Expenditure for the Financial year	**(3,345,485)**	**(3,345,485)**
Net funding	3,334,377	3,334,377
Balance at 31 March 2026	**(166,883)**	**(166,883)**

Changes in taxpayers' equity for 2024-25	General fund £'000	Total reserves £'000
Balance at 1 April 2024	**(140,489)**	**(140,489)**
Changes in NHS ICB taxpayers' equity for 2024-25		
Net expenditure for the financial year	(3,191,854)	(3,191,854)
Net Recognised NHS ICB Expenditure for the Financial Year	**(3,191,854)**	**(3,191,854)**
Net funding	3,176,569	3,176,569
Balance at 31 March 2025	**(155,774)**	**(155,774)**

The notes on pages 130-157 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Cash flows from operating activities			
Net operating expenditure for the financial year	-	(3,345,483)	(3,191,849)
Depreciation and amortisation	5	299	280
Decrease in trade & other receivables	11	3,206	13,957
Increase/(decrease) in trade & other payables	13	3,871	(355)
Provisions utilised	14	(1,283)	(836)
Increase in provisions	14	4,535	2,806
Net cash outflow from operating activities	-	**(3,334,855)**	(3,175,998)
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	-	**(3,334,855)**	(3,176,352)
Cash flows from financing activities			
Grant in Aid Funding Received	-	3,334,377	3,176,569
Repayment of lease liabilities	-	(178)	(388)
Net cash inflow from financing activities	-	**3,334,199**	3,176,181
Net decrease in cash & cash equivalents	12	**(656)**	(170)
Cash & cash equivalents at the beginning of the financial year	-	**1,253**	1,424
Cash & cash equivalents (including bank overdrafts) at the end of the financial year	-	**597**	1,253

The notes on pages 130-157 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 2025-26 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 Pooled budgets

The ICB has entered into a joint arrangement with both Staffordshire County Council and Stoke 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 18 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.

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. 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 & 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.

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 1.11.1 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.

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.

From 1 April 2025, intangible assets are carried at cost. Where intangible assets have been carried historically under a revaluation approach following initial recognition, the carrying net amount as 31 March 2025 will be considered to be the deemed historic cost. In accordance with the GAM this change in valuation is being applied prospectively.

Note 1.11.3 Depreciation, amortisation & 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.

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.

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

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

Note 1.17.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

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 or assets measured at fair value through other comprehensive income, 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.

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 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 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.

As IFRS 18 is presentational and IFRS 19 relates to subsidiaries, for which the ICB has none, there is no requirement for the ICB to provide a calculated impact assessment.

Note 2. Other operating income

	2025-26 Total £'000	2024-25 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**1,298**	1,880
Prescription fees and charges	**15,843**	15,932
Dental fees and charges	**20,663**	18,210
Other Contract income	**2,662**	2,607
Total Income from sale of goods and services	**40,466**	**38,629**
Other operating income		
Other non contract revenue	**62**	160
Total Other operating income	**62**	**160**
Total Operating Income	**40,528**	**38,789**

Note 3.1 Disaggregation of income - income from sale of good and services (contracts)

	2025-26			
Source of Revenue	**Education, training and research £'000**	**Prescription fees and charges £'000**	**Dental fees and charges £'000**	**Other Contract income £'000**
NHS	1,298	-	-	-
Non NHS	-	15,843	20,663	2,662
Total	**1,298**	**15,843**	**20,663**	**2,662**
Timing of Revenue				
Point in time	1,298	15,843	20,663	2,662
Total	**1,298**	**15,843**	**20,663**	**2,662**

	2024-25			
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				
Point in time	1,880	15,932	18,210	2,607
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

4.1.1 Employee benefits

Employee Benefits	Total Permanent Employees £'000	Total Other £'000	2025-26 Total £'000
Salaries and wages *	22,993	2,704	**25,697**
Social security costs	3,082	13	**3,095**
Employer Contributions to NHS Pension scheme	5,105	17	**5,123**
Apprenticeship Levy	98	-	**98**
Termination benefits **	14,210	-	**14,210**
Gross employee benefits expenditure	**45,488**	**2,735**	**48,222**
Less recoveries in respect of employee benefits	(255)	(190)	**(445)**
Total - net admin employee benefits	**45,233**	**2,545**	**47,778**

* Salaries and wages have increased significantly when compared to 2024/25 as a result of in housing the All Age Continuing Care service from Midlands and Lancashire CSU from 1st April 2025. Further analysis of whole-time equivalent numbers can be found in note 4.2.

** There are 210 exit packages in the financial year ended 31st March 2026. These arise following the Government Reset programme which was launched on 13th March 2025. There are a combination of voluntary and compulsory redundancies which have occurred or are scheduled to occur over the coming months. All Management of Change consultations have been launched – some have been completed whilst others remain in progress.

Employee Benefits	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**

Note 4.1.2 Recoveries in respect of employee benefits

Employee Benefits	2025-26 Permanent Employees £'000	2025-26 Other £'000	2025-26 Total £'000
Salaries and wages	(255)	(190)	(445)
Total recoveries in respect of employee benefits	**(255)**	**(190)**	**(445)**

Note 4.2 Average number of people employed

	2025-26 Permanently employed Number	2025-26 Other Number	2025-26 Total Number	2024-25 Permanently employed Number	2024-25 Other Number	2024-25 Total Number
Total	**395.02**	**12.19**	**407.21**	277.14	14.36	291.50

Note 4.3 Exit packages agreed during the reporting period

	2025-26 Compulsory redundancies Number	2025-26 Compulsory redundancies £	2025-26 Other agreed departures Number	2025-26 Other agreed departures £	2025-26 Total Number	2025-26 Total £
Less than £10,000	4	21,703	5	35,455	9	57,158
£10,001 to £25,000	22	407,832	20	350,234	42	758,066
£25,001 to £50,000	27	1,014,207	20	745,387	47	1,759,594
£50,001 to £100,000	19	1,186,790	27	1,931,134	46	3,117,924
£100,001 to £150,000	17	1,764,265	34	4,087,929	51	5,852,194
£150,001 to £200,000	2	343,666	12	2,111,968	14	2,455,634
Over £200,001	1	208,908	-	-	1	208,908
Total	**92**	**4,947,371**	**124**	**9,839,701**	**210**	**14,209,478**

There were no exit packages agreed during the 2024-25 reporting period.

Analysis of Other Agreed Departures

	2025-26 Other agreed departures Number	2025-26 Other agreed departures £	2024-25 Other agreed departures Number	2024-25 Other agreed departures £
Voluntary redundancies including early retirement contractual costs	124	9,839,701	-	-
Total	**124**	**9,839,701**	-	-

Note 4.3 Exit packages agreed during the reporting period (continued)

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

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”.

An outline of these follows:

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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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.

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.

Note 4.4 Pension costs (continued)

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

	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	6,318	13,387
Services from foundation trusts	910,937	823,357
Services from other NHS trusts	1,332,970	1,240,878
Services from Other WGA bodies	1	2
Purchase of healthcare from non-NHS bodies	345,956	406,794
Purchase of social care	43,532	44,679
General Dental services and personal dental services	74,175	71,098
Prescribing costs	238,331	240,178
Pharmaceutical services	53,283	47,768
General Ophthalmic services	23,124	25,367
GPMS/APMS and PCTMS	264,157	246,681
Supplies and services – clinical	593	601
Supplies and services – general	14,014	16,661
Consultancy services	1,927	1,635
Establishment	4,898	5,611
Transport	10,080	9,852
Premises	5,151	4,770
Audit fees *	270	270
Other non statutory audit expenditure		
· Internal audit services	84	132
· Other services	37	37
Other professional fees	248	142
Legal fees	887	944
Education, training and conferences	362	566
Total Purchase of goods and services	**3,331,336**	**3,201,409**
Depreciation and impairment charges		
Depreciation	250	280
Amortisation	49	-
Total Depreciation and impairment charges	**299**	**280**
Provision expense		
Provisions	4,535	2,806
Total Provision expense	**4,535**	**2,806**
Other Operating Expenditure		
Chair and Non Executive Members	117	143
Grants to Other bodies	258	-
Research and development (excluding staff costs)	1,414	1,855
Expected credit loss on receivables	159	-
Other expenditure	115	98
Total Other Operating Expenditure	**2,062**	**2,097**
Total operating expenditure	**3,338,233**	**3,206,592**

Note 5. Operating expenditure (continued)

* The external audit fee is inclusive of VAT.

The auditor's liability for external audit work carried out throughout the period is limited to £2m.

Note 6. Better payment practice code

Measure of compliance	2025-26 Number	2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Non-NHS Trade invoices paid in the Year	41,995	740,720	54,130	789,349
Non-NHS Trade Invoices paid within target	41,262	729,054	53,630	774,818
Non-NHS Trade invoices paid within target	**98.25%**	**98.43%**	**99.08%**	**98.16%**
NHS Payables				
NHS Trade Invoices Paid in the Year	4,167	2,251,131	2,832	2,101,830
NHS Trade Invoices Paid within target	4,151	2,250,838	2,822	2,101,432
NHS Trade Invoices paid within target	**99.62%**	**99.99%**	**99.65%**	**99.98%**

The Better Payment Practice Code requires the ICB to pay valid invoices by their due date or within 30 days of receipt of the invoices, whichever is the later.

Note 7. Finance Costs

	2025-26 £'000	2024-25 £'000
Interest		
Interest on lease liabilities	2	5
Total interest	**2**	**5**
Total finance costs	**2**	**5**

Note 8.1 Property, plant & equipment

2025-26	Information technology £'000	Total £'000
Cost or valuation at 01 April 2025	144	144
Cost/Valuation at 31 March 2026	**144**	**144**
Depreciation 01 April 2025	-	-
Charged during the year	29	29
Depreciation at 31 March 2026	**29**	**29**
Net Book Value at 31 March 2026	**115**	**115**
Purchased	115	115
Total at 31 March 2026	**115**	**115**

Note 8.1 Property, plant & equipment (continued)

2024-25	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	-	-
Charged during the year	-	-
Depreciation at 31 March 2025	**-**	**-**
Net Book Value at 31 March 2025	**144**	**144**
Purchased	-	144
Total at 31 March 2025	**144**	**144**

Note 8.2 Economic lives of property, plant & equipment

	Minimum Life (years)	Maximum Life (Years)
Information Technology	1	5

Note 9.1 Right-of-use assets

2025-26	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2025	1,198	1,198
Cost/Valuation at 31 March 2026	**1,198**	**1,198**
Depreciation 01 April 2025	866	866
Charged during the year	221	221
Depreciation at 31 March 2026	**1,087**	**1,087**
Net Book Value at 31 March 2026	**111**	**111**

The net book value at 31 March 2026 relates to a non-clinical building leased from Stoke 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 9.1 Right-of-use assets (continued)

2024-25	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**

Note 9.2 Lease liabilities

	2025-26 £'000	2024-25 £'000
Lease liabilities at 01 April 2025	(208)	(623)
Interest expense relating to lease liabilities	(2)	(5)
Repayment of lease liabilities (including interest)	178	389
Lease remeasurement	-	31
Lease liabilities at 31 March 2026	**(32)**	**(208)**

Note 9.3 Lease liabilities - maturity analysis of undiscounted future lease payments

	2025-26 £'000	2024-25 £'000
Within one year	(32)	(208)
Balance at 31 March 2026	**(32)**	**(208)**

Note 9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2025-26 £'000	2024-25 £'000
Depreciation expense on right-of-use assets	221	280
Interest expense on lease liabilities	2	5

Note 9.5 Amounts recognised in Statement of Cash Flows

	2025-26 £'000	2024-25 £'000
Total cash outflow on leases under IFRS 16	178	389

Note 10.1 Intangible non-current assets

2025-26	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2025	**210**	**210**
Cost / Valuation At 31 March 2026	**210**	**210**
Amortisation 01 April 2025	**-**	**-**
Charged during the year	49	**49**
Amortisation At 31 March 2026	**49**	**49**
Net Book Value at 31 March 2026	**161**	**161**

2024-25	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	**-**	**-**
Charged during the year	-	**-**
Amortisation At 31 March 2025	**-**	**-**
Net Book Value at 31 March 2025	**210**	**210**

Note 10.2 Economic lives of intangible assets

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	1	5

Note 11. Receivables

Note 11.1 Trade and other receivables

	Current 2025-26 £'000	Current 2024-25 £'000
NHS receivables: Revenue	939	2,531
NHS prepayments	7	-
NHS accrued income	5,466	4,448
Non-NHS and Other WGA receivables: Revenue	7,217	8,486
Non-NHS and Other WGA prepayments	1,469	665
Non-NHS and Other WGA accrued income	1,476	1,780
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	3,699	5,774
Expected credit loss allowance-receivables	(398)	(239)
VAT	1,029	676
Other receivables and accruals	13	3
Total Trade & other receivables	**20,918**	**24,125**

As at 31 March 2026 there were no non-current trade and other receivables.

Note 11.2 Receivables past their due dates but not impaired

	2025-26		2024-25	
	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000
By up to three months	21	3,908	2,110	2,712
By three to six months	-	-	6	1,417
By more than six months	378	949	-	4,085
Total	**399**	**4,857**	**2,116**	**8,214**

Note 11.3 Loss allowance on asset classes

2025-26	Trade and other receivables - Non DHSC Group Bodies £'000	Total £'000
Balance at 01 April 2025	(239)	(239)
Lifetime expected credit losses on trade and other receivables	(159)	(159)
Total	**(398)**	**(398)**

Note 11. Receivables (continued)

2024-25	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

	2025-26 £'000	2024-25 £'000
Balance at 01 April 2025	1,253	1,424
Net change in year	(656)	(170)
Balance at 31 March 2026	**597**	**1,253**
Made up of:		
Cash with the Government Banking Service	597	1,253

Note 13. Trade and other payables

13 Trade and other payables	Current 2025-26 £'000	Current 2024-25 £'000
NHS payables: Revenue	3,003	9,073
NHS accruals	20,825	2,947
Non-NHS and Other WGA payables: Revenue	13,107	19,010
Non-NHS and Other WGA accruals	125,443	123,703
Social security costs	369	243
Tax	381	276
Other payables and accruals *	15,624	19,628
Total Trade & Other Payables	**178,752**	**174,880**

As at 31 March 2026 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 5 years.

* Other payables include £1.918m outstanding pension contributions as at 31 March 2025 (2024-25: £1.808m).

Note 14. Provisions

	Current 2025-26 £'000	Current 2024-25 £'000
Continuing care	4,912	2,619
Other *	5,088	4,131
Total Provision	**10,000**	**6,749**

Note 14. Provisions (continued)

* 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.

VAT on wheelchair contracts – ongoing review where the outcome may result in the ICB having to settle liability.

	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2025	**2,619**	**4,131**	**6,749**
Arising during the year	4,342	2,847	**7,189**
Utilised during the year	(88)	(1,196)	**(1,283)**
Reversed unused	(1,961)	(694)	**(2,654)**
Balance at 31 March 2026	**4,912**	**5,088**	**10,000**
Expected timing of cash flows:			
Within one year	4,912	5,088	**10,000**
Balance at 31 March 2026	**4,912**	**5,088**	**10,000**

Note 15. 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:

	2025-26 £'000	2024-25 £'000
In not more than one year	1,353	1,284
In more than one year but not more than five years	5,411	5,136
In more than five years	7,553	8,454
Total	**14,317**	**14,874**

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 16. 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 16.1 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 16.1.1 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 16.1.2 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 16.1.3 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 16. Financial instruments (continued)

Note 16.2 Financial assets

	2025-26 Financial Assets measured at amortised cost £'000	2025-26 Total £'000	2024-25 Financial Assets measured at amortised cost £'000	2024-25 Total £'000
Trade and other receivables with NHSE bodies	2,286	**2,286**	1,928	1,928
Trade and other receivables with other DHSC group bodies	4,120	**4,120**	5,357	5,357
Trade and other receivables with external bodies	12,405	**12,405**	15,737	15,737
Cash and cash equivalents	597	**597**	1,253	1,253
Total	**19,408**	**19,408**	24,275	24,275

Note 16.3 Financial liabilities

	2025-26 Financial Liabilities measured at amortised cost £'000	2025-26 Total £'000	2024-25 Financial Liabilities measured at amortised cost £'000	2024-25 Total £'000
Trade and other payables with NHSE bodies	1,190	**1,190**	2,056	2,056
Trade and other payables with other DHSC group bodies	22,639	**22,639**	9,790	9,790
Trade and other payables with external bodies	154,174	**154,174**	162,516	162,516
Private Finance Initiative and finance lease obligations	32	**32**	208	208
Total	**178,034**	**178,034**	174,570	174,570

Note 17. Operating segments

The ICB considers that it has only one operating segment: commissioning of healthcare services.

	2025-26					
	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Total	**3,386,013**	**(40,528)**	**3,345,485**	**21,901**	**(188,784)**	**(166,883)**

	2024-25					
	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Total	3,230,643	(38,789)	3,191,854	26,063	(181,838)	(155,774)

Note 18. Pooled budgets

The ICB has entered into pooled budget arrangements with both Staffordshire County Council and Stoke 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	2025-26 Expenditure £'000	2024-25 Expenditure £'000
Better Care Fund	Staffordshire Council	Adult Social Care	24,578	23,649
Better Care Fund	Staffordshire Council	Implementation of the Care Act	2,692	2,590
Better Care Fund	Staffordshire Council	Carers Hub	819	788
Better Care Fund	Staffordshire Council	Health Tasks	2,827	2,286
Better Care Fund	Staffordshire Council	Step Across	1,750	2,742
Better Care Fund	Stoke City Council	Adult Social Care	13,539	13,028
Better Care Fund	Stoke City Council	Partnership & Effectiveness Posts	40	137
Better Care Fund	Stoke City Council	Health Tasks	646	646
			46,891	**45,865**

Note 19. Losses and special payments

Losses:

No losses were reported during 2025/26 (2024/25: £0)

Special payments:

	Total Number of Cases 2025-26 Number	Total Value of Cases 2025-26 £'000	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Compensation payments (*HM Treasury Approved*) *	1	110	-	-
Ex Gratia Payments	1	4	1	58
Total	**2**	**114**	**1**	**58**

* A special payment was made to resolve a complaint regarding the failure to assess and provide Continuing Care funding between 2010 and 2015.

Note 20. Related parties

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 (£33m):

- University Hospitals of North Midlands NHS Trust (Integrated Care System partner)
- Midlands Partnership University NHS Foundation Trust (Integrated Care System partner)
- North Staffordshire Combined Healthcare NHS Trust (Integrated Care System 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. Events after the reporting period

There are no events after the reporting period that would impact the income, expenditure, assets or liabilities recorded within the financial statements for the reporting period.

Note 22. Financial performance target

The NHS Staffordshire & Stoke-on-Trent Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended), performance against those duties was as follows:

	2025-26 Target	2025-26 Performance	2024-25 Target	2024-25 Performance
Revenue resource use does not exceed the amount specified in Directions	3,346,226	3,345,485	3,176,960	3,191,854
Revenue administration resource use does not exceed the amount specified in Directions	29,411	28,717	20,802	20,222

Note 22. Financial performance target (continued)

As can be seen from the table above, the ICB remained within its statutory target for both administration resource and overall revenue resource during the reporting period.

Note 23. Mental health expenditure

The ICB is required by NHS England to spend a proportion of its overall allocation on mental health services to meet the Mental Health Investment Standard (MHIS). The required level of spend to meet the MHIS is set by NHS England for each ICB.

	2025-26 £'000	2024-25 £'000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	271,036	240,400
Eligible mental health expenditure	271,093	240,500
Mental health expenditure above minimum investment required	57	100
Mental health expenditure as a proportion of total expenditure	8.10%	7.53%

Mental health expenditure accounted for 8.1% of the ICB's total expenditure during 2025/26 (7.53% in 2024/25). This represents an increase of 0.57% from the previous year. The increase reflects a higher proportion of the ICB's overall expenditure being directed towards mental health services during the year.

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 2026, 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 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 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 2025-26; 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 2025-26 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 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 2025-26 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 2025-26; 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.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, 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.

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.

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 2025-26).
- 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 and year end 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 and year end journals
    - challenging assumptions and judgements made by management in its significant year end 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 expenditure recognition, and the significant accounting estimates related to expenditure 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 2026.
We have nothing to report in respect of the above matter.

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 March 2026. 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 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules and 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 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

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

18 June 2026

Acronyms

A&E – Accident and Emergency
ADHD – attention deficit hyperactivity disorder
AGS – Annual Governance Statement
AHP – Allied Health Professional
CAF – Cyber Assurance Framework
CAMHS – child and adolescent mental health services
CCRA – Climate Change Risk Assessment
CDOP – Child Deaths Overview Panel
CEO – Chief Executive Officer
CETV – cash equivalent transfer value
CFO – Chief Finance Officer
CHC – Continuing Healthcare
CMO – Chief Medical Officer
COPD – chronic obstructive pulmonary disease
CPIS – Child Protection Information Sharing
CQC – Care Quality Commission
CSCS – Construction Skills Certification Scheme
CVD – cardiovascular disease
CYA – children and young adult
CYP – children and young people
D2A – Discharge to Assess
DHSC – Department of Health and Social Care
DPN – Deteriorating Patient Network
DSF – Deficit Support Funding
DSPT – Data Security and Protection Toolkit
ED – Emergency Department
EDI – Equality, Diversity and Inclusion
EeRS – Electronic Eyecare Referral Service
EHIA – Equality and Health Inequalities Impact Assessment
EPaCCS – Electronic Palliative Care Coordination System
EPR – Electronic Patient Record
EPRR – Emergency Preparedness, Resilience and Response
EQIA – Equality and Quality Impact Assessment
ESCA – Essential Shared Care Agreements

FFP – Families First Partnership

FOI – Freedom of Information

FTSU – Freedom to Speak Up

GAM – Group Accounting Manual

GIRFT – Getting It Right First Time

GP – General Practitioner

GTT – glucose tolerance testing

HMT – His Majesty's Treasury

HR – Human Resources

HWB – Health and Wellbeing Board

ICB – Integrated Care Board

ICC – integrated care coordination

ICP – Integrated Care Partnership

ICS – Integrated Care System

IFR – Individual Funding Request

IG – Information Governance

IHA – Initial Health Assessment

INT – Integrated Neighbourhood Team

IPC – Institute of Public Care

JESIP – Joint Emergency Services Interoperability Principles

JFP – Joint Forward Plan

JSNA – Joint Strategic Needs Assessment

JSSAT – Joint Safeguarding Self-Assurance Tool

LCFS – Local Counter Fraud Specialist

LD – learning disabilities

LeDeR – Learning from Lives and Deaths of people with learning disabilities and autism

LEV – low emission vehicle

LIF – Locality Improvement Framework

LMNS – Local Maternity and Neonatal System

LTC – long-term condition

MACPT – multi-agency child protection teams

MARS – mutually-agreed resignation scheme

MART – Maintenance and Reliever Therapy

MDT – multi-disciplinary team

MH – mental health

MHST – Mental Health Support Team

MLCSU – NHS Midlands and Lancashire Commissioning Support Unit

MNVP – Maternity and Neonatal Voices Partnership

MPFT – Midlands Partnership University NHS Foundation Trust

NCMD – National Child Mortality Database

ND – neurodiversity

NEM – non-executive member

NHSE – NHS England

NICE – National Institute for Health and Care Excellence

OD – Organisational Development

ONS – Office for National Statistics

PADS – Planning, assuring and delivering service change for patients

PALS – Patient Advice and Liaison Service

PCN – Primary Care Network

PHB – Personal Health Budget

PHSO – Parliamentary and Health Service Ombudsman

PMO – Programme Management Office

QHB – Queen's Hospital, Burton

QIA – Quality Impact Assessment

ReSPECT – Recommended Summary Plan for Emergency Care and Treatment

RHA – review health assessments

RSV – respiratory syncytial virus

RTT – referral to treatment

SAR – Safeguarding Adult Review

SAR – Subject Access Request

SBAF – System Board Assurance Framework

SEND – special educational needs and disabilities

SIA – Sustainability Impact Assessment

SRO – Senior Responsible Officer

SSOT – Staffordshire and Stoke-on-Trent

STW – Shropshire, Telford and Wrekin

SWM – Sustainability West Midlands

TCFD – Taskforce on Climate-related Financial Disclosures

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

UKHSA – United Kingdom Health Security Agency

ULEV – ultra-low emission vehicle

UTC – Urgent Treatment Centre

UV – ultraviolet

VAST – Voluntary Action Stoke-on-Trent

VCSE – voluntary, community, and social enterprise

VR – voluntary redundancy

VSM – Very Senior Manager

VWX – virtual work experience

WM – West Midlands

WMAS – West Midlands Ambulance Service

WDES – Workforce Disability Equality Standard

WRES – Workforce Race Equality Standard

YES – Youth Employment and Skills

ZEV – zero emission vehicle