Staffordshire and Stoke-on-Trent Integrated Care Board Meeting

HELD IN PUBLIC

Thursday 18th September 2025
1.00pm – 3.30pm

North Staffordshire Combined Healthcare NHS Trust Boardroom at Lawton House, Bellringer Road, Trentham, Stoke-on-Trent ST4 8HH

[A = Approval / R = Ratification / S = Assurance / D = Discussion / I = Information]

	Agenda Item	Lead(s)	Enc	A/R/S/D/I	Time	Pages
1.	Welcome and Apologies	Chair	---	---	1.00pm	
2.	Leadership Compact	Chair	Enc 01	A		3
3.	Conflicts of Interest	Chair	Enc 02	---		4-5
4.	Minutes of meeting held on 17th July 2025	Chair	Enc 03	A		6-27
5.	Action Log – progress update on actions	Chair	Enc 04	D		28-31
6.	Questions submitted by members of the public in advance of the meeting	Chair	---	D	1.05pm	
Strategic and System Development						
7.	ICB Chair and Chief Executive Report	DP/PEJ	Enc 05	I	1.15pm	32-39
8.	System Winter/Surge Plan	PS	Enc 06	I/S	1.25pm	40-112
System Governance and Performance						
9.	SBAF Quarter 2 2025/2026 Report	CC	Enc 07	D/S	1.40pm	113-152
10.	Quality and Safety Report Quality and Safety AAA Chairs Report	HJ SH	Enc 08 Enc 09	I/S I/S	1.55pm 2.10pm	153-156 157-160
11.	Staffordshire and Stoke-on-Trent Health and Care Senate AAA Chairs Report	RG	Enc 10	I/S	2.20pm	161-163
12.	ICS Finance and Performance Report Finance and Performance Committee AAA Chairs Report – August and September	CF/PS CF	Enc 11 Enc 12a/b	I/S I/S	2.25pm 2.40pm	164-195 196-203
13.	ICS People, Culture and Inclusion Committee Assurance and Performance Report Staffordshire and Stoke-on-Trent ICB People,	MI	Enc 13	I	2.45pm	204-216 217-222

	Culture and Inclusion Committee AAA Chairs Report - Part B June and September	MI	Enc 14a/b	I/S	2.55pm	
14.	Staffordshire and Stoke-on-Trent ICB Strategic Commissioning and Transformation Committee AAA Chairs Report	ML	Enc 15	I/S	3.00pm	222-226
15.	Staffordshire and Stoke-on-Trent ICB Remuneration Committee AAA Chairs Report	ML	Enc 16	I	3.10pm	227-229

Any Other Business						
16.	Items notified in advance to the Chair	All	---	---	---	
17.	Questions from the floor relating to the discussions at the meeting	Chair	---		3.15pm	
18.	Meeting Effectiveness	Chair	---		---	
19.	Close	Chair	---		3.30pm	
20.	**Date and Time of Next Meeting** **Thursday 17th November 2025 1.00pm – 3.30pm** **Staffordshire County Council Chamber, County Buildings, Martin Street, Stafford, ST16 2DH.**					

ICS Partnership leadership compact

Trust

- We will be **dependable**: we will do what we say we will do and when we can't, we will explain to others why not
- We will act with **integrity** and **consistency**, working in the interests of the population that we serve
- We will be willing to take a **leap of faith** because we trust that partners will support us when we are in a more exposed position.

Courage

- We will be **ambitious** and willing to **do something different** to improve health and care for the local population
- We will be willing to make **difficult decisions** and take proportionate risks for the benefit of the population
- We will be **open to changing course** if required
- We will **speak out** about inappropriate behaviour that goes against our compact.

Openness and honesty

- We will be **open** and **honest** about what we can and cannot do
- We will create a **psychologically safe environment** where people feel that they can raise thoughts and concerns without fear of negative consequences
- Where there is disagreement, we will be prepared to **concede** a little to reach a consensus.

Leading by example

- We will **lead with conviction** and be ambassadors of our shared ICS vision
- We will be committed to **playing our part** in delivering the ICS vision
- We will live our **shared values** and agreed leadership behaviours
- We will positively promote **collaborative working** across our organisations.

Respect

- We will be **inclusive** and encourage all partners to contribute and express their opinions
- We will **listen actively** to others, without jumping to conclusions based on assumptions
- We will take the time to understand others' points of view and **empathise** with their position
- We will respect and uphold **collective decisions** made.

Kindness and compassion

- We will show **kindness**, **empathy** and **understanding** towards others
- We will **speak kindly** of each other
- We will support each other and seek to solve problems **collectively**
- We will challenge each other **constructively** and with **compassion**.

System first

- We will put **organisational loyalty and imperatives** to one side for the benefit of the population we serve
- We will spend the Staffordshire and Stoke-on-Trent pound **together** and **once**
- We will develop, agree and uphold a **collective** and **consistent** narrative
- We will present a **united front** to regulators.

Looking forward

- We will **focus on what is possible** going forwards, and not allow the past to dictate the future
- We will be **open-minded** and willing to consider new ideas and suggestions
- We will show a willingness to **change the status quo** and demonstrate a positive 'can do' attitude
- We will be open to **conflict resolution**.

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2025-2026
INTEGRATED CARE BOARD (ICB)
AS AT 04 SEPTEMBER 2025

Key
- Declaration completed for financial year 2025/2026 (shaded)
- Declaration for financial year 2025/2026 to be submitted (unshaded)

Note: **Key relates to date of declaration**

Date of Declaration	Title	Forename	Surname	Role	Organisation	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
20th September 2024	Dr	Buki	Adeyemo	Chief Executive Officer	North Staffordshire Combined Healthcare Trust (NSCHT)	Nothing to declare	1. Board of Governors University of Wolverhampton (ongoing) 2. Mental Health Network, NHS Confederation, NHS CEO Representative (ongoing)	Nothing to declare	Nothing to declare	(h) interest recorded on the Conflicts Register
15th July 2024	Mr	Nadeem Tony	Ahmed	ICB Participatory (non-voting) member	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Director of Dentaire Ltd and TT Partners Ltd, Principal dentist at Dentaire Dental Care (ongoing)	1. Chair of Local Dental network - Shropshire and Staffordshire (ongoing)	Nothing to declare	1. Brother is an ENT surgeon and head of department at QE Hospital Birmingham (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) interest recorded on the Conflicts Register.
11th July 2024	Ms	Helen	Ashley	Acting CEO	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	Nothing to declare	Nothing to declare	1. Member of Derbyshire Community Health Services FT (2014 - ongoing)	Nothing to declare	(h) recorded on conflicts register.
12th September 2024	Mr	Neil	Carr OBE	Chief Executive Officer	Midlands Partnership University NHS Foundation Trust (MPFT)	1. CEO of MPFT (ongoing)	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing) 4. Visiting Professor - Wagner College, New York (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
17th July 2025	Dr	Joanna	Chan	Primary Care Partner Member	Staffordshire and Stoke-on-Trent Integrated Care Board	1. GP Partner at Dale Medical Practice (2003 - ongoing) 2. Clinical Director, Seisdon PCN (2019 - ongoing) 3. Director of GP First PCN Limited (2019 - ongoing)	1. GP Clinical Champion Staffordshire Training Hub (2023 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) Recorded on CCG Conflicts Register.
28th April 2025	Mr	Simon	Constable	Chief Executive	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	Nothing to declare	1. Lay Member of Keele University Council (April 2025 - four-year term, 10-12 days per year)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
13th September 2024	Mrs	Claire	Cotton	Director of Governance	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	1. Employee of University Hospital of North Midlands NHS Trust (UHNM) (2000 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
8th April 2025	Dr	Elizabeth	Disney	Chief Transformation Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	1. Brother is Clinical Lead and Consultant at UHNM (1st September 2024 to date). 2. Brother's partner is owner-operator of Nature and Nurture Psychology, a child and family psychology service based in Staffordshire (November 2024 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on the conflicts register.
2nd April 2025	Dr	Paul	Edmondson-Jones	Interim Chief Executive	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Employed session a week (0.1 wte) by MPFT as Head of SSoT PH Alliance (as a locum public health consultant) (June 2024 - ongoing)	1. Fellow of the Faculty of Public Health (FFPH) and registered with the GMC (December 2022 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
1st April 2025	Mrs	Lisa	Ellis	Executive Support Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
17th April 2025	Ms	Claire	Finn	Chief Finance Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	1. Trustee of Newfield Charity - no link to SSOT (ongoing) 2. HFMA Branch committee member (ongoing)	1. Family member works for 360 assurance (not director) - hosted NHS provider carrying out internal audit services for the NHS – do not currently provide any service to SSOT. (ongoing)	(h) Interests recorded on the conflicts register.
4th January 2024	Mr	Patrick	Flaherty	Chief Executive Officer and ICB Board Member	Staffordshire County Council	1. Chief Executive Officer of Staffordshire County Council (July 2023 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on ICB conflicts register.
8th May 2025	Mrs	Julie	Houlder	Non-Executive Member	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Chair of Derbyshire Community Health Foundation Trust (January 2023 - ongoing) 2. Associate Charis Consultants Ltd (January 2019 - ongoing) 3. Owner Craftykin Limited (July 2022 - ongoing) 4. Owner of Elevate Coaching (October 2016 - ongoing)	1. Director Windsor Academy Trust (January 2019 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on ICB conflicts register
1st April 2025	Mr	Chris	Ibell	Chief Digital and Information Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
30th July 2025	Ms	Mahishmi	Irvine	Chief People Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	1. YMCA Trustee (September 2023 - ongoing)	Nothing to declare	(h) recorded on conflicts register.

Date of Declaration	Title	Forename	Surname	Role	Organisation	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
6th April 2025	Mrs	Heather	Johnstone	Chief Nursing and Therapies Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Visiting Fellow at Staffordshire University (March 2019 - March 2028 ongoing)	Nothing to declare	1. Spouse is employed by UHB at Heartland's hospital (2015 - ongoing) 2. Daughter is Marketing Manager for Voyage Care LD and community service provider (August 2020 - ongoing) 3. Brother-in-law works for Optima Health and UHNM (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
25th July 2024	Mr	Shokat	Lal	Non-Executive Member	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Member of the Black Country Integrated Care Partnership through day job at Sandwell Council (ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
21st July 2025	Mr	Mike	Lawton	Non-Executive Member	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Employment with Black Country Housing Group (May 2024 - ongoing) 2. Employment with EMH Group, Leicester (March 2024 - ongoing)	Nothing to declare	Nothing to declare	1. Wife works as Specialist BMS in Pathology Lab UHNM (2024 - ongoing) 2. Son-in-Law works in procurement as a buyer for UHNM (2024 - ongoing) 3. Daughter works as a Pharmacist Trainer for Boots based in Nottingham (2024 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
23rd April 2025	Ms	Anna	Mather	Healthwatch Staffordshire Manager	Healthwatch Staffordshire	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
2nd April 2025	Mr	David	Pearson	Chair	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	1. Spouse and daughter work for North Staffs Combined Health Care NHS Trust (2018 - ongoing)	(h) recorded on conflicts register.
16th May 2025	Mrs	Siobhan	Reilly (Heafield)	Non-Executive Member	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Trustee at Beth Johnson Foundation Charity (Sept 2023 - ongoing)	Nothing to declare	1. Partner is NHSE employee – Midlands Director of Performance (2007 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
9th April 2025	Mrs	Tracey	Shewan	Director of Corporate Governance	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. I sometimes do shifts for MPFT that I am not paid for, last shift February j2023 (ongoing)	Nothing to declare	1. Sibling is a registered nurse with MPFT (July 2022 - ongoing) 3. Daughter works for West Midlands Ambulance Service (WMAS) (July 2022 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
9th April 2024	Mr	Phil	Smith	Chief Delivery Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
2nd April 2025	Mrs	Josie	Spencer	Non-Executive Member	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Non-Executive Director Leicestershire Partnership Trust (May 2023 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) interest recorded on the conflicts register.
14th May 2025	Mr	Paul	Winter	Associate Director of Corporate Governance and DPO	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required

ANY CONFLICT DECLARED THAT HAS CEASED WILL REMAIN ON THE REGISTER FOR SIX MONTHS AFTER THE CONFLICT HAS EXPIRED

1. Financial Interest *(This is where individuals may directly benefit financially from the consequences of a commissioning decision, e.g. being a partner in a practice that is commissioned to provide primary care services)*
2. Non-financial professional interests *(This is where an individual may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the ICB)*
3. Non-financial personal interests *(This is where an individual may benefit personally, but not professionally or financially, from a commissioning decision e.g. if they suffer from a particular condition that requires individually funded treatment)*
4. Indirect interests *(This is where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g. spouse, close relative (parent, grandparent, child etc) close friend or business partner*
5. Actions taken *to mitigate identified conflicts of interest*
(a) Change the ICB role with which the interest conflicts (e.g. membership of an ICB commissioning project, contract monitoring process or procurement would see either removal of voting rights and/or active participation in or direct influencing of any ICB decision)
(b) Not to appoint to an ICB role, or be removed from it if the appointment has already been made, where an interest is significant enough to make the individual unable to operate effectively or to make a full and proper contribution to meetings etc
(c) For individuals engaging in Secondary Employment or where they have material interests in a Service Provider, that all further engagement or involvement ceases where the ICB believes the conflict cannot be effectively managed
(d) All staff with an involvement in ICB business to complete mandatory online Conflicts of Interest training (provided by NHS England), supplemented as required by face-to-face training sessions for those staff engaged in key ICB decision-making roles
(e) Manage conflicts arising at meetings through the agreed Terms of Reference, recording any conflicts at the start / throughout and how these were managed by the Chair within the minutes
(f) Conflicted members to not attend meetings, or part(s) of meetings: e.g. to either temporarily leave the meeting room, or to participate in proceedings but not influence the group's decision, or to participate in proceedings / decisions with the agreement of all other members (but only for immaterial conflicts)
(g) Conflicted members not to receive a meeting's agenda item papers or enclosures where any conflict arises
(h) Recording of the interest on the ICB Conflicts of Interest/Gifts & Hospitality Register and in the minutes of meetings attended by the individual (where an interest relates to such)
(i) Other (to be specified)

Staffordshire and Stoke-on-Trent Integrated Care Board

HELL IN PUBLIC

Thursday 17th July 2025 1.00pm – 3.30pm

Midlands Partnership NHS Foundation Trust Headquarters Boardroom, St George's Hospital, Corporation Street, Stafford, ST16 3SR

Members:	**Quoracy**	**15/05/2025**	**17/07/2025**	**18/09/2025**	**20/11/2025**	**15/01/2026**	**19/03/2026**
David Pearson (DP) Chair Staffordshire & Stoke-on-Trent ICB	Over 50% of the quantum (nine out of seventeen members) with there being an equitable balance to represent that of a Unitary Board, split between proportions of Executive, Non-Executive and Partner Members, including: • the Chief Executive plus one other Executive Director (from CFO, CTO, CDO) • either the Medical Director (CMO) or the Director of Nursing & Therapies (CNTO) • three Independent Members: i.e. Chair plus two Non-Executive Members • three Partner Members: with ideally at least one from each of the three cohorts	Y	Y				
Dr Paul Edmondson-Jones (PEJ) Interim Chief Executive Officer, Staffordshire & Stoke-on-Trent ICB (Interim CEO as from 15th July 2025)		Y	Y				
Claire Finn (CF), Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB (commenced in post as from 1st June 2025)		Y	Y				
Phil Smith (PS) Chief Delivery Officer, Staffordshire & Stoke-on-Trent ICB		Y	Y				
Heather Johnstone (HJ) Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB		X	Y				
Dr Rachel Gallyot (RG) Interim Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB (Interim Chief Medical Officer as from 15th July 2025)			Y				
Elizabeth Disney (ED) Chief Transformation Officer, Staffordshire & Stoke-on-Trent ICB		Y	Y				
Julie Houlder (JH) Non-Executive Member, Staffordshire & Stoke-on-Trent ICB		Y	Y				
Shokat Lal (SL) Non-Executive Member, Staffordshire & Stoke-on-Trent ICB		Y	Y				
Josephine Spencer (JS) Non-Executive Member, Staffordshire & Stoke-on-Trent ICB		Y	Y				
Mike Lawton (ML) Non-Executive Member, Staffordshire & Stoke on Trent ICB		X	Y				
Siobhan Heafield (SH) Non-Executive Member, Staffordshire & Stoke on Trent ICB (commenced in post as from 7th July 2025)			Y				
Jon Rouse (JR) Chief Executive, City of Stoke-on-Trent Council		Y	Y				
Patrick Flaherty (PF) Chief Executive, Staffordshire County Council		X	X				
Dr Simon Constable (SC) Chief Executive Officer, University Hospitals of North Midlands NHS Trust		X	Y				
Neil Carr (NC) Chief Executive, Midlands Partnership NHS University Foundation Trust		Y	X				
Dr Buki Adeyemo (BA) Chief Executive, North Staffordshire Combined Healthcare NHS Trust		Y	Y				
Participant Members:							
Simon Fogell (SF) Stoke-on-Trent Healthwatch		X	X				
Anna Mather (AM) Healthwatch Support Staffordshire		Y	Y				
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		Y	Y				
Mish Irvine (MI) Chief People Officer, Staffordshire & Stoke-on-Trent ICB		Y	X				
Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		Y	Y				
Paul Winter (PW) Associate Director of Corporate Governance & DPO, Staffordshire & Stoke-on-Trent ICB		Y	Y				
Dr N Tony Ahmed (TA) Dental Participant Board Member		Y	Y				
Dr J Chan (JC) Primary Care Service Parter Member		Y	Y				

In attendance:							
Alex Brett (AB) Chief People Officer, Midlands Partnership NHS University Hospital			Y				
Gemma Treanor (GT) Head of ICS People Function, Staffordshire & Stoke on Trent ICB			Y				
Stephen Gunther (SG) Corporate Director : Public Health, Protection and Wellbeing			Y				
Claire Cotton (CC) Director of Governance, University Hospital of North Midlands			Y				
Lisa Ellis (LE) Executive Support Officer, Staffordshire and Stoke on Trent ICB (minutes)		Y	Y				

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Public Board meeting and advised that it was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. The meeting is being recorded and will be available on the ICB website after the meeting.	
	Apologies	
	Apologies were received from: Mish Irvine – represented by Gemma Treanor Neil Carr – represented by Alex Brett Pat Flaherty Simon Fogell DP welcomed Siobhan Heafield, newly appointed Non-Executive Member to her first meeting of the ICB Board. He also welcomed to Claire Finn, Chief Finance Officer to her first meeting of the ICB Board following her appointment in June. DP advised this is the first Board meeting for Dr Paul Edmondson-Jones as Interim Chief Executive Officer and Dr Rachel Gallyot as Interim Chief Medical Officer.	
	Confirm Quoracy	
	DP confirmed that the meeting was quorate.	
2.	**Leadership Compact**	
	DP reminded members of the importance of the Leadership Compact document which was used in all the meetings transacted by the ICB and guides the way business is conducted.	
3.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.	
4.	**Minutes of the Meeting held on 15th May 2025**	
	The minutes of the meeting held on 15th May 2025 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED.**	
5.	**Action log**	
	Action log reviewed and updated accordingly.	

6.	**Questions submitted by members of the public in advance of the meeting**	
	Ian Syme **Question One - Ambulance Handover Delays** *UHNM last year acknowledged Ambulance Handover delays at Royal Stoke ED are unacceptable and dramatic necessary improvements to its UEC service are its number1 priority.* *The national UEC plan is now very specific. Ambulance Handover delays at an ED must be a MAXIMUM of 45 minutes, not an Average of 45 minutes, a Maximum delay of 45 minutes.* *This is not a target it is a requirement and incumbent on NHS Acute Trusts to implement.* *According to July 2025 UHNM board papers average Ambulance Handover delay (most recent metric) is now 64minutes yet to attain the requirement of 45-minute maximum delay, average ambulance handover needs to be around 18/19 minutes meaning a massive improvement from UHNMs present position.* *In the first 3 months of this year (2025/26) Ambulance lost hours at Royal Stoke ED exceeded 17000 hours, the worst in the West Midlands, and extrapolating those figures would mean that Handover delays 2025/26 would be worse than 2024/25.* *Whilst there are certainly green shoots of recovery namely a recent reduction of over 500 hours to a level of 1000 ambulance lost hours in one week even that is still not sufficient to attain a maximum delay of 45 minutes as now required of UHNMs Royal Stoke ED.* *As set out in the ICB Performance and Finance Report page 113 of 258 pages; WMAS indicate a potential cost increase from £3million to £6million, a significant cost pressure, to cover additional operating costs due to Ambulance handover delays. To have ambulances stuck outside an ED waiting to offload a patient, beside being dire for all involved, is frankly a considerable waste of precious resources!* *Both UHNM and the ICB are still reporting average Ambulance Handover delays which as per my previous point does not reflect the task in hand i.e. to attain the 45minute Maximum handover.* *How in the future will our System/ICB be recording and publicly reporting data that gives a more accurate assessment of Ambulance Handover delays and the trajectory required of Royal Stoke ED to attain the Maximum 45-minute Ambulance Handover delays as per UEC Plan 2025/26?* PS thanked Ian Syme for his question and advised that our ambulance handover times in quarter one have remained unacceptable and assured the Board and members of the public that we closely monitor all of these metrics on a daily basis and added that the NHS best practice standard is to handover ambulances within 15 minutes, which is reported on page 119 of the Board papers and added that whilst the national planning asks for 2025/2026 is a maximum handover time of 45 minutes and UHNM have committed to resolving the ambulance handover situation, which is also a priority shared by the system. PS added that our trajectory for this year for ambulance handover improvement is aligned to the impact of key work programmes, notably the significant internal UHNM Urgent Emergency Care (UEC) Improvement plan and community-based demand management initiatives and quarter two has seen implementation of elements of this plan, including a new continuous flow model within UHNM and he highlighted that over the last several days 90% of handovers took place within 45 minutes. PS advised that other key changes planned for this year to support improvement are linked to a new co-located UTC at Royal Stoke, supporting care closer to home in terms of community transformation and ICC and whilst the full suite of metrics relating to UEC and ambulances is reported through system governance and provided commitment to looking at the reporting within the Board assurance report to ensure we reflect our progress against the 45 minute operational planning requirement in addition to the national 15 minute standard.	

	Ian Syme **Question Two - Maternity** *UHDB NHS Trust's Queens Hospital Burton unit is the main maternity unit serving South Staffordshire women.* *At May 2025 Staffs Stoke ICB meeting I questioned the apparently more constrained improvement trajectory to its Maternity Services that UHDB was having in relation to UHNM both trusts having been CQC rated inadequate previously. UHNM is now CQC rated good for Maternity whilst UHDB is still rated inadequate.* *UHDB Board papers for their Board meeting 15th July 2025 report that Section 31 conditions invoked by the CQC in August 2023, 2 of 6 conditions had still not been removed. A further five conditions under Section 31 were invoked by the CQC in December 2024 none of which have been removed as yet.* *In 2014 Queens Hospital Burton Maternity Service was recognised as the best in the British Isles.* *When are South Staffordshire women likely to get the good Maternity Service, as a minimum, that should be provided to them by UHDBs Maternity Unit at Queens Hospital Burton?* HJ thanks Ian Syme for his comprehensive question and stated that the CQC concerns always take time to remove the actions and sections 31s and stated that the sections are ongoing and advised that she recently liaised with the Chief Nurse at both the ICB and UHDB, who confirmed that are still waiting removal. She added that UHDB will continue to be involved in the Maternity Safety Support Programme and work continues to drive improvements and also advised that they are regularly reporting more positive outcomes. They continue to wait for the CQC report following the visit in December. HJ advised that colleagues continue to work with UHDB, and Derby and Derbyshire ICB to monitor any issues as they arise and also of noted improvements and provided assurance that the Quality and Safety Committee is updated.	
	Allison Gardner MP **Question One – wheelchair services** *I note on page 75 that whilst waiting times for service users waiting 18+ weeks has reduced those waiting 52 weeks+ remain high. Could you outline the demographic of the patients (e.g. children) waiting longer than 52+ weeks and the type of wheelchair the tend to wait for e.g. moulded wheelchairs.* ED thanked Allison Gardner for the question and advised that she has not got the detail regarding the over 52 wait but agreed to share the information outside of the meeting. She stated that there were 223 adults and 66 children waiting over 18 weeks as at the end of May, with the majority of patients awaiting bespoke equipment and she added that the delays relate to supplier delay/equipment order backlog and/or prioritisation of clinical appointments for specialist seating.	**ED**
	Allison Gardner MP **Question Two – wheelchair services** *On page 246 you reference discussing an exit and transition plan for the current provider. Is this confirmation that you will not be continuing with AJM and that, in planning for transition and using an outcome-based contract, any future provider will address any backlog and not be able to blame previous providers for any future supply issues.* ED thanked Allison Gardner for her question and advised that the current contract with AJM ends on the 31st March 2026 and the ICB will be going to the market and undertaking a procurement for a new contract to commence on the 1st April 2026, which AJM may or may not bid for the service. She advised that when the contract is awarded to the successful bidder, work on transitioning to the successful bidder will include the caseload of service user referrals that are open and will transfer onto the new contract. She also added that as part of the procurement process, we are reviewing	

	our key performance and quality outcome metrics and they will be issued when the Invitation to Tender is launched. **Allison Gardner MP** **Question Three – Neighbourhood Health** *On page 246 I note that there is a collaborative for Neighbourhood health. Can I ask, in developing the neighbourhood health programme, that we consider supporting proposals for a neighbourhood health centre (previously an Integrated Care Hub) in Longton to support the south of the city.* ED thanked Allison Gardner for her question and stated that page 246 refers to the provider collaborative and the role the provider collaborative will have in delivering neighbourhood health and advised that colleagues are awaiting more detail as part of the planning guidance for the next financial year, therefore any future consideration as to locations will be developed as part of that programme and will be in partnership with local populations and MPs responsible for those constituent areas. JR asked if the previous programme around the delivery of four care hubs will be replaced. ED confirmed it will and stated that the guidance on the future the guidance will supersede this and added that there is an opportunity to look at what neighbour health means for us as a system . **Allison Gardner MP** **Question Four – morality rates** *Could you update me on what the infant mortality rates currently are in Stoke-on-Trent and Staffordshire and actions taken to reduce the levels.* PEJ thanked Allison Gardner for her question and stated that he will also provide a comprehensive written response. He stated that the rates we have access to refer to an average from 2021 to 2023 and for Stoke on Trent the rate is 7.6% per thousand live births and for Staffordshire it is 5.2% per thousand live births, which gives an average of 5.8% per thousand live births. He added that last year a Midlands Infant Mortality Forum was established and chaired by the Regional Director of Public Health and has representative from all partners, including the police, clinical academics and local universities. He stated that there is an ICS infant mortality action plan, which has been delivered jointly with the Local Council and Public Health. PEJ stated that there have been a number of achievements over the past few years, including: • Significant reduction in smoking at the time of delivery, which has reduced from 12% to 4.9% • Infant mortality dashboard has been established across the ICS • Improved multi-disciplinary care in maternity, focusing on complex needs during pregnancy • New work programme on per-conception care, particularly targeting healthy weight, alcohol and other preventative approaches JR noted that this matter falls under the remit of the Children's Health Partnership Board, which he chairs. He took the opportunity to thank SC and his colleagues at UHNM for their collaboration in learning from previous cases, particularly those involving the tragic deaths of babies within the first 28 days of life. He expressed his appreciation for the openness and willingness of clinicians, midwives, and nurses, who have worked closely with the public health community to drive progress in this area.	**PEJ**
7.	**ICB Chair and Chief Executive Report**	
	DP referred to the recent announcement of his decision to step down as Chair of the Integrated Care Board, describing the role as a privilege. He explained that during the transition period, he would remain flexible, with his departure aligning with the clustering arrangements to ensure a safe and comprehensive handover. DP presented the report and highlighted the significant work underway as part of the NHS reset across both Staffordshire and Stoke-on-Trent ICB and Shropshire, Telford and Wrekin ICB. He commended the collaborative efforts of both teams, noting the positive progress being made through	

their close working relationship. He clarified that the ICBs are not merging but are instead entering into cluster arrangements. He confirmed that both ICB Boards will continue to operate independently, while sharing a single Chief Executive and Chair as part of the new structure.

DP reported that the 10-year plan has been released, which highlights the importance of easier access to care closer to home and has been published alongside the draft model ICB blueprint and a publication of the NHS Oversight Framework.

DP referred to the Provider Collaborative arrangements and reported that Janet Dawson Chair of NSCHT has agreed to step into the role of Chair of the Provider Collaborative Board, which will also include other non-executive colleagues within its membership and stated that a number of priorities have been agreed:

- Priority One: Neighbourhood Health – Jon Rouse and David Atherton
- Priority Two: Community Transformation, including Urgent and Emergency Care and Winter – Neil Carr and Anwar Tufail
- Priority Three: Support/Enabling Services – Buki Adeyemo

DP highlighted that there is an error within the report (page 25, item 2.8.1) regarding the LIF and stated that the award to Tamworth was £300K, not £100K as reported.

PEJ provided an update on the ICB Blueprint and NHS Reset, noting that a Regional Transformation Board has now been established. He reported that Transition Committees have been formed for both Staffordshire and Stoke-on-Trent ICB and Shropshire, Telford and Wrekin ICB. Additionally, four working groups have been set up to support key aspects of the transition process: People, Governance, Technical and Communications, Operating Model, and Quality and Safety. He advised that discussions are ongoing regarding the appointment of the Cluster Chair and Chief Executive. Once these appointments are confirmed, both ICBs will begin to develop future structures. PEJ provided assurance that both ICBs will continue to work collaboratively with teams, including providers who may assume key functions over time.

PEJ referred to recent media coverage and reported that, as part of the Afghan Resettlement Programme, the ICB has been working closely with the Ministry of Defence to support the healthcare needs of over 1,200 Afghan evacuees currently based at Swynnerton Barracks. He highlighted this as a significant example of partnership working, which has received notable recognition from the Ministry of Defence.

PEJ was pleased to report that Gill Boast, ICB Practice Nurse Facilitator, General Practice Nurse (GPN) Facilitator, and GPN Foundation School Training Programme Lead at the Staffordshire Training Hub, has received the Chief Nursing Officer Silver Award, which was presented by Professor Jamie Waterall, Chief Public Health Nurse for England.

PEJ referred to the GP patient survey and stated that a full report will be presented to the next meeting. He stated that the survey covers the period December 30th 2024, to 1st April this year and locally there was a 30% response rate and overall Staffordshire and Stoke on Trent saw an improvement in many areas and is above the national and regional average.

PEJ reminded Board members of the extensive work undertaken in relation to Gordon Street, noting that the Board made the decision in 2023 to end the contract due to the practice consistently ranking in the bottom five for patient satisfaction over nearly five years. He confirmed that the contract was terminated, and a new provider and premises were secured. PEJ was pleased to report significant improvements this year: patient satisfaction has risen from 8% to 46%, experience with reception from 40% to 80%, experience of contacting the practice from 20% to 64%, and overall experience from 34% to 75%. He thanked Board members for their support of the ICB and the Primary Care Team throughout this process.

JH referred to the neighbourhood community events and asked if there was any documentation produced from those events which can be shared with people who were not able to attend. ED

	reported that the community events are recorded and documented and a written summary will be drafted and will be made available. JH referred to four areas of focus within the health literacy programme and queried whether frailty was included. PEJ explained that frailty is not currently one of the four focus areas, as it is a significantly broader and more complex issue. He confirmed that frailty is a programme currently in development, and colleagues will consider how best to approach it, with a plan of action to be determined moving forward. JH referred to the metrics and highlighted the increase in walk-ins, although there has been a reduction in 111 calls and reduction is GP referrals and asked what the correlation during this period is. PS stated that our acute providers have seen a significant increase in terms of walk in demand and ambulance attendance and stated that a deep dive has been conducted, which has not identified any discernible cause when looking into the nature of conditions people are presenting with. He provided assurance that colleagues will continue to look at the data and stated that this is a pattern that is mirrored across the region. AM informed the Board that, following the publication of the 10-Year Plan and the Patient Safety Report, a decision has been made to abolish six organisations, one of which is Healthwatch. She noted that further guidance is awaited, as the implications of this decision are not yet fully clear and provided assurance that efforts are being made to ensure the patient voice is not lost during this transition. She added that an open letter and a petition have been created to advocate for the continued representation of patient voices, both of which will be submitted to Parliament ahead of the summer recess. ML referred to the Locality Improvement Framework, noting his role as a panel member. He shared with the Board that it has been an exceptionally insightful experience, marked by strong collaboration and effective multi-agency working. **The ICB Board received the report and were assured the leadership are working on each topic as raised.**	
8.	**Fit for the Future – 10 Year Plan**	
	PEJ provided an overview of the 10-year plan, highlighting the key messages. He advised that there are three major shifts, consisting of hospital to community, analogue to digital, and sickness to prevention, highlighting that the ICBs and ICSs will need be expected to develop plans targeting 2028/29 and also advised that there are five key themes: • Getting the care that you need • Seamless healthcare • Fixing the basics • Sickness to prevention • Great place to work PEJ also highlighted that there will be focus on prevention, linking it to existing work around smoking, obesity, physical activity, and alcohol through the Local Prevention Board, and emphasised the importance of using this plan as a long-term mandate for systemic change. PEJ agreed to forward the full slide pack to LE for circulation to Board members. SL acknowledged the involvement of multiple stakeholders and raised the importance of considering how the changes are communicated and unpacked for the local population and emphasised that the workforce needs to understand the shift in approach, particularly as the system evolves beyond being the sole 'front door' to care, which will vary locally and may present challenges for many communities. PEJ stated that that there is a dedicated chapter focused on supporting staff through this transition and highlighted the potential of tools like the NHS App to deliver equal benefits across the system and stressed the need to find effective ways to embed these changes.	**LE**

	SH highlighted the needs of older people who may need support with the digital agenda. She mentioned she is involved with a charity for older people which holds and mentioned that "Tea and Tech" session for elderly residents and emphasised that the scale of work required to support such initiatives should not be underestimated. JR referred to the topic of neighbourhood health and suggested it be brought forward for discussion at a future meeting, highlighting the significant opportunities it presents for all partners and noted that all provider Trusts are expected to become Foundation Trusts and transition into Integrated Health Organisations (IHOs), enabling them to take greater responsibility for a system-wide approach. He also stressed the importance of patient and service user empowerment, noting that the 10-Year Plan signals a shift in this direction and added that this transformation can only be realised if the necessary digital infrastructure is in place, identifying digital improvement as a critical priority for system-wide progress. CI stated that within one provider alone there are over 400 systems and stressed the importance of not losing sight of the core responsibility to support patients and service users effectively. He emphasised the need for increased investment to ensure that digital transformation helps the patients and service users. **The ICB Board received and noted the presentation and work being undertaken.**	
9.	**Joint Health and Wellbeing Strategy**	
	Stephen Gunter (SG) in attendance and presented the report and provided a brief background, noting that the ICB is a key partner in the Stoke-on-Trent Health and Wellbeing Board. He reiterated the Board's role in promoting, driving, and improving the health and wellbeing of local residents and patients. He introduced the Strategy, which has undergone extensive consultation and aligns closely with the broader NHS and Integrated Care Partnership (ICP) priorities. Specifically, the Children and Young People's section reflects the priorities of the Children and Young People's Partnership Board, chaired by Jon Rouse. SG concluded by stating that the strategy is now presented for the Board's approval, adoption and requested support for its implementation. ED added that the strategy presents a significant opportunity to build on discussions already held at the Board, particularly around the neighbourhood health agenda and the clarity provided by the Strategy enables a more focused understanding of population needs at a place-based level and added that this approach is seen as critical for the future, allowing the ICB and its partners to prioritise effectively and tailor interventions to local needs and the strategy supports this by embedding neighbourhood-level thinking into broader system planning. ED emphasised that this document not only reflects the work already undertaken through the Health and Wellbeing Board but will also be instrumental in shaping how the ICB functions going forward, both at place level and within more detailed neighbourhood contexts. DP welcomed the report, which is well written and asked how this will get shared. SG confirmed that the Strategy is now live and available online and has been circulated among partners. He added that the emphasis is on ensuring it is not treated as a static or "shelf" document and stated that its, its success will be driven by the delivery groups established under the broader Health and Wellbeing Board structure. He added that these delivery groups are tasked with translating the strategy into action. Examples include: • **Citywide Mental Wellbeing Partnership** – recently convened to progress mental health priorities • **Place-Based Partnership** – focusing on physical activity initiatives • **Children and Young People's Partnership** – continuing to lead on the children's health and wellbeing agenda	

	SG conclude by stating that the Strategy provides a framework for these groups to work collaboratively and effectively, ensuring that the ambitions set out are realised through targeted, place-based action. JH praised the Strategy and welcomed that so much of it is around specific outcomes and added that it is really important to have an outcome-driven approach with the ICB's renewed role in strategic commissioning, the ability to use these outcomes to inform and guide delivery at both place and neighbourhood levels is critical and the Strategy offers a valuable opportunity to embed this thinking into how the system works collaboratively to meet local needs. PEJ referred to comments regarding empowering patients and stated that personal responsibility is one of the themes within the Strategy and it is about working with individuals to empower them to make healthy choices and working with the Local Authorities to ensure patients make the right choices. JR stated that patients are more likely to make the choices if they are part of a strong resilient community and as professionals it is about how do we use the neighbour health construct and broader work to build up community confidence and resilience. HJ echoed the comments and acknowledged the positive impacts from both a quality and safety aspect but added that there is a missed opportunity in relation to highlighting the quality and equality impact assessments. ML welcomed the report and stated that he intends to use it alongside the Local Improvement Framework for Stoke-on-Trent. **The ICB Board approved the Stoke-on-Trent Joint Health & Wellbeing Strategy 2025/2028.**	
10.	**SBAF Quarter 1 2025/2026**	
	Claire Cotton (CC) in attendance and presented the executive summary and highlighting key updates and reflections on the strategic risk landscape. Board members were reminded of the session held in April, where the Board reviewed the eight strategic risks from the previous year's Board Assurance Framework (BAF) and agreed to carry them forward. Following which the Team have refreshed these risks and provided an updated assessment. She added that while most risk levels have remained static, two notable changes were highlighted: • Reducing Health Inequalities – showing a downward trend, indicating improvement. • Sustainable Finances – showing an upward trend, reflecting current financial pressures. CC stated that a detailed scrutiny has been undertaken at Committee level and it was acknowledged that the current BAF document has become lengthy and detailed and the Team are exploring a "BAF on a page" approach to improve clarity and accessibility, with a view to introducing this in the next cycle. CC confirmed that once all Quarter 1 BAFs are available, the system will undertake a refreshed mapping exercise to assess alignment of strategic risks across partners, a process previously used to ensure consistency and shared understanding. CC concluded by providing recognition to the ICB Governance Team who have undertaken the majority of work in preparing the updated BAF and expressed her gratitude for their continued efforts behind the scenes. DP welcomed the report provided assurance the colleagues will welcome the BAF on a page. He referred this and the AAA reports which have become embedded across all organisations, which is welcomed and a significant improvement. JH welcomed a BAF on a page and stated at the last Audit Committee, members expressed concern regarding the lack of reduction in risk levels across the strategic risks and as a result, several questions were raised to ensure that the mitigations currently in place are appropriate and effective. CC stated that these concerns will be addressed as part of the next review cycle, with a focus on	

	ensuring that risk management actions are not only documented but demonstrably impactful in reducing risk exposure over time. TS noted that quarter two will provide greater visibility of future actions and how they are being tracked and emphasised that if actions are not effectively mitigating the risks or having the intended impact, this will become clear through the monitoring process. She added that this reinforces the importance of robust tracking and evaluation mechanisms to ensure that strategic risks are being actively managed and that mitigation efforts are delivering measurable results. JR welcomed the report, stating that it reflects a strong sense of ownership and local interpretation of the national framework and highlighted that the report does not "pull its punches" in its assessment of risk, describing it as practical, grounded, and focused on the real challenges the system is facing. He praised the report for being forward looking rather than retrospective and remarked that it is one of the best he has seen in the health and care sector and expressed hope that it will be recognised both regionally and nationally as an example of best practice. SH welcomed the report and, as a new member of both the Board and the ICB, shared that it provided a comprehensive overview of the organisation's current position. The report was seen as a valuable introduction to the breadth and depth of work underway, offering clear insight into the key strategic risks and priorities. **The ICB Board received the report and were assured that each risk level and assurance assessment accurately reflects the current position and confirmed the adequacy of those controls and assessments.**	
11.	**FPPT Report**	
	TS presented the report and confirmed that the full Fit and Proper Person Test (FPPT) submission has now been completed and submitted to the Regional Team and advised that all Board members and their respective organisations have been assessed and confirmed as meeting the requirements. TS thanked all partners for their participation in what can often feel like a complex and detailed process and added that the level of scrutiny involved in these assessments is significant, and often not fully visible to the public. It was noted that the process ensures that individuals meet the high standards expected of those in leadership roles within the NHS. TS thanked LE for ensuring that board reference templates are completed and retained promptly, particularly during periods of executive transition. She provided assurance that Internal Audit have reviewed the FPPT processes, identifying some areas for improvement, particularly in recruitment which is being taken forward. **The ICB Board received the report and were assurance that all members of the ICB's Unitary Board meet the Fit and Proper Person Test requirements.**	
12.	**Quality and Safety Report**	
	HJ presented the report and advised that from 1st April 2025, in Staffordshire and Stoke-on-Trent, the Multi-agency Safeguarding Hub (MASH) has been renamed the Safeguarding Integrated Front Door (SIFD) and stated that it is the intention to streamline access to support and to ensure patients receive the right help faster and also eliminating duplication. HJ reported that the Quality Improvement Network goes from strength to strength and currently has 713 members across Staffordshire and Stoke on Trent which is a 56% increase over the last 12 months and will serve as an excellent launchpad for cluster level working in the future. HJ shared that positive progress has been made in respect to the learning from lives and deaths of people with learning disabilities and added that learning is being shared and work has commenced with Shropshire, Telford and Wrekin ICB.	

HJ referred to urgent emergency care and specifically a report received by the System Quality Group regarding harms relating to patients waiting over eight hours in an ambulance and patients waiting over 48 hours in an emergency department and added that more work is required and added that she has asked that we access the same information for patients of South Staffordshire who access services in urgent care and other providers and confirmed that once information has been received a report will be presented to a future Board meeting.

HJ referred to the quality impact assessments and stated that at our request NHS England have been doing a review following concerns expressed by partners and stated that a draft report has been received and early indications highlight that it is a positive report and the final report will be issued by the end of July.

DP welcomed the update and referred to the changes in relation to the safeguarding arrangements and highlighted the positive change to simplifying access and keeping communities safe going forward. JR asked if these arrangements are these for Staffordshire or Staffordshire and Stoke on Trent. HJ confirmed that the arrangements are for Staffordshire, as Stoke on Trent made the relevant changes some time ago and also confirmed that there are two separate arrangements/services.

JH referred to safeguarding, specifically asking whether the education sector is involved in the ongoing workshops and also enquired about the potential for using digital solutions to facilitate the transfer of safeguarding data. JR stated that Local Authorities are working towards implementing an electronic portal to support this data transfer and emphasised that colleagues are continuing to work through the details to ensure the right balance between digital efficiency and maintaining the human quality of safeguarding processes.

DP welcomed the system wide urgency and emergency care winter quality review and referred LeDeR and sought confirmation that there has been a 26% increase in the total number of notifications received and asked if there is sufficient capacity to deal with the increase. HJ confirmed that there has been a 26% increase and confirmed that there is capacity and will present a report to highlight the trends over the past would of years and also advised that the ICB is now offering support to Shropshire, Telford and Wrekin and advised that we have an established bank of reviewers who will undertake the reviews, rather than relying on external reviewers.

The ICB Board:

- **Received the report**
- **Were assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System**

Quality and Safety AAA Chairs Report

JS presented the report and highlighted that the meeting was not quorate; however, all items requiring approval were subsequently approved virtually.

JS reported that while there have been improvements in initial health assessments for Looked After Children, concerns remain around consistency, in particular, review health assessments have shown a decline in compliance and stated that the Committee welcomed the report but requested additional data, which will be included in the next update. It was noted that a proposed reduction in the risk score for this item was challenged, due to ongoing variability in performance, which will be revisited at the Quality and Safety Committee in August.

JS stated there a number of items were approved virtually:

- Patient Safety Incident Response Plan – Midlands Partnership Trust
- Patient Safety Incident Response Plan – National Unplanned Pregnancy Advisory Service
- Stoke on Trent Joint Dementia Strategy

	JS added that further patient safety improvement plans from other providers are expected to come through the Committee in due course. JS advised that this meeting marked her final formal chairing of the Committee by JS and expressed appreciation for the opportunity to work with HJ and her team over the past three years. She welcomed SH into the role, noting her extensive experience and highlighted that the Committee is in a strong position moving forward. **The ICB received and noted the report.**	
13.	**Staffordshire and Stoke on Trent Health and Care Senate AAA Chairs Report – May**	
	RG presented to report and advised that the Senate approved the Integrated Medicines Optimisation Group (IMOG) decision to approve seven NICE Tas for NHS England commissioned drugs and all of these were specialised drugs and recommended for entry on the formulary as RED drugs. She also advised that Tirzepatide (brand name Mounjaro) for weight loss was recommended for entry on the formulary as a RED drug, to allow for availability in secondary care weight loss clinics. RG reported that Senate approved the decision made by the IMOG in relation to the palliative care medication on the formulary and added that a position statement has been produced to deprescribe bath and shower gels for skin conditions due to limited clinical value. It was noted that the Senate endorsed the Staffordshire and Stoke on Trent Alcohol Strategy and also clinically approved the revised service specification for Community ENT. **The ICB Board received and noted the report.**	
	Staffordshire and Stoke on Trent Health and Care Senate AAA Chairs Report – June	
	RG presented the June report and advised that the Senate approved the decisions made by IMOG against the specialised drugs funded by NHS England and added that the Senate also approved the streamline recommendation for the medical treatment of the ulcerative colitis and Crohn's disease pathway. She also added that Lurasidone, psychotic medication was also approved for shared care. RG advised that the Senate discussed the clinical model for weight management, which is a NICE recommendation and a must do. She added that there is a phased implementation and the Senates role was to approve the clinical model. She added that there are strict criteria for implementation and also financial implications which will be presented to the Finance and Performance Committee It was noted that the Senate clinically approved the ISC Diagnostic Strategy and Diagnostic Strategy Delivery plan and also approved the terms of reference for the Value Based Steering Group, which is a sponsorship for the Senate through the clinical values programme and will be aligned to the Senates objectives to ensure embedded a value-based healthcare across the system JH referred to the weight management programme, in particular the communication to the public and the impact regarding the strict criteria, which must be having an impact on our local GPs and asked what we can do to support this, given the constraints and asked how many patients are being supported. RG confirmed that there is a phased roll out programme and the model has been designed to take off the day-to-day pressure for general practice and colleagues are working closely with Primary Care to ensure that there is no impact on general practice. She added that there are a significant number of patients who are purchasing the medication privately. She stated as the eligibility criteria changes the funding model will be different and will be constantly reviewed and will update the Board when required. RG confirmed that she will share the number of patients being supported. PEJ stated that Primary Care Hubs are contacting patients in accordance with the criteria and added that it is a 12 year roll out programme criteria. He commended that work being undertaken through	**RG**

	primary care and not secondary care model, which is part of the direction of travel of hospital community and gives an opportunity to link into the work being undertaken by the Local Authorities. JR referred to the potential increase in acute pancreatitis for patients using the weight loss medication which is a potential risk and stated that the manufacturers have recommend pre-genetic testing and asked clinical colleagues if they are comfortable with the level of risk and have the potential impacts on secondary and tertiary care in terms of patients experiencing these issues. RG stated that NICE guidance is being followed but stated that the biggest risk is those patients purchasing the medication privately, which may have an impact on the NHS. She provided assurance that those patients receiving the medication via the NHS are closely monitored. SH stated the importance of early diagnosis of pancreatitis which can be done relatively easily through blood tests when under medical supervision and highlighted the importance for patients to be under medical supervision with the whole package and to be continually monitored. DP expressed appreciation for the update and commended the Senate for the significant work it has undertaken since its establishment. **The ICB received and noted the report.**	
14.	**ICS Finance and Performance Report**	
	CF presented the financial element of the report, highlighting that as of Month 2, there is an adverse variance of £2.9 million against the financial plan. She added that the primary driver for this variance is slippage in the Cost Improvement Programme (CIP) and provided assurance that all partner organisations remain committed to delivering the agreed financial plan and significant work is ongoing to: • Identify further efficiency opportunities • Assess and mitigate overall financial risk • Ensure continued progress in implementing efficiency measures. CF added that the overall financial risk has reduced month-on-month, indicating positive momentum and stated that a further £22 million of efficiencies have now moved into the implementation phase, reinforcing the system's commitment to recovery and delivery. CF reported that as of Month 3, the system is now reporting a balanced financial plan with no year-to-date variance, which is a significant improvement from the previous position. She added that the financial plan is supported by £95 million in deficit support funding, which is conditional and must be earned through delivery against the plan and advised that funding for Quarters 1 and 2 has been received, however, stricter criteria applies for Quarter 3, with performance being assessed based on the Month 5 position and will be subject to a range of metrics and will require regional and national sign-off. CF emphasised the importance of continued delivery against the plan to maintain eligibility for this support and advised the Board that there has been an announcement this week stating if we deliver the plan this year, the £95 million deficit funding will not need to be repaid next year. DP welcomed the finance update and asked CF whether she felt assured that all partners are fully committed to delivering the plan and maximising its impact. CF acknowledged that Month 6 will be particularly challenging, as this is when the CIP is expected to take full effect. She advised that a positive meeting was held with UHNM, where assurance was received regarding actions being taken to minimise financial risk and the ICB position is being reviewed daily by colleagues to monitor progress and mitigate emerging risks and financial workshops are being held to support delivery and maintain momentum. CF reiterated the importance of continued collaboration and proactive risk management to ensure the system remains on track.	

JH sought clarification on whether the criteria for accessing the £95 million deficit support funding includes performance improvement metrics in addition to financial ones. CF confirmed that the criteria are based purely on financial metrics.
JR raised concerns regarding the assumptions underpinning the financial plan, particularly in relation to workforce reductions. He referred to both the Finance and Workforce reports, noting that the plan was partly predicated on a reduction of 1,000 posts across the system, which is a reasonable assumption given the scale of the required £306 million savings and highlighted that the current workforce position shows a net reduction of only 6 posts and asked whether vacancies are being held as part of the plan and asked how much of the plan's delivery is reliant on non-recurrent savings. CF acknowledged the concern and advised that he has requested a detailed breakdown of savings to be returned by mid-August, to ensure a clear understanding of where savings are being realised and added that a significant proportion of pay-related savings are focused on corporate cost reductions, which we have seen nationally significant growth and is a key area for us to focus on, together with bank and agency costs.

PS presented the performance element of the report, highlighting that winter preparations are progressing at pace and emphasised that the management of winter will be critical to the successful delivery of the operational plan, with increased importance placed on the system's approach this year. He added that preparations are being shaped by the new national UEC plan, which outlines a broader set of responsibilities for winter preparedness and response and there will be three key learning points from the national guidance:

- Greater emphasis on the role of community neighbourhoods, particularly in supporting vulnerable individuals in their own homes
- Preventing unnecessary escalation to acute services
- Focus on early warning systems and tactical interventions to avoid tipping into critical incidents.

PS emphasised that ways of working will be as critical as system capacity in managing winter pressures and noted that the approach for this year has been agreed by system CEOs and will move beyond the traditional demand-capacity model to a more holistic strategy and will place equal emphasis on primary care, neighbourhood teams, and ambulance services, ensuring tangible system-wide benefits. He stated that the framework is structured around 12 strategic pillars, each with an executive lead and he will take on the role of Winter Director, providing overarching leadership and coordination.

It was noted that NHS England will adopt a different approach this year, including a site visit in September and they will also lead an EPRR-style readiness assessment and the Board will be required to submit a Board Assurance Statement as part of this process.

PS highlighted that this winter presents an opportunity to do things differently, with a focus on innovation and system transformation. He shared an example of mobile diagnostic capability, such as x-ray in a car, as one of the exciting developments being explored and confirmed he will update the Board in due course as these innovations progress.

PS

PS informed the Board that the ICB is leading preparations for the upcoming resident doctor strike and provided assurance that the system has the resources and processes in place to manage patient flow effectively and protect capacity for the most clinically vulnerable patients. He added that some impact is expected, particularly on the elective care programme and provided assurance that mitigation plans are being developed, with system partners working collaboratively to reduce risk and it is anticipated that a finalised plan will be in place by the end of the week.

ED raised a point of accuracy in the Board papers, specifically regarding the out of area placements data on page 125 and acknowledged the known pressures and challenges in this area but highlighted that the report inaccurately reflects the number of beds removed from normal capacity due to Project Crystallise and confirmed that the papers will be updated with accurate figures in due course. BA

	added that while bed numbers are a key factor, it is important to also consider the broader range of associated issues impacting out of area placements. DP requested clarification on the submission timeline and assurance process for the NHS England template and asked whether the September Board meeting would provide sufficient opportunity for the Board to gain confidence and assurance. PS confirmed that the submission deadline is the end of September and stated that the Assurance Statements will be presented at the September Board meeting, however, some elements may require virtual sign-off by the Chair outside of the formal meeting. He added that the overall winter plan follows a formal governance route through all providers and Local Authorities and a final version of the plan will be presented to the November Board for ratification. BA stated that while the national template may apply a uniform lens, the system's 12 pillar approach will ensure a more comprehensive view, which allows the system to remain sighted on all key issues, ensuring that no critical areas are overlooked in winter planning and preparedness. JR noted the positive progress reflected in the report, with more indicators rated green than red and acknowledged the significant effort across the system to achieve this. However, he raised a concern regarding virtual ward occupancy, noting that the system does not have a large number of virtual beds, which could undermine the winter plan and asked what actions are being taken to increase occupancy and ensure effective use of step-up and step-down pathways. PS stated that there are several challenges, namely: • The system did not build the capacity levels originally planned • There is a lack of trust in virtual models, particularly among clinical teams. Work is ongoing via the Integrated Discharge Hub to build confidence and support adoption • The step-up function has underperformed, though there are clear benefits to be gained from improving this aspect of virtual ward use • There is variation across the system, and this issue will be addressed as part of the 12-pillar winter planning framework. PS provided assurance that targeted work is underway to improve virtual ward utilisation and integrate it more effectively into winter resilience planning. SH expressed concern about the current utilisation of virtual wards and suggested there may be opportunities to enhance the model through IT and digital innovation and suggested building on the existing toolkit used in care homes and exploring a hub-and-spoke or buddy system, which can link to meaningful recognition and support mechanisms. PS agreed and emphasised the importance of integrating virtual wards into the system's care co-ordination infrastructure and added that virtual wards should be accessed through the Integrated Care Co-ordination Centre, serving as the single point of access for care professionals and added that integration is key to improving accessibility, trust, and utilisation of virtual care models. DP referred back to JR's earlier observation about the positive shift in performance metrics, noting the increase in green ratings across the report. He took the opportunity to commend Executive colleagues for their hard work and commitment in driving this improvement across the system. **The ICB Board:** • **Acknowledged the performance overview** • **Acknowledged the financial position**	
	Finance and Performance Committee AAA Chairs Report – June	
	JS presented the report as read and it was noted that there was no escalation to be alerted to the Board. **The ICB Board received and noted the report.**	

	Finance and Performance Committee AAA Chairs Report – July	
	JS presented the report and informed the group that discussions are ongoing regarding the scheduling of meetings to better align with the timing of financial data reporting. JS referred to the digital strategy report, specifically in relation to the integrated EPR business case and advised that there is significant financial risk with taking this forward and highlighted that the risk rating has been increased to level 20 and provided assurance that work is underway to mitigate the revenue impacts. JS referred to the workforce update and stated that there have been some improvements against plan, however the whole time equivalent (WTE) and spend is not currently aligned and further work is required to understand the discrepancy. JS informed the Board that a verbal update was provided regarding the Provider Collaborative Assurance Report and the Committee noted that further clarity is anticipated around certain aspects of the ongoing developments within the provider collaborative. JS concluded by advising that the Committee had approved the Terms of Reference for the System Performance Group. **The ICB received and noted the report.**	
15.	**ICS People, Culture and Inclusion Committee Report**	
	GT presented the report and advised at month three year to date is minus 482 WTE and are heading in a positive direction in terms of workforce reduction, which represents a position of 42 WTE under the planned performance level. She added that work continue with providers to reduce the use of bank staff and she also added that agency usage continues to reduce with 52 WTE equivalent under plan. GT stated as previously mentioned, we are implementing enhanced workforce and financial controls, alongside transformation activities and these initiatives are expected to come to fruition throughout the year and colleagues are tracking them very closely. She added that to address the mismatch that has been identified, we are triangulating the data and working to close the loop, which involves getting into the detail and liaising closely with both workforce and finance colleagues to ensure alignment and clarity. GT reported that sickness absence levels were 4.8% in May and noted that June's data is not yet available, but it is hoping that this is a continued trajectory and added that turnover rates are continuing to reduce, but this is providing a challenge to providers in the assumption they have built into the plan and turnover of vacancies. She highlighted the importance of staff wellbeing and advised that colleagues are continually monitoring this as teams progress through the ongoing NHS transition. This ensures that any emerging concerns are identified early and appropriate support is provided. JS referred to the sickness rates and noted that the figures are for the whole system and asked if colleagues are aware of the impact on the ICB due to the NHS transition. She also referred to the appraisal rates which are around 80% for both agenda for change staff and medical staff, which, while not alarmingly low, may not be fully reflective of the level of support staff need, particularly during periods of significant change and stated that it may be worth considering whether appraisals are being used effectively as a tool to support staff through transition. GT stated that she will share sickness levels for the ICB and stated that this forms part of our risks which were identified at the beginning of the year, which include health and wellbeing and the impact on staff during the transition. She acknowledged the comments regarding the appraisal rates and provided assurance that this will be picked up via the Comments and executive colleagues. **The ICB Board received and noted the report.**	**GT**

	Staff Survey Results 2024/2025	
	GT presented the report and was pleased to announce that SSOT was the best performing system overall out of the Midlands ICS/s and achieved higher scored than the overall Midlands and National result in all People Promise themes, positive result as a system and working together collectively. She added that overarching themes have been identified and will be monitoring through the PCI Committee who will receive an update in the autumn. DP welcomed the positive nature of the report, while acknowledging that the results were captured prior to the NHS reset announcement. She noted that colleagues have already begun to generate a number of ideas on how to maintain momentum and support staff through the next phase of change. JS acknowledged the positive results presented, noting that they were gathered prior to the NHS Reset announcement. She shared that Non-Executive Members have been actively discussing the implications, recognising the system-wide impact, particularly on providers managing cost improvement programmes and vacancies, as well as the ICB. She welcomed the PCI Committee's continued oversight and suggested that face-to-face interactions could be beneficial in maintaining engagement and support. She also commended the professionalism of staff during this period of change and expressed her gratitude for their continued hard work. PEJ welcomed these comments and agreed to highlight them at the next team brief, ensuring that staff are aware of the appreciation and ongoing support. SH referred to the recent discussions among Non-Executive Members and asked whether colleagues have considered using Monkey Surveys and pulse checks to gather staff feedback. She noted that these tools have previously proven helpful and emphasised the importance of regular and effective communication with staff, especially during times of transition. ML acknowledged that the report was conducted prior to the NHS Reset and expressed that Non-Executive Members took great comfort in the evident culture of speaking up across the organisation. Referring to the "Each Voice Counts" section, ML noted that the organisation scores very strongly, suggesting that staff feel confident and willing to share concerns when they arise. ML added that if regular pulse checks via SurveyMonkey are implemented, there is a high degree of confidence that the feedback received will be genuine and reflective of staff sentiment, reinforcing the value of continued engagement and open communication. **The ICB Board:** • **Received and noted the report and noted the common themes and proposals for collaboration in those areas to have the greatest impact on our workforce.**	**PEJ**
	Annual Report 2024/2025	
	GT presented the report, which captures key achievements across the system, highlighting several successful national pilots including: • Volunteering for Health • T Levels • Care Leavers Initiatives GT emphasised the ongoing focus on widening participation and access, and the progress in embedding the Anchoring Institution Strategy. GT reaffirmed the organisation's strong commitment to Equality, Diversity and Inclusion (EDI) throughout these activities. Assurance was provided that the PCI Committee is actively overseeing all initiatives and has already drafted its 2025/2026 delivery plan and colleagues are currently awaiting the long-term Workforce Plan, which will help shape future activity in response to emerging risks and challenges, particularly in collaboration with providers and the Shropshire, Telford and Wrekin ICB.	

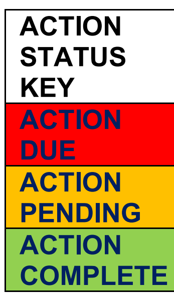
	AP reflected on the recent debate held at the PCI Committee, noting that it provides a strong local platform as we move forward into the next phase, focused on local jobs for local people and aligned with the 10-year workforce plan. She emphasised that provider commitment remains strong and commended the paper for its quality and relevance and concluded by recognising the great work already underway and reaffirmed the collective commitment to continue driving this forward. **The ICB Board:** • **Received and noted the report** • **Were assured on the delivery of People, Culture and Inclusion programmes in 2024/25.** • **Ratified that the report as a reflection of 2024/25 programme activities, achievements and impact ongoing support and engagement of partners in the delivery of People, Culture and Inclusion Programmes**	
	ICB People, Culture and Inclusion Committee AAA Chairs Report - July	
	SL presented the report and emphasised the importance of having a robust establishment control process in place. He highlighted the need to maintain a careful balance between finance and performance and stressed the importance of ongoing monitoring to ensure that this balance is sustained effectively across the system. He referred to the Annual Report and acknowledged the significant hard work undertaken by Chief People Officers across the system he recognised MI and GT for their leadership in co-ordinating efforts and ensuring continuity of work. SL acknowledged the numerous discussions throughout the meeting regarding staff wellbeing, communication, and the challenges of managing uncertainty and change and noted that while there is resilience within the system, it's important to recognise that for some individuals, this period remains particularly difficult and emphasised the need to consider how best to support staff moving forward. DP agreed, reinforcing that the impact on staff should not be underestimated and stressed the importance of remaining professional and transparent in all communications and actions, to ensure staff feel supported and informed during this time. **The ICB Board:** • **Received and noted the report.**	
16.	**Staffordshire and Stoke on Trent ICB Strategic Commissioning and Transformation Committee AAA Chairs Report – June and July**	
	ML extended thanks to ED for her strong commitment over the past four months in helping to grow the credibility and visibility of the Committee, which are instrumental in strengthening the Committee's profile and impact. ML presented the report and congratulated both Local Authorities on receiving "Good" ratings from the CQC, recognising this as a significant achievement. He also acknowledged the ongoing challenges faced by Local Authorities, including cost pressures, rising demand in social care, and inflation and in response to these pressures, ML confirmed that the Local Authorities and the ICB have agreed on a joint approach to managing funding and eligibility for care under Section 117. He commended ED and JR for their strong collaboration and leadership in driving this work forward. ML referred to the Health and Care Improvement priorities for 2025/2026, highlighting key areas of focus discussed by the Committee. He reported that discussions also covered: • Staffordshire County Council's recommissioning of living care services • Stoke-on-Trent's efforts to promote greater integration of health and care services. ML stated that these topics were explored in detail, reflecting the Committee's commitment to collaborative planning and system-wide improvement.	

	ML informed the Committee that an update on the ICS Green Plan had been received, and members were assured of the programme's progress and a link to the full report has been shared and is also available on the website for wider access. He also noted that the Committee received updates on Gordon Street and the current wheelchair commissioning process, which reflect the Committee's continued oversight of key operational and service developments across the system. ML concluded by noting that the Committee is beginning to gain real momentum, with good-quality decisions being made and strong engagement from all members. He expressed appreciation for the constructive contributions throughout the meeting and confirmed that the report reflects the key points discussed. DP welcomed the update and stated it is really encouraging as well how quickly the Committee is getting up to speed with some meaty business, thanks to you and ED and others that have accelerated that drive to really make this happen. JR agreed, reflecting on the transformational difference the Committee has made and attributing much of the progress to ED's arrival and ML's leadership, noting that the Committee has now become a true engine room for commissioning and transformation. He highlighted the value of having a central forum to resolve issues collectively and praised the emerging clarity in the relationship between strategic and joint commissioning governance at locality level, including the ability to escalate and delegate appropriately. He referred to the work undertaken on the 1st July as a strong example of progress, what began as a challenging and unresolved issue was transformed into a collaborative, collegiate solution, with support from Deloitte and a shared commitment to working together and the ability to escalate and delegate which is exactly how it should work. **The ICB Board:** • **Received and noted the report**	
17.	**Staffordshire and Stoke on Trent ICB Audit Committee AAA Report**	
	JH presented the report and highlighted the counter-fraud narrative and the upcoming guidance on the new corporate offence around failure to prevent fraud. **The ICB Board:** • **Received and noted the report.**	
18.	**Staffordshire and Stoke on Trent ICB Remuneration Committee AAA Chairs Report – May and June**	
	SL presented the report as read. **The ICB Board:** • **Received and noted the report.**	
19.	**Items notified in advance to the Chair**	
	Annual report Healthwatch AM informed the Board that the Healthwatch Annual Report was published on 30th June. The report summarises the work and impact of Healthwatch over the past 12 months and agreed to share the report with LE, who will forward to Board members for their information.	**LE**
20.	**Questions from the floor relating to the discussions at the meeting**	
	Ian Syme expressed that he was saddened to read about DP stepping down as Chair of the ICB.	

	Ian Syme (IS) Question One - UEC / Ambulance Handover Delays IS raised serious concerns about ambulance handover delays, highlighting both financial and operational implications and stated that UHNM was identified as the worst-performing trust in the West Midlands for ambulance turnaround times and added that the West Midlands region is currently the worst in England for handover delays. He noted that ambulance handover delays could increase system costs from £3 million to £6 million, due to additional operating pressures and acknowledged that there is no central funding to cover these costs, which ICBs have had to absorb, which has ramifications for wider system investment. He stated that this funding could be used more effectively elsewhere, rather than compensating for system inefficiencies and impacting on children waiting in emergency departments, mental health patients experiencing prolonged boarding and 12-hour trolley waits and referred to a new initiative by the London Ambulance Service. IS asked how will the winter plan and the UEC plan align to address these systemic issues, particularly ambulance handover delays? PS responded to the concerns raised by acknowledging the financial and operational pressures caused by ambulance handover delays and advised that the ICB is in active discussions with the lead commissioner for the ambulance service regarding additional payments to support system pressures and stated that from a performance perspective, category 2 response times have significantly improved and have remained within the 30-minute standard this year. He agreed that ambulance handovers are not an isolated issue, but a system wide challenge, particularly around patient flow and stated that all these aspects of the winter plan are important in terms of making sure that only those who actually need acute care are conveyed through to hospitals and stated that there is a commitment from UHNM to make improvements, ensuring that only patients who truly need acute care are conveyed to hospital, with a strong emphasis on diversion and navigation through the Single Point of Access. It was noted that UHNM has committed to making improvements, and recent changes have been deep-rooted, with early signs of progress, notably, over 80% of ambulances were handed over within 45 minutes this month. PS stated that there is a need for continued improvement across all parts of the system, including reducing conveyance rates, improving hear and treat / see and treat performance and strengthening system-wide collaboration to support flow and reduce delays. PS emphasised that these issues are being addressed through the 12pillar winter planning framework and that alignment between the winter plan and the UEC plan is a priority in ongoing discussions with system partners. CF emphasised the importance of system-wide collaboration, stating that it is incredibly important that all partners work together to address ambulance handover delays. She acknowledged that current handover times are not acceptable but stressed the need to also understand and optimise the operating model, ensuring that all available care pathways are being used appropriately to reduce unnecessary conveyance to emergency departments and the ICB is engaged in daily conversations with the ambulance service to support improvements and ensure alignment across the system. SC acknowledged that the challenges around urgent and emergency care have been consistently discussed both at this forum and at UHNM Board level and he reaffirmed his personal commitment to improving UEC and emphasised that this is a genuine system-wide response, not solely a UHNM issue and added that UHNM is front and centre in ensuring ambulance crews are released quickly, to avoid operational and financial consequences for both patients and the wider system. He added that a system-wide UEC improvement plan is in place, which feeds directly into the winter plan, and the two must be closely aligned. He highlighted that there are ongoing challenges with data quality, which impacted performance reporting in June and the system is working collaboratively and constructively, with a shared commitment to improvement.	

	SC pushed back on the earlier characterisation of UHNM as consistently the worst performer for ambulance handovers and acknowledged that while challenges remain, recent weeks have shown measurable improvement, stating that progress has been made and UHNM has moved up the regional performance league table, with some of the best figures recorded in over a year and added that in the last few weeks, UHNM has achieved its strongest performance in terms of reduced ambulance handover delays during his 10 month period as Chief Executive, which is a positive trajectory, but recognised that continued effort and system-wide collaboration are essential to sustain and build on this progress. SC reported that 41 minutes was the average handover was last week, which is a significant improvement, but highlighted that more work is required. He also added that the 12 hour wait time has also reduced substantially too. He stated that it is difficult when you're comparing different types of emergency department is very challenging, as UHNM is a big emergency department, handling helicopters as well as other ambulance services, not just West Midlands ambulance service and also, fulfilling an important role as a district General Hospital, but also taking specialty referrals. He concluded by stated that we are starting to see some improvements, but we are nowhere near that where we should be and we are working very well together as a system to make sure it sustains. Ian Syme Question Two - my care my way home first IS raised a concern regarding previous commitments made in January 2020 around community hospital beds and hub development and advised the Board that at that time, 184 community hospital beds were closed across Leek, Bradwell, and Longton Cottage Hospitals and stated that there was a commitment to commission replacement beds from both the provider sector and independent nursing homes. He also stated that there was also a promise to establish community hubs at Bradwell and Leek and to build a new hub at Longton using capital funding. He expressed concern that he now understands the hubs will not be formalised as part of the current plan and emphasised that the community was given a clear promised and asked how do we move forward on this, and how do we communicate this change to the public? TS acknowledged the commitments made in January 2020 regarding community hospital beds and hub development and stated at the time, funding was identified, but capital finance was not released, which prevented the planned new build at Longton from progressing. She added that despite this, services have been established in Leek that support the integrated neighbourhood model originally envisioned for the hubs. She confirmed that while the formal hub structures have not been realised, community-based services are in place and actively supporting local residents and agreed to provide further detail outside of the meeting. TS emphasised the importance of viewing this within the context of the 10-year plan and reiterated that there is still a commitment to community-based care, including a need to review and support the teams currently working in the community. Ian Syme clarified that the capital funding referenced in 2020 was specifically for anew build at Longton and modifications at Bradwell and Leek Hospitals and expressed concern that there has been no formal report or update since 2020 on the status of these commitments. He added that the original plan included relocating services into the proposed hubs, and this should be compared against what has actually been delivered and stated that the community was given a clear promise. DP thanked Ian Syme for raising the issue and acknowledged the importance of the concerns and requested that TS and ED take the matter forward outside of the Board meeting to unpack the historical commitments and understand the current position. JR responded to the disclosure that the Longton Hub will not proceed under the previous programme, expressing that this will be of interest to a wider group, including Members of Parliament and local council members and stated that there is a need to re-engage with the community and revisit the vision for neighbourhood health, particularly across the four localities and added that the system should consider what future provision should look like in each geography, in light of changing circumstances and community needs.	

21.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the Leadership Compact.	
22.	**Close**	
	There being no further business, the Chair closed the meeting.	
23.	**Date and time of Next Meeting**	
	Date and Time of Next Meeting Thursday 18th September 1.00pm – 3.30pm, North Staffordshire Combined Healthcare NHS Trust Boardroom at Lawton House, Bellringer Road, Trentham, Stoke-on-Trent ST4 8HH.	



Staffordshire and Stoke-on-Trent ICB Board Meeting ACTIONS

Meeting Date	Agenda Item	Action	Due Date	Responsible Officer	Outcome/update (Completed Actions remain on the Live Action Log for the following committee and are then removed to the 'Closed Actions' Worksheet)
17/07/2025	Questions submitted from members of the public	Allison Gardner MP Question One – wheelchair services I note on page 75 that whilst waiting times for service users waiting 18+ weeks has reduced those waiting 52 weeks+ remain high. Could you outline the demographic of the patients (e.g. children) waiting longer than 52+ weeks and the type of wheelchair the tend to wait for e.g. moulded wheelchairs.	Completed	Elizabeth Disney	ED thanked Allison Gardner for the question and advised that she has not got the detail regarding the over 52 wait but agreed to share the information outside of the meeting. She stated that there were 223 adults and 66 children waiting over 18 weeks as at the end of May, with the majority of patients awaiting bespoke equipment and she added that the delays relate to supplier delay/equipment order backlog and/or prioritisation of clinical appointments for specialist seating. Additional information shared to Allison Gardner - The overall number of service users waiting has reduced and, importantly, that reduction has been maintained. It is worth noting that the waitlist is fluid and changes daily. As of the most recent data run, there are currently 60 breaches over 52 weeks. The breakdown of need among these 60 cases is as follows: • 9 service users are awaiting specialist equipment, such as moulded seating systems. Of these, 6 are adults and 3 are children. • 24 are categorised as high need, typically involving powered wheelchairs or tilt-in-space chairs. This group includes 19 adults and 5 children. • The remaining 27 are classed as medium need, which includes active user chairs and some specialist buggies, with 23 adults and 4 children in this

					category. Of the 60 breaches, 11 service users have appointments booked and scheduled to take place in the coming weeks. The type of wheelchair being waited for varies depending on each individual's prescription. These can range from attendant-propelled or self-propelled chairs, to manual or electric wheelchairs, and seating solutions such as matrix or moulded seats. The complexity and individual nature of each prescription can impact lead times for assessment, ordering, and delivery.
17/07/2025	Questions submitted from members of the public	Allison Gardner MP Question Four – morality rates Could you update me on what the infant mortality rates currently are in Stoke-on-Trent and Staffordshire and actions taken to reduce the levels.	Completed	Paul Edmondson-Jones	PEJ thanked Allison Gardner for her question and stated that he will also provide a comprehensive written response (sent on the 19th August). He stated that the rates we have access to refer to an average from 2021 to 2023 and for Stoke on Trent the rate is 7.6% per thousand live births and for Staffordshire it is 5.2% per thousand live births, which gives an average of 5.8% per thousand live births. He added that last year a Midlands Infant Mortality Forum was established and chaired by the Regional Director of Public Health and has representative from all partners, including the police, clinical academics and local universities. He stated that there is an ICS infant mortality action plan, which has been delivered jointly with the Local Council and Public Health. PEJ stated that there have been a number of achievements over the past few years, including: • Significant reduction in smoking at the time of delivery, which has reduced from 12% to 4.9% • Infant mortality dashboard has been established across the ICS • Improved multi-disciplinary care in maternity, focusing on complex needs during pregnancy • New work programme on per-conception care, particularly targeting healthy weight, alcohol and other preventative approaches

17/05/2025	Staffordshire and Stoke on Trent Health and Care Senate AAA Chairs Report - June	JH referred to the weight management programme, in particular the communication to the public and the impact regarding the strict criteria, which must be having an impact on our local GPs and asked what we can do to support this, given the constraints and asked how many patients are being supported. RG confirmed that there is a phased roll out programme and the model has been designed to take off the day-to-day pressure for general practice and colleagues are working closely with Primary Care to ensure that there is no impact on general practice. She added that there are a significant number of patients who are purchasing the medication privately. She stated as the eligibility criteria changes the funding model will be different and will be constantly reviewed and will update the Board when required. RG confirmed that she will share the number of patients being supported.	Completed	Rachel Gallyot	For Cohort 1 the assumptions are set out below: Locality No of Eligible Patients Year 1 70% Year 1 (Assumed Take Up) Monthly No New Patients @70% Year 1 North Staffs & Stoke 899 629 52 South East Staffs 371 260 22 South West Staffs 433 303 25 Total ICB Footprint 1,703 1,192 99 Year 1 will run from Sept 25 – Sept 26 so in this financial year its likely we will only reach around 700 patients as we only have funding in place until 31st March 2025. A business case is going to be needed to secure future funding from April 26 onwards to finish the reach to cohort 1 and open up to cohort 2. Criteria for cohort 1 is a BMI of 40 or higher plus 4 out of 5 comorbidities (Dyslipidemia, Hypertension, Obstructive sleep apnoea, Cardiovascular disease, Type 2 diabetes.) We will have a number of primary care specialist hubs being run and patients will be contacted by these hubs when they are eligible. Due to the small numbers involved this year, the hubs will be prioritising highest BMI & 5/5 comorbidities first and we have the comms team helping us with messages and all GP practices have been sent a script to go on their websites to help with the roll out.
17/05/2025	ICS People, Culture and Inclusion Committee Report	JS referred to the sickness rates and noted that the figures are for the whole system and asked if colleagues are aware of the impact on the ICB due to the NHS transition. She also referred to the appraisal rates which are around 80% for both agenda for change staff and medical staff, which, while not alarmingly low, may not be fully reflective of the level of support staff need, particularly during periods of significant change and stated that it may be worth considering whether appraisals are being used effectively as a tool to	Completed	Gemma Treanor	The current ICB sickness rate is 2.28% (June 25), which is a reduction from the same time last year (3.06%). The rates have steadily declined from 5.04% in November 2024. Support for staff health and wellbeing continues via day to day leadership, health and wellbeing resources, Occupational health contract and Staff Support and Counselling Services. The ICB People Team will continue to monitor the sickness rates carefully throughout this period of change, recognising the impact on our people. The appraisal rates are being explored via CPOs and at the next PCI Committee on 4th September.

		support staff through transition. GT stated that she will share sickness levels for the ICB and stated that this forms part of our risks which were identified at the beginning of the year, which include health and wellbeing and the impact on staff during the transition. She acknowledged the comments regarding the appraisal rates and provided assurance that this will be picked up via the Comments and executive colleagues.			

Enclosure No: 05

Report to:	**Integrated Care Board**					
Date:	**18 September 2025**					
Title:	Chair and Chief Executive Officer Report					
Presenting Officer:	David Pearson, Chair, and Paul Edmondson-Jones, interim CEO					
Author(s):	David Pearson, Chair, and Paul Edmondson-Jones, interim CEO					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☐
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	Choose an item.				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Any impacts on ICB Undertakings?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:

This report provides a strategic overview and update on national and local matters, relevant to the Staffordshire and Stoke on-Trent health and care system that are not reported elsewhere on the agenda.

It includes a general update from the Chair and Chief Executive as well as a specific focus on our portfolio areas, where applicable, as well as some of our enabling functions. Updates on the below areas may be included:

- Improving Population Health
- Planned Care and Cancer
- Children, Young People and Maternity
- Urgent and Emergency Care
- Community Transformation and Neighbourhood Health
- Mental Health, Learning Disabilities, Autism and Downs Syndrome
- Primary Care
- People Team
- Finance
- Provider Collaboratives
- Key figures from our population
- Quality and safety
- Vaccinations and immunisations

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
N/A	

(3) Implications:	
Legal / Regulatory	The areas discussed reflect ICB Statutory Duties and Functions
CQC / Patient Safety	This report type may assist the 2024 ICS CQC inspection
Financial (CFO-assured)	N/A for the report, although topics covered each have financial implications
Sustainability	N/A for the report
Workforce / Training	N/A no specific training implications / workforce matters inherent to each topic
Equality & Diversity	N/A in terms of Equality Act 2010 or Public Sector Equality Duty
Due Regard: Inequalities	Access to services and reducing inequalities is implicit throughout
Due Regard: wider effect	N/A – no decisions are required for the paper itself: it is to raise awareness

(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, signed off by QIA on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:					
BAF1	Responsive Patient Care - Elective	☒	BAF5	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☒	BAF6	Sustainable Finances	☒
BAF3	Proactive Community Services	☒	BAF7	Improving Productivity	☒
BAF4	Reducing Health Inequalities	☒	BAF8	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

(7) Recommendations to Board / Committee:
To receive the report and be assured the leadership are working on each topic as raised.

1.0 Chair and CEO Update

1.1 Appointment of Chair for Clustered ICBs

Following a national appointment process, Ian Green OBE has been confirmed as the Chair of the newly formed cluster between NHS Staffordshire and Stoke-on-Trent and NHS Shropshire, Telford and Wrekin Integrated Care Boards (ICBs).

Over the last 15 years, Ian has held Non-Executive Director posts within the NHS, including Chair of Salisbury NHS Foundation Trust, Non-Executive Director of the South-Central Ambulance Trust Board and, more recently, Chair of NHS Shropshire, Telford and Wrekin.

During his time as Chair of the Salisbury Trust, the organisation achieved a CQC rating of 'Good' for maternity services and some of the highest staff survey results nationally.

Ian's Chair role in Staffordshire and Stoke-on-Trent ICB will begin 1 November 2025.

Under the clustering arrangements, both Integrated Care Boards will remain separate statutory organisations but will increasingly operate with a single management team. This approach will enable shared innovation, best practice, and a unified focus on improving outcomes for the populations they serve.

1.2 ICB Reform Update

The process to appoint a new cluster Chief Executive is underway. A preferred candidate has been identified, and formal confirmation is expected in the coming weeks.

Work is also progressing to develop a high-level operating model for the ICBs by October. Workshops to discuss how functions are grouped, and how the organisations are structured, will be held. Following the workshops, the operating model will be refined by senior leaders from both Staffordshire and Stoke-on-Trent and Shropshire, Telford and Wrekin ICBs.

The Model Region Blueprint has now been shared and sets out the future role that regions will play as part of a new NHS operating model. NHS England and the Department of Health and Social Care (DHSC) are being brought together and redesigned into a smaller, more agile centre, with seven regions responsible for performance management and oversight of providers. The implementation of the regional blueprint will help to inform further development of the NHS operating model and we will be reviewing both documents to identify gaps, duplication, or concerns regarding responsibility and accountability.

1.3 HSJ Awards

Colleagues at University Hospitals of North Midlands (UHNM) and University Hospitals of Derby and Burton (UHDB) have been shortlisted in the 2025 Health Service Journal Awards. UHNM has been recognised for Acute Sector Innovation of the Year, Driving Efficiency through Technology, and Modernising Diagnostics, while UHDB has been shortlisted for Medicines, Pharmacy and Prescribing Initiative of the Year and Provider Collaboration of the Year. The awards ceremony will take place in London on 20 November.

1.4 NHS Oversight Framework (NOF) Rating

A new NHS Oversight Framework (NHS England » NHS Oversight Framework 2025/26) has been introduced, which sets out a revised approach to assessing NHS providers for 2025/26. The framework assesses organisations against a range of agreed metrics and then publishes the results as part of its commitment to greater transparency for patients and the public.

NHS England (NHSE) has recently published the dashboard, which includes each organisations segment score, and the provider national league table position. Congratulations to all organisations but particularly to North Staffordshire Combined NHS Trust and Midlands Partnership University Foundation Trust who are ranked as 1 and 2 in the national non-acute hospital trust league table. Both providers are also in segment 1 (high performing).

ICBs will not be allocated segments in 2025/26, recognising that this is a year of significant change and disruption. ICB performance against the full suite of oversight metrics will be published to aid planning and improvement and NHSE will continue to review how well each ICB is performing its statutory duties as part of statutory annual assessments.

1.5 Strategic Planning

NHS England published a draft Planning Framework in August 2025, marking a shift from annual cycles to a rolling five-year planning horizon, aligned with the ambitions set out in the NHS 10-Year Health Plan. This change supports longer-term service development and better alignment with population health needs.

Key changes include:

- Separate five-year commissioning plans for ICBs and delivery plans for providers
- Stronger emphasis on place-based partnerships and integrated planning
- Launch of a Planning Community of Practice to support collaboration

Work is underway to consider how best to meet the framework's expectations over the coming months, with further discussions planned across relevant teams and partners.

2.0 Primary Care

2.1 Burton Ploughing Match

"Queen's Nurses" Sister Rose Bain and Sister Gill Boast attended the Burton Ploughing Match to support the health care needs of the local farming community. They encouraged farmers and members of the pubic to have their blood pressure checked and provide other health and lifestyle advice. Rose has been liaising with Staffordshire Agricultural Society and has also been invited to Uttoxeter's Ploughing match later in September.

2.2 Get Winter Ready! Over 20 Local Events taking place

In August and September, Primary Care Networks and GP practices across Staffordshire and Stoke-on-Trent held more than 20 community events designed to help people get ready for winter. These events were packed with essential advice and support – from fuel poverty organisation Beat the Cold – Stoke-on-Trent and Staffordshire's Fuel Advice Charity to learning about Pharmacy First services, discovering the wider general practice workforce and other local health and community groups ready to support people through the colder months.

Some events are also provided information on:
- Winter vaccinations and how these provide protection and reduce risk of getting severe symptoms
- How to stay well in winter by accessing Primary Care services
- The NHS App – a simple and secure gateway to NHS services

At just one recent event, over 400 free winter health bags were handed out, filled with useful information and resources to keep warm, healthy, and informed.

2.3 Weight Management Hubs

The Primary Care weight management hubs are going live in September 2025. These hubs will provide a lifestyle and prescribing service and follow the new NICE Technology Appraisal guidance (TAG) for Tirzepatide (Mounjaro). Further details are available on the Weight Management Medication - Staffordshire and Stoke-on-Trent, ICS website. Hubs will be run from the following locations with start dates being confirmed.

- North Staffs & Stoke on Trent x6
- Stafford & Surrounds
- Seisdon
- Cannock & Rugeley x3
- Lichfield & Burntwood
- Tamworth
- Burton x 4

2.5 Antimicrobial Resistance Programme

Primary care guidelines for adults have been developed and localised for the ICS, using the experience and expertise of a multi-disciplinary team (MDT). The primary care guidelines include a good practice toolkit and will be supported by ongoing communications to ensure appropriate antimicrobial prescribing and use. The next step is to development the children's primary care guidelines.

Recognising the growing work programme and the progress made on antimicrobial prescribing, Rakhi Aggarwal from the ICB was approached to comment on prescribing habits and local plans by The Pharmaceutical Journal.

3.0 The People Team

South Asian Heritage Month was marked across the system in August through a range of events themed 'Roots to Routes'. Colleagues came together to commemorate and celebrate South Asian cultures, histories, and communities.

The system is reporting a Month 4 (July 2025) variance to the operational workforce plan, with total WTE above expected levels. This is primarily due to increased bank usage linked to Industrial Action. Work is ongoing to assess the impact and to realign with the plan.

A recent deep dive into rising sickness levels was presented at the People, Culture and Inclusion Committee, revealing a link to reduced turnover and emerging winter risks. The Committee reviewed current initiatives and agreed further action via the ICS Experience, Health and Wellbeing Committee to strengthen support for employee wellbeing.

4.0 Finance

At month 4 the system position is a £19.5m deficit which is £0.4m favourable variance to a £19.9m deficit plan (month 3 £0.3m favourable variance). The year-to-date (YTD) variance sits within the ICB (£11.4m), UHNM (£11.0m) and MPFT £2.9m with NSCHT on plan. The biggest driver of our variance to plan is the efficiency programme phasing. As a system we are forecasting to meet our year-end financial plan of break even, subject to the receipt of £95m deficit support funding (DSF). Net risk has reduced to £59.7m at month 4 down from £70.5m at month 2 and £97.3m at the final plan submission. This is primarily made up of efficiency risk (£78.3m) and additional cost risk (£25.0m) offset by efficiency mitigations (£13.3m) and other non-recurrent mitigations (£34.2m). UHNM currently holds the largest net risk position of £32.0m with the ICB at £20.2m, MPFT £7.5m and NSCHT £0.0m.

The planning timeline has been brought forward this year, with final plans due for submission by the end of November. We are currently awaiting confirmation of the national planning framework and associated allocations; key information is required by the end of September including:

- Deconstructing the block contracts
- Underlying position (start point)
- Planning assumptions across finance and activity

5.0 Planned Care and Cancer

Funded by NHS England and supported by the ICB, the Alzheimer's Society has been working with the three Community Diagnostic Centres (UHNM, UHDB and Royal Wolverhampton NHS Trust) across Staffordshire and Stoke-on-Trent to deliver environmental enhancements for patients living with dementia, learning disabilities or autism. Site visits with service users have led to a series of recommendations which, where feasible, have been implemented. For example, at Sir Robert Peel, new signage for the treatment rooms has been introduced and Perspex screens removed from entrance areas which eases navigation around the Community Diagnostic Centres (CDC) and offers better communication and visibility of reception staff. With the Hanley CDC at early build stage, the recommendations have been easier to implement, and significant changes have been made based on these including changing of the flooring from speckled pattern to plain and removal of floor lighting around the reception area which will aid patients who may have cognitive difficulties or are visually impaired. Funding also supports CDC staff to participate in dementia training which has seen a marked increase in their confidence and knowledge of this condition. Overall, the project is making a difference such that it will help improve access to diagnostics and patients have a better experience with these services.

6.0 Urgent and Emergency Care

July and August 2025 have continued to see increased demand for Urgent and Emergency Care services across the system, albeit at a lesser rate than previous months. Performance against the key metrics of A&E 4-hour, 12-hour time in department and ambulance average handover all saw improvements during July but challenges have been seen in all metrics in August, with all metrics except 12-hour time in department being off plan. The mobilisation of the 24/7 Hospital Ambulance Liaison Officer (HALO) model at Royal Stoke Hospital is showing sustained improvements in hand over delays. The System Winter Plan has continued to be developed

along with the refreshed System Escalation Plan both of which will be progressing through test and system governance in September.

7.0 Key figures from our population

		Last 4 months in current financial year				Comparator month		Change on same month previous year		
		Apr-25	May-25	Jun-25	Jul-25	Jun-24	Jul-24	No.	%	Direction
*	111 calls received	29,352	28,747	25,980	26,406		28,415	-2,009	-7.1%	↓
	Percentage of 111 calls abandoned	1.0%	0.7%	0.8%	0.8%		3.1%		-2.3%	↓
	A&E and Walk in Centre attendances (UHNM)	22,303	23,436	22,442	23,117		21,691	1,426	6.6%	↑
	A&E and Walk in Centre attendances (other providers)	17,943	19,109	19,866	20,272		19,860	412	2.1%	↑
	Outpatient procedures (UHNM)	12,555	12,831	13,056	14,209		13,730	479	3.5%	↑
	Outpatient procedures (other providers)	12,947	12,961	13,825	14,274		15,219	-945	-6.2%	↓
	GP appointments (all)	521,111	518,868	540,696	573,733		552,045	21,688	3.9%	↑
**	Physical Health Community contacts (attended)	145,510	148,500	149,150		148,165		985	0.7%	↑
**	Mental Health Community contacts (attended)	47,860	47,215	50,565		41,520		9,045	21.8%	↑

		Last 4 months in current financial year				Comparator month		Change on same month previous year		
#		Feb-25	Mar-25	Apr-25	May-25	Apr-24	May-24	No.	%	Direction
##	Non elective admissions (UHNM)	7,486	8,234	6,349	6,384		8,644	-2,260	-26.1%	↓
	Non elective admissions (other providers)	6,599	7,330	7,161	7,634		7,084	550	7.8%	↑
	Elective and Day Case spells (UHNM)	8,856	9,446	8,973	9,485		9,261	224	2.4%	↑
	Elective and Day Case spells (other providers)	9,185	9,546	9,348	9,585		9,661	-76	-0.8%	↓

Most datasets are subject to change upon refresh.

Variation in Planned Care type activities (e.g. Elective/ Day Case admissions, OP/ GP appointments) is influenced by a variety of factors, including the number of working days in the month (activity in some months is affected by bank holidays and weekend days).

* NHS 111 - following the switchover to DHU in April 2024, published data is no longer available. Data is available through a local solution from June 2024 onwards.

** The comparison with the same month the previous year is the same month for most measures, apart from when measures sometimes lag one month behind (e.g. Mental/ Physical Health contacts).

Inpatient activity - The Elective and Day Case, and Non-Elective inpatient activity positions for June and July are in the process of validating at the point of needing to deliver this report.

Non-elective (NEL) admissions (UHNM) - The reduction in NEL admissions at UHNM is due to a coding change: Some Same Day Emergency Care (SDEC) cases that were coded as inpatient admissions during 2024/25 are submitted under the SDEC in 2025/26.

8.0 Quality and Safety

A quality assurance review of the ICB's Quality Impact Assessment (QIA) process has been carried out by NHS England. The outcome of the review was: 'Significant Assurance; strong evidence that SSOT QIA process is robust and sustainable' (NHSE – July 2025).

The system's first collaborative meeting to review the challenges of Right Care Right Person has taken place. A joint report is due at the end of September. The learning from this work is

expected to show a reduction in concerns, while also supporting partners to build greater understanding and strengthen relationships.

9. Vaccination

The winter flu vaccination programme began on 1 September, with eligibility including children aged two and three, school-aged children from reception to year 11, and pregnant patients. From 1 October, the programme will expand to adults aged 65 and over, those in clinical at-risk groups, carers, care home residents, household contacts of immunosuppressed individuals, and front-line health and social care workers. COVID-19 vaccinations will also be available from 1 October for people aged 75 and over, care home residents, and those who are immunosuppressed. In addition, RSV vaccinations continue to be offered to eligible individuals aged 75–79 as part of the catch-up cohort and will be routinely available as individuals turn 75.

David Pearson, ICB Chair

Paul Edmondson-Jones, interim ICB Chief Executive Officer

Enclosure No: 06

<table>
<tr><td>Report to:</td><td colspan="6">Staffordshire and Stoke-on-Trent Health & Care Senate</td></tr>
<tr><td>Date:</td><td colspan="6">18 September 2025</td></tr>
<tr><td>Title:</td><td colspan="6">System Winter Plan 2025/26</td></tr>
<tr><td>Presenting Officer:</td><td colspan="6">Tom Bailey, Hayley Allison, Dr Steve Fawcett</td></tr>
<tr><td>Author(s):</td><td colspan="6">Tom Bailey, Jack Butler</td></tr>
<tr><td>Document Type:</td><td colspan="2">Other</td><td colspan="4">If Other: System Winter Plan</td></tr>
<tr><td rowspan="2">Action Required (select):</td><td>Information (I)</td><td>☐</td><td>Discussion (D)</td><td>☒</td><td>Assurance (S)</td><td>☐</td></tr>
<tr><td>Approval (A)</td><td>☒</td><td>Ratification (R)</td><td>☐</td><td colspan="2">(check as necessary)</td></tr>
<tr><td>Is the decision within SOFD powers & limits</td><td>Yes / No</td><td colspan="5">YES</td></tr>
<tr><td>Any potential / actual Conflict of Interest?</td><td>Yes / No</td><td colspan="5">YES
If Y, the mitigation recommendations –
Provider representatives may have conflicts for approval of schemes within the system plan.</td></tr>
<tr><td>Any financial impacts: ICB or ICB?</td><td>Yes / No</td><td colspan="5">YES
If Y, are those signed off by and date:
Financial spend managed within budget and taken to F&PC for approval.</td></tr>
<tr><td>Any impacts on ICB Undertakings?</td><td>Yes / No</td><td colspan="5">YES
If Y, are those signed off by and date:
Underpinning approach to ICB planning for Winter and periods of Surge.</td></tr>
<tr><td>Appendices:</td><td colspan="6">ICB Board Paper, PowerPoint slide deck presentation, ICB Board Assurance Statements</td></tr>
</table>

(1) Purpose of the Paper:

The ICB Board is asked to review and confirm approval of the System Winter Plan for 2025/26 and review the NHS England ICB Board Assurance Statements and confirm approval for submission to NHS England.

The System Winter plan articulates the system approach to mitigating the impacts upon all facets of the SSOT health and care system during periods of increased demand, specifically during the forthcoming winter period.

The System Winter Plan describes the revised system approach to surge and winter planning, including;

- The System approach to planning and associative governance
- The System lessons learned from 2024/25 and how these inform planning for this year
- The System 'pillars' approach to developing a holistic, system-wide plan
- The System Capacity plan
- The System Escalation plan
- The System pillars deliverables and how these will be monitored
- The System financial spend and how schemes fit within the available budget

The plan is designed to support system partners in proactively putting into place provision to address the forecast increases in demand expected during the winter period. The forecast activity has been calculated utilising the System Capacity model and builds upon previous work to forecast bed requirements and activity levels during the forthcoming months.

The collective development of the System Winter plan outlines the many initiatives and schemes that have been or will be implemented to provide mitigation to these pressures and to facilitate the system collective efforts to manage demand during winter.

ICB Board is asked to review the components of the System Surge Plan in order to ensure that all aspects have been considered and addressed adequately and confirm approval.

The plan has been subject to governance review by a range of system forums and committees, including provider public board meetings and is presented for formal approval from the board.

(2) History of the Paper & Whether for I-D-S-A-R (as above):	Date
System Performance Group	27 August 2025
UEC Clinical Advisory Group	27 August 2025
Finance & Performance Committee	02 September 2025
System Quality & Safety Committee	10 September 2025
UHNM Trust Public Board meeting	10 September 2025
MPFT Trust Public Board meeting	11 September 2025
NSCHT Trust Public Board meeting	11 September 2025

(3) Implications:	
Legal or Regulatory	System-wide risk relating to non-delivery of Winter Plan. Performance implications will necessitate regulatory oversight and scrutiny.
CQC or Patient Safety	The System Escalation plan component of the System Winter Surge Plan is intended to outline and define system responsibilities for risk management and escalation. Quality involvement from all partners will be integral throughout development of the plan – the Quality & Safety Committee is to receive, review and approve the system surge plan to mitigate risks. Quality Impact Assessment will be undertaken. All providers are CQC registered.
Financial (CFO-assured)	Spend commitments have been regularly presented to system CFOs throughout the development of the plan – linked to Surge/Winter Plan initiatives and schemes. Any additional funding received from NHSE will be assessed initially by the system surge MDT, with appropriate assurance and reporting mechanisms put into place. Monthly reports to UEC Board and Winter Oversight Group are in place to ensure oversight and assurance. The ICB Finance team is a quorate member of the System Surge MDT and Winter Oversight Groups. The Finance and Performance Committee will approve the spend commitments once finalised, post discussion and agreement in principle at UEC Board and System Performance Group and with System CEOs.
Sustainability	Risks relating to de-escalation and ensuring funded schemes are stood down in timely fashion will be added to Risk Register as in previous years. The System Surge Plan will extend into Q1 2026/27 to ensure de-escalation trajectories are built into the plan at the outset.
Workforce or Training	Workforce risks are managed via System Workforce plan & escalated via Risk Register.
Equality & Diversity	Equality Impact Assessment to be undertaken. No current risks identified.

Due Regard: Inequalities	Impact assessments will be undertaken for all aspects of the System Winter Surge plan to ensure adequate assessment of inequalities and access to services. Initiatives will be developed with the aim of providing equality of care for all stakeholders and patient groups. Where possible, geographic equity has been implemented to ensure equal access to primary care and other area-specific services.
Due Regard: wider effect	The wider effects of the approval and implementation of the System Winter Surge plan are manifold are relate to all parts of the health system within Staffordshire and Stoke-on-Trent. While the plan will articulate the approaches utilised to address access to urgent and emergency care, the initiatives and schemes to be developed will aim to facilitate an improved patient journey, experience and, most pertinently, patient outcomes. To achieve this, a holistic view of the UEC pathway and wider system has been considered and action taken to ensure that all points in the patient journey (from admission avoidance to ED 'front door' and all the way through to home first discharges and social care access and support) are supported to ensure optimal patient flow is in place to mitigate the impacts of periods of surges in demand and winter pressures. The System plan also seeks to ensure the protection of Elective Care activity as a requisite foundation to maintain system performance with regard to elective recovery.

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☒	☐	☐	To be completed. In progress
	QIA	☒	☐	☐	*If N, why* Click or tap here to enter text. *If Y*, signed off by QIA on In progress
Has there been Public / Patient Involvement?		☐	☐	☒	Although there has been ICS Finance / DoF engagement in co-producing the strategy

(5) Integration with the System Board Assurance Framework & Key Risks:

SBAF1	Responsive Patient Care - Elective	☒	**SBAF5**	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☒	**SBAF6**	Sustainable Finances	☒
SBAF3	Proactive Integrated Community Services	☐	**SBAF7**	Improving Productivity	☐
SBAF4	Reducing Health Inequalities	☐	**SBAF8**	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

The SSOT System Winter Plan has been developed in collaboration with all System partners to map out a Staffordshire and Stoke-on-Trent wide plan in advance of winter.

The plan utilises a 'pillars' approach. Seeking to assess and delivery the plan across all facets of the SSOT health and care system to ensure a holistic approach to deliver services safely during periods of increased demand for services.

The thirteen pillars relate to key components of the system from pre-hospital (vaccination, primary care, community transformation, the Integrated Care Centre (ICC), Acute Care at Home and the Ambulance

service) to in-hospital (front door and inpatient acute, UEC escalation management, Infection Prevention Control (IPC) and Mental Health) to post-hospital (Discharge, Local Authorities).

Each pillar has a named executive and managerial lead and a slide within the system plan outlining the deliverables that the leads will take forward to support safe winter delivery and measurable metrics that will enable assessment of progress and monitoring as implementation and delivery commence.

The system plan also outlines key components underpinning development and delivery of the plan, relating to:

- The System Capacity Plan – Containing details of all schemes (including those funded by the ICB, system partner organisations and, if made available, via NHSE winter monies) designed to provide increased capacity over the winter period, the impacts of those schemes, timescales and funding source(s).

- The System Escalation Plan – Outlining the measures to be taken when there are extreme patient safety risks within the system. The Escalation plan is designed to minimise and mitigate risk by sharing risks across the system.

In addition, the System Winter Plan contains information outlining:

- Additional capacity schemes that upon implementation, will offer tangible capacity.

- Additional enabling schemes
  Those schemes that have a significant impact upon management of increased demand for UEC services, but do not provide a physical bed space.

- Additional enabling schemes provided by alternative budgets
  These schemes are extremely important to delivery of the system surge plan and have been approved for implementation but are funded via existing and alternative budgets. The schemes within this section are already accounted for in respective baseline allocations.

The System Winter Plan has been developed via a Multidisciplinary Team (MDT) approach, ensuring that all system partners, and ICB directorates and relevant portfolios, are sighted on activities, initiatives and mitigations planned across the system. This level of collaboration and engagement is designed to ensure that action taken to address issues in one part of the system do not negatively impact upon another.

Development in this way seeks to ensure that clinical, finance, patient safety and communications partners will be involved and sighted at all stages to ensure a holistic system approach to development of the plan.

Underpinning the development of the System Winter Plan are the outputs from the 2024/25 Winter Lessons Learned event which the ICB hosted and facilitated in May 2025. The actions and outputs are outlined and at the forefront of system planning during this cycle.

In addition, System risks to delivery are outlined within the plan to ensure that all partners and providers are sighted on pertinent risks and the mitigations in place ahead of the anticipated surges in demand and winter pressures.

The agreed governance route for all decisions relating to the development of the System Winter plan, and the sign-off processes in place is included to ensure oversight, scrutiny, challenge and review from a range of organisations, non-executives and experts to foment development of the plan and ensure that it adequately addresses considerations from across the ICS.

The scale of the challenge faced across the ICS during the forthcoming winter period is illustrated utilising outputs from the System Capacity model. These outputs show the scale of anticipated excess demand across the system and focus upon the anticipated pressures forecast. The forecast demand represents an increase upon levels experienced in 2024/25 but the primary pressure point (namely medical bed base at RSUH) mirrors that observed in previous years.

Modelling for 2025/26 does however suggest that there are significant increases to excess demand expected at both County Hospital and Queen's Hospital, Burton. The system surge MDT meeting has ensured, and will continue to ensure, that considerations for these sites are fully explored and mitigated via the system plan and illustrations of the forecast pressures are included within the presentation pack.

The system approach to mitigating bed pressures is visually presented via waterfall diagram to illustrate how each of the agreed "capacity" schemes will offset a proportion of the expected demand. Where capacity is situated outside of the acute hospital, an acute bed equivalent value has been calculated.

System financial spend will be presented to System CEOs and CFOs on a regular basis to ensure that forecast expenditure is accurately reported and that spending decisions are taken forward via appropriate governance to ensure that all financial implications are modelled in line with SFIs and approved accordingly.

A full Quality Impact Assessment (QIA) will be undertaken and is in progress to ensure consideration of the impact of schemes from a quality and patient safety perspective. Similarly, a full Equality Impact Assessment will be completed to ensure appropriate consideration of impacts during delivery of the plan.

The ICB approach to System winter planning is once again based upon adherence to the ICS Partnership Leadership Compact. The compact will be presented regularly at the outset of all meetings and governance forums to ensure that, regardless of levels of system pressure, that the wider system team works in a respectful and progressive manner.

Note: the plan is an evolving document and will be under constant review.

Review and scrutiny of the system surge plan will continue as per the Governance and Sign-off schedule, with recalibration as required during periods of escalated demand.

(7) Recommendations to Board / Committee:

ICB Board is asked to review and confirm approval of the system surge plan.

The Integrated Care Board is asked to review the ICB Board Assurance Statements and confirm approval for submission to NHS England.

1. Introduction

The Staffordshire and Stoke-on-Trent ICS System Winter Plan has been developed in partnership with all constituent organisational partners within the ICS.

This includes:

- University Hospital North Midlands (UHNM)
- Midlands Partnership University Foundation Trust (MPFT)
- North Staffordshire Combined Healthcare Trust (NSCHT)
- Staffordshire County Council
- Stoke-on-Trent City Council
- University Hospitals of Derby and Burton (UHDB)
- West Midlands Ambulance Service (WMAS)

Engagement with provider partners that serve the ICS population but sit within other ICSs has been carried out to ensure a joined-up approach and to factor in relevant considerations from partner organisations.

Additionally, partner organisations from the voluntary care sector are engaged via the Integrated Discharge Hub (IDH) and South Staffordshire Transfer of Care hub to facilitate referrals and ensure that the full breadth of VCSE offers are available to patients and that utilisation is maximised.

The system winter surge plan utilises a 'pillars' approach. Seeking to assess and delivery the plan across all facets of the SSOT health and care system to ensure a holistic approach to deliver services safely during periods of increased demand for services. The pillars are aligned to the NHS England "Fit For Future: 10 Year Health Plan for England" and build upon system progress in key areas.

The thirteen pillars relate to key components of the system from pre-hospital (vaccination, primary care, community transformation, the Integrated Care Centre (ICC), Acute Care at Home and the Ambulance service) to in-hospital (front door and inpatient acute, UEC escalation management, Infection Prevention Control (IPC) and Mental Health) to post-hospital (Discharge, Local Authorities).

Each pillar has a named executive and managerial lead and a slide within the system plan outlining the deliverables that the leads will take forward to support safe winter delivery and measurable metrics that will enable assessment of progress and monitoring as implementation and delivery commence.

The system plan is underpinned by the SSOT system 2025/26 UEC Improvement Plan and key delivery milestones and dependencies are outlined within the plan, to illustrate key deliverables and timeframes for implementation. Delivery of the UEC Improvement Plan is fundamental to operational delivery across the system and the system plan builds upon these milestones to inform and guide delivery of key mitigations ahead of and during the winter period.

The system plan also outlines key components underpinning development and delivery of the plan, relating to:

- The System Capacity Plan – Containing details of all schemes (including those funded by the ICB, system partner organisations and, if made available, via NHSE winter monies) designed to provide increased capacity over the winter period, the impacts of those schemes, timescales and funding source(s).

- The System Escalation Plan – Outlining the measures to be taken when there are extreme patient safety risks within the system. The Escalation plan is designed to minimise and mitigate risk by sharing risks across the system.

The System Winter Plan has been developed via a collaborative multi-disciplinary team (MDT) approach to ensure engagement, awareness and involvement of all system partners. The inextricable links between services provided by system partner organisations, and the ramifications of targeted improvement work within one sphere of the wider system, dictates that this involvement has been critical to ensuring the buy-in and sign-off of the Plan by all system partner organisations.

The System Winter Plan has received or will receive enhanced review and scrutiny and has been subject to governance approval from a range of internal and external governance forums. The System Winter Plan has been presented for approval to the below forums:

- UHNM Trust Board meeting (10 September)
- North Staffordshire Combined Healthcare Trust Board meeting (11 September)
- MPFT Trust Board meeting (11 September)
- Stoke-on-Trent City Council Operational Board Meeting (23 September)
- Staffordshire County Council Health and Care Senior Leadership Team (15 September)
- System Health & Care Clinical Senate (11 September)
- ICB Urgent and Emergency Care Board (28 August)
- ICB Urgent and Emergency Clinical Advisory Group (28 August)
- ICB System Performance Group (27 August)
- ICB Finance and Performance Committee (2 September)
- ICB System Quality & Safety Committee (17 September)
- People, Culture and Inclusion Committee (9 October)
- ICB Public Board (18 September)

In addition, the System Winter plan was submitted to NHS England on Friday 1 August and post further update and refinement, presented to NHS England during the Winter Assurance visit undertaken at Royal Stoke Hospital on 11 September.

The System Winter Plan is a ‘live’ document and will be under continual review to ensure that all activities and decisions are made to enhance the system response to the forthcoming winter period.

The plan links closely with the national UEC plan 2025/26 and is developed and implemented alongside the wider work streams of the Delivery portfolio.

All relevant Risks to delivery are outlined within the plan to ensure that all partners and providers are sighted on pertinent risks and the mitigations in place ahead of the anticipated surges in demand and winter pressures.

2. NHS England Winter Assurance visit

As part of the regional oversight arrangements, a team from NHS England carried out a system Winter Assurance Visit to Staffordshire and Stoke-on-Trent at the Royal Stoke hospital site on Thursday September 11th.

The visit included winter assurance presentations from system partners, followed by an opportunity to test the operational logic and realism of the system winter surge plan (including the escalation plan aspects), confirmation from system leaders with regard to mobilisation of surge/winter capacity and identification of risks to delivery.

Formal NHS England feedback post the assurance visit is presently awaited (at the time of writing). However, initial feedback has been received post submission of the draft system plan and Key Lines of Enquiry return which were made to the NHS England regional team in July and August.

Positive feedback was received regarding the system's "detailed surge plan", "updated capacity modelling" and a "clear ambition to maintain patient safety and system resilience". NHS England also highlighted that the system winter planning framework is "structurally comprehensive, with clear governance, a centralised coordination model and a system-wide commitment to collaborative delivery". The embedding of lessons learned was also highlighted throughout the feedback received.

NHS England reiterated key areas for system focus relating to translating detailed plans into delivery, greater demonstration of system-wide quality assurance, greater detail regarding infection prevention and vaccination planning, alongside continued focus on ambulance handovers, escalation, frailty services and ensuring that the delivery of the system surge plan is calibrated to meet operational realities and emergent challenges.

3. System Winter Plan Approach

The thirteen pillars underpinning the System Winter Surge Plan are illustrated in Figure 1 (below):

Figure *1:*

SYSTEM WINTER PLAN										System Executive Lead/System Winter Director: Phil Smith			
	1	2	3	4	5	6	7	8	9	10	11	12	13
Chapter	Vaccination	Primary Care	Community Transformation	Integrated Care Coordination	Acute Care At Home	Ambulance Service	Front Door & Inpatient Acute	UEC Escalation Management	Infection Prevention Control	Mental Health	Discharge (Complex)	Staffordshire Local Authority	Stoke City Local Authority
Additionality	Childhood Vaccs/Imms Respiratory Syncytial Virus (RSV) Increase vaccination rates for staff & patients	Additional capacity in general practice Increased availability of urgent dental care appointments PCN Winter preparedness events	Delivery of Respiratory offer (Provider Collaborative) Frailty review Falls response High Intensity Use (HIU) review End of Life	Increased Clinical Presence in the Integrated Care Coordination (ICC)/ Surge staffing plan	Expanding Urgent Community Response (UCR) service offer Surge capacity	Additional clinicians in emergency operating centres and SPoA Expand overnight support for 999 Additional operational & triage Clinical Validation Team (CVT) clinicians investment	Acute capacity additionality Delivery of Co-located UTCs Release to Rescue	Escalation Capacity Escalation & De-Escalation Co-ordination	7-day Infection Prevention & Control (IPC) cover Rapid Ppoint of Care (PoC) testing	Inpatient Length of Stay (LoS) reduction Out of Area Placements reduction Reduce delays for admission Reduce Readmissions	Discharge to Assess (D2A) productivity and efficiency opportunities	Additional social care assessment capacity for Urgent Care 2 Everbody goes Home2 model to extending to overnight support Flexible Brokerage capacity to meet fluctuating UEC demands.	Moderate frailty model Enablement LoS efficiencies Increased capacity in in-house enablement
Enabling	Infrastructure for delivery of Vaccination programme	Enhanced Health in Care Homes Directed Enhanced Service (DES)/Local Enhanced Service (LES) Primary Care Access Programme	Development of Integrated Neighbourhood Teams	Pathway Development	Increased headcount to support delivery of home visits. Delivery of capacity & utilisation inline with operational planning 'Pull Practitioner' role deployed across all 3 acutes Enhanced Respiratory & Paediatric VW pathways.	Protocol for conveyance of over 65s Increased Hear & Treat, See & Treat rates Improved utilisation of SDEC & alternative conveyance Sustained improvements in response times 24/7 Hospital Ambulance Liaison Officer (HALO)	UEC Improvement Plan: Front Door Processes; Frailty; Clinical Pathways; Bed & Site Management Ward Processes P0 Discharges Paediatrics Surge Plan Protect Electives	System Coordination Centre (SCC) Emergency Prepardness Resilience & Response (EPRR) UEC Improvement Plan	Virus Resilience Plans Cohorting/ Isolation plan	High Intensity Use (HIU) Mental Health UEC improvement plan	Better Care Fund (BCF) Review and allocation of resource to discharge Voluntary Community & Social Enterprise (VCSE) offer Integrated Discharge Hub (IDH) - Discharge/flow targets	Deteriorating Patients Pathway Clear Escalation Process : Complex Patients Choice Urgent FNC Review Provider Improvement Response Teams (PIRT) Care Home Intensive Support Team (CHIST) Care market communications	Care Market Management - comms Provider Improvement Response Team (PIRT) Care Home Intensive Support Team (CHIST) Approved Mental Health Professionals (AMHP) Provider of Last Resort (POLR) Enablement
Exec Lead	Rachel Gallyot	Rachel Gallyot	Elizabeth Disney	Jennie Collier	Katy Thorpe	Jeremy Brown	Katy Thorpe	Phil Smith	Rachel Gallyot	Ben Richards	Jennie Collier	Andrew Jepps	Peter Tomlin
Managerial Lead	Lynn Millar	Sarah Jeffery	Helen Slater	Tracy Morley	Helen Lancaster	Rob Till	Helen Lancaster	Kate Farrow	Matthew Missen	Rachel Birks	Hayley Bishop	Bev Jocelyn	Lee Calvert

Demand & Capacity Modelling/Performance Reporting

Workforce

Finance

System/Clinical Escalation Plan - Risk Management/Risk Sharing - Harm Reviews

Communications

System winter oversight pillars

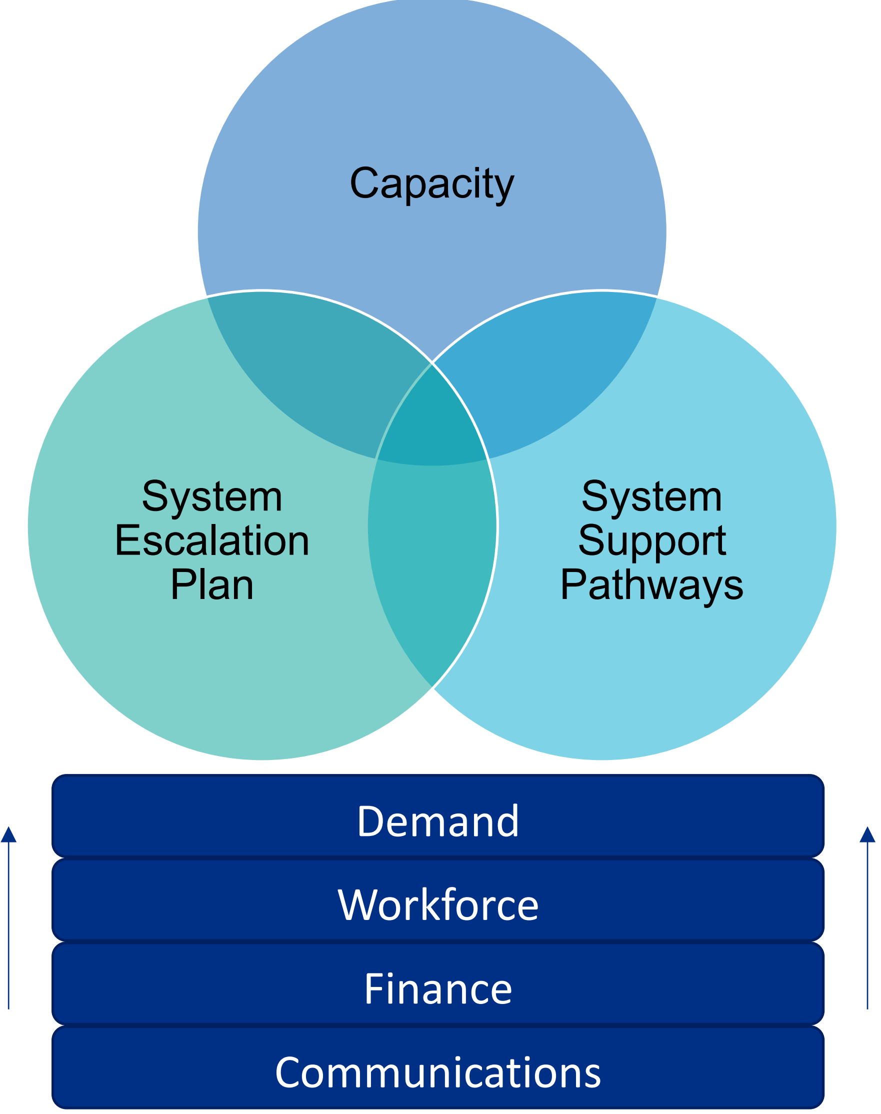
Each of the oversight pillars has a full slide within the presentation that outlines the pillar deliverables and monitoring metrics. Each pillar has deliverables aligned to the NHS England UEC Plan 2025/26 and the national and regional winter planning letters and principles for delivery of a safe winter.

The oversight pillars are linked closely to the system 2025/26 UEC improvement plan and the key delivery milestones and dependencies are outlined within the plan.

System Capacity Plan

Figure 2 illustrates the underpinning approach to the system capacity plan, the close alignment to the system escalation plan and system support pathways and the impacting factors that have been considered in development of the capacity mitigations.

Figure 2:



Underpinning the System Capacity Plan, extensive bed modelling has been undertaken to ensure that mitigations and schemes/initiatives developed and mobilised are proportionate to the levels of demand expected this winter. Initiatives and schemes with the Plan outline system actions to address and mitigate the forecast bed deficit, albeit delivery is dependent on the availability of workforce to deliver. This is a significant risk detailed within the plan and held on the system risk register.

The system capacity model (developed in collaboration with PWC ahead of winter 2022/23) factors in system demand from previous years, levels of flu and Covid-19 infections and related impact upon the system, the system bed base, patient flows, community bed base, virtual wards, ambulance conveyance information, staffing levels, elective demand and activity and other contributing factors.

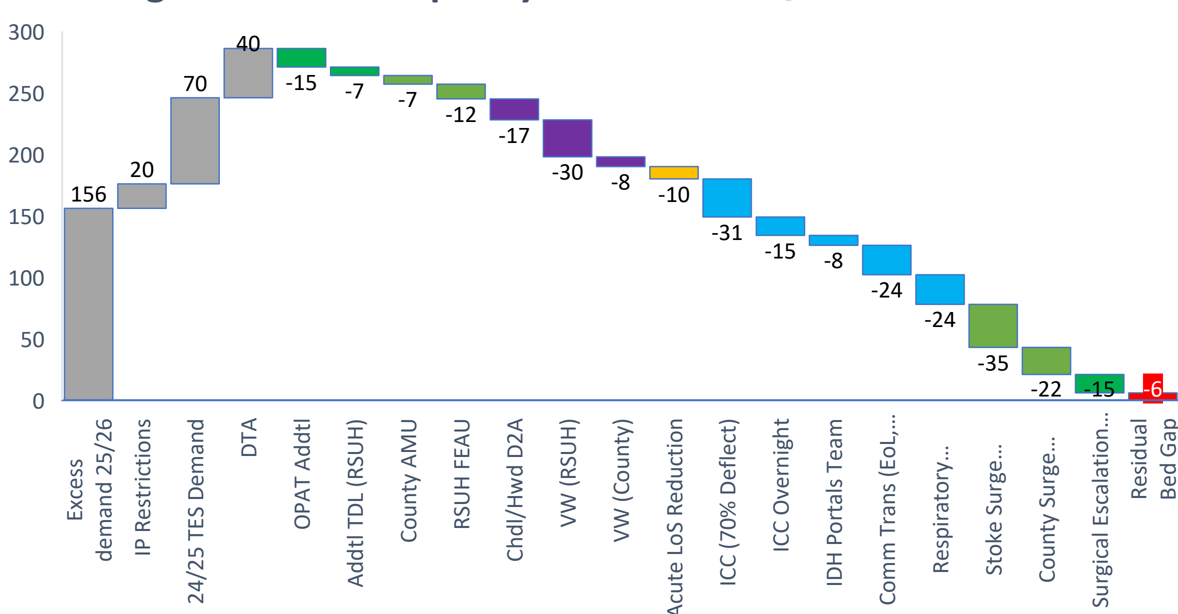
The system bed model has been refreshed to include 2024/25 actual episodic data and, via development with performance and information colleagues from across the system, is now equipped to present forecast demand and bed need information at a divisional level.

Assessment of forecast demand and pressures at a divisional level illustrates that the area of greatest forecast pressure is the medical bed base at Royal Stoke University Hospital (RSUH). Modelling also forecasts increased pressures upon the bed base at County Hospital and work with colleagues from University Hospitals of Derby and Burton (UHDB) shows a similarly increased level of excess demand and associative pressure at Queen’s Hospital, Burton.

Wider modelling indicates that the other divisions within UHNM have sufficient capacity to meet expected levels of non-elective demand. Where this is not the case, mitigations have been built into the plan, with the UHNM-wide position assessed and forming the basis for mitigations.

The Figure 3 Waterfall diagram (below) illustrates the anticipated UHNM Trust excess demand and system mitigations. The residual deficit during December and January is forecast to be circa 6 beds.

Figure 3.



The System modelling is based upon a 'worst case scenario' set of data and assumptions.

This a deliberate step and is designed to try and ensure optimal system resilience during the winter period. The underpinning assumptions are presented fully within the System Winter Plan and are modelled upon the impacts of Covid-19, Flu and other seasonal diseases peaking simultaneously and during periods of increased non-elective demand.

All system modelling takes into account the mandated protection of elective and cancer capacity and activity.

The system bed model allows members of the ICS team to proactively model demand and capacity, as well as testing out scenarios (such as increased/decreased Covid-19 or flu impacts) on a 'live' basis to ensure a robust system contingency is in place as winter progresses.

Within the System Capacity Plan, there are three categories outlined. These relate to:

- Acute capacity; physical beds within an acute hospital.
- Acute bed equivalent capacity: community beds or schemes that yield and equivalent tangible impact.
- Enabling schemes; schemes that are designed to provide vital initiatives or programmes of work to mitigate increased non-elective and are fundamental to system delivery, but do not offer a tangible and quantifiable 'bed impact'. For example, additional primary care appointments.

All capacity schemes are detailed within the System Winter Plan.

The system plan is informed by previously completed Quality and Equality Impact Assessments and the learning outcomes from the review of these exercises in previous years. Once again, the system is in the process of undertaking detailed quality and equality impact assessments for all proposed schemes and mitigations as per the system processes.

Despite system-wide collaboration and work, there remains a small residual capacity deficit in January 2026. This forecast deficit is significantly reduced when assessed against those of previous winters. Work remains ongoing to source additional capacity and proactive assessment of further opportunities in the event of further funding being received is in place via the Winter Oversight and System Surge MDT forums.

System Escalation Plan

The System Escalation Plan has been further developed for 2025/26 and is designed to provide system resilience during times of increased demand and pressure, learning from previous experience as the system has become rapidly stressed leading to the development of unmitigated risks.

The Escalation Plan seeks to address issues in light of the increased levels of demand which has contributed to systems pressures, including ambulance handover delays, workforce challenges and increased clinical risk.

The principles underpinning the System Escalation Plan relate to agreed parameters and triggers dictating enhanced action, the need for all partner organisations to be sighted on risk along the entire patient pathway and agree escalation actions to minimise and mitigate risk by sharing risk across the system.

To enact the System Escalation Plan, appropriate structures and forums have been put into place, these include;

- Regular System Strategic (Chief Operating Officers (COO)) call (including representation from all partner organisations – including West Midlands Ambulance Service and Local Authorities).
- The continued delivery the ICS System Co-ordination Centre (SCC) as commenced during December 2022 and recognised regionally and nationally as an exemplar.

The System Escalation Plan will define system actions in response to critical incidents, escalated OPEL status and other urgent events/incidents.

System Winter Plan testing.

In order to provide robust scrutiny and testing of the system plan, a system-wide Winter Exercise, lead by Emergency Preparedness, Resilience and Response (EPRR) colleagues was undertaken on the 10th September.

The exercise was designed to assess the robustness, coherence and operational readiness of the system plan and to proactively identify risks, gaps and opportunities

for further development and mitigation to ensure system-wide resilience during peak periods of winter pressure.

Attendees from across the breadth of the system participated in the exercise, with representatives focused upon key areas for strategic reflection and collective action linked to:

- Clinical and operational safety
- Urgent and emergency care performance
- Emergency department oversight
- Strategic response to pressure
- Governance and decision-making
- Workforce resilience

Operational representatives from acute, mental health and community trusts participated alongside colleagues from primary care, local authorities and social care and the ICB participated in the exercise to ensure holistic assessment and perspective.

Outputs will be shared across the system and utilised to ensure system readiness as we enter the winter period.

The principles and approach to the exercise were developed by NHS England, to ensure an objective approach, with system representatives from across the region attending a subsequent Midlands-wide test event in Birmingham on September 17th to collectively assess outputs and undertake further testing and assessment of system plans.

System Workforce

Fundamental to delivery of the system winter plan will be aspects relating to workforce availability, productivity and health. System Workforce considerations are addressed by the system People team, with members of the team a quorate member of both the Winter Oversight and Surge MDT forums. The ICS People Function will delivery support to facilitate rollout of the plan and to support delivery of the additional winter capacity schemes and initiatives being implemented across the system.

Underpinning the workforce approach is targeted work with providers to ensure that additional workforce numbers required to support each scheme are in place. Workforce related risks are held on the ICB Risk Register and initiatives and workstreams are in place to mitigate the impact of such risks as we enter the winter period.

Workforce has been identified throughout the Winter Planning process as presenting the most significant challenge facing the system as we enter the winter period. Increased sickness rates, staff turnover and vacancies across the system all factor into this enhanced level of challenge and risk. Despite a robust System Workforce Plan, the workforce risks are not fully mitigated and remain significant.

To mitigate these challenges, a collaborative and innovative approach to workforce supply has been developed and adopted to try to engage previously untapped pools

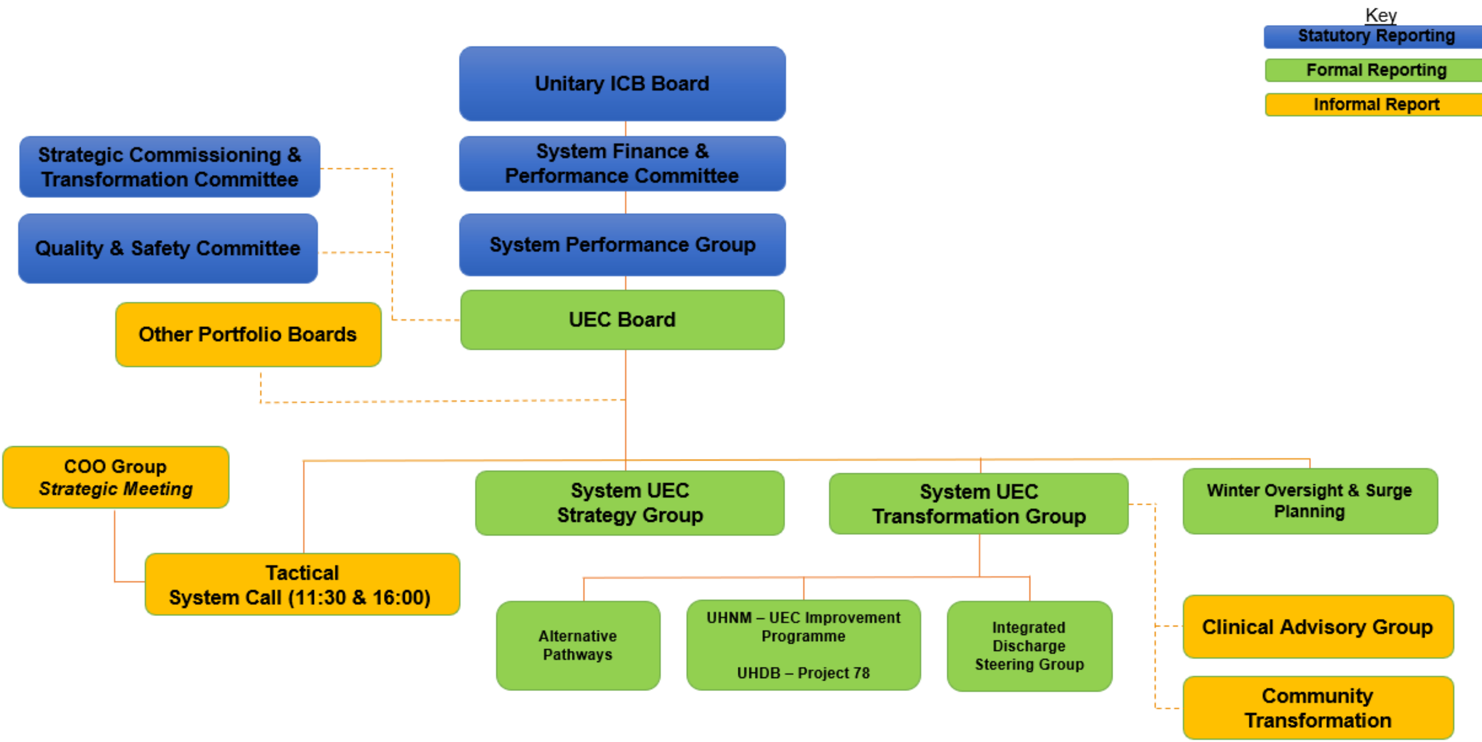
of staff and provide attractive offers to incentivise existing staff, or those that may wish to return to work.

Processes and forums have been put into place to ensure that partner organisations can model and assess workforce supply on a continual basis, to ensure that any one part of the system is not detrimentally affected, leading to wider impact. This holistic approach has led to a degree of system collaboration designed to mitigate demands of individual organisations in order to balance the wider need across the entire healthcare system.

4. Summary and Next Steps

The Staffordshire and Stoke-on-Trent ICS System Winter Plan will continue to be evaluated and evolved according to need as we move through the winter period and beyond. The Winter Planning process has been closely aligned to the System Winter Oversight Group, UEC Board and associative workstreams and will remain as a concurrent process to ensure synergies and coalescence with other system priorities. An overview of the full governance cycle in place to ensure appropriate review, challenge, oversight and action is included below in Figure 4 to illustrate the mechanisms utilised and the reporting processes in place.

Figure 4:



To ensure appropriate review, oversight, scrutiny and management throughout the winter period, the weekly System Winter Oversight and System Surge Planning MDT meetings will continue, overseeing mobilisation, recalibration and assessment of operational pressures and issues.

The Winter Oversight group is chaired by the Portfolio Director for Delivery and has representation from senior leads for all of the thirteen oversight pillars. This forum provides oversight and escalation mechanisms during the planning, implementation and delivery of winter surge plans and schemes.

The System Surge planning MDT meeting is Co-Chaired by the ICB Head of Urgent Care and UEC Delivery and Improvement Lead, with representation from senior system operational staff, this forum will continually re-evaluate schemes and utilisation of resources across the system, recommending proactive decisions regarding the deployment of resource to mitigate winter pressures and other events/incidents and reporting directly to Winter Oversight Group and UEC Board.

The System Surge Planning MDT has direct links to senior System operational teams and a direct relationship to ensure operational awareness, input, oversight and action.

During previous periods of escalated Winter pressures and in response to the system declaration of a “critical incident” the system mobilised a Winter Steering Group, chaired by the ICB Chief Executive and with input from all system Chief Operating Officers and clinical leaders. This remains a contingent measure to ensure system-wide escalation, if required.

The System Winter Plan will remain a ‘live’ document and be recalibrated as required to try to ensure that the ICS addresses winter pressures in a robust, compassionate

and holistic means, prioritising patient care and access and minimising risks to patient safety and system staff and resources.

5. Recommendation

The Integrated Care Board is asked to: confirm approval of the System Winter Plan.

The Integrated Care Board is asked to review the ICB Board Assurance Statements and confirm approval for submission to NHS England.

Appendix 1: System Surge Plan slide deck.

Staffordshire & Stoke-on-Trent System Winter Surge Plan 2025/26

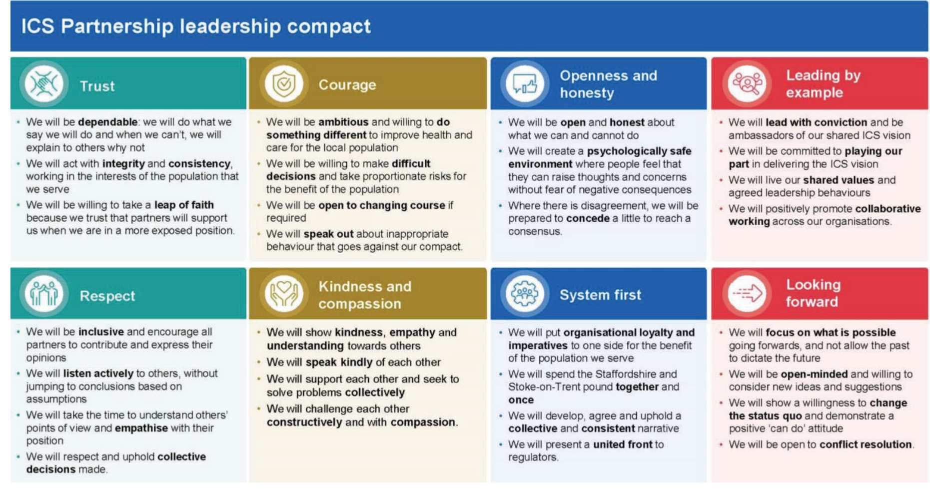
ICB Public Board Meeting
18th September 2025

Introduction

This plan introduces the approach adopted by the Staffordshire & Stoke-on-Trent Integrated Care System (SSOT ICS) to plan for resilience across our health and care services through winter 2025/26. This plan is set in the context of what is predicted to be a difficult winter; all health and care services are expecting and preparing for the impacts of Industrial Action, delivery of the 2025/26 operational planning requirements and associated financial challenges this places upon delivery. These challenges are anticipated alongside sustained surges in demand that will impact upon the resilience of services, and therefore the patient and staff experience of receiving and delivering care across Staffordshire & Stoke-on-Trent.

SSOT ICS continues to work together to plan for this winter, using intelligence from patient and staff feedback, our own data modelling and that of public health, and best practice from other areas, to offer the most efficient and effective health and care services possible, within this context.

As in previous years the plan is underpinned by our ICS Leadership Compact.



Priorities

The primary objective of the SSOT Integrated Care System is to work in partnership to ensure people receive the right level of care in the right location this winter, enabling an improved quality of experience & outcomes and improved flow across the SSOT system.

The SSOT System Surge/Winter plan outlines the multifaceted approach being undertaken ahead of winter this year, to build resilience across urgent and emergency care services, elective services, urgent cancer care and beyond.

The plan is underpinned by extensive system demand and capacity modelling ahead of what is anticipated to be a difficult winter for the healthcare system, both locally, regionally and nationally.

The plan seeks to address and assure against system priorities as outlined within the national NHS England Urgent & Emergency Care plan for 2025/26, namely;

- Improving ambulance response times
- Reducing ambulance handover delays
- Reducing waiting times in emergency departments (both the 4-hour and 12-hour targets)
- Reducing waiting times for mental health patients
- Reducing delays to discharge for patients that are discharge-ready
- Seeing more children waiting in emergency departments within 4-hours

The plan will prioritise addressing healthcare concerns and issues in advance of them leading to conveyance to or attendance at a hospital or other healthcare setting. Vaccination promotion and uptake, and other initiatives aimed at preventing the need for attendance or admission to hospital, will underpin this.

The plan will seek to target resource to those most vulnerable during winter, via extensive work with primary and community care teams and proactive liaison with care homes.

The system plan will prioritise safe and timely discharge for admitted patients to the place they call home.

For patients admitted to hospital, the system will seek to ensure they receive high-quality and safe services, building on learning from system reviews of patient outcomes and harm.

Approach & Governance

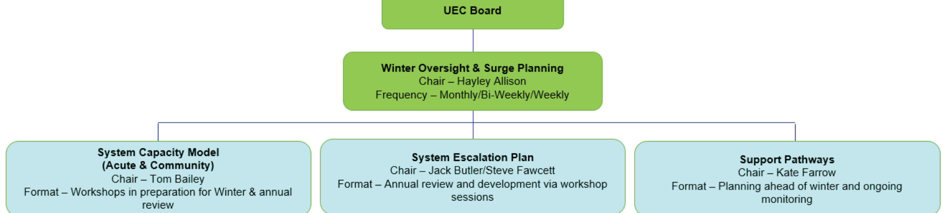
2024/25 Lessons learned: Key learning points & actions

- In May 2025, the system undertook its annual ‘Winter Review’, in addition to the Critical Incident Review completed in March 25 (slide 34). This review was attended by partners from across the ICS. During this session, several areas of good practice were identified alongside key learning. This was discussed via UEC Governance with onward reporting to the ICB Board and Health Overview & Scrutiny Committees across SSOT.
- The highest impact areas have been summarised below along with a summary of how this is being addressed in 2025/26.

Learning from 24/25	How we will address in 25/26
7-day working initiatives	• 7-day resourcing for impactful schemes, such as discharge facilitators in ED and extended coverage of the Integrated Care Coordination (ICC) offers prioritised. • All relevant initiatives outlined for 7-day coverage
Full implementation of the High Risk of Delay (HRD) Tool to proactively identify high risk patients	• HRD tool fully funded for implementation ahead of winter. • Successful appointment to HRD coordinator roles. • Full roll-out of HRD project in Sept 2025. • Wider initiatives (e.g. Acute Care at Home Pull Practitioner) prioritised to support HRD impact.
Closer alignment to system portfolios	• Revised planning approach, utilising ‘pillars’ with SRO ownership & capturing wider system working. • Winter Oversight group underpinning revised governance approach, membership from system portfolios to support ‘pillar’ approach. • System plan to include wider holistic assessment of system activities to support winter planning and delivery.
Embedding learning from System Critical Incidents	• Full System Critical Incident review undertaken. Actions embedded within System Escalation Plan (including metric monitoring and escalation approach).
Development of system surge plan earlier to facilitate pre-emptive workforce and implementation activities	• System surge planning commenced in June to ensure development is accelerated. • Plan to be taken to ICB Board in September. 2 months earlier than previous. • Earlier development of system surge plan, to facilitate pre-emptive workforce and implementation activities
Utilising lessons learned to inform surge planning for 25/26	• 2024/25 Lessons Learned referenced throughout 25/26 plan. • Key learning points presented and cross-checked in development and implementation of plan
Greater engagement with primary care and care homes	• Primary Care identified as a key ‘pillar’ of surge plan delivery. Integral to plan development from the outset and with key deliverables (and supporting metrics to assess progress). • Focus on care homes across multiple pillars, including Community Transformation, Primary Care, ICC and Acute Care at Home.
Increased focus on infection prevention and vaccination to mitigate winter pressures	• Infection Prevention and Vaccination key pillars to plan development and delivery. Leads participating in system planning work from the outset and wider plans fundamental to successful delivery. • Key metrics established and will be monitored to pre-emptively assess risks and seek to mitigate.
Targeting resource to highest impact schemes/initiatives	• Initiatives and schemes proposed from across the system assessed collectively via Surge MDT, Oversight Group and system SROs • All proposals assessed with regard to deliverability, impact and cost to inform prioritisation and targeted resource to highest scoring schemes (i.e. those most likely to deliver the greatest impact most efficiently.
Further development of system escalation plan, including early warning signs and triggers	• Fully embedded daily UEC metrics, based upon system Critical Incident (CI) reviews to pre-empt escalations and necessitate appropriate and agreed system actions. Monitored daily via system calls and enacted immediately as required. • Workshop approach to refine and develop further the system escalation plan based upon learning points and CI review outputs

Governance & Leadership

- Effective leadership, agility of action and robust governance processes are essential components of the plan. This plan will be led by the ICB UEC Team, under the leadership of the Phil Smith, Chief Delivery Officer as SRO for delivery, and will report on a monthly basis into NHS Staffordshire & Stoke-on-Trent Integrated Care Board through system governance.
- SSOT Winter Director leadership will be provided by Hayley Allison who will lead in partnership with the ICB UEC team.
- For 2025/26 the Winter Oversight & Delivery model has been refreshed and now reports directly into UEC Board and subsequently System Finance & Performance Committee and ICB Board via agreed governance (slide 15).
- To support development and delivery of the winter plan a number of 'Pillars' have been agreed covering key workstreams (slide 15). Each workstream has an identified SRO and managerial lead:



- Each sub-group will report to the Winter Oversight & Surge Planning Group on a weekly basis, reporting on both actions taken to support delivery of the 'pillar' deliverables and monitoring against agreed metrics within the Winter Plan. This will enable the leadership team to assess plans in an agile manner and to also consider the impact of, as yet unknown scenarios, such as Industrial Action.
- A short weekly update will be produced each Friday and circulated to system executives and clinical leads. This will include:
  - Key intelligence from national and regional departments
  - Performance against agreed metrics
  - Escalations/actions required from partners to improve performance / achieve objectives of the key actions
- Formal plan sign off will take place in August/September, via all ICB and provider boards (see slide 16) ahead of the completion of the required 'NHSE Board Assurance Statements' on 30th September.

Winter Oversight Support Pillars

SYSTEM WINTER PLAN										System Executive Lead/System Winter Director: Phil Smith			
	1	2	3	4	5	6	7	8	9	10	11	12	13
Chapter	**Vaccination**	**Primary Care**	**Community Transformation**	**Integrated Care Coordination**	**Acute Care At Home**	**Ambulance Service**	**Front Door & Inpatient Acute**	**UEC Escalation Management**	**Infection Prevention Control**	**Mental Health**	**Discharge (Complex)**	**Staffordshire Local Authority**	**Stoke City Local Authority**
Additionality	Childhood Vaccs/Imms Respiratory Syncytial Virus (RSV) Increase vaccination rates for staff & patients	Additional capacity in general practice Increased availability of urgent dental care appointments PCN Winter preparedness events	Delivery of Respiratory offer (Provider Collaborative) Frailty review Falls response High Intensity Use (HIU) review End of Life	Increased Clinical Presence in the Integrated Care Coordination (ICC)/ Surge staffing plan	Expanding Urgent Community Response (UCR) service offer Surge capacity	Additional clinicians in emergency operating centres and SPoA Expand overnight support for 999 Additional operational & triage Clinical Validation Team (CVT) clinicians investment	Acute capacity additionality Delivery of Co-located UTCs Release to Rescue	Escalation Capacity Escalation & De-Escalation Co-ordination	7-day Infection Prevention & Control (IPC) cover Rapid Ppoint of Care (PoC) testing	Inpatient Length of Stay (LoS) reduction Out of Area Placements reduction Reduce delays for admission Reduce Readmissions	Discharge to Assess (D2A) productivity and efficiency opportunities	Additional social care assessment capacity for Urgent Care 2Everbody goes Home2 model to extending to overnight support Flexible Brokerage capacity to meet fluctuating UEC demands.	Moderate frailty model Enablement LoS efficiencies Increased capacity in in-house enablement
Enabling	Infrastructure for delivery of Vaccination programme	Enhanced Health in Care Homes Directed Enhanced Service (DES)/Local Enhanced Service (LES) Primary Care Access Programme	Development of Integrated Neighbourhood Teams	Pathway Development	Increased headcount to support delivery of home visits. Delivery of capacity & utilisation inline with operational planning 'Pull Practitioner' role deployed across all 3 acutes Enhanced Respiratory & Paediatric VW pathways.	Protocol for conveyance of over 65s Increased Hear & Treat, See & Treat rates Improved utilisation of SDEC & alternative conveyance Sustained improvements in response times 24/7 Hospital Ambulance Liaison Officer (HALO)	UEC Improvement Plan: Front Door Processes; Frailty; Clinical Pathways; Bed & Site Management Ward Processes P0 Discharges Paediatrics Surge Plan Protect Electives	System Coordination Centre (SCC) Emergency Prepardness Resilience & Response (EPRR) UEC Improvement Plan	Virus Resilience Plans Cohorting/ Isolation plan	High Intensity Use (HIU) Mental Health UEC improvement plan	Better Care Fund (BCF) Review and allocation of resource to discharge Voluntary Community & Social Enterprise (VCSE) offer Integrated Discharge Hub (IDH) - Discharge/flow targets	Deteriorating Patients Pathway Clear Escalation Process : Complex Patients Choice Urgent FNC Review Provider Improvement Response Teams (PIRT) Care Home Intensive Support Team (CHIST) Care market communications	Care Market Management - comms Provider Improvement Response Team (PIRT) Care Home Intensive Support Team (CHIST) Approved Mental Health Professionals (AMHP) Provider of Last Resort (POLR) Enablement
Exec Lead	Rachel Gallyot	Rachel Gallyot	Elizabeth Disney	Jennie Collier	Katy Thorpe	Jeremy Brown	Katy Thorpe	Phil Smith	Rachel Gallyot	Ben Richards	Jennie Collier	Andrew Jepps	Peter Tomlin
Managerial Lead	Lynn Millar	Sarah Jeffery	Helen Slater	Tracy Morley	Helen Lancaster	Rob Till	Helen Lancaster	Kate Farrow	Matthew Missen	Rachel Birks	Hayley Bishop	Bev Jocelyn	Lee Calvert

Demand & Capacity Modelling/Performance Reporting

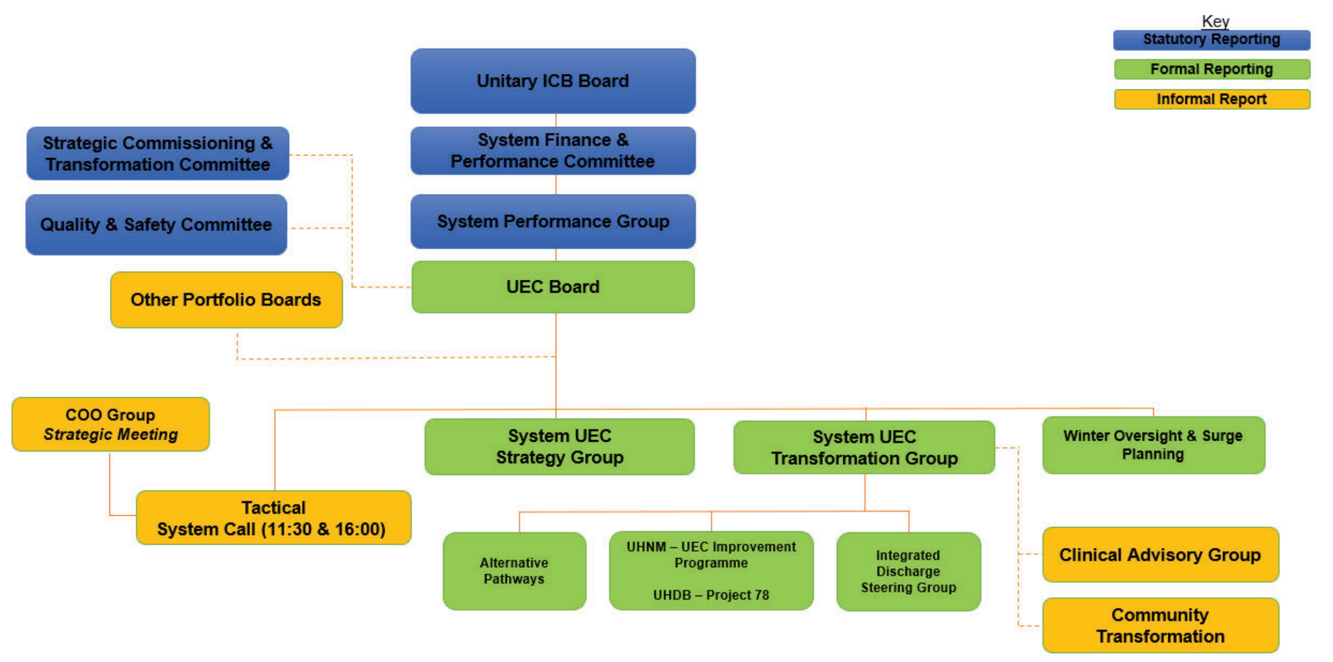
Workforce

Finance

System/Clinical Escalation Plan - Risk Management/Risk Sharing - Harm Reviews

Communications

UEC Governance structure – 2025/26



Proposed Governance & Sign-off

Meeting	Revised Date	Date
System Performance Group	August	27.08.25
UEC Clinical Advisory Group	August	28.08.25
UEC Board	August	28.08.25
Finance & Performance Committee	September	02.09.25
ICB People Committee	September	04.09.25
UHNM Trust Board	September	10.09.25
SSOT ICS EPRR Test	September	10.09.25
NHSE Assurance Visit	September	11.09.25
Clinical Senate	September	11.09.25
NSCHT Trust Board	September	11.09.25
MPFT Trust Board	September	11.09.25
SCC Health & Care SLT	September	15.09.25
System Quality & Safety Committee	September	17.09.25
Regional Winter Scenario Stress Test	September	17.09.25
ICB Board	September	18.09.25
SOTCC Operational Business Meeting	September	23.09.25
Staffordshire Health OSC	October	20.10.25
Stoke-on-Trent Health OSC	November	06.11.25

2025/26 UEC Improvement Plan

- In addition to the Winter plan the ICS developed underpinning UEC Improvement Plan covering 2025/26. Key workstreams include Alternative Pathways, In Hospital & Post Hospital programmes in addition to work being undertaken in conjunction with wider ICB portfolios (interdependencies).
- An overview of the key deliverable actions and metrics planned of winter is shown below, further detail on workstreams and actions is included in slide 11.

Key Delivery Milestones and Dependencies

Workstream	Apr	May	June	July	Aug	Sep	Oct	By Nov
Alternative Pathways	Opening further referral pathways, telephony improvements, Agree Data Sets			Opening of Phase 2 priority pathways, review of unmet demand, Senior clinical decision-making model			ICC Business Case Development for 26/27 Q3	70% redirection Rate 20% increase in referrals
	Continuation of ICC Overnight Service	Mobilisation of NHS111 referral pathway		ACAH Referral Management System Live	ICC System Workshop	Embedding of workshop outputs		
Front Door/ In-Hospital	RSUH HALO Model development	Mobilisation of RSUH HALO Model	Deployment of new site clinical flow policies	TOC for ED/Front Door	Roll out of revised navigation and triage process	Replicate TOCs for Ambulance Conveyances Enhanced HRD pathways live		Royal Stoke UTC Operational Full HRD Deployment
			Conveyance Audit					
			Revise HRD Tool implementation	Dashboard Development				
	System UTC Designation							
Discharge	Development of D2A productivity review Workstreams		Discharge Lounge Development				Embedding outputs of readmissions from D2A review	Maximised productivity and efficiency opportunities for Winter
			Clinical Pathway Audit					
		D2A productivity review						
Surge/Winter Planning	24/25 System Critical Incident Review	24/25 Winter Review	Review Winter Governance	Draft Winter NHSE Submission	ICS Governance approval of Winter Plan	Mobilisation of Winter plan	Implementation and monitoring of plan	Winter Plan Live
			Development of additional schemes					

Performance Impact		Apr	May	June	July	Aug	Sep	Oct	By Nov
Performance Impact	4hr	65.68%	70.01%	68.21%	70.82%	74.70%	77.58%	73.69%	72.72%
	12hr	16.41%	14.21%	15.24%	10.15%	11.85%	14.49%	18.11%	19.91%
	Avg. Time	01:32:32	01:08:25	01:18:57	00:41:51	00:41:00	00:45:00	00:54:00	01:11:00
	Cat 2	00:26:12	00:25:58	00:29:30	00:22:34	00:18:28	00:26:25	00:34:00	00:40:40

25/26 UEC Improvement Plan:

Improvement & Strategy: We aim to reduce avoidable deconditioning through UEC pathways

Interdependencies

BCF Review – Working with partners to support the ongoing review of BCF services supporting patients across UEC pathways.

Community Transformation – Supporting the development of the neighbourhood teams' model across the system via the agreed key impact areas:

- Frailty - Proactive, moderate and severe model.
- Falls – Development of a falls pathways that supports both the proactive and reactive response.
- Care Homes – An agreed model that delivers support, training and escalation pathways.
- High Intensity Users – *See alternative pathways*
- Long Term Conditions Pathways – COPD, Pneumonia and End of Life Care.

Mental Health – Support colleagues from the Mental health teams to apply best practice to reduce long waits for patients with mental health needs within UEC pathways.

Alternative Pathways

Integrated Care Coordination (ICC)
Further enhance our ICC offer both in and out of hours to support an alternative to ED.

Acute Care at Home (ACAH) – UCR & VW

- Work to further increase the capacity and pathways available to support admission avoidance.
- Undertake a review of VW demand and capacity inline with national guidance around remote monitoring.

WMAS – Work with ambulance service colleagues alongside the wider system to implement increased call validation and reduction in ambulance handover delays.

High Intensity Users – Ensure a clear focus ensure appropriate responses are available to reduce hospital admission

UTCs – Work with colleagues across the system to co-locate UTC with T1 departments inline with planning guidance and designate non-co-located UTC provision across SSOT that aligns to patient needs and national direction.

In Hospital

UHNM – Delivery of the UHNM UEC Improvement Programmee workstreams:

- Front door processes
- Frailty model development including development of integrated frailty model.
- Clinical pathways development including SDEC and assessment units.
- Site Management
- Ward Processes

UDHB – Delivery of UHDB Improvement Programme Workstreams:

- Minor Injuries Expansion (QHB Capital Works)
- UTC Designation
- Data Validation – Audit & Improvement Assumptions
- Workforce Optimisation
- Chase Role
- VW utilisation/expansion

Post Hospital

System IDH Transformation - Development of the System IDH model based on the progress to date within the North.

North IDH Improvement Plan

- **HRD Tool** – Continue to develop the HRD tool and support rollout into in patient wards and settings across the system.
- **Discharge Facilitation** – Work to implement the agreed centralised discharge facilitation model.
- **End of Life Care Pathway** - Standardised discharge processes to reduce avoidable in hospital deaths via earlier patient identification and case finding
- **Embed VSCE offer in IDH** - Working with the BCF review to further develop opportunities for growth of the VCSE sector in discharge and prevention pathways.

D2A Review:

- Review current model across the pathways looking at opportunities to enhance pathways where appropriate.
- Working with colleagues to review demand and capacity with a view to right sizing linked to population need.

Surge:

- Review of the system bed model considering learning from 24/25 period including demand increases and IPC restrictions to inform creation of 25/26 surge planning.
- Daily Management of surge/spikes co-ordinated through SCC including the implementation of the new OPEL framework for Integrated Care Systems (ICS)

Risks to delivery

- The UEC Portfolio has a robust process for the management and escalations of risks inline with the agreed portfolio Governance.
- Monthly risk register reviews are completed as an MDT with a highlight report of risks scoring 12 or above, new risks or risk closures discussed at UEC Board.
- Currently 4 risks have been identified as having a potential impact upon the winter plan delivery, details of these are provided below alongside initial mitigatory actions. This will continue to be reviewed, and any escalations taken via the Winter Oversight Framework.

Risk	Detail	Mitigation	Risk Held by:
Mobilisation of Surge Capacity	Risk to delivery if planned capacity/mitigations are not implemented & delivered in line with plan.	RAG rating of all system mitigation initiatives & schemes completed. Implementation/delivery overseen at System Winter Oversight Group.	UEC
Workforce availability	Appropriately skilled workforce is required to delivery the mitigations & additional capacity underpinning system delivery of the Winter/Surge plan.	A system workforce plan will be developed and managed before and during mobilisation of winter to ensure sufficient staffing is available to deliver the planned mitigation schemes and additional escalation capacity.	System People Team
Patient Quality & Safety	Delivery of high-quality patient care is heavily impacted by increased demand for UEC services. Longer waits and treatment in sub-optimal locations contribute to patient harms.	Quality Impact Assessments (QIA) to be completed for all mitigation schemes. Harm review process is in place and managed by Director of Nursing & Quality to regularly review instances of patient harm and to ensure learning is implemented to mitigate future recurrences.	Nursing & Quality
Financial spend	The system plan outlines implementation versus the available system surge budget. Risk remains however, if demand surges beyond modelling, that additional resource and spend will be required, presenting a risk to financial balance. De-escalation of schemes is also required to ensure overspend is mitigated.	All schemes and mitigations are mapped to available budget and will be managed appropriately, with regular finance reports to UEC Board and system Finance & Performance Committee. De-escalation plans will be in place and managed accordingly to seek to ensure schemes and capacity are closed on time.	Finance

System Capacity Model

Scope

Detailed demand and capacity modelling has once again been undertaken to assess the impact of increased demand across the system.

As part of this, key drivers were assessed, including; emergency department attendances, length of stay, variation by day of the week and time of the year (including certain days within the year where demand has been historically high, such as New Year's Day and the days afterward), bed occupancy levels, the profile of seasonal infectious diseases and the impact of infection prevent restrictions.

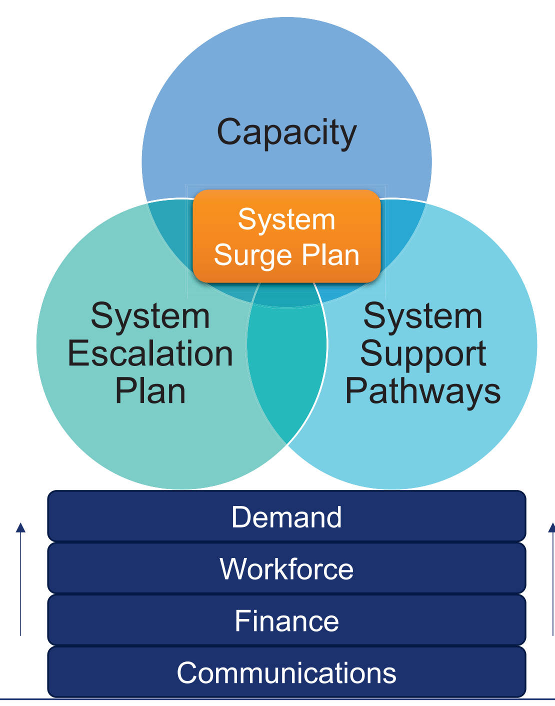
In addition, a full data exercise has been carried out, following NHS England regional guidance, to assess demand scenarios relating to:

- Baseline activity (the level of activity routinely experienced)
- Surge activity
    - An increase of 4% in ED attendance and proportionate increases in demand for other services, such as 999 & 111 calls, admissions, discharges, mental health and paediatric presentations
- Super Surge activity
    - A further incremental increase in the metrics assessed via Surge planning to anticipate concerted pressure upon the UEC system.

Utilisation of the system bed capacity model has underpinning development of these scenarios. A full refresh of the model has been undertaken, utilising actual spell-level data (data relating to individual patient attendances, admissions) to ensure seasonal fluctuations and variability are built into forecasts and reflect the unique environment of the Staffordshire and Stoke-on-Trent area and system.

Alongside the system bed model assessment of SSOT demand, we are working closely with neighbouring systems to develop plans which ensure equitable assessment of services used by our population. Detailed modelling for Queen's Hospital, Burton is included and sharing of information, plans and relevant assumptions and data with The Black Country and other neighbouring systems is in place.

System Surge Plan Components



Capacity
Dedicated agreed priority schemes providing additionality above the baseline, either:

- Mitigating bed deficit
- Efficiency subsequently impacting bed base

System Escalation Plan

- Risk management and aligned triggers
- Process and protocols agreed upfront
- Support to workforce

System Support Pathways

- Enabling functions key to system delivery during winter
- Includes imperative workstreams fundamental to reducing admissions and conveyances and facilitating safe discharges
- Clinically led with input from across the wider system

Inpatient Capacity Modelling

Underpinning Assumptions

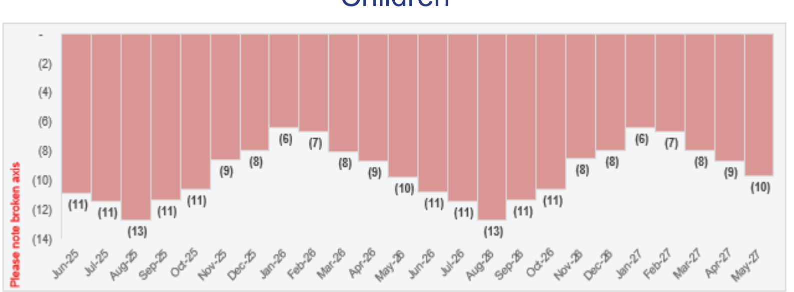
- 92% Bed Occupancy.
- Medically Fit For Discharge (MFFD) at 128 patients in a bed overnight (across Royal Stoke University Hospital (RSUH) and County Hospital).
- An average of 35 Decision To Admit patients is included in the demand for RSUH inpatient beds.
- To represent additional demands at County hospital, an average of 5 DTAs is included in the demand for County inpatient beds.
  - Alongside the average DTA levels, additional excess demand has been modelled to reflect increased pressure during height of winter.
- Flu/COVID (Severe Winter Adjustment) at 2017/18 levels – this equates to a pressure of 6/7% per day.
- The model is built upon actual, spell-level data. Infection Prevention (IP) challenges from previous years (inc. 24/25) are reflected in the baseline bed requirements.
- Full protection of Elective activity.
- Full Year modelling undertaken.
- Average Length of Stay (ALoS) of 2.28 days. ALoS for RSUH Medical beds of 2.26 days (based on UHNM actual data).

Demand

- The model has been updated with actual UHNM data (to end June 2025) which, given levels of demand experienced last winter, has impacted upon the forecast bed demand.
- Medical beds at RSUH remains the highest area of excess demand, however pressure upon Network and Surgical beds at RSUH has also increased compared to previous years.
- Excess demand at County Hospital has been reassessed to reflect actual data and experience from winter 24/25, including the addition of DTA pressures.
- Demand for Children's beds is mitigated via internal capacity as illustrated on slide 17

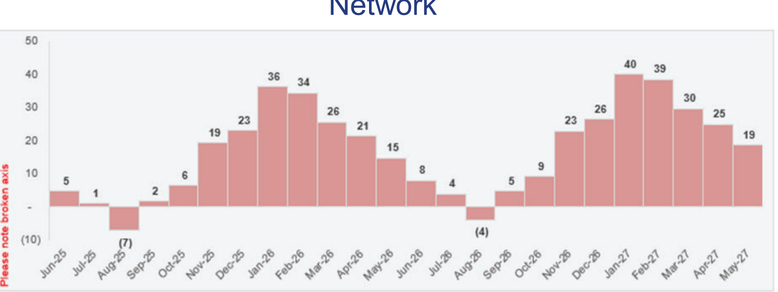
Capacity modelling – Children, Surgical, ICU and other

Children



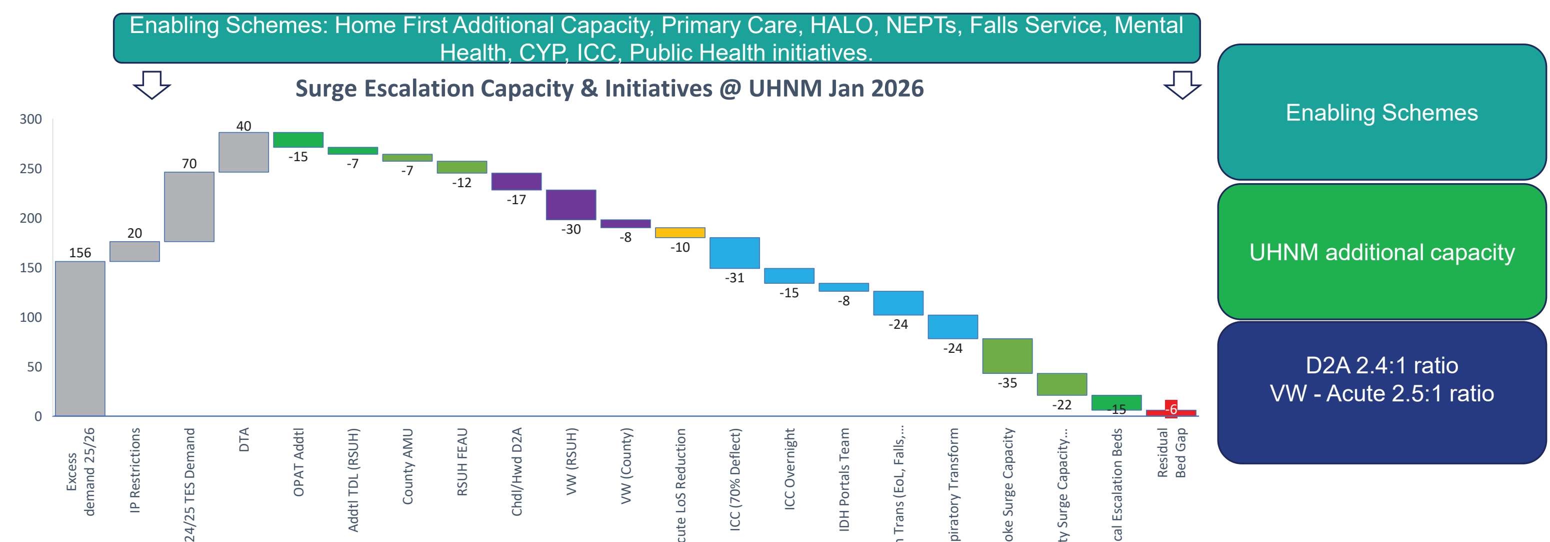
Surgical

Network



- Modelling forecasts sufficient capacity Children's division
- Network & Surgical division demand has increased to a higher level as illustrated.
- Excess demand pressures across UHNM will be mitigated via Network escalation capacity of 9 beds, alongside wider UHNM escalation plans.

UHNM Bed Modelling – Residual Gap



- Full glossary of acronyms utilised on the chart is included overleaf
- ‘Acute Bed Equivalent’ calculations for community & other supporting schemes represented.
- Additional OPAT and TDL mobilisation building upon established service delivery models.
- Additional schemes outlined within the plan.

Waterfall Chart Glossary

Acronym	Detail
IP/IPC	Infection Prevention/Infection Prevention Control
TES	Temporary Escalation Space
DTA	Decision To Admit (Patients awaiting admission from ED)
OPAT	Outpatient Antibiotic Therapy
TDL	Transitional Discharge Lounge
AMU	Acute Medical Unit
FAU	Frailty Assessment Unit
D2A	Discharge To Assess
VW	Virtual Wards
LoS	Length of Stay
ICC	Integrated Care Commissioning (the system's Single Point of Access for Healthcare professionals
IDH	Integrated Discharge Hub
EoL	End of Life
HIU	High Intensity Users (those patients that frequently attend ED or utilise services)

Queens Hospital Burton

Burton Bed GAP updated: includes ED Queue and DAU demand

Updated with Apr-Jun actuals forecast forward to March 2026 (** forecasts currently being worked on to automate figures below)

Burton General and Acute Sites 95% Beds Used Vs Core Capacity (23:59)												
Midnight Occupied Beds includes ED queue & DAU												
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Beds Used 95% Occupancy	372	374	369	369	374	382	400	405	396	416	401	388
Total Site Core Bed Capacity	378	378	378	378	378	378	378	378	378	378	378	378
Total Site Core Bed Capacity (Excluding ring fenced beds)	364	364	364	364	364	364	364	364	364	364	364	364
Total Bed Gap (95% Occupancy vs. core)	6	4	9	9	4	-4	-22	-27	-18	-38	-23	-10
Total Bed Gap/Projected patient queue (95% Occupancy vs. useable)	-8	-10	-5	-5	-10	-18	-36	-41	-32	-52	-37	-24
Closure of the GAP	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Peel Ward										10	10	10
POD B								4	4	4	4	4
Total Escalation Capacity	0	0	0	0	0	0	0	4	4	14	14	14
Total Bed Gap/Projected patient queue (95% Occupancy vs. useable)	-8	-10	-5	-5	-10	-18	-36	-37	-28	-38	-23	-10
DAU	13	13	13	13	13	13	13	13	13	13	13	13
QHB TES						6	17	17	8	8	8	8
CH TES										10	10	10
Ward 15 (EAL move)									2	2	2	2
Total Escalation Capacity	13	13	13	13	13	19	30	30	23	33	33	33
Total Bed Gap/Projected patient queue (95% Occupancy vs. useable)	5	3	8	8	3	1	-6	-7	-5	-5	10	23
Efficiency				2	2	4	4	6	6	6	6	6
Total Bed Gap/Projected patient queue (95% Occupancy vs. useable)	5	3	8	10	5	5	-2	-1	1	1	16	29

- Full modelling TBC post review and sign-off, alongside lead commissioner.
- Work ongoing with UHDB to confirm modelling numbers and escalation capacity and mitigations.
- Burton facing mitigation schemes will be assessed and developed in advance of winter to support acute escalation capacity.

Additional Capacity Schemes

Title	Summary	Impact	Timescale
Acute Care at Home “Pull Model”	2 x Senior liaison practitioner to ‘pull’ suitable patients from ED at both RSUH & QHB into Virtual Ward beds. Reducing unnecessary admissions & ED pressure	Increased VW utilisation. Acute patient flow.	October 2025 – March 2026
Additional OPAT service	Building upon existing (and well-reviewed) service at RSUH to increase capability and caseload of OPAT service.	15 bed impact anticipated	October 2025 – March 2026
IDH FEAU “Pull” Model”	Increased discharges via IDH direct from FEAU, without patients admitted into acute beds. Reduced LoS for frail patients	6 bed impact anticipated	October 2025 – March 2026
X-Ray At Home	X-Ray at home pilot targeting community falls. Aim to reduce need for ambulance conveyance & admissions	75 bed impact anticipated across full time period	October 2025 – March 2026
RSUH Transitional Discharge Lounge	Converting space & staffing at RSUH for additional discharge lounge capacity	7 bed impact anticipated	November 2025 – March 2026

Enabling Schemes

Title	Summary	Impact	Timescale
IDH ED portals Discharge Facilitator (7/7 working)	Expansion of existing and well-functioning discharge facilitator roles to cover weekend working. Increased volume of discharges & alleviation of Monday morning pressures	Improved discharge and patient flow Enabling scheme Estimated 13 acute bed equivalent impact	October 2025 – March 2026
24-Hour Wrap Around Care	24hr wrap-around service for patients that do not require D2A bed but require initial assessment at home with enhanced care package on discharge.	Discharge to patient's home with additional support. Prevent hospital re-admissions Estimated impact of 4 acute bed equivalent	October 2025 – April 2026
Vaccinations for patients discharged to care homes	Recruitment of 2 x b5 vaccinators covering Mon-Fri 9-5. Delivering vaccinations to patients being discharged to care homes.	Reducing risk of transmission of flu/Covid to Care Homes. Reduce re-admissions Protecting high-risk patients	October 2025 – March 2026

Additional/Enabling Schemes – alternative budgets

Title	Summary	Impact	Timescale	Funding Source
Non-Emergency Patient Transport (NEPTs)	Additional capacity for NEPTs crews during winter period. Provision of patient transport to facilitate improved patient flow and facilitate discharges	Facilitated discharge Improved patient flow Additional patient transport capacity	October 2025 – April 2026	ICB surge funding £546,557
Primary Care – Winter MDT hubs	Same Day urgent access hubs to delivery addtl GP appts. 46,154 additional appts N Staffs: 40 ringfenced appts for next-day hospital discharge follow-up for frail patients	Admission avoidance Greater Prim. Care provision during surge	December 2025 – April 2026	Primary Care budget £1.5m
Home First Additional Hours	Additional 1000 hours per week for Home First service during Winter months to mitigate patient flow and manage surge in demand	Increased Home First provision to protect discharge capacity	November 2025 – March 2026	MPFT baseline
System Vaccination initiatives	Respiratory syncytial virus (RSV) Vaccination programme commenced 1 September. Delivered to older age & maternity cohorts. COVID vaccination programme to commence 3 October – targeted to vulnerable patients & care homes	Increased vaccination uptake	September 2025 – December 2026	Baseline
HRD (High Risk of Delayed Transfer of Care) tool	Risk stratification tool to enable IDH team to proactively identify and track specific cohorts of patients upon arrival at ED. Initial focus on vulnerable patients, inc. rough sleepers and patients of no fixed abode, reinstatements (those patients with existing package of care in place) and patients living alone with a clinical frailty score of 5+	IDH able to support a higher volume of patients to access care and facilitate support from a wider range of services – inc voluntary and charity sectors, virtual wards	September 2025 onwards	UHNM
Staffordshire Fire & Rescue "Home from hospital" service	Supported discharge for patients discharged from RSUH. Continuation of service from 23/24. Service review showed good outcomes, minimal readmitted patients and facilitated discharges.	Facilitated discharge. Readmission avoidance Enabling scheme	October 2025 – March 2026	BCF
Staffordshire Fire & Rescue Falls service	Falls service operated by SFRS to reduce admissions and responses/conveyances from WMAS Continuation of existing service	Reduced admissions Reduced ambulance involvement	October 2025 – March 2026	BCF

Assessment of schemes & mitigations

Scheme/Mitigation	Impact	Summary	Confidence in delivery (RAG Rating)
Outpatient Antibiotic Therapy (OPAT) additional	15 beds equivalent	Additional OPAT impact based upon discharge facilitation & re-admission avoidance	
Additional TDL (RSUH)	7 beds	Escalation beds	
County Hospital AMU	7 beds	Escalation beds	
RSUH Hospital FEAU	12 beds equivalent	Admission avoidance impact.	
Cheadle & Haywood hospitals D2A beds	40 D2A beds	17 acute bed equivalent impact. Impact across SSOT.	
Virtual Wards (RSUH)	30 beds equivalent	Numbers from Ops plan – ratio of VW:Acute bed impact	Rqrs increased occupancy
Virtual Wards (County)	8 beds equivalent	Numbers from Ops plan – ratio of VW:Acute bed impact	
Acute Hospital Length of Stay reduction	10 beds equivalent	LoS reductions. Detail TBC	Rqrs quantification/clarity HRD impacts, reduce LoS
Integrated Care Coordination	31 beds equivalent	Based upon increased referral numbers & achieving 70% deflection rate	Dependent upon funding & receiving right type of activity/referrals. High confidence re delivery & ongoing work
Integrated Care Coordination (Overnight)	15 beds equivalent	Based upon increased referral numbers & achieving 70% deflection rate	
Integrated Discharge Hub Portals Team	8 beds equivalent	Composite of schemes as per overleaf	Schemes assessed overleaf
Community Transformation	24 beds equivalent	EoL, Falls, Frailty, HIU	EoL operational – utilisation Falls/Frailty – funding & staffing HIU – Discuss w/ UHNM re lead
Respiratory Transformation	24 beds equivalent	Provider collaborative workstream. Priority areas identified.	TBC
Royal Stoke Surge Capacity	35 beds	Escalation Capacity	
County Hospital Surge Capacity	23 beds	Escalation Capacity	

Assessment of schemes & mitigations

Scheme/Mitigation	Impact	Confidence in delivery (RAG Rating)
Acute Care At Home Pull Practitioner Model	Virtual Ward utilisation, improved patient flow, HRD roll-out support	Rests upon capacity & occupancy
Integrated Discharge Hub Frailty & Elderly Assessment Unit (FEAU) Pull Model	6 bed equivalent impact forecast	Building on County work to adopt at RSUH. Assessment capacity to FEAU, utilising HRD. Rqrs dedicated post
Integrated Discharge Hub Emergency Department Discharge Facilitator 7–day working	Improved discharge & patient flow. 7-day coverage	Clarity w/ UHNM start date to confirm mobilisation
D2A 24-Hour Wrap-Around Care	Facilitating discharge to patient's home Re-admission avoidance 4 bed equivalent	Building upon last year. Model functional. Small numbers but tangible impact. Ring-fence step-up beds (rqrs agreement in South) Evaluated positively
UHNM Vaccinations for patients discharged to Care Homes	Reducing risk of transmission in care homes, reduced readmissions, protecting high-risk patients	
Hospital Ambulance Liaison Officer (HALO) 24/7 cover	ED flow, admission avoidance, ambulance handover improvement	In place.
Integrated Care Coordination Overnight service	NHSE mandated scheme. Protects system flow 24/7	If funding available, then confident in delivery
Integrated Care Coordination additional Surge/Winter staffing	Increased ICC capacity to address winter/surge demand	If funding available, then confident in delivery
Royal Stoke UTC	Support delivery of winter plan, moving ambulatory patients out of ED to create additional ED flow capacity.	
NEPTS	Additional crews to mitigate winter/surge pressures. Alleviate discharge delays	

Managing the peak

- The planned interventions described leave an expected peak deficit of -6 across UHNM.
- This will be further mitigated by the impact of enabling schemes. Although these schemes are non-quantifiable in terms of acute beds or equivalent, they are essential to maximise admission avoidance.
- The remaining deficit will be managed through a combination of outlying patients, maintaining occupancy in excess of 92%, and the holding of patients with a DTA in ED. This will be supplemented by the clinical risk share approach across system partners.
- In the event that demand for UEC services exceeds the levels modelled within the system surge plan, additional “Super Surge” actions can provide additional, in extremis, mitigations, these include; Use of temporary escalation spaces, the spot purchase of additional community discharge to assess beds, AMRAU escalation spaces (10 bedded space, held in reserve specifically to mitigate excess demand) and the review and use of clinical space currently being utilised for non-clinical purposes.
- Should these final actions fail to satisfactorily reduce risk across the System a Business Continuity Incident will be declared and a Command and Control structure established.

De-Escalation

- All system capacity modelling is underpinned by the monthly excess demand trajectory.
- Assessment of the trajectory, and recalibration as required during operational delivery over winter, will inform the system approach to de-escalating capacity and schemes appropriately.
- The weekly System Surge Oversight executive report will illustrate progress against plan, both for mobilisation and de-escalation.
- System Winter Oversight Group will hold accountability (alongside COOs and equivalent senior leadership) for ensuring that schemes, initiatives and capacity are de-escalated in a timely manner, with regular reporting (financial and operational) embedded into the monthly reporting cycle.
- A monthly progress report will be produced for F&PC & UEC Board to ensure oversight and agreement on de-escalation trajectories, with appropriate challenge and scrutiny.

Escalation Management

Escalation Management

- During peak demand, it is likely that the system will have to make tactical decisions to ensure patient safety. To enable this proactively, a set of UEC Daily Metrics (slide 30) are reported, work is ongoing to review and refine these ahead of winter 25/26.
- The revised SSOT System Escalation Plan sets out how the health and care system will manage surges in the Operational Pressure Escalation Levels (OPEL). The plan articulates actions to be undertaken by all system providers to mitigate and de-escalate from extreme operational pressure. The revised plan will be signed off by the Clinical Advisory Group & UEC Board in September.
- The **SSOT Winter Director** assumes oversight of delivery, with escalations to Chief Operating Officers as required as part of normal responsibilities.
- The **System Coordination Centre** (and provider operational teams) works across seven days a week, supporting operational decision making across the system. This will include oversight of non-elective pathways, elective cancellations, maternity, neonatal and mental health escalations.
- The daily system operating rhythm remains in place across seven days a week, with all partners joining the **system calls** daily at 11:30 and 16:00 as needed.
- The **Regional Operational Call** takes place at 14:15 daily, seven days a week.
- Handover to **out of hours tactical and strategic on-call** occurs at 17:00 daily, Mon-Fri for ICB colleagues. Provider on call handovers take place daily at times based on organisational need.
- Standard Operating Procedures are in place for ambulance handovers, long bed waits etc as per usual protocols.
- The SSOT Escalation Plan sets out routes of escalation from operational / tactical to strategic responders who are led by the Winter Director. Emergency Preparedness, Resilience and Recovery remains the responsibility of each Accountable Emergency Officer.

UEC Daily Metrics

- Daily Metrics are used alongside the real time within SHREWD to support decisions in relation to escalation/de-escalation.
- The agreed metrics are updated at 12:00 following System Calls and alongside operational context to support decision making via Strategic Calls.
- The previous end of day position is also recorded Metrics are updated to each morning to support oversight arrangements.

UEC Metric Monitoring

	Metrics	Threshold		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
				26/05/2025	27/05/2025	28/05/2025	29/05/2025	30/05/2025	31/05/2025	01/06/2025
				End of Day	End of Day	End of Day	End of Day	End of Day	End of Day	End of Day
ICS	System OPEL Level to be reduced and maintained.	OPEL 3		3	3	3	3	3	3	3
WMAS	Average handover time since midnight to be in line with 4-week average	**RSUH:**	01:02:00	00:27:45	01:03:41	01:21:06	01:05:27	00:55:42	01:47:41	01:12
		CH:	00:21:00	00:18:32	00:32:54	00:19:00	00:21:58	00:21:39	00:28:40	00:15:49
		QHB:	00:35:00	00:21:52	01:02:01	02:01:31	00:46:46	01:44:38	00:28:51	00:20:54
	CAT2 response time to be in line with 4-week average position and maintained.	00:24:55		00:18:26	00:19:51	00:27:11	00:28:02	00:28:00	00:26:36	00:18:27
Acute	Trust OPEL level to be reduced and maintained.	**RSUH**: OPEL 3		3	3	3	3	3	3	3
		QHB: OPEL 3		2	3	3	3	3	3	2
	DTA within ED at 08:00 at to be line with planning and expected daily activity.	**RSUH:**	39	12	25	44	46	38	38	34
		CH:	3	0	1	2	3	4	10	11
		QHB:	8	1	1	14	7	13	7	5
	RSUH **medicine** Simple & Timely discharges to be in line with UHNM projections.	Mon: 54 Tues: 58 (64) Weds: 63 (83) Thurs: 70 (70) Fri: 70 (74) Sat: 39 (39) Sun: 35		42 (-12)	57 (-7)	63 (-20)	63 (-7)	44 (-30)	43 (+4)	36 (+1)
	RSUH **medicine** Complex discharges to be in line with UHNM projections. *Please note: does not include ED Admission Avoidance work*	Mon: 21 Tues: 21 Weds: 21 Thurs: 21 Fri: 21 Sat: 19 Sun: 13		7 (-14)	13 (-8)	13 (-8)	15 (-6)	16 (-5)	17 (-2)	15 (+2)
		EoD		-19	-37	-72	-74	-24	-36	-54
	QHB Simple & Timely discharges to be in line with UHDB projections.	Mon: 43 Tues: 52 Weds: 53 Thurs: 51 Fri: 61 Sat: 33 Sun: 25		33 (-10)	33 (-19)	61 (+9)	44 (-7)	52 (-9)	31 (-2)	27(+2))
	QHB Complex discharges to be in line with UHDB projections.	Mon: 4 Tues: 6 Weds: 6 Thurs: 6 Fri: 6 Sat: 3 Sun: 2		4	8	4 (-2)	15 (+9)	10 (+4)	4 (+1)	5(+3)
		EoD		-17		-33	-45	-9	-7	-19
	Number of pathway 2 D2A patients waiting within acute bed base to be in line with 4-week average.	UHNM		47	43	40	36	39	43	
		IPC impacted		0	0	0	0	0	0	0
		UHNM minus IPC	29	47	43	40	36	39	43	0
		QHB:	7	11	9	8	10	10	10	
		OOA	35	33	28	30	26	31	30	
		Total	**71**	**91**	**80**	**78**	**72**	**80**	**83**	**0**
		>4 days			57	59	56	52		
		Longest Wait			14	14	14	13		
MPFT	Number of D2A unmet demand patients across the system to be in line with agreed threshold.	Total:	45		39	54	54	61		
		>7 days:	25		22	32	31	38		
		D/c Confirmed			6	8	6	14		

Learning from Critical Incidents 24/25

- Following the periods of Critical Incident during 24/25 the system has completed a full review of the incidents, identified areas of good practice and learning to support development of our 25/26 surge plan.
- This review was completed by the ICB supported by provider operational, clinical and EPRR leads before being approved via System Governance and presentation at Health Overview & Scrutiny Committee.
- An overview of Key Lessons is included below:

Overview of Key Lessons Identified
Activation, Triggers and Stand-down and the timeliness of a Critical Incident system response to be reviewed, and then how recovery is facilitated as a system.
Learning regarding operational processes in the system were identified and better ways of working were implemented by staff to ease pressure and demand. Improvements such as developing existing roles and identifying efficiencies were raised that could be considered in Winter 2025 planning.
Data, analytics and information sharing themes were identified in various themes, where they could be used for better situational awareness of the system and to support future planning. Mental Health information to be shared in the system to understand 12hr breaches.
Care homes and Acute settings could consider using data and analytics to facilitate more proactive work regarding care home pathways in times of pressure, along with a review of Band 2 care home pathways at a system level.
Staff Wellbeing was a key feedback point covering various topics such as staff burnout, resourcing and staff communications. Staff feel extra pressure in a critical incident and expectations need to be managed in the system of impacted staff. Staff need to feel empowered to work effectively in a critical incident with the correct support measures implemented at every stage of an incident. The system to consider a review into pressure points in an incident so more resource can be built into appropriate areas, utilising the people hub, staff development and other methods.
Communications to staff were sent out effectively and efficiently, however standardising the message content needs to be considered to manage expectations of staff. Further communications to various care groups to be considered around how they can support urgent care.
Priority, clarity and consistency in the system around standing down non-essential meetings, training and events where there are increased pressures on staff.
ICB to explore the possibility of adding Local Authority Adult Social Care metrics to SHREWD to increase shared situational awareness.
ICB & WMAS to collaborate strategically on stronger and clearer messaging around Rapid and Immediate Offload requests at hospitals.
Staff worked above and beyond consistently, and there was positive feedback from a patient level.
Creative solutions were identified and staff felt empowered to implement in a critical incident.

Support Pillars

Vaccination

Deliverables

- Submission of System Vaccination Plan – August 2025
- Local communication and engagement campaign for winter vaccines (flu, COVID-19 and RSV) with particular focus on those at-risk
- Strengthened childhood flu vaccination offer through GP practices and school-aged immunisation services
- All older adults eligible for RSV catch-up programme to be offered a vaccine by 31st August 2025
- Continued implementation of older adult catch-up and routine RSV programmes to 2025/26 targets
- Trust vaccination plans to be in place by 1st August 2025 to include:

a) Improved communication and engagement with staff together with bookable and walk-in clinics

b) Stretch target of +5 percentage points uptake in flu vaccinations for staff from 2024/25

c) NHS hospital requirement to offer flu vaccination on discharge to patients going to a care home

Monitoring Metrics

- Flu
  - 65 years & over – 76.3% February 26
  - 2–3-year-olds – 41.5% by February 2026
  - At risk (18-64 years) – 41.8% by Feb 26
  - Primary School – 49.6% by Jan 26
  - Secondary School – 40.1% by Jan 26
  - Trust Direct Patient Contact (HCWs) – 46% by Feb 26
- RSV
  - Older adult catch up 72.5% by Mar 26
  - Older adult routine 62% by Mar 26
- Full monthly trajectories are available within the NHSE submission 11/07/2025 below.

Data &
tions Return SSOT

Primary Care

Deliverables

- Additional capacity (46k appointments) in general practice to mitigate against prioritisation of acute access and de-prioritisation of complex care during surge period.
- Increased sign up to NHS App
- PCN delivery of patient events to focus on staying well, promoting autumn/winter vaccination programme/RSV, self care, NHS App, ARRS roles, Pharmacy First – with focus on cohorts at high risk of deterioration.
- Continued optimisation of Community Pharmacist Consultation Service (CPCS)
- Increased availability of urgent dental care appointments.
- Full Primary Care Winter Plan can be accessed below.

Monitoring Metrics

- Urgent Access MDT Hubs
  - Number of additional appointments delivered
  - Percentage utilisation rate
  - Percentage DNA rate
- Number of patient events held and number of attendees (1 event per 50k population)
  - Number of events
  - Number of attendees
- Modern General Practice
  - Cloud Based Telephony - % of practices available
  - Increased number of pharmacy first referrals
  - 100% of practices with online consultations throughout core hours by 1st October
  - Increased uptake and usage of NHS App
- Delivery of 16,190 additional urgent dental appointments by 31st March 2026 – Actual vs plan.

Community Transformation

Deliverables

- To deliver an integrated end to end Frailty and Falls service for Staffordshire & Stoke-on-Trent across primary, community and secondary care
  - Delivery of an evidence-based model to deliver improved patient outcomes inc. prevention, early identification and review
  - Patient education/empowerment and shared decision making and training and education of the workforce
  - Use of digital/remote monitoring where appropriate
  - Alignment of VCSE to care pathway at a neighbourhood level
  - Self-Care/Management and supporting people to remain at their lowest point of dependency
  - Financially sustainable model to meet current and future demand.
- Implementation of the Hospice 24/7 advice line (further work ongoing regarding Palliative Care Virtual Ward)
- Integrated respiratory service currently being developed by provider collaborative – service deliverables to be determined at forthcoming workshop.
- Early implementor sites for Integrated Neighbourhood Teams being confirmed with focus on top 2-4% of the population. *(Agreed early implementor sites only)*

Monitoring Metrics

- Reduce non elective admissions and attendances over 65+
- Reduce non-elective admissions and attendances from care homes 65+
- Reduce number of conveyances for falls by WMAS
- Reduce number of falls related emergency admissions (65+)
- Increased number of patients dying in their preferred place of death.
- Reduced number of bed days/ length of stay
- Reduced prescribing spend

Note: Respiratory pathway for Stoke and Cannock led by provider collaborative but anticipate reduction in ED attendances, admissions and LOS for asthma, pneumonia & COPD patients.

Integrated Care Coordination

Deliverables

- Increased awareness of the ICC offer to ensure all health and social care professionals including WMAS, care agencies, paramedics on scene (CBC) Community teams, GPs and care homes call the ICC first for advice and support.
- Expanding referrals from NHS111 in a phased approach.
- Introduction of new pathways in line with the identified unmet demand captured by the service both in and out of hours
- Increased senior clinical support to ensure positive risk taking to keep people and patients closer to home where appropriate for their care
- Adequate workforce in skill and number to deliver the above in line with the funding requirements already requested
- Agreement of system wide strategy for ICC following the workshop planned in August.

Monitoring Metrics

- 20% increased contacts from baseline (trajectory needed)
- Increased deflection rates from appropriate and real opportunities with new pathway opportunities to support alternative care offers (achieve 70% deflection from baseline of 50% currently)

Acute Care at Home

Deliverables

- Identify and agree all schemes and budget.
- Finalise plans linked to UEC transformation plan.
- Additional capacity created and monitored against plan.
- Increase access for respiratory and paediatric patients.
- Increase resource (headcount) to support home visits.
- Develop Palliative Care Virtual Ward with system partners to support admission avoidance.
- Utilising ACAH Occupational Therapist resource, in collaboration with the ICC to increase redirection of Falls responses to alternative pathways.
- Additional VW pull practitioner resource within acutes in increase utilisation of VW capacity.

Monitoring Metrics

- Increased numbers of patients streamed to UCR.
- Continuously achieve 70% of UCR patients seen in 2hrs, with system aim of 80%.
- VW Activity volumes for UCR referrals.
- VW capacity & utilisation in line with operational planning trajectories.
- OPAT expansion.

West Midlands Ambulance Service

Deliverables

- Full workforce recruitment for current vacancies.
- Establishment of a “reserve pool” to onboard additional candidates as required.
- Delivery of a 23% increase in H&T (during period 25th Nov – 31st March).
- Paramedic support to ICC supporting an increase in Call Before Convey referrals.
- WMAS improvement plans to support increased S&T rates.

Monitoring Metrics

- Workforce recruitment – increased budgeted establishment
- Increased Hear & Treat rates – in line with trajectory
- Increased See & Treat rates
- Increased referrals from scene to UCR/ICC/Alternative pathways
- Category 2 response performance

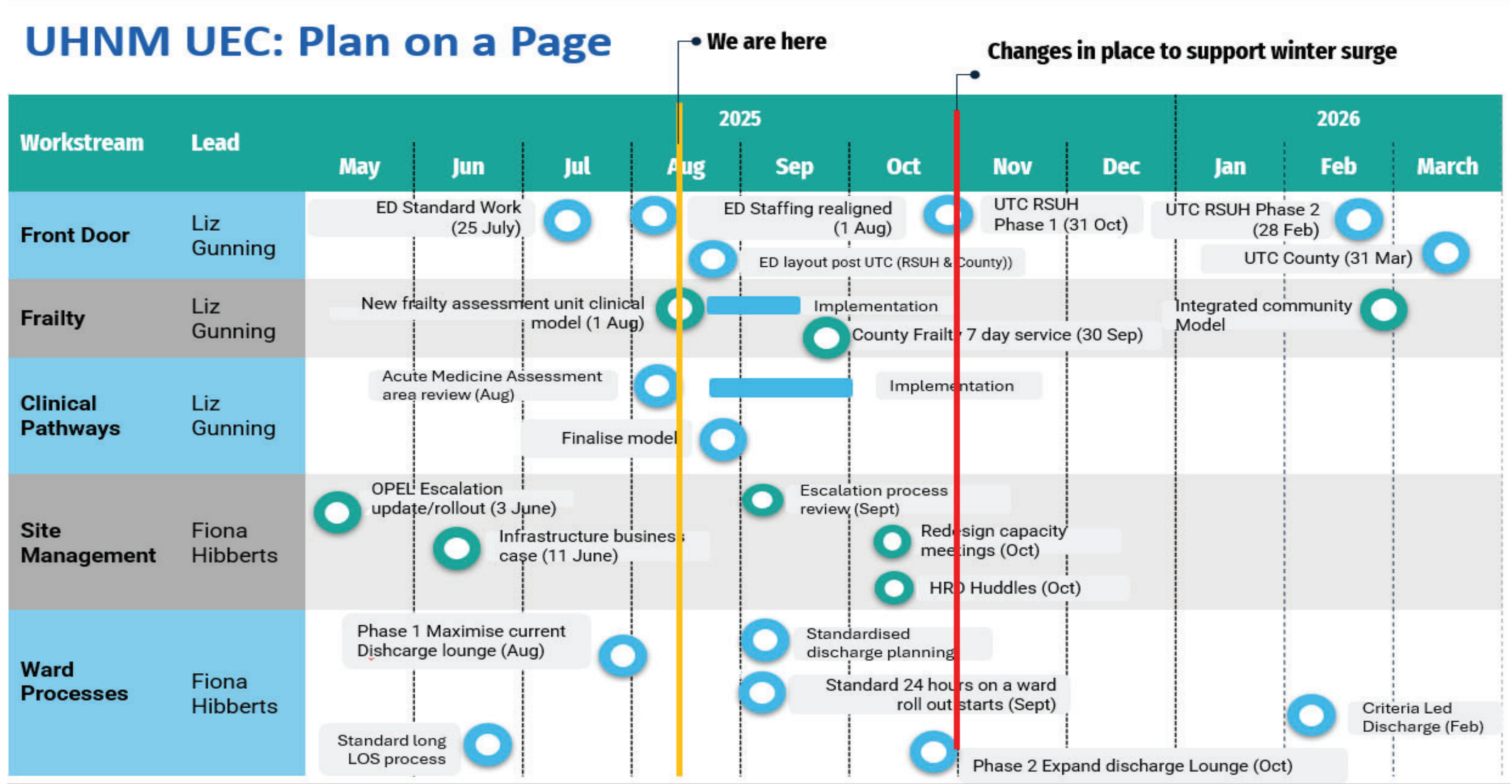
Acute Front Door & Inpatient - UHNM

Deliverables

- Identify and agree all schemes and budget
- Finalise plans linked to UHNM UEC transformation plan
- Additional capacity created and monitored against plan
- Opening of UTC at Royal Stoke then County Hospital
- Paediatric surge capacity

Monitoring Metrics

- Reduced ambulance hand over times
- Reduced average LoS
- Increase numbers of patients streamed away from ED
- *Improved Time to Assessment/ Time in ED performance*
- *Increased number of patient streamed to portals – direct from community*
- *Increased same day discharge (<24hrs) numbers*



UHNM UEC: Plan on a Page
We are here
Changes in place to support winter surge
Workstream
Lead
2025
2026
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
March
Front Door
Liz Gunning
ED Standard Work (25 July)
ED Staffing realigned (1 Aug)
UTC RSUH Phase 1 (31 Oct)
UTC RSUH Phase 2 (28 Feb)
ED layout post UTC (RSUH & County))
UTC County (31 Mar)
Frailty
Liz Gunning
New frailty assessment unit clinical model (1 Aug)
Implementation
Integrated community Model
County Frailty 7 day service (30 Sep)
Clinical Pathways
Liz Gunning
Acute Medicine Assessment area review (Aug)
Implementation
Finalise model
Site Management
Fiona Hibberts
OPEL Escalation update/rollout (3 June)
Escalation process review (Sept)
Infrastructure business case (11 June)
Redesign capacity meetings (Oct)
HRO Huddles (Oct)
Ward Processes
Fiona Hibberts
Phase 1 Maximise current Dishcarge lounge (Aug)
Standardised discharge planning
Standard 24 hours on a ward roll out starts (Sept)
Criteria Led Discharge (Feb)
Standard long LOS process
Phase 2 Expand discharge Lounge (Oct)

ICB UEC Escalation Management

Deliverables

- Submit System Plan 1 August. Refine & recalibrate during winter
- Finance spend in line with budget
- Escalation Capacity brought online as per plan trajectory – to mitigate system bed deficit
- Governance sign-off/approval of plan as per milestones
- De-Escalation of capacity
- Maintain DTA assumed levels
- EPRR Scenario Testing

Monitoring Metrics

- Average Ambulance Handover – in line with operational planning
- *A&E 4 Hour performance – in line with operational planning*
- *A&E 12 Hour performance – in line with operational planning*
- *Cat 2 Response Time – in line with operational planning*
- *DTAs – in line with surge planning parameters*
- *Bed model capacity – in line with agreed system capacity plan and mitigations*

Infection Prevention Control

Deliverables

- 24/7 IPC cover: In place routinely or planned for the winter across all Trust's. In place for community with provision from MPFT using telephone triage and management by GP OOH outside of core hours.
- Community IPC Capacity - Proposal in development for increased capacity to respond to outbreaks within community settings, particularly social care settings.
- Forecasting- engagement with UKHSA field epidemiology service to understand projected forecasts for common winter infections with a view of applying these to modelling locally.
- Staff Vaccination plans: All Trust have staff vaccination plans in place to offer 100% Trust staff vaccination. Primary Care to have oversight of GP Practice delivery through peer vaccination model.
- Rapid PoC testing- In place at UHDB. Rapid Testing used for UHNM, MPFT, NSCHT with North Staffs Pathology lab providing test turnaround <1.5hrs. Full respiratory panel completed for symptomatic patients.
- Virus Resilience Plans: Trust have risk assessment and protocol for management of specific viruses in settings. Multi-agency exercise to take place in August to support development of joint ICS plan.
- Cohorting/ Isolation plans- All Trust have in these in place.
- New pathways for swabbing and antivirals during winter in place to streamline community outbreak response.

Monitoring Metrics

- UKHSA and local epidemiology reports on incidence rates and count of admissions with common winter pathogens- RSV, Flu A+B, Covid-19, Norovirus.
- Number of beds restricted due to IPC
- Number of beds empty due to IPCs

- *Note – IPC Monitoring of bed occupancy due to IPC restrictions is a manual process, discussions with intelligence team to scope a surveillance approach to bed occupancy due to IPC isolation cohorting in place.*

Mental Health

Deliverables

- Submit Mental Health element of the System Plan.
- Delivery of OOA patients' reduction plan.
- Monitoring of AMHP referral to assessment timescales.
- Development & delivery of CRFD plan in collaboration with LAs.
- Delivery of LoS improvements via delivery of operational improvement plan.
- Ongoing review of capacity and demand to enable heat mapping and review against workforce capability for CRHTT to support alternative to hospital admission.

Monitoring Metrics

- Number of 48/72 hr delays for MH patients in ED (data from acute with validation by MH Trust)
- Achievement of Emergency/Urgent/Routine Mental Liaison response times at RSUH, County and QHB (data from MH Trust)
- Reduced number of patients waiting >6hrs for AMHP attendance (data not currently collected)
- Reduced number of CRFD patients in MH Beds (data from MH Trust)
- Longest waiting CRFD in MH patient by MH Provider (data from MH Trust)
- Number of inappropriate OOA patients (data from MH Trust)
- ALOS - working age adults / ALOS – older persons (data from MH Trust)
- NHS 111 Option 2 utilisation data

Discharge

Deliverables

- Objectives and outputs agreed within D2A productivity working group
  - Right Size D2A capacity to support complex discharges
  - Efficiency in processes out of the hospital through the pathways and discharge from the pathway
  - Ensure appropriate capacity that is require for timely assessment on site (CHC/DST) is available and the responsibility of this process is clear.
  - Optimisation of clinical care pathways
- Create the right capacity and pathways to support none D2A complex pathways
  - Expand the VCSE pathways, co-production of care and pathways for Housing and Homelessness
- Deliver the opportunities within the HRD tool programme
  - Maximise tracing capability and the volume of care reinstatements with LA commissioned timescales
- Objectives and outputs agreed within UHNM UED Programme
  - Ward and discharge processes, reduction of overall LOS in the n-hospital process and decision making.
  - Centralisation of the DF workforce.

Monitoring Metrics

- Increased simple and timely discharges per day against target (SPC run chart to monitor)
- Complex discharges each day against target split by pathway (SPC run chart)
- Complex discharge demand from ED/Portals split
- *Reduction in longest delays awaiting discharge*
- *Numbers of patients sent to discharge lounge.*
- *Discharges before 10am, 12pm, 5pm – (SPC run chart to monitor progress)*

Local Authority – Staffordshire County Council

Deliverables

- Improved timeliness of social care assessments for urgent care patients
- Increase in the number of patients able to return home (if agreed and implemented)
- Timely brokering of service for urgent care patients.

Monitoring Metrics

- The percentage of social care assessments for urgent care patients completed to target timescale
- The number of patients able to return home with night needs who would have otherwise required a bed-based service (if agreed and implemented)
- The percentage of brokering to target timescale of service for urgent care patients.

Local Authority – Stoke-on-Trent City Council

Deliverables

- Managing deteriorating patients to avoid ED attendance/escalation
- Using POLR appropriately as escalation measure. Not BAU.
- Reshaping team objectives & culture, redesign.
- Designing hyperlocal partnership-based frailty model
- Development of neighbourhood care model
- Delivery of comms & training via Managers Quality Network forum
- Timely delivery of Mental Health assessments in ED
- To have more people return ‘home’ following urgent care episode

Monitoring Metrics

- Increased number of enablement plans
- AMHP referral to assessment times
- Amount of people able to return to their current place of habitude – ie home from discharge
- Unmet demand and brokerage to placement timescales – people move within 7 days of brokerage process
- Timely allocation and completion of assessment
- Reduction in new 24 hour care placements

CYP

Deliverables

- The Enhanced Primary Care (EhPC) offer at Royal Stoke to stream CYP presenting with low acuity from ED.
- Hospital at Home service is utilised as a community offer for children who require monitoring rather than hospital-based care.
- UHNM in the process of establishing a Single Point of Access for ED / CAU for CYP.
- Asthma Community Nurse to support CYP presenting to ED who are not admitted, post exacerbation support will be provided with a view to reducing re-attendances.
- Mobilisation of MPFT Crisis Care Suite, which includes a crisis assessment centre, a Section 136 suite, and a dedicated CYP unit in the event that there is no system alternative MH response or 136 suite available.
- NSCHT has a 24/7 Crisis Care Suite and a dedicated CYP Section 136 suite, links directly with ED to support assessment in the most appropriate setting.
- MHLT - joint assessment with our community CYP teams/Community Home Treatment Team (ISH) to ensure timely assessment/co-ordinated discharge/transfer. NSCHT also have close links with Provider Collaborative hosted by Birmingham Women's and Children's to support Tier 4 admission, where appropriate.

Monitoring Metrics

- Number of appointments specifically for CYP
- Number of CYP supported via hospital a home (CCNT)
- Number of CYP supported by the Community Asthma Nurse
- Decrease in the number of CYP accessing ED for MH supported via:
  - NSCHT
  - MPFT

Quality & Patient Safety

Deliverables

- Quality & Nursing team will support the development of 25/26 Winter Plan which achieves the local and regional quality and patient standards
- Plans will reflect the learning gained from 24/25 with regards to impact, reducing inequality and clinical variance.
- Quality Impact Assessments completed in line with RASCI & NQB recommendations across all pillars and schemes
- Risk and Issues are clearly understood across all pillars/schemes with mitigations in place where possible
- Agreed mechanisms are in place which captures actual or potential harm and evaluates the impact upon patient care as a result in delays
- Robust operational guidance & policies are in place to support operational and clinical decision-making during periods of surge.

Monitoring Metrics

- Across all the pillars & schemes it is expected that:
  - There is a demonstrable reduction in delays which have the potential to cause harm across all pillars/schemes
  - Reporting is in place to evaluate any harm caused (ie AAR) as a result of delays across the system
  - Monitoring of the risks of potential or actual harm that has occurred and the impact on patients and staff when TES is used.

Workforce

Deliverables

- Workforce planning and recruitment to address the deficit/mitigate supply risks within each support pillar.
- Develop and deploy surge and super surge workforce models, ensuring safe staffing levels maintained e.g. bank, additional hours, skill mix, internal redeployment and volunteer roles.
- Mutual Aid agreement and robust process for mobilisation of workforce across System as required
- System wide workforce assurance through weekly reporting, monitoring workforce availability and resilience.
- Targeted promotion of vaccination programme and infection prevention and control for front line staff
- Review EPRR processes to ensure any potential future Industrial Action is mitigated
- Continued focus on workforce experience, health and wellbeing with particular focus on 'winter wellness'. Targeted support in areas of high sickness absence, focussing on highest reasons for absence. Additionally, offering flexible working and rostering to maximise workforce availability and reduce burnout, support for new starters and improved on-boarding. All monitored by the ICS Experience, Health and Wellbeing group.

Monitoring Metrics

- Monthly People Metrics – Sickness, Turnover, vacancies
- Bank and agency usage (currently report monthly via PWR)
- Number of System Mutual Aid requests and workforce deployed (via the People Function)

Communications

Deliverables

- Data driven campaigns to support workstream/pillar deliverables:
  - C&E campaigns for winter vaccines (flu, COVID-19 and RSV) for staff and those at-risk, NHS App, and Hospice 24/7 advice line
  - Awareness campaign for ICC (all health and social care professionals)
  - Patient education – self-care, Pharmacy First, NHS111, Home Care is Best Care, Falls prevention, digital/remote monitoring, UTCs
  - Campaigns to respond to emerging challenges across the system
- Develop toolkits to share with system partners for local amplification
- Engagement to understand local barriers/influence behaviour change – share existing intelligence with workstreams
- Comms support for PCN events

Monitoring Metrics

- Increased take up of winter vaccines, particularly for staff and targeted groups
- Increased utilisation of NHS App and Hospice 24/7 line
- Increased utilisation of ICC as first call for advice and support
- Reduction in people presenting to UEC with conditions that could have been prevented, alleviated through self-care or being seen by alternative community service
- Increased attendance at PCN events

Finance

Deliverables

- Identification of ICB funding available, initial commitments against funding and remaining resource available
- Collation of Provider internal budgets and ongoing reporting of performance against budget
- Consolidated (ICB / Provider) monthly monitoring of spend against plan as well as forecast outturn
- Highlight where actual or forecast expenditure is above plan to enable corrective action and / or escalation to be undertaken
- Establish early indication of slippage to enable redistribution of funding to other contingent schemes where possible

Monitoring Metrics

- Provision of monthly reporting identifying year to date and forecast outturn performance against Plan

Winter Planning 25/26

Board Assurance Statement (BAS)

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

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the ICB's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Integrated Care Board's (ICB) name.

This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the ICB Winter Plan for 2025/26.		
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.		
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.		
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.		
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.		
Plan content and delivery		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.		
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.		
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.		

ICB CEO/AO name	Date	ICB Chair name	Date

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.		
2. In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.		
3. Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.		
Capacity		
4. The profile of likely winter-related patient demand across the system is modelled and understood, and individual organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.		
5. Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.		
6. Action has been taken in response to the Elective Care Demand Management letter,		

issued in May 2025, and ongoing monitoring is in place.		
Leadership		
7. On-call arrangements are in place, including medical and nurse leaders, and have been tested.		
8. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.		

Enclosure No: 07

Report to:	**Integrated Care Board**				
Date:	**18 September 2025**				
Title:	**Q2 2025/26 System Board Assurance Framework (SBAF) Update**				
Presenting Officer:	Claire Cotton, Director of Governance, UHNM				
Author(s):	Lia Pitarokoili, Head of Governance				
Document Type:	Report	If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)** ☐	**Discussion (D)** ☒	**Assurance (S)** ☒		
	Approval (A) ☐	**Ratification (R)** ☐	*(check as necessary)*		
Is the decision within SOFD powers & limits	**Yes / No**	NO			
Any potential / actual Conflict of Interest?	**Yes / No**	*NO*			
Any financial impacts: ICB or ICS?	**Yes / No**	*NO*			
Any impacts on ICB Undertakings?	**Yes / No**	*NO*			
Appendices:	SBAF Q2 2025/26 report				

(1) Purpose of the Paper:

The enclosed report sets out the updated System Board Assurance Framework (SBAF) for Quarter 2 2025-26 and is submitted to ICB Board for oversight and assurance. The SBAF has been presented to or circulated offline among all ICB Committees in September.

(2) History of the Paper & Whether for I-D-S-A-R (as above):	**Date**
Finance and Performance Committee (D/S)	2/9/2025
Strategic Commissioning and Transformation Committee (D/S)	3/9/2025
People, Culture and Inclusion Committee (D/S)	4/9/2025
Audit Committee (D/S)	(circulated offline)
Quality and Safety Committee (D/S)	(circulated offline)

(3) Implications:

Legal / Regulatory	UK Corporate Governance Codes and Controls Assurance Audits. SBAF completion is a key component of the ICB's Risk Management Strategy.
CQC / Patient Safety	There are no implications for CQC or other regulators
Financial (CFO-assured)	Managing financial risks will help mitigate Financial Management Concerns
Sustainability	Managing 'Greener NHS' risks will help mitigate Sustainability Concerns

Workforce / Training	Mitigation of workforce risks to meet the requirements of NHS Long Term Workforce Plan. There are no training implications resulting from this paper
Equality & Diversity	N/A
Due Regard: Inequalities	N/A
Due Regard: wider effect	N/A

(4) Statutory Dependencies & Impact Assessments:					
		Yes	**No**	**N/A**	**Details**
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	N/A in relation to this Report
	EIA	☐	☐	☒	N/A in relation to this Report
	QIA	☐	☐	☒	N/A in relation to this Report
Has there been Public / Patient Involvement?		☐	☐	☒	N/A in relation to this Report

(5) Integration with the System Board Assurance Framework & Key Risks:					
SBAF1	Responsive Patient Care - Elective	☒	**SBAF5**	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☒	**SBAF6**	Sustainable Finances	☒
SBAF3	Proactive Integrated Community Services	☒	**SBAF7**	Improving Productivity	☒
SBAF4	Reducing Health Inequalities	☒	**SBAF8**	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

The System Board Assurance Framework (SBAF) sets out the principal risks to the achievement of the ICB's Strategic Ambitions and provides a structured means through which Committees can assess delivery against those. It is also a key source of evidence in demonstrating how the ICB discharges its responsibility for internal control. The SBAF sets out the key controls in place to manage these risks, the assurances available on their effectiveness, any gaps in control or assurance, and the actions to further reduce each risk to our Strategic Ambitions.

The attached SBAF provides the Board with the Q2 update for 2025/26.

During Q2, SBAF objective owners reviewed the rationale for each risk level and assessed the progress made during the quarter, including mitigating actions undertaken. They evaluated the key controls framework, considered sources of planned assurance, and identified any gaps in control or assurance.

The report also reflects on actions from Q1 (delivered, impact reasons for non-delivery and support required) and sets out future actions aimed at improving assurance and further reducing risk levels. This approach supports the Committees and ICB Board in tracking progress and understanding impact quarter by quarter.

The SBAF includes eight Strategic Risks which provide coverage of the four Strategic Ambitions. All Strategic Risks for this quarter are assessed as High, reflecting the continued complexity and challenges across the system. The risk levels across all Strategic Objectives have remained static since Q1.

SBAF 8 (Sustainable Workforce) has the highest number of linked operational risks (17) whereas SBAF 3 (Proactive Planning & Delivery of Integrated Locality Based Community Services) has the lowest number of linked operational risks (8).

Strategic Ambition 2 (Address inequalities in access, experience and outcomes from health and care services) and Strategic Ambition 3 (Achieve a sustainable and resilient Integrated Care System) remain the 'most threatened', each with 5 Strategic Risks posing a threat.

The majority of Strategic Risks (6 out of 8) are currently rated as having 'Partial Assurance', indicating that while some controls are in place, further work is required to fully mitigate risks. SBAF 5 (High Quality, Safe Care Outcomes) and SBAF 8 (Sustainable Workforce) have 'Acceptable Assurance'.

The System Risk Map (Section 5) brings together risk assessments from UHNM, CHC, MPFT, and the ICB to create a single, system-wide perspective. It highlights both alignment and variation in risk perception across the system, showing where risks are consistently rated high (e.g., financial stability, workforce, and quality and safety) and where they diverge. This enables the Board to pinpoint shared challenges and areas where collaboration, mitigation, and assurance efforts can be most effective. By visualising these risks side by side, we strengthen collective governance, target assurance on the areas of greatest impact, and drive integrated action to deliver safe, effective, and sustainable care across the ICS.

A Summary SBAF is being developed for Q3, which will aim to provide the Board with a clear, high-level view of system risks and assurance. This will complement the detailed version, which will continue to be presented at Board Assurance Committees for consideration - ensuring the right balance between strategic oversight and operational detail, and supporting well-informed decision-making.

(7) Recommendations to Committee:

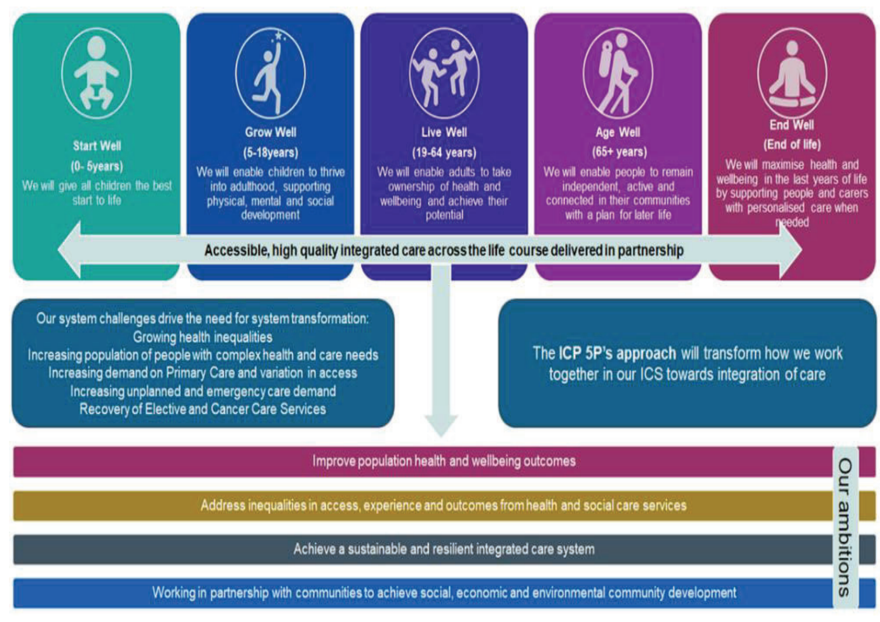
The ICB Board is asked to consider whether risk levels and assurance assessments are an accurate reflection of the position and discuss and confirm the adequacy of those controls and assessments.

Integrated Care Board

System Board Assurance Framework (SBAF)

Quarter 2 2025/26

1 Introduction and Overview



The System Board Assurance Framework (SBAF) provides the ICB with a structured and dynamic mechanism to identify, assess, and monitor the strategic risks which might compromise the achievement of its Strategic Ambitions (SA) (see Strategic Framework within ICP Strategy).

The SBAF sets out the key controls in place to manage those risks. It evaluates the strength and adequacy of the assurances available to the ICB and highlights any gaps in controls or assurance, along with the actions needed to address them which are aimed at either providing additional assurance or to reduce the likelihood or consequence of the risk, towards the target. The target risk score ('tolerance') is aligned with our Risk Appetite Statement (Risk Management Strategy, Appendix 4).

Background

To refresh the SBAF for 2025/26, and in line with our annual review progress, a Board Development session was held in April 2025. This session provided an opportunity to review each strategic risk and determine whether it remained relevant, with a particular focus on ensuring risks were described at a system wide level. As a result, it was agreed that all strategic risks would be carried forward into 2025/26, while some minor changes were agreed. The SBAF is a dynamic, evolving document which will continue to be developed and improved in terms of format and function throughout 2025/26 and beyond.

Assessment

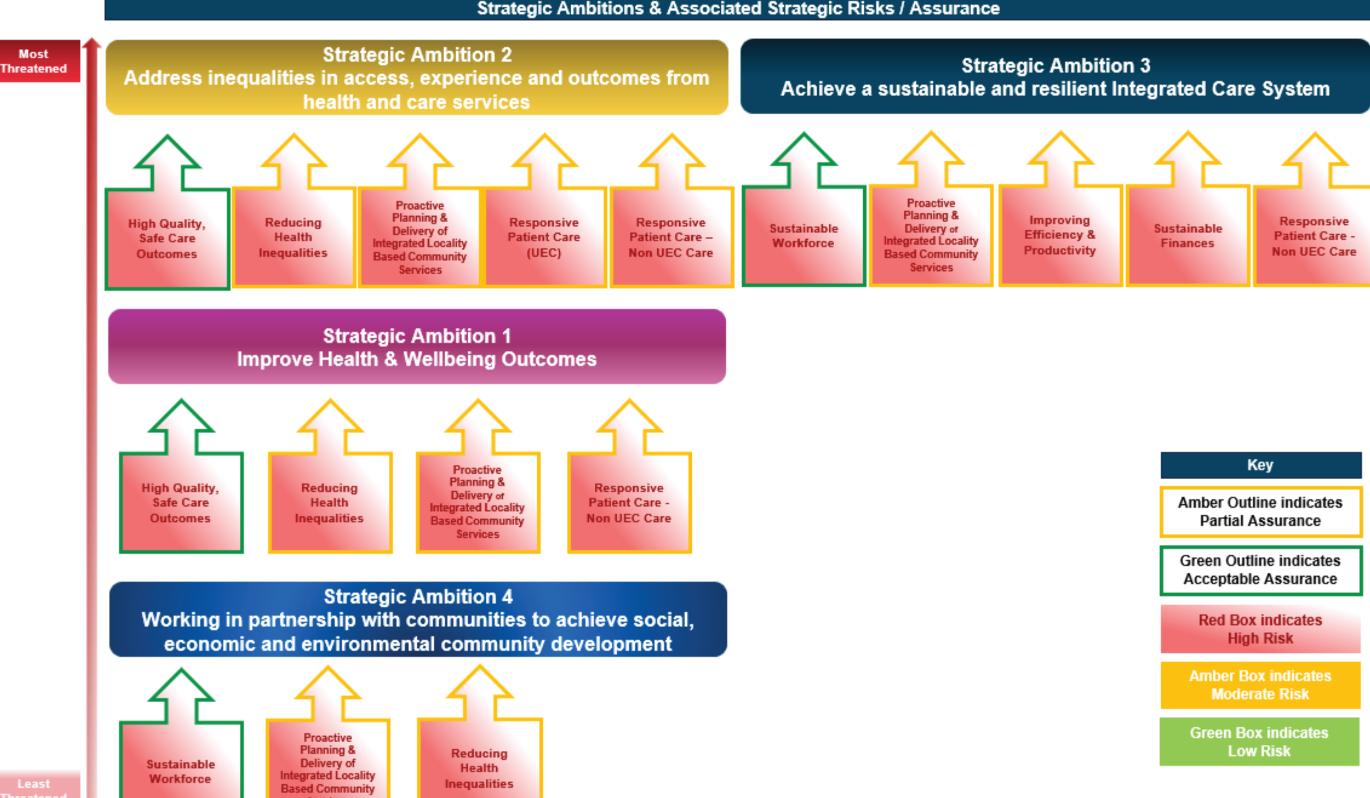
	All Strategic Risks for this quarter are still assessed as **High**, reflecting the continued complexity and challenges across the system.
	The risk levels across all Strategic Objectives have remained static since Q1 2025/2026.
	SBAF 8: Sustainable Workforce has the **highest number** of linked operational risks (17) whereas **SBAF 3: Proactive Planning & Delivery of Integrated Locality Based Community Services** has the **lowest number** of linked operational risks (8).
	Strategic Ambition 2: *Address inequalities in access, experience and outcomes from health and care services* and **Strategic Ambition 3**: *Achieve a sustainable and resilient Integrated Care System* remain the 'most threatened', each with 5 Strategic Risks posing a threat.
	The majority of Strategic Risks (6 out of 8) are currently rated as having **'Partial Assurance'**, indicating that while some controls are in place, further work is required to fully mitigate risks. **SBAF 5: High Quality, Safe Care Outcomes** and **SBAF 8: Sustainable Workforce** have **'Acceptable Assurance'**.
	The top 3 System Risks for this Quarter are: (1) Financial Sustainability; (2) Workforce Sustainability; and (3) Quality and Safety of Services.

Recommendations

- Consider whether each risk level and assurance assessment accurately reflect the current position
- Consider whether the actions identified are sufficient to either reduce the risk level or provide additional assurance

SBAF Risk Level RAG Rating		Assurance Assessment Ratings	
	Low	**Significant Assurance**	**High level of confidence in delivery of existing mechanisms / objectives**
	Moderate	**Acceptable Assurance**	**General confidence in delivery of existing mechanisms / objectives**
	High	**Partial Assurance**	**Some confidence in delivery of existing mechanisms / objectives, some areas of concern**
		No Assurance	**No confidence in delivery**

2 Threat to our Strategic Ambitions



3 Summary Board Assurance Framework (SBAF)

Assurance Committee	No.	Strategic Risk Title	Q1	Q2	Q3	Q4	Risk Movement	Assurance Assessment	Linked Risks	Threat to Ambitions
Finance & Performance Committee	SBAF 1	Responsive Patient Care – Urgent & Emergency Care	High	High				Partial Assurance		SA2
	SBAF 2	Responsive Patient Care – Non UEC Care (e.g. Elective, Cancer Diagnostics, Community/Mental Health/Primary Care)	High	High				Partial Assurance		SA1 SA2 SA3
Strategic Commissioning & Transformation Committee	SBAF 3	Proactive Planning & Delivery of Integrated Locality Based Community Services	High	High				Partial Assurance		SA1 SA2 SA3 SA4
	SBAF 4	Reducing Health Inequalities	High	High				Partial Assurance		SA1 SA2 SA4
Quality & Safety Committee	SBAF 5	High Quality, Safe Care Outcomes	High	High				Acceptable Assurance		SA1 SA2
Finance & Performance Committee	SBAF 6	Sustainable Finances	High	High				Partial Assurance		SA3
	SBAF 7	Improving Efficiency & Productivity	High	High				Partial Assurance		SA3
People, Culture & Inclusion Committee	SBAF 8	Sustainable Workforce	High	High				Acceptable Assurance		SA3 SA4

4 Linked Operational Risks and Risk Overview

SBAF 1	Risk Title	Risk Score
1197	D2A Capacity	15
1199	Ambulance handover delays	25
1206	A&E Four Hour performance	12
1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1508	NHS Reform Programme	4
1526	Planned care national and local performance standards not achieved	16
1541	Relocation of GP OOH Face to Face locations from Royal Stoke & County Hospital	16
1551	System Surge Capacity	20

SBAF 2	Risk Title	Risk Score
1219	UHNM Electronic Patient Records (EPR)	20
1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1508	NHS Reform Programme	4
1551	System Surge Capacity	20
1554	Poor communication between Primary Care & Maternity Services	9

SBAF 3	Risk Title	Risk Score
1219	UHNM Electronic Patient Records (EPR)	20
1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1508	NHS Reform Programme	4
1554	Poor communication between Primary Care & Maternity Services	9

SBAF 4	Risk Title	Risk Score
1173	Choice of place of Birth	6
1221	Migration to ISFE2 Ledger system	10
1394	Risk to dental access remövery post COVID & patients inability in accessing NHS dental services due to capacity & workforce pressures	8
1457	Gaps in AHP workforce on UHNM Neonatal Unit	9
1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1508	NHS Reform Programme	4
1510	Maternity and neonatal voices partnership (MNVP) contribution to achieving Maternity Incentive Scheme (MIS) for Trusts standard 7	9
1554	Poor communication between Primary Care & Maternity Services	9

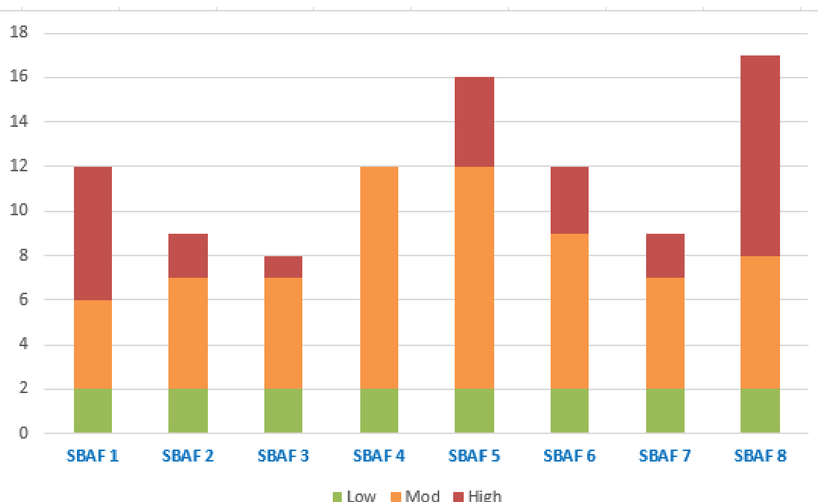
SBAF 5	Risk Title	Risk Score
1173	Choice of place of Birth	6
1202	"Looked after Children"	9
1239	Neonatal consultant workforce	12
1430	Inadequate provision of Epilepsy Nurse Specialists	16
1444	Demand for paediatric dietetic services	20
1457	Gaps in AHP workforce on UHNM Neonatal Unit	9
1479	De-escalation of system surge capacity	8
1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1508	NHS Reform Programme	4
1510	Maternity and neonatal voices partnership (MNVP) contribution to achieving Maternity Incentive Scheme (MIS) for Trusts standard 7	9
1551	System Surge Capacity	20
1554	Poor communication between Primary Care & Maternity Services	9

SBAF 6	Risk Title	Risk Score
1205	Potential Counter Fraud Risk	9
1479	De-escalation of system surge capacity	8
1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1508	NHS Reform Programme	4
1510	Maternity and neonatal voices partnership (MNVP) contribution to achieving Maternity Incentive Scheme (MIS) for Trusts standard 7	9
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
1180	NHS Provider License	10
1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1508	NHS Reform Programme	4
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
1253	Digital Workforce recruitment and retention	6
1444	Demand for paediatric dietetic services	20
1479	De-escalation of system surge capacity	8
1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1508	NHS Reform Programme	4
1511	Ability to deliver the 25/26 Operational workforce plan	16
1512	Ability to deliver required ICB & 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

Visual Risk Matrix Overview: *The table represents a comprehensive breakdown of risks across the SBAF strategic objectives.*



SBAF 8**: Sustainable Workforce and **SBAF 5**: High Quality, Safe Care Outcomes, have the highest number of **linked operational risks.

5 System Risk Map

Risk	UHNM	CHC	MPFT	ICB
Financial Stability	20	10	20	High
Workforce	15	(15) 16	12	High
Quality and Safety of Services	16	15	12	High
Information Systems / Digital	16	16	16	
Estate Infrastructure / Relevance	12		16	
Balancing Capacity and Demand			12	High
Financial Plan Delivery	20	16		
Reducing Health Inequalities	12			High
Commercial Effectiveness			12	
Staff Health & Wellbeing			12	
Effective Engagement & Coproduction			12	
Strategic Direction & Partnerships		16		
Proactive Planning & Delivery of Integrated Locality Based Community Services				High
Improving Efficiency & Productivity				High
Research and Innovation Excellence	12			

***Overview of Strategic Risks:** The top 3 System Risks for this Quarter are: (1) Financial Sustainability; (2) Workforce Sustainability; and (3) Quality and Safety of Services.*

6 System Board Assurance Framework (SBAF)

SBAF 1: Responsive Patient Care – Urgent & Emergency Care

Finance & Performance Committee | Chief Delivery Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	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,
Event	then should demand outstrip capacity, there will be pressure points within the UEC system,
Effect (Consequence)	resulting in poor outcomes and experience for patients, increased pressure for our workforce and consequently poor performance and non-delivery of operational planning targets.

SA1	Improve Health and Wellbeing Outcomes		SA3	Achieve a sustainable and resilient Integrated Care System	
SA2	Address inequalities in access, experience and outcomes from health and social care services	●	SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Risk Assurance and Tolerance

Quarter	Q1	Q2	Q3	Q4	Risk Tolerance Statement	Linked Risks		
Risk Level (Low/Moderate/High)	High	High			The consequence of not having the correct capacity in the UEC system will inevitably impact on delivery and patients not able to access the UEC they require. The biggest risk is having long waits for ambulances in the community.	Low	2	→
						Mod	4	→
						High	6	↑

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	●
No Assurance	No confidence in delivery	

Rationale for Risk Level & Progress Made in the Quarter (e.g. mitigating actions to reduce risk level):

Throughout Q2 the key priority areas for improvement remain 4-hour Emergency Department (ED) performance towards achieving 78% by March 2026, 12-hour ED performance, and reducing ambulance handover delays and therefore category 2 performance. Whilst improvements have been made continued focus on delivery is required to support delivery of our operational planning commitments and subsequent risk reduction. Our UEC governance infrastructure continues to ensure collective leadership for system oversight for delivery and improvement, with all system partners. During the period UHNM have been moved into Tier 1 for UEC Oversight, additional support will be provided by NHS England regionally with national oversight.

Development of the system-wide surge plan has commenced, with enhanced oversight in place via creation of a Winter Oversight Group which will oversee investment across UEC pathways to increase capacity and initiatives/schemes designed to optimise admission and attendance avoidance. The 2025/26 surge plan builds upon the 24/25 system winter review and thematic learning to address key considerations such as surges in activity above forecasted levels and the ongoing increased Infection Prevention and Control arrangements that have impacted flow of patients within bed-based services. A full refresh and reset of the system capacity bed model is in progress to ensure forecasts are updated to reflect the issues observed this past winter. Full governance review of the winter review outputs and actions is also underway to ensure tangible actions are taken to mitigate issues prevalent during periods of increased demand and activity in UEC pathways.

During the quarter the focus for the portfolio has been in delivery of the system UEC improvement plan and associated actions. Improvement actions relating to front door processes, assessment units, management of frail and deteriorating patients, discharge transformation continue to be prioritised. Concurrently, admission and attendance avoidance actions relating to the ongoing development of the system Integrated Care Coordination (ICC) offer and wider community transformation workstreams are pivotal in delivery of plans.

Operational pressures have remained albeit at a reduced level as we have entered summer months. Operational mitigations and actions are monitored daily via our System Coordination Centre (SCC) and via wider UEC Governance.

Key Controls Framework

- Daily System Co-ordination Centre (SCC) & Daily System calls (Twice daily when required).
- Regional Capacity Calls attended by System Co-ordination Centre.
- System UEC Improvement plan – the system has agreed a focused plan to drive improvements across the UEC system.
- System UEC 25/26 Surge Plan is in development via a multidisciplinary approach and will once again be presented to partner organisations boards and to ICB Board for final ratification.
- The SCC proactively manages the daily capacity and demand across the system and leads daily system COO calls to manage pressure. Following recent peer review and assessment by NHS England the SCC has been recommended for national accreditation.
- System Escalation Plan, a further refresh of the system escalation plan is underway with system partners. The revised plan will be reviewed in line with the updated NHSE OPEL Framework and supported by collaboration with our system partners and ahead of sign off at the UEC Board.
- System UEC Strategy – whilst outlining longer term plans of improvement, the UEC Strategy development ensures that the UEC Portfolio has a clear vision for UEC development, any in year improvements will be striving to meet the improvements set out in the long-term System UEC Strategy.
- ICB Finance & Performance Committee and System Performance Group; these groups are tasked with being assured on delivery and offer good-strength controls into the decision-making processes, supporting the other principal controls outlined. Surge reports monthly to these forums.
- ICB Strategic Commissioning & Transformation Committee is tasked with being assured on transformation and ensuring alignment between Portfolios (Transformation Programmes) and SBAF controls.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	Daily System Calls Realtime data feeds and escalation via SHREWD Weekly UEC Performance Reports Monthly UEC MDT Weekly COO Group Meeting	●	●		
2nd Line (system)	System Performance Report to Finance & Performance Report to Finance & Performance Committee and ICB Board.	●	●		
	Weekly updates to System Winter Oversight Group		●		
	Monthly updates to System Delivery Group.	●	●		
	Monthly update to System Performance Group.	●	●		
	Monthly update to Finance and Performance Committee including productivity/operating plans and financial updates.	●	●		
	Fortnightly SLT update.	●	●		
	Surge Plan Assurance by: • UEC Board. • Children & Young People (CYP) Programme Board. • UEC Clinical Advisory Group. • Finance & Performance Committee. • UHNM Trust Board. • Clinical Senate. • SOTCC Operational Business Meeting. • MPFT Trust Board. • NSCHT Trust Board. • SCC Health & Care Senior Leadership Team. • Stoke City Council Health & Care Senior Leadership Team • System Quality Committee. • ICS People, Culture & Inclusion Committee (Ref. UEC Workforce) • Local Health Resilience Partnership (LHRP)		●		
3rd Line (external)	Tier 1 UEC Improvement framework – Executive weekly.	●	●		
	Stoke-on-Trent Health Overview & Scrutiny Committee	●			
	Staffordshire Health Overview & Scrutiny Committee				
	NHS England - Surge Plan Assurance Visit.		●		
	NHS England Regional Assurance Visit/Peer Review.		●		

Gaps in Control or Assurance

What are the gaps to be addressed to improve adequacy of assurance?

- Residual bed capacity gap.
- Operational pressures resulting from the implementation of enhanced IPC measures, which may temporarily reduce available capacity.
- Workforce deliverability across all areas of UEC pathway.
- Surge beyond the predicted peak.
- Service delivery challenges linked to sustained IPC practices within the Care Home sector.
- Unforeseen demand due to major incident.
- Individual organisation risk management.

FUTURE Actions
(Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)

No.	Action Required	Outcome of Action	Lead Director	Progress, Impact & Planned Actions
1	Delivery of System UEC Improvement Plan against trajectory	Achieve Operational Plan requirements. 4-Hour ED Target 12-hour ED target Cat 2 response – 30 mins.	Chief Delivery Officer	**Q1 Progress & Impact:** Action plans and delivery underway, Q1 stocktake completed. UEC Conveyance audit to be undertaken with system partners, outputs to be taken forward via provider collaborative and alternative pathways group. 24/7 Hospital/Ambulance Liaison Officer (HALO) implemented. Initial reductions in ambulance handover delays seen. Discharge audits & reviews to be formalised and action plan developed. **Planned Actions (Q2):** Approval via appropriate governance for the designation of UTC's across SSOT. ICC strategy event to be undertaken in August. Deployment of multiple tests of change within UHNM focusing on ED front door activity, ambulance arrivals and enhanced clinical flow model in line with UHNM UEC Improvement Plan. Commencement of the D2A review productivity workstream.
2	System surge planning	Development of system plan to mitigate increased activity prior, during & post winter.	Chief Delivery Officer	**Q1 Progress & Impact:** Completion of 24/25 system winter review & learning to inform 25/26 surge planning. Presentation to Finance & Performance Committee, ICB Board and HOSCs to share outputs and actions of 24/25 review. Commencement of delivery of action plan. Initial review of UHNM Bed Model Scoping and agreement of surge capacity and initiatives.

				Review and submission of the initial winter Key Lines of Enquiry (KLOE) as part of the winter assurance process. **Planned Actions (Q2):** Full refresh & reset of system capacity bed model (UHNM). Review of the Queens Hospital Burton (QHB) bed model and mitigation in partnership with UHDB & Derbyshire ICB. Development & approval of System Surge Plan and System Escalation Plan. Undertake EPRR testing of System Surge & Escalation plans. Commence mobilisation of agreed surge capacity schemes.
3	Integrated Care Coordination	Increasing appropriate utilisation and efficacy of system ICC offer.	Chief Delivery Officer/ Chief People Officer	**Q1 Progress & Impact:** Opening of additional referral pathways. Embedding digital solutions to facilitate increased NHS 111 referrals. Review of unmet demand data to identify improvement opportunities. Development of senior clinical decision maker model. **Planned Actions (Q2):** ICC strategy event to be undertaken in August. Finalisation of senior clinical decision maker model. Continue opening additional referral pathways.

SBAF 2: Responsive Patient Care – Non UEC Care (e.g. Elective, Cancer Diagnostics, Community/Mental Health/Primary Care)

Finance & Performance Committee | Chief Delivery Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	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,
Event	then services will not improve in line with national expectations,
Effect (Consequence)	resulting in potential patient harm and reputational damage to the ICS.

SA1	Improve Health and Wellbeing Outcomes	●	SA3	Achieve a sustainable and resilient Integrated Care System	●
SA2	Address inequalities in access, experience and outcomes from health and social care services	●	SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Risk Scoring and Tolerance

Quarter	Q1	Q2	Q3	Q4	Risk Tolerance Statement	Linked Risks		
Risk Level (Low/Moderate/High)	High	High			The tolerance of failing to deliver against this risk should be low as underachievement will have a knock-on effect to subsequent milestones. All efforts must therefore be focussed on delivery.	Low	2	→
						Mod	5	↑
						High	2	→

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	●
No Assurance	No confidence in delivery	

Rationale for Risk Level and Progress Made in the Quarter (e.g. mitigating actions to reduce risk level):

Significant progress has been made in reducing long wait patient cohorts. However, due to operational constraints there are still over 100 patients forecast to be waiting for 65 weeks or longer at the end of June. Focused work is underway to improve this position. Clearance of long waiters has been impacted by reduced elective capacity due to UEC surge escalations. Impacts will continue into Q2 due to industrial action and planned maintenance over the summer. Nevertheless, progress is being made to achieve zero 65 week-waits and business cases have been approved during quarter one to deliver additional activity.

For cancer, the main drivers for being off plan during Q1 are the number of referrals being higher than predicted for some tumour sites e.g. breast and skin; there have been a number of late tertiary referrals; patient choice is affecting the backlog; ongoing workforce and surgical capacity constraints. Within the trusts, actions to improve include daily and weekly oversight of 28-day PTL; weekly oversight of oncology capacity; increased surgical capacity including weekend lists for colorectal and skin cancer; tracking against sustainable backlog trajectories. The ICB has submitted four funding bids to support cancer recovery and contribute towards improved performance in line with the National Cancer Waiting Time Standards (28-day FDS, 31-day and 62-day combined performance) for endoscopy, lung, pathology and extended theatre capacity.

Key Controls Framework

- Weekly Tier 2 accountability meetings with NHS England (NHSE).
- 2025/26 operational plan delivery and reporting.
- Portfolio performance steering group (reporting to portfolio Board).
- Regular monitoring backlogs of Staffordshire and Stoke-on-Trent patients in other systems to ensure equitable access to recovery milestones.
- Weekly meeting with UHNM to review specialty level challenges.
- System improving productivity through Getting it Right First Time (GIRFT) review and best practice adoption.
- NHSE supporting provision of mutual aid as required.
- Review of core capacity and demand across the system.

Assurance Map					
Defence Line	**Sources of Planned Assurance**	**Q1**	**Q2**	**Q3**	**Q4**
1st Line (organisation)	Weekly Elective Oversight Management Group (EOMG)	●	●		
	Weekly COO Group	●	●		
2nd Line (system)	System Performance Report to Finance & Performance Committee and ICB Board	●	●		
	Portfolio Performance Steering Groups (reporting to Portfolio Boards – IPH, Children, Young People & Maternity, Mental Health, Learning Disabilities and Autism. Frailty and Long-Term Conditions, Primary Care, Planned Care & Cancer)	●	●		
3rd Line (external)	NHSE oversight via Tier 1 meeting (replaced by Tier 2 meeting from November 2024)	●	●		

Gaps in Control or Assurance
What are the gaps to be addressed to improve adequacy of assurance?
ICB team to maintain focus on development of speciality pathways, to ensure that patients are following the most appropriate pathway, with the most appropriate tests and treatment setting.

FUTURE Actions
(Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)

No.	Action Required	Outcome of Action	Lead Director	Progress, Impact & Planned Actions
1	Develop plan for focused speciality review with end of end pathway approach.	Identification of opportunities to reduce duplication and improve productivity	Chief Delivery Officer	The 5 clinical symptomatic pathways that were developed and approved in 2024/25 will continue to be implemented. Work will also continue on developing the second phase of pathways. **Q1 Progress & Impact**: Audit of compliance is being developed in relation to primary care QIF (Quality Improvement Framework) for phase one pathways. **Planned Actions (Q2)**: Urology pathway has been developed and is due to be submitted for confirm and challenge with the acute trusts.
2	System capacity and demand review.	Greater understanding of opportunities for productivity improvement	Chief Delivery Officer	Opportunities for productivity improvement are ongoing, including GIRFT (Getting It Right First Time) recommendations and pathway review. Ophthalmology is a key GIRFT area of focus for UHNM. **Q1 Progress & Impact**: Continued focus on productivity opportunities to maximise theatre capacity. **Planned Actions (Q2)**: Demand and capacity modelling for services with higher waiting time pressures.
3	System collaborative for contracts to develop plans for efficiency and delivery of elective activity.	Increased delivery of activity and continued reduction of long wait patients supporting Elective Recovery	Chief Delivery Officer & SRO System Collaborative	Elimination of 65 week waits and continued focus on delivery against the 2025/26 national success measures. **Q1 Progress & Impact**: 65-week waits have continued to fall, however, clearance is taking longer than anticipated. **Planned Actions (Q2)**: Continued focus on the clearance of 65-week wait backlog.

4	Additional capacity investment to increase activity and productivity and clear remaining >65 week waits.	Longest waiting patients treated	Chief Operating Officer UHNM	Elimination of 65 week waits and continued focus on delivery against the 2025/26 national success measures. **Q1 Progress & Impact**: Additional capacity has been created at UHNM for services with higher waiting time pressures, including ENT, gynaecology and MSK. **Planned Actions (Q2)**: Maximise utilisation of additional capacity and surgical hubs to support clearance of 65-week wait backlog.
5	Provider indicative activity plans set that balance the national operational planning standards with levels of financial resources available	Greater control of activity and financial costs	Chief Delivery Officer	Indicative Activity Plans to be agreed with providers by 30 June for monitoring and management during Q2 and beyond. **Q1 Progress & Impact**: Indicative activity plans were developed and issued during Q1. **Planned Actions (Q2)**: Conclude indicative activity plan setting for those not agreed in Q1. Monitor activity levels and impacts against indicative activity plans.
6	Excluded Restricted Procedure (ERP) reflected in all provider contracts	Unapproved restricted procedures will not be funded to ensure that resources are spent effectively	Chief Delivery Officer	Monitor compliance with the ERP and clinical audit of restricted procedures. **Q1 Progress & Impact**: Contract variations completed as part of contract setting for 2025/26. **Planned Actions (Q2)**: Monitor compliance with the ERP and enact contract reconciliation.

SBAF 3: Proactive Planning and Delivery of Integrated Locality Based Community Services

Strategic Commissioning and Transformation Committee | Chief Transformation Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If we do not deliver integrated community services based on population need,
Event	then services will remain reactive and generic and not sensitive to the needs of the population,
Effect (Consequence)	we will continue to see increases in demand and acuity of need.

SA1	Improve Health and Wellbeing Outcomes	●	SA3	Achieve a sustainable and resilient Integrated Care System	●
SA2	Address inequalities in access, experience and outcomes from health and social care services	●	SA4	Working in partnership with communities to achieve social, economic and environmental community development	●

Risk Assurance and Tolerance

Quarter	Q1	Q2	Q3	Q4	Risk Tolerance Statement	Linked Risks		
Risk Level (Low/Moderate/High)	High	High			The consequence of not mitigating this risk and moving to a more proactive needs-based community model of care is that our system will remain reactive and reliant on services, particularly secondary and UEC. This will not meet the needs of our population, will challenge the sustainability of services and is not in line with our strengths-based strategy for our population.	Low	2	➔
						Mod	5	↑
						High	1	➔

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	●
No Assurance	No confidence in delivery	

Rationale for Risk Level and Progress Made in the Quarter (e.g. mitigating actions to reduce risk level):

Mental Health Urgent & Emergency Care (UEC)

Anyone seeking urgent mental health support in England will be able to do so via the 111 number. In recognition of the significant role the ambulance service plays in responding to mental health calls, there is a dedicated national investment programme to improve capacity of the ambulance service to meet mental health needs. In conjunction with this wrap around care, funding has been allocated to invest in alternative models of crisis support, such as crisis cafes, safe havens, and crisis houses, providing an alternative to A&E or inpatient psychiatric admission. The aspirations and vision of this programme is the development and implementation of comprehensive crisis pathways that are able to meet the continuum of needs and preferences for accessing crisis care, whether it be in communities, people's homes, emergency departments, accessing MH services or transport by ambulance.

Right Care Right Person – All phases have now been completed by Staffordshire Police. Development of an MOU around points of escalation continues via the quarterly review meetings. Quality and safeguarding concerns raised have reduced significantly since the beginning of the full implementation of the Right Care Right Person policy. Work continues to develop the relationships via the quarterly review meetings.

Crisis Assessment Centre (MPFT) – The new facility due to open in early August 2025 at St. George's Hospital site in Stafford. Operating 24 hours a day, seven days a week, the specialised facility will offer urgent assessment and support to individuals experiencing a mental health crisis who have come into contact with emergency services. It serves as an alternative to emergency departments for people facing urgent but non-life-threatening mental health

needs. The new facility provides a Crisis Care Suite comprising two crisis assessment rooms and houses MPFT's new 136 Suite, offering a health-based place of safety for people detained under Section 136 of the Mental Health Act. A key aspect of the136 Suite is its ability to accommodate both a child or young person, as well as an adult admission at the same time should this be required.

Crisis SMS Text Support - In June 2025 a New 24/7 urgent mental health support text services launched in North Staffordshire Combined Healthcare NHS Trust (NSCHT) and there is a plan to launch a concurrent offer in MPFT from September 2025.

Anyone across Staffordshire and Stoke-on-Trent can now access 24/7 urgent mental health support by text with the launch of two new free text services across the area. The services allow individuals to text a trained responder at any time of day or night.

Safe Haven Provision – Work continues between the ICB and NSCHT on the revision and procurement of a crisis alternative and inpatient step-down facility. Feedback has been correlated from the previous procurement exercise in 2025, and this feedback has been used to refine the specification of requirements to allow a further procurement process later in 2025 to potentially be successful in commissioning a provider to deliver the service.

Community Mental Health Transformation

The implementation of the Mental Health Framework provides a historic opportunity to address this gap and achieve radical change in the design of community mental health care by moving away from siloed, hard-to-reach services towards joined-up care and whole population approaches and establishing a revitalised purpose and identity for community mental health services.

The Framework sets out how the vision for a new place-based community mental health model can be realised, and how we can modernise mental health services to shift to whole person, whole population health approaches. In particular, the need to drive a renewed focus on people living within their communities with a range of long-term severe mental illnesses.

The 10-year NHS Plan has built upon this with greater emphasis on the Neighbourhood Health model. Work has commenced as to what this neighbourhood vision pertains to for mental health services

MPFT have been conducting a pilot as an associate site for the 24/7 Community Mental Health model, they haves begun work to align this model of care to the new Neighbourhood teams' model, integrating Physical health, mental health and VCSE provision across 4 pilot areas.

Intensive & Assertive Outreach ongoing review actions:

Following the adoption of criteria in order for Rio to identify patients who are eligible for the intensive outreach support. A caseload management tool is in development and testing to compliment the clinical team working with this cohort of patients. This will assist with identification, management and on-going support for patients.

Integrated Mental Health Teams (IMHTs), Older Adult Teams (OATs), Early Intervention in Psychosis Teams (EITs), and Forensic community teams have assessed caseloads and completed eligibility forms based on the Sheffield Criteria.

Total numbers of patients have been provisionally identified by both MPFT and NSCHT. However, further work is required to cross reference and bring the numbers identified more in line with respective patient populations.

On-going workforce training analysis is underway to determine the specific needs of the workforce supporting patients in this area and current gaps.

An IAO Status board has been implemented, allowing teams to track engagement and plan actions. This board is reviewed at each MDT meeting, and necessary actions are taken.

Updated action plans on the Intensive and Assertive Outreach model have been presented and publicised at the ICB Board in May 2025 and an additional reflective review involving all stakeholders is taking place in August 2025 to understand progress against objectives over the last 6 months and planning ahead for the remainder of the financial year.

Updates on the on-going IAO review are provided via the Delivery Group and via the Portfolio Board where required

Within the Integrated Community Equipment (ICE) contract, targeted initiatives, including the development of a new eligibility framework, refinement of decision-making panels, and sustained engagement with frontline teams, are driving improvements in service sustainability. A strong emphasis on operational efficiency is reflected in actions to increase recycling rates and implement tighter controls, such as same-day order gateways. These efforts are critical

to reducing waste, managing overspend, and ensuring long-term financial resilience. Alongside this, continuous engagement with staff, system-wide education initiatives, and closer collaboration with local authorities are helping to build a more informed, cohesive workforce and ensure that services are co-designed with partners and communities.

In parallel, the ongoing review and realignment of the Better Care Fund (BCF) ensures that resources are strategically deployed to meet population needs and strengthen system resilience. Phase 2 of the BCF review will focus on those schemes not reviewed in phase 1 and include some more detailed evaluations of schemes already reviewed where significant overspends and inefficiencies are apparent. There is significant appetite in Stoke-on-Trent to review and develop the local frailty offer to better meet needs and demand.

Further work is progressing to map and strengthen support for care homes, aiming to improve coordination across the system and promote greater consistency and equity in service provision. Importantly, focus is on a more preventative, community-based model of care in line with the BCF objectives. Initiatives to review and integrate falls prevention pathways, enhance wraparound care home support, and further develop Home First and Discharge to Assess (D2A) pathways, underpinned by improvements in data integrity, will enable earlier interventions, reduce avoidable hospital admissions, and support individuals to remain independent within their communities. This work will span various portfolios.

Work on strengthening relationships with the local authorities continues with honouring secondment opportunities and joint commissioning meetings.

Neighbourhood health aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care. This will be achieved by better connecting and optimising health and care resource through 3 key shifts at the core of the government's health mission:

- from hospital to community – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
- from treatment to prevention – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
- from analogue to digital – greater use of digital infrastructure and solutions to improve care

Through our 2025/26 Neighbourhood Health and Care programme we will standardise our approach using 6 core components for consistency:

1. Population Health Management
2. Modern General Practice
3. Standardising Community Health Services
4. Neighbourhood Multidisciplinary Teams (MDTs)
5. Integrated Intermediate Care ('Home First' Approach)
6. Urgent Neighbourhood Services

The integrated care system will prioritise specific groups within this cohort where there is the greatest potential to improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care, both improving outcomes and freeing up resources so systems can go further on prevention and early intervention. Focus on around 2% to 4% of the population. Examples of population cohorts with complex needs include:

- adults with moderate or severe frailty (physical frailty or cognitive frailty, for example, dementia)
- people of all ages with palliative care or end of life care needs
- adults with complex physical disabilities or multiple long-term health conditions
- children and young people who need wider input, including specialist paediatric expertise into their physical and mental health and wellbeing
- people of all ages with high intensity use of emergency departments

At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations. This is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

Key Controls Framework

- Mental Health portfolio team (manages implementation programme)
- Mental Health portfolio programmes (cross system working)
- Mental Health Portfolio Board in place with system mental health SRO
- Neighbourhood Health Steering Group established reports to Strategic Commissioning & Transformation Committee

- Regular updated to Stoke-on-Trent and Staffordshire joint Commissioning Board
- Programme boards for End of life, Frailty and Long-term conditions.
- Community Transformation Portfolio board to be reviewed in line with ICB Reform and Provider Collaborative arrangements
- Alignment of neighbourhood health programme with portfolio and enabling function boards
- PHM data being extracted to identify 2-4% and population segmentation approach
- Review of priority service specifications aligned to BCF

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	Community Transformation team meetings: Delivery plan reviewed to assure programme actions are on track for delivery	●	●		
	Children and Young People team meetings: Delivery plan reviewed to assure programme actions are on track for delivery	●	●		
	Mental Health team meetings: Delivery plan reviewed to assure programme actions are on track for delivery.	●	●		
2nd Line (system)	Strategic Commissioning and Transformation Committee: Neighbourhood Health Programme update received monthly	●	●		
	Finance & Performance Committee: receive appropriate papers aligned to operational delivery plans	●	●		
	Mental Health Portfolio Board: system forum to oversee the system-wide delivery of health and wellbeing initiatives	●	●		
	Health & Wellbeing Board: one for each LA held quarterly to assure the system-wide delivery of health and wellbeing initiatives				
	Joint Commissioning Board: one for each LA to jointly plan and oversee joint commissioning opportunities	●	●		
3rd Line (external)	Regional Long Term Conditions and Frailty Meetings Programme: Reports for progress assurance against Operational Plan and NHSE Guidance.	●	●		

Gaps in Control or Assurance

What are the gaps to be addressed to improve adequacy of assurance?

- Risks and Issues highlighted through normal Governance routes.
- Development of Provider Collaborative will impact Governance and roles and responsibilities.

FUTURE Actions
(Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)

No.	Action Required	Outcome of Action	Lead Director	Progress, Impact & Planned Actions
1	Agree neighbourhood footprint aligned to PCNs and early implemented sites	Clarity to PCNs and other Providers	Chief Transformation Officer	Confirm neighbourhood geographies Utilise pathfinder tool to identify 2-4% population at PCN level Work with Provider Collaborative to establish early implemented work programmes **Q1 Progress & Impact**: Neighbourhood geographies defined with 25 in the ICS, aiming to be geographically aligned to PCNs. Early implementor sites agreed for East Staffordshire and Stoke North. Increased number of PCNs signed data sharing agreement to enable primary care data to flow into Pathfinder tool. Pathfinder tool utilised along with other data sets to identify cohort of population in East Staffs that will be supported by Integrated Neighbourhood Team (INT).

FUTURE Actions (Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)				
No.	**Action Required**	**Outcome of Action**	**Lead Director**	**Progress, Impact & Planned Actions**
				Provider collaborative work programme in development to support the delivery of the Neighbourhood Health and Care programme. Submission made to National Neighbourhood Health Implementation Programme (NNHIP). **Planned Actions (Q2)**: Meeting with Cannock PCNs regarding early implementor and review of Pathfinder data. Targeted work with East Staffordshire PCN ahead of follow sessions scheduled for August and September ICB to attend practice manager session to provide an update on the neighbourhood health programme and the implementation of INTs. PCN and MPFT to review existing resource and identify resourcing requirements for the establishment of an INT Digital support to be identified Review of target cohort to identify operational and clinical leads to attend follow up session in September PCN to continue to work with practices to sign data sharing agreements to ensure more practice data is included within pathfinder tool. OD framework to be developed with the PCN Sessions to be arranged with provider collaborative in August/September to develop work plans in line with the 6 core components of neighbourhood health Data workshop to be convened to undertake deep dive of pathfinder data for CYP and LD to identify programmes of work in line with the 6 core components ICB primary care team support to progress utilisation of pathfinder and risk stratification in general practice. Workforce baseline received from NHSE – under review within the People Team
2	Agree changes to Stoke Joint Commissioning Boards (JCB) governance	Strengthened governance with broader system membership	Chief Transformation Officer	Implement the agreed changed and explore similar review of Staffs JCB governance. **Q1 Progress & Impact**: Governance Review Completed; Governance arrangements for the Stoke Joint Commissioning Board (JCB) have been reviewed and agreed, new terms of reference will still need to go through cabinet.

FUTURE Actions (Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)				
No.	**Action Required**	**Outcome of Action**	**Lead Director**	**Progress, Impact & Planned Actions**
				Planned Actions (Q2): Operationalise new way of working. Explore similar review of Staffs JCB governance. Explore opportunities to standardise approaches across JCBs to ensure consistency, reduce duplication, and enhance system coherence.
3	Alignment of Community Transformation Programmes to the Better Care Fund (BCF) to maximise value for money and implementation of neighbourhood health	Clarity on BCF funding to support neighbourhood health	Chief Transformation Officer	Systematic Review aligned to Component 3 of the neighbourhood health guidance including Primary Care and Voluntary Sector Integrated Commissioning with Local Authorities regarding D2A (subject to review outcome) Review of workforce aligned to neighbourhood health **Q1 Progress & Impact**: Priority list of service specifications agreed, aligned to BCF and VCSE review and guidance from Neighbourhood health programme. Reviews in progress aligned to MPFT Service Development and Improvement Plan (SDIP). Primary care services aligned to NH also under review. Phase 2 of the Better Care Fund (BCF) review is now underway. Two oversight meetings have been held to date. While progress has been made, stakeholder engagement remains inconsistent, and further work is required to ensure full and sustained participation across all partners. ICB and Stoke LA colleagues have worked on a proposal funded via the Better Care Fund. **Planned Actions (Q2)**: Continued review of service specifications and development of short form specification template and outcome frameworks. Continue BCF review with a focus on Home first and discharge pathways.

SBAF 4: Reducing Health Inequalities

Strategic Commissioning and Transformation Committee | Chief Medical Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If we are unable to work together as an Integrated Care System across organisation and sector boundaries,
Event	then we will have less (or no) impact on reducing health inequalities of the population of Staffordshire and Stoke-on-Trent,
Effect (Consequence)	resulting in sustained or increased health inequalities, worsening health and wellbeing of the population, potentially increased cost of health and care and worsened quality of service experienced.

SA1	Improve Health and Wellbeing Outcomes	●	SA3	Achieve a sustainable and resilient Integrated Care System	
SA2	Address inequalities in access, experience and outcomes from health and social care services	●	SA4	Working in partnership with communities to achieve social, economic and environmental community development	●

Risk Assurance and Tolerance

Quarter	Q1	Q2	Q3	Q4	Risk Tolerance Statement	Linked Risks		
Risk Level (Low/Moderate/High)	High	High			Tolerance is low as reducing health inequalities and working in partnership impacts on 3 of the 4 Strategic Ambitions. The target date is long-term and as such risk scoring would be expected to reduce over a longer period as health inequalities improvement is made and can be demonstrated.	Low	2	→
						Mod	10	↑
						High	0	→

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	●
No Assurance	No confidence in delivery	

Rationale for Risk Level & Progress Made in the Quarter (e.g. mitigating actions to reduce risk level):

Early targets for progress to reduce health inequalities were set against the agreement of an Integrated Care Partnership Strategy which was published at the end of March 2023, (this was reflected in the target risk). Evaluation of the reduction of health inequalities will be over a longer period (c. 10 years) and the target risk will be reviewed on this basis. The foundations to achieving this have been progressed in terms of the Integrated Care Partnership Strategy, Health Inequalities Strategy, Alcohol Strategy, procurement of a strategic partner to support the scale, spread and sustainment of a Population Health Management approach for SSOT that will positively impact on HI, establishment of the Improving Population Health (IPH) Portfolio Board, agreement of localities inside the two Place's aligned with UTLA's (Staffordshire – District and Borough Council alignment (8) and Stoke-on-Trent – Geographical alignment (4)), and now the launch of the Locality Improvement Framework (LIF) at Q1 2025/26.

The LIF invests £2.2m in localities, providing a basis to incentivise integrated locality working based on population need and reducing health inequalities. Each locality will have an allocation of funding that it will be able to use for projects that will have clear and measurable impact on health outcomes, following changes in lifestyle and behaviour by working together as integrated community services. Sprints have taken place across all 12 localities to use the data to segment the population and identify cohorts who have poor outcomes.

6 business cases have been received from locality partners describing how they will tackle the biggest issues in their populations.

The locality outcomes will form the basis of the System Outcomes Framework and will bridge the HI Strategy and LIF.

Key Controls Framework

- Portfolio governance heavily partnership based with District/Borough Council leadership in role of CE Sponsor.
- People and Communities is one of the 5P's of the ICP Strategy.
- Place Development Boards have agreed the construct of 'Place'.
- IPH Team (manage implementation programme to scale, spread and sustain PHM approach across SSOT).
- IPH Portfolio Programmes (cross working to ensure HI and Prevention are considered during design).
- Other Portfolios (matrix working with portfolios to design interventions and deliver transformational change).
- H&CS (provide system health and care viewpoint on any interventions being designed).
- IPH Portfolio Board (provide strategic oversight and is the portfolio aligned with this risk).
- ICP (has ICS partnership wide oversight).
- Defined scope of IPH Portfolio and incumbent programmes.
- CSU Procurement guidance to ensure procurement exercises have been/are robust.
- Report/ed procurement exercise outcomes to ICB EWT.
- PHM Strategic Partner contracted (3 years) to support scale, spread and sustain of PHM approach for SSOT.
- Locality development plans well-articulated and co-produced.
- HI Strategy developed collaboratively through workshops and extended partnership discussions.
- HI Strategy principles formally endorsed on 3 June by ICP.
- Regular committee reporting moved from Quality & Safety Committee to Strategic Commissioning & Transformation Committee (reporting requirements still to be agreed).
- HI Outcomes Framework in development.
- Locality Improvement Framework agreed, transacted, and launched from 1 April 2025 for delivery over 3 years.
- LIF Evaluation Panels briefed and scheduled to evaluate locality business cases.
- Alignment with large, locality-based initiatives i.e. Supportive Communities, Together Active, Family Matters, Strengthening Communities.
- PHM support to Neighbourhood Development Programme.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	IPH Team Meetings: MS Planner reviewed to assure programme actions are on track for delivery (weekly).	•	•		
2nd Line (system)	Strategic Commissioning & Transformation Committee: IPH Portfolio Progress update provided to assure committee of progress (bi-monthly) to be confirmed by SCTC.				
	Finance & Performance Committee: IPH elements of Quarterly Stocktake and ICS Operational Plan to provide assurance against LTP and 1YOP delivery.	•	•		
3rd Line (external)	Regional HI Programme: IPH Portfolio Progress Reports for progress assurance against LTP.	•	•		
	Regional Prevention: IPH Portfolio Progress Reports for progress assurance against LTP.	•	•		
	NHSE: IPH elements of Quarterly System Review provided to assure progress against LTP and 1YOP delivery.	•	•		

Gaps in Control or Assurance

What are the gaps to be addressed to improve adequacy of assurance?

- Maintaining stakeholder relationships, engagement, involvement and commitment to ICP Strategy aims by all ICP partners.
- GP DSA sign-up for PHM to include primary care data in the linked dataset (engagement with individual practices and weekly review of position continues) – progress is visible since Collective Action ceased.

FUTURE Actions
(Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)

No.	Action Required	Outcome of Action	Lead Director	Progress, Impact & Planned Actions
1	Develop HI Outcomes Framework	Additional Control	Chief Medical Officer	Develop and agree approach to co-produce HI OF (ensure alignment with System OF) **Q1 Progress & Impact:** Locality improvement Framework is being implemented and locality outcomes are being agreed with partners to agree a locality core20plus5 framework. Workshops

FUTURE Actions (Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)				
No.	**Action Required**	**Outcome of Action**	**Lead Director**	**Progress, Impact & Planned Actions**
				have been completed and coalition teams identified. **Planned Actions (Q2):** Business cases to be submitted and assurance process in place. Agree metrics with locality coalition teams to demonstrate how they will reduce health inequalities and demonstrate measurable change to access, experience and outcomes.
2	LIF Delivery	Additional Assurance	Chief Medical Officer	Continue with locality SPRINTS, Business Case development, Evaluation Panels, Contracting and Funding Transfer. **Q1 Progress & Impact**: coalitions forming through sprint workshops **Planned Actions (Q2):** Evaluation panels in place, devolve funding through agreed contracting mechanisms. Metrics and outcomes are being collated to inform the LIF monitoring and outcomes framework
3	HI Annual Report	Additional Assurance	Chief Medical Officer	Update and publish HI Annual Report (data). **Q1 Progress & Impact**: Health inequalities strategy approved. **Planned Actions (Q2):** Health inequalities strategy published. Health inequalities data being updated to deliver statutory reporting duties.
4	Impact Sustainability	Additional Control	Chief Medical Officer	Begin to develop approach to systematically demonstrate impact of investment (leading to systematic evaluation of return on investment and then sustainable funding of interventions/projects/services that have been invested in using transformation monies). **Q1 Progress & Impact**: Data sharing agreements for Pathfinder linked data set continue to grow. **Planned Actions (Q2):** 39 DSAs received covering 400, 000 patient populations. Demonstrations of Pathfinder in LIF workshops supporting uptake rates. Locality oversight to be developed to ensure milestone delivery, including process for monitoring and reporting.

SBAF 5: High Quality, Safe Care Outcomes

Quality & Safety Committee | Chief Nursing & Therapies Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If we cannot ensure high quality, equitable and safe patient care,
Event	then we will be unable to achieve high standards of quality and safety,
Effect (Consequence)	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

SA1	Improve Health and Wellbeing Outcomes	●	SA3	Achieve a sustainable and resilient Integrated Care System	
SA2	Address inequalities in access, experience and outcomes from health and social care services	●	SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Risk Assurance and Tolerance

Quarter	Q1	Q2	Q3	Q4	Risk Tolerance Statement	Linked Risks		
Risk Level (Low/Moderate/High)	High	High			The system will prioritise quality and safety over performance and finance to prevent patient harm but will tolerate moderate risk levels resulting from system pressures.	Low	2	→
						Mod	10	↑
						High	4	→

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	●
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	
No Assurance	No confidence in delivery	

Rationale for Risk Level & Progress Made in the Quarter (e.g. mitigating actions to reduce risk level):

UEC

As previously reported the ICB CNTO team attended Fundamentals of Care joint bimonthly informal visits to UHNM ED departments with the UHNM patient experience team. The visits identified no areas of concerns but did identify some areas of good practice and some areas of learning. The visits have been put on hold to allow the department the opportunity to review the identified learning and take any necessary actions and to provide the ED Harms group to identifying ways of widening its scope to address gaps.

The latest information on Queens Hospital Burton ED performance regarding Fundamentals of care and risks in off-loading ambulances for primary initial assessment and unsustainable pressure within ED have been captured and have necessitated changes to established workflows to ensure safe and compassionate care.

Actions implemented in response to the rising number of patients staying for extended periods have included:
Medication management - drug rounds have been incorporated into ED practice, and a drug trolley has been provided to facilitate safe and efficient administration.

All staff receiving training to ensure ordering of air mattresses for patients at risk of pressure damage.
Nutrition and hydration - a dedicated housekeeper provides snacks and drinks five days a week. Additionally, hot meals are served twice daily for the longest stay patients, with sandwiches and toast available 24hours a day.
It is acknowledged that the focus has been upon immediate, physical harm and does not reflect the entirety of a patient’s pathway nor the experience of being delayed.

Perinatal Services

Due to the high rates of infant mortality across the system a joint OHID (Office for Health Improvement & Disparities) and NHSE supportive system review is underway with an action plan being developed.

The committee received assurance there had been sustained improvement over a twelve-month period for induction of labour breach performance.

Final reports have been received from the CQC following the inspections of the Royal Wolverhampton NHS Trust's maternity services at New Cross Hospital and University Hospital of North Midlands NHS Trust (UHNM) maternity services at Royal Stoke University Hospital have been rated 'Good'. University Hospital of Derby and Burton (UHDB) Maternity Services were inspected during Q4 (2024). The trust have received the CQC report and is reviewing for factual accuracy, however the CQC section 29a and 31 regulations remain in place.

The Maternity Safety Support Programme (MSSP) remains in place across UHDB, and support is provided by NHSE maternity improvement advisors and NHSE Midlands Perinatal team for Quay Improvement. derby and Derbyshire ICB are the lead commissioners for maternity and Neonatal services at UHDB who we work closely with.

IHA/RHA (Updated 25-07-25)

Initial Health Assessment (IHA) timeliness remains slightly below the required 85%, however, the time children are waiting for an IHA has dropped significantly, therefore children are not waiting for several weeks for the IHA as they were previously. This demonstrates continued positive progress against the recovery plan as a health system with the exception of children placed outside of our area which are being escalated on a case-by-case basis.

Review Health Assessment (RHA) timeliness also remains below the threshold of 85%, although some improvement continues and the length of wait continues to reduce for Staffordshire & Stoke-on-Trent children who remain in our area.

Providers have instigated harm reviews and so any health assessment undertaken outside of expected timescales, where a child has experienced harm, will be reported as an incident. To date, there have been no incidents of harm reported as a direct result of a delay in health assessment.

QIA – audit draft

Quality and Safety Committee has received an overview of the QIA work programme and the actions being taken to ensure the ICBs statutory duty is fulfilled. The committee were informed of the eighteen QIAs completed within the period October 2024 to January 2025, eight of these were done so retrospectively, however, between February 2025 and May 2025, 83% (10/12) QIAs were completed in advance of the decision made by the ICB. This is a continued trend of improvement from the previous reporting periods.

Following the letter in April and May 2025 from Staffordshire County Council and Stoke-on-Trent City Council to NHS England Midlands Region which shared their concerns regarding the deliverability and safety of the 2025/26 system plan, NHSE carried out an independent review of the QIA process. The review evaluated the robustness and effectiveness of the ICB's process, adherence to the process and identify any areas for improvement and notable areas of good practice. The final report has been shared with the ICB for comment and to date the feedback is positive. Meeting to take place with NHSE end of July 2025 to finalise report.

Wheelchair Services

The total number of service users waiting 18+ weeks decreased for 12 consecutive months (71% reduction between May-24 and Feb-25). However, the numbers have increased in the last 2 months and the number of service users waiting 52+ and 65+ weeks (long waits) remains significantly higher than expected; 2025/26 M3 longest waits of 93 weeks (adults) and 85 weeks (CYP). Contract Performance Notice (18+ weeks) and Service Development Improvement Plan (eliminate 52+ weeks) proposed Jul-25. The ICB worked with the provider to strengthen quality governance arrangements, sharing best practice from NHS system partners to update the duty triage guidelines including reprioritisation and clinical harm review. Referrer MDTs have been put in place to strengthen communication and sharing of information to inform (re)prioritisation and harm reviews. Routine quality visits have been undertaken by the ICB. Director-to-Director escalation has taken place and oversight of 52+ weeks caseload through monthly CRM/CQRM.

Paediatric Hearing Screening Improvement Programme (PHSIP)

The 5-year lookback review at UHNM has commenced, however we have no early findings to date. We are working with all parties in relation to capacity and supporting families, children and staff affected by the 5 – year look back. This has now been commissioned. Both MPFT and UHNM are currently working towards readiness for Improving Quality in Physiological Services (IQIPS) accreditation. Following an initial assessment UHDB Queens Hospital of Burton (QHB) are responding to the recommendations.

Right Care, Right Person

The Staffordshire & Stoke-on-Trent ICS Right Care, Right Person (RCRP) Partnership meeting has been formalised to provide a safe space for reflection on partnership progress, discuss any ongoing issues or concerns and identify shared priorities and opportunities for future development of RCRP. The aim is to foster open dialogue, mutual support, and collaborative planning among system partners. Alongside this forum the Right care right person [RCRP] stakeholder system review meeting enables integration of a system deep dive into escalations of concern around RCRP. Unfortunately, these meetings to date have been cancelled due to challenges with data production. The terms of reference proposed, for the system deep dive, include agreed timelines for sharing of PID between providers and for completing thematic reviews/AARs (After Action Review) as relevant, sharing of investigation and learning to facilitate the process going forward.

Key Controls Framework

- Quality Impact Assessment agreed and implemented (Policy and Procedures).
- ICB Quality Strategy with agreed outcomes.
- Local Maternity and Neonatal Service Partnership Board and Quality and Safety Oversight Forum (sub-group) and attendance at relevant internal UHNM meetings. Meets Monthly.
- Established system wide Safeguarding arrangements.
- Quality & Safety Committee (QSC).
- System Quality Group (SQG).
- Reporting to and attendance at NHSE meetings, i.e. monthly SSOT Delivery Oversight Meeting.
- All Age Continuing Health Care has a robust governance process in place and reports internally through QSC, Finance & Performance Committee and externally to NHSE against progress.
- LeDeR group including system partner attendance and shared learning as well reporting into QSC (quarterly) and Learning Disabilities and Autism Partnership (LDAP) board monthly.
- Portfolio groups/boards or other meetings which meet monthly.
- Established system wide Safeguarding arrangements in place including Staffordshire and Stoke-on-Trent Safeguarding Partnership.
- PSIRF monthly oversight meetings.
- Contract quality review meetings undertaken monthly.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	Monthly Quality and Safety Assurance report to ICB Board	●	●		
	Bimonthly Assurance paper and Chair Update from Quality & Safety Committee to ICB Board	●	●		
	Bi-Monthly LMNS report, SQG Assurance Paper and Peoples Assembly update to Quality & Safety Committee	●	●		
	Quarterly Quality Strategy implementation plan updates to Quality & Safety Committee	●	●		
	Tri-annually QIA Assurance and CQI Subgroup report to Quality & Safety Committee	●	●		
	Quarterly LeDeR Assurance Report and SEND Update and Assurance Report to SQG	●	●		
	AD hoc assurance reports from IHA/RHA working group/CHC Assurance report and Paediatric Audiology Improvement Programme update received by Quality & Safety Committee	●	●		
2nd Line (system)	Monthly Provider Update/Assurance and escalation reports to SQG	●	●		
	Bimonthly PSIRF oversight report to SQG	●	●		

	Quarterly Soft Intelligence/Complaints report to SQG	●	●		
	Monthly Provider Update and Assurance report to SSoT LMNS Partnership Board.	●	●		
	Update reports to Staffordshire and Stoke-on-Trent Health Safeguarding and Looked after Children Strategic Oversight Group	●	●		
	Deep Dive presentation to QSC	●	●		
	Neonatal Update to Infant Mortality Group	●	●		
	Infection Prevention Control (Health Economy Group) Update/Assurance report to QSC received quarterly	●	●		
3rd Line (external)	Quarterly Update and Assurance report to Regional Quality Group – NHSE led	●	●		
	Provider's escalation of CQC activity to SQG	●	●		
	Monthly System Delivery Meeting (inc UHNM)	●	●		
	Quarterly System Delivery Meeting (NSCHT/MPFT)	●	●		
	Escalation to Paediatric Audiology Improvement Silver & Gold cells (ad hoc).	●	●		
	ICS update to the Regional Infant Mortality Group	●	●		
	Bi-monthly Midlands Nursing and Midwifery Excellence network report.	●	●		
	Monthly Staffordshire County Council and Stoke-on-Trent City Council Care home updates to SQG	●	●		

Gaps in Control or Assurance

What are the gaps to be addressed to improve adequacy of assurance?

- Maintaining Patient safety and achieving fundamentals of care within UEC pathways during periods of pressure requires further work.
- Risk and potential harm which may be as a result of delays within specific community services requires an agreed improvement plan to be put into place, subsequent monitoring.
- Improving workforce within Community Paediatric services is necessary to support achievement of the IHA/RHA targets.

FUTURE Actions
(Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)

No.	Action Required	Outcome of Action	Lead Director	Progress, Impact & Planned Actions
1	Collaboration with system partners and regional and national ICBs to look at innovative ways of improving the IHA challenges locally, regionally and nationally.	Reduction in timeline	Assistant Chief Nursing & Therapies Officer	UHNM are reporting no waiting list within their patient cohort. MPFT continue to report delays due in part to the Community Paediatric team not currently at full capacity work is ongoing to increase capacity. Monitoring continues with the dashboard is showing improvement in IHA compliance. **Q1 Progress & Impact:** Position remains the same, timescales are being met in the North but not yet in South, however, the length of wait is decreasing. **Planned Actions (Q2):** To maintain or improve the improvements being made in IHAs.
2	ED Harms oversight approach with UHNM established	Patients experience safe and effective care	Chief Nursing & Therapies Officer	Following completion of the ED Harm review process an action plan has been developed which incorporates learning from the review. The plan has been presented to the UEC Board who

	which will see bi - monthly visits to ED supporting continuous learning and improvement approach.			retain oversight. The UEC delivery group will continue to support completion of the actions against the agreed timeline. **Q1 Progress & Impact:** Bi monthly visits have taken place at RSH and County. Any identified risks are raised immediately with senior leadership team. To date no escalations have been raised. **Planned Actions (Q2):** Continue with visits in Q2. **Planned Actions (Q3)**: Visits on hold whilst actions are taken to address the learning outcomes identified.
3	Collaborative approach to understanding and mitigating risk and potential harm resulting from delays within specific service provision.	The potential for harms as a result of a delay is reduced	Chief Nursing and Therapies Officer	**Paediatric Dietetics –** a T&F group has been established to support a system approach to the management of continued delays within the Paediatric Dietetic Service. A business case has been developed to support improvement within the service. Oversight for this programme has been confirmed to be with the CYP Board. **Q1 Progress & Impact:** A business case has been developed with regard to resourcing addition. The risk remains on the risk register. **Planned Actions (Q2):** Continue to work collaboratively with providers to mitigate the risk where possible. Once the outcome of the business case is known plans will be developed. **Wheelchair Services –** following discussions with the provider it has been agreed that an improvement plan will be developed to support oversight of any patient waiting in line with the "wait well" principles. Compliance monitoring will be undertaken through the contract. **Q1 Progress & Impact:** Initial improvements in waits deteriorated within Q1 escalation meetings conducted with further improvement plans agreed. **Planned Actions (Q2):** Escalation through the contract process to be taken forward. **Planned Actions (Q3):** Further Quality visits will take place during Q3.
4	Maternity Transformation plan in place which outlines a 3-year approach to improving services.	Achieve Ockenden recommendations and respond to national guidance/requirements across maternity and neonatal services	Chief Nursing and Therapies Officer	The Quality and Safety Oversight Forum (QSOF) continues monthly. LMNS continues oversight of Year 3 (25/26) implementation of the Three-year delivery plan for maternity and neonatal services across the system. Progress against the three-year delivery plan continues with UHNM confirmed as achieving overall implementation of 97% of the care bundle recommendations. Following a tragic maternal death Maternity and Newborn Safety Investigation team (MNSI) have completed their investigation making four safety recommendations. The LMNS will co-ordinate and ensure there is collaboration across the system to ensure the recommendations are implemented and embedded.

				Q1 Progress & Impact: QSOF continues monthly, and progress continues against the Three-Year Delivery Plan. Saving Babies Lives Care Bundle (SBLCB) 3.2 was published in May 2025 and Local Maternity & Neonatal System (LMNS) SBLCB Trajectories have been agreed, and the next SBLCB quarterly review meeting is in September. The LMNS (Local Maternity & Neonatal System) safety recommendation is progressing, and the draft standardised postnatal guidance is in development working collaboratively with trusts, GPs, Health Visitors and the Maternity and Neonatal Voices Partnership (MNVP). **Planned Actions (Q2):** Continue with oversight of Three-Year Delivery through QSOF monthly. SBLCB quarterly review meeting in September 2025. Finalise SSoT Postnatal Guidance.
5	Develop a Staffordshire and Stoke on Trent Multi- Agency Thematic Review/Deep Dive into ongoing incidents around the Right Care Right Person process.	Compliance with the Right Care, Right Person national framework		(New Action - added to SBAF in Q2) Stakeholder forum in place to undertake collective overview of individual investigations identify themes and agree recommendations and improvement plan.
6	System approach to improving outcomes of patients who are CHC eligible.	Individualised and need appropriate care commissioned which supports optimum patient outcomes	Chief Nursing and Therapies Officer	Work continues to progress to reduce the number of delays in assessment and reviews. The IHAT team are now established and embedded within the process focusing upon supporting personalised and least restrictive care for individuals. Improvement continues with regards to achieving national KPIs. - **Q1 Progress & Impact:** Q1 national 28 day and DSTs in acute achieved, 80.3% and 2%, respectively. Single point of access (SPA) process amended to maximise clinical resource has resulted in significant improvement and reduction of the booking day for Decision Support Tools (DSTs). Previously day 19 now day 14 (average). Positive work continues, led by IHAT working collaboratively with system partners to support personalised and least restrictive care for individuals, this has also been expanded into the Continuing Healthcare (CHC) Learning Disability and Autism (LDA) cohort. **Planned Actions (Q2):** Continue to drive improvements and ongoing delivery of the quality premium KPIs. Working with system partners to deliver the CHC training plan. Finalise the integrated support protocol jointly with the LAs.

SBAF 6: Sustainable Finances

Finance & Performance Committee | Chief Finance Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If financial cost pressures are not controlled,
Event	then we will not achieve our statutory financial duties,
Effect (Consequence)	resulting in financial intervention from NHSE including reduced local discretionary decision making, reduce capital resources, reduced opportunity to apply for additional funds, impacting on services and waiting lists.

SA1	Improve Health and Wellbeing Outcomes		SA3	Achieve a sustainable and resilient Integrated Care System	●
SA2	Address inequalities in access, experience and outcomes from health and social care services		SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Risk Assurance and Tolerance

Quarter	Q1	Q2	Q3	Q4	Risk Tolerance Statement	Linked Risks		
Risk Level (Low/Moderate/High)	High	High			Tolerance is high as costs related to maintaining patient safety and workforce issues may cause additional financial demand.	Low	2	→
						Mod	7	↑
						High	3	↑

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	●
No Assurance	No confidence in delivery	

Rationale for Risk Level & Progress Made in the Quarter (e.g. mitigating actions to reduce risk level):

At Month 3 the System position is a £17.9m deficit which is a £0.3m favourable variance to a £18.2m deficit plan. However, Month 3 CIP delivery is £45.7m against a plan of £59.9m which is £14.2m adverse to plan. Development of System CIP shows £231.3m as either Implemented or Fully Developed. The CIP delivery currently seen as 'likely' is £232.9m (76% of plan) which is a £73.4m risk to plan. Therefore, the risk level remains high for Q2.

Key Controls Framework

- System Financial Plan agreed.
- Weekly monitoring of CIP position for each organisation.
- Weekly meetings of ICB Efficiency Oversight Group.
- Reporting on progress through System Performance Group and Finance and Performance Committee.
- Monthly budget holder meetings to ensure delivery remains on track.
- Weekly meeting of System Chief Finance Officers.
- Weekly System Finance Deputies meetings held to support System meetings.
- Fortnightly System Senior Leadership Team meeting.
- Given the risk within the delivery of the UHNM plan, monthly efficiency stock-take meetings with the ICB, UHNM and NHSE have been established.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	Monthly System finance reports articulating risk / mitigations.	●	●		
2nd Line (system)	Monthly System Finance Report to Finance & Performance Committee.	●	●		
	Monthly Provider Collaborative Report to Finance & Performance Committee.	●	●		
	Monthly System Performance Report to Finance & Performance Committee.	●	●		
	Monthly escalation report from System Performance Group.	●	●		

3rd Line (external)	Annual value for money assessments completed by external auditors.	•	•		
	Annual Internal audit review of efficiency programme plans and delivery.	•	•		

Gaps in Control or Assurance

What are the gaps to be addressed to improve adequacy of assurance?

The System is working to ensure that all new risks are understood and that efficiency schemes and mitigations are in place in order to deliver the financial plan. In the anticipation of 3 year allocations being issued in the early Autumn, work is beginning on a £ year medium term financial plan which will demonstrate the trajectory to delivering a sustainable financial balance.

FUTURE Actions
(Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)

No.	Action Required	Outcome of Action	Lead Director	Progress, Impact & Planned Actions
1	System to focus on identification and delivery of additional efficiency plans to mitigate the current unidentified savings gap primarily through the touch choices workstream.	Additional Assurance	Chief Finance Officer/Tough Choices Workstream SRO	Weekly SPG meeting agreed implementation of schemes. Delivery now the responsibility of the 4 System partners. ICB Financial Improvement and CIP schemes workshop taking place on 10 June to understand current status and develop further plans. Put into delivery new ideas on tough choices to support the 2025/26 financial position. Drive further benefit from existing workstreams and seek to mitigate risks. **Q1 Progress & Impact:** The ICB held a further workshop on 9 July where further actions for the Planned Care; Mental Health/Joint Commissioning; CHC and Medicines & Prescribing/Tough Choices workstreams were identified to be taken forward. Weekly reporting on CIP development remains in place with submission to NHSE and monitoring takes place at the System Performance Group meetings. For the Tough Choices workstream, SROs have been identified, and meetings held to review and follow up on actions to be taken. The intention is for all relevant work to transition to BAU. **Planned Actions (Q2):** Work continues across all organisations to identify, develop and approve CIP projects so that these can be implemented and put into delivery. This will reduce the level of risk in CIP as schemes are further developed.
2	System Finance and Operational Teams to develop a medium-term plan to define the transformational solutions and actions that will ensure the	Additional Assurance	Chief Finance Officer	The task for Q1 is for CFOs to review the Underlying Positions following the agreement to the 2025/26 plan. These ULPs to be signed off by the CFO Group and reported through to System Finance & Performance Committee.

	delivery of the integrated care strategy and trajectory for return to financial sustainability.			Thereafter, the System will be working on the development of a medium / longer term financial model as part of the national timescale. **Planned Actions (Q2):** We are anticipating guidance around medium and long term planning requirements and multi-year financial allocations in Q3. Current indications suggest there will be a requirement for a medium term plan by the end of Q3.
3	Financial Recovery Director in post to ensure delivery of the CIP target.	Additional Assurance	Chief Finance Officer	System Recovery Director to ensure that plans for the £306m are fully developed and embedded into Business as Usual. CFO to ensure that the responsibility for the oversight, monitoring and reporting of those plans is transferred. **Q1 Progress & Impact:** The Recovery Director has generated pace across the System in mobilising the efficiency programme and provided capacity and independent challenge, working with the System CFOs to ensure that schemes were properly developed with strong underpinning evidence. At Month 3, £231.3m is showing as either Implemented or Fully Developed. **Planned Actions (Q2):** The Recovery Director's contract ended on 5 August and the regular monitoring of System wide delivery of efficiencies and ongoing scrutiny of schemes to ensure all System CIP shows as Implemented or Fully Developed will continue and be led by the Director of Planning. The current focus is on embedding disciplines initiated by Recovery Director into BAU across all System partners.
4	Deloitte/Kingsgate to continue support to a number of projects to reduce the risk to CIP delivery and financial improvement.	Additional Control	Chief Finance Officer	Deloitte/Kingsgate to complete support on existing workstreams and to continue support in developing workstreams. Organisations to agree any further support needed to drive their CIP programmes. **Q1 Progress & Impact:** The Intervention & Investigation Regime supported by Deloitte/Kingsgate commenced in November 2024 and has been supported by a number of follow-on projects and areas of support. The approved business case for £1.6m remains in place, a number of support programmes have now concluded with a range of financial benefit from £22.8m to £29.5m. **Planned Actions (Q2):** Two further support requests have been scoped and approved (D2A Demand and Capacity modelling and Planned Care additional activity management).

				The learnings from this work to be embedded into BAU.
5	Provider Collaborative to develop the CIP of £14.2m for Enabling Functions	Additional Control	Provider Collaborative MD	Deloitte/Kingsgate support in place and options for delivery to follow after completion of their review at the end of July. Provider Collaborative to develop schemes for the delivery of the £14.2m requirement. **Q1 Progress & Impact**: The original plan to seek support from Deloitte has been put on pause whilst opportunities across a wider ICB Cluster footprint are explored **Planned Actions (Q2):** Provider CFOs have agreed to deliver the £14.2m savings target set for the Provider Collaborative and are going to identify schemes to take forward.

SBAF 7: Improving Efficiency and Productivity

Finance & Performance Committee | Chief Finance Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If the ICB and provider partners are unable to develop and deliver recurrent efficiency schemes and productivity gains, during 2025/26 required to address the system recurrent deficit of c. £278m.
Event	then we will fail to achieve the operational improvements, aligned with the national agenda, which underpin our performance targets and fail to deliver the recurrent financial efficiency requirements which underpin delivery of our statutory financial target of breakeven,
Effect (Consequence)	resulting in financial intervention from NHSE including reduced local discretionary decision making, reduced capital resources, reduced opportunities to apply for additional funds, impacting on services and waiting lists.

SA1	Improve Health and Wellbeing Outcomes		SA3	Achieve a sustainable and resilient Integrated Care System	●
SA2	Address inequalities in access, experience and outcomes from health and social care services		SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Risk Assurance and Tolerance

Quarter	Q1	Q2	Q3	Q4	Risk Tolerance Statement	Linked Risks		
Risk Level (Low/Moderate/High)	High	High			Efficiency and Productivity improvement is an essential ingredient of the System Plan and so a lower risk appetite target has been set.	Low	2	→
						Mod	5	↑
						High	2	↑

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	●
No Assurance	No confidence in delivery	

Rationale for Risk Level & Progress Made in the Quarter (e.g. mitigating actions to reduce risk level):

Month 3 CIP delivery is £45.7m against a plan of £59.9m which is £14.2m adverse to plan. Development of System CIP shows £231.3m as either Implemented or Fully Developed. The CIP delivery currently seen as 'likely' is £232.9m (76% of plan) which is a £73.4m risk to plan. Therefore, the risk level remains high for Q2.

Work continues across all organisations to identify, develop and approve CIP projects so that these can be implemented and put into delivery. This will reduce the level of risk in CIP as schemes are further developed.

All providers have productivity programmes which underpin elements of their efficiency plans. These are monitored via their own PMOs and where financially assessed, reported as part of their efficiency plans as highlighted above.

Key Controls Framework

- Weekly monitoring of development of CIP plans for each organisation and submission to NHSE.
- Reporting on progress through System Performance Group and Finance and Performance Committee.
- Given the risk within the delivery of the UHNM plan, monthly efficiency stock-take meetings with the ICB, UHNM and NHSE have been established.
- Weekly System/IFP finance deputies meetings held to support System meetings.
- Weekly System CFOs meeting.
- Fortnightly System Senior Leadership Team meetings.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	Monthly System finance reports articulating risk / mitigations.	●	●		
2nd Line (system)	System Finance Report to Finance & Performance Committee.	●	●		

	QIA Process incl. reports to Quality & Safety Committee to support checking of schemes from productivity programmes	•	•		
	Monthly escalation report from System Performance Group to Finance and Performance Committee	•	•		
3rd Line (external)	Annual value for money assessments completed by external auditors.	•	•		
	NHSE & Auditor review of QIA process that supports all schemes rolled out for Efficiency Programme	•	•		
	Internal audit review of efficiency programme plans, and delivery. Findings presented annually at the March Audit Committee		•		

Gaps in Control or Assurance
What are the gaps to be addressed to improve adequacy of assurance?
The CIP delivery currently seen as 'likely' is £232.9m (76% of plan) which is a £73.4m risk to plan.

FUTURE Actions
(Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)

No.	Action Required	Outcome of Action	Lead Director	Progress, Impact & Planned Actions
1	Continue to develop and apply the agreed System approach to improving productivity encompassing all sectors.	Additional assurance	Chief Finance Officer	To be encompassed within the I&I work and reported to the Finance and Performance Committee quarterly. **Q1 Progress & Impact:** Month 3 CIP delivery is £45.7m against a plan of £59.9m which is £14.2m adverse to plan. Development of System CIP shows £231.3m as either Implemented or Fully Developed. The CIP delivery currently seen as 'likely' is £232.9m (76% of plan) which is a £73.4m risk to plan. **Planned Actions (Q2):** • Continuation of weekly assessment of efficiency development • Individual organisational "lock ins" or equivalent to identify further schemes, address barriers to in-year delivery • Provider collaborative programmes on community transformation and enabling functions have a key focus on productivity opportunities
2	Further support projects are currently being considered and scoped to further deliver against financial improvement targets/CIP.	Additional assurance	Chief Finance Officer	MPFT: Non-pay, Contracts and Procurement UHNM: Job plan activity delivery Provider Collaborative: Enabling Functions improvement support, scope received and approved by the Provider Collaborative Board, submitted for final agreement **Q1 Progress & Impact:** The Intervention & Investigation Regime supported by Deloitte/Kingsgate commenced in November 2024 and has been supported by a number of follow on projects and areas of support. The projects listed below are now complete • ICB: CHC - Complex Care Commissioning Review (incl. S117 etc.) • ICB: CHC Market (Inflation) Management • ICB: ISP Model for Independent Sector activity needs and Planned Care support • ICB: ISP Contract Support to Transact and Deliver IS Savings

				• UHNM: Surgery Deep Dives - Anaesthetics Review, Implementation Support - Orthopaedics & Ophthalmology The close down reports show that financial benefit delivery with a range of £22.8m to £29.5m has been supported through these workstreams. **Planned Actions (Q2):** Deloitte/Kingsgate support continues as a Phase 4 under the approved £1.6m business case, against which there is now c.£1.1m of projects approved. Two further support requests for support from Deloitte/Kingsgate have been scoped and approved (D2A Demand and Capacity modelling and Planned Care additional activity management). The learnings from this work to be embedded into BAU. Further scopes for projects continue to be encouraged, the aim being for support to reduce the risk to CIP delivery and financial improvement. It has been made clear that any further work must have tangible in year benefit to enhance delivery under existing schemes or rapidly put into place new mitigating schemes for other risk areas. Provider CFOs have agreed to deliver the £14.2m savings target set for the Provider Collaborative and are going to identify schemes to take forward. For the Tough Choices workstream, SROs have been identified, and meetings held to review and follow up on actions to be taken. The intention is for all relevant work to transition to BAU.
3	Primary Care Collaboratives fully in place covering all of SSoT	Additional assurance	Chief Medical Officer	Continued support to emerging primary care collaboratives including shared learning approaches. **Q1 Progress & Impact:** A north primary care collaborative has been established with recognised leadership linked into the provider collaborative. **Planned Actions (Q2):** Primary care team and CMO to work on continued development with the South.

SBAF 8: Sustainable Workforce

People, Culture & Inclusion Committee | Chief People Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If recruitment activity across the ICS reduces due to financial pressures; and there is an ongoing reduction in recruitment to non-registered and / or trainee posts,
Event	then workforce gaps will increase, employee health and wellbeing will be affected, and turnover may increase; and the future pipeline will destabilise.
Effect (Consequence)	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.

SA1	Improve Health and Wellbeing Outcomes		SA3	Achieve a sustainable and resilient Integrated Care System	●
SA2	Address inequalities in access, experience and outcomes from health and social care services		SA4	Working in partnership with communities to achieve social, economic and environmental community development	●

Risk Assurance and Tolerance

Quarter	Q1	Q2	Q3	Q4	Risk Tolerance Statement	Linked Risks		
Risk Level (Low/Moderate/High)	High	High			Tolerance is high in recognition of the workforce pressures and financial position. The system work programmes focus on reform, collaboration, productivity, maintaining safe staffing levels to reduce the impact.	Low	2	→
						Mod	6	↑
						High	9	↓

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	●
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	
No Assurance	No confidence in delivery	

Rationale for Risk Level & Progress Made in the Quarter (e.g. mitigating actions to reduce risk level):

Recognising the financial challenges and challenging landscape for 2025/26, the overarching risk reflects the current workforce challenges and system position.

Summary of the risk register, rationale for the Q2 score and progress as follows:

- All risks reflect the challenging 25/26 Operational Plan, NHS & ICB Infrastructure reductions and Reform.
- All residual risk scores on the risk register are currently 16 or under.
- Regular review and scrutiny around risks continues via PCI Committee, ensuring risks are reflective of the system-wide health and social care workforce challenges.
- In addition to individual risk actions, the overarching risk is being addressed via targeted programmes of work, interventions and collaborative work at System and organisational level with evidence of an improved position in several areas including retention, wellbeing and strengthening the future pipeline.
- Whilst turnover is decreasing, sickness absence rates continue to fluctuate therefore actions continue at Trust and System level to prevent further deterioration through prevention and targeted support. All monitored and driven via the ICS Employee Experience, Health and Wellbeing Sub-Committee – with a recent review and alignment to the System Prevention Strategy
- In addition, the 2024 Staff Survey Results have been analysed at Trust and System level, with actions being identified to further improve experience and wellbeing of our workforce.
- The System OD plan is currently being reviewed to address the risk around culture, behaviour and leadership in an uncertain and financially challenged environment.
- The ICS People Delivery Plan for 2025/26 will be finalised once the refreshed Long Term Workforce Plan is published. The plan will consider the overarching workforce risks, challenges and priorities, aligning to the 25/26 Operational Plan.

Key Controls Framework

- Several strategies and plans provide direction and a framework including ICS People Plan and strategic delivery plan, ICS Operational Workforce Plan, National NHS Long Term Workforce plan and Skills for Care Workforce Strategy (translated locally and plans reviewed to respond to the ambitions and targets).
- NHS Chief People Officer (CPO) forum and CPO and Deputies Forum.
- System People Assurance report to ICB Board.
- System Workforce Planning Group including collaboration on strategic, portfolio and operational planning.
- System Education, Training and Development Sub-Committee – strategy, and delivery plans on track.
- System Employee Experience and Health and Wellbeing Group – strategy in development, workstreams identified and plans on track.
- System Organisational Development (OD) Plan being reviewed
- System Leadership and Talent Steering Group, some slippage in progressing sub-committee and plans due to priorities shifting to Reform/Reset work.
- System Equality, Diversity & Inclusion (EDI) Group and programme activities progressing well with additional resource in place.
- NHSE support and review meetings.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	Trust People Committees (review and assurance)	●	●		
	People Metrics, Key performance indicators and assurance reporting.	●	●		
	People Risk Register and Board Assurance Framework.	●	●		
	NHS Trust and ICB Vacancy Oversight process and meetings.	●	●		
	Trust vacancy oversight panels.	●	●		
2nd Line (system)	ICS People, Culture & Inclusion Committee	●	●		
	People Metrics, Key performance indicators and assurance reporting presented.	●	●		
	Operational Plan and workforce Controls reporting, monitoring and assurance.	●	●		
	Annual deep drive of high scoring risks driving the SBAF risk.	●	●		
	ICB Board	●	●		
	ICS People Culture and Inclusion Committee highlight and People Assurance Report.	●	●		
	ICB Finance & Performance Committee	●	●		
	People Metrics Report presented including agency, vacancies, workforce position, workforce controls and performance against operational plan.	●	●		
3rd Line (external)	NHSE - System Review Meetings	●	●		
	People Metrics and KPI report presented to assure performance against Operational plan	●	●		
	NHSE – Regional Workforce Transformation and Development teams	●	●		
	Quarterly review meetings to report and assess the progress of workforce development funding spend.	●	●		

Gaps in Control or Assurance

What are the gaps to be addressed to improve adequacy of assurance?

- Capacity to meet reporting and assurance requirements from NHSE.
- Ability to meet demand and Long-Term Workforce Plan growth with financial deficit, workforce controls, supply, future pipeline, and availability of registrants.
- Workforce development funds limited from NHSE and other sources to support innovative future workforce supply solutions and programmes.

FUTURE Actions (Actions to Increase Assurance or to Reduce Likelihood / Consequence Scores)				
No.	**Action Required**	**Outcome of Action**	**Lead Director**	**Progress, Impact & Planned Actions**
1	Collaboratively review and update the long-term ICS People Plan in line with ICB Blueprint, 10 Year Plan and refreshed Long Term Workforce Plan	Additional Assurance	Chief People Officer	Once ICB Blueprint and Regional blueprint finalised, and 10-year plan published, work will commence to review the ICS People Plan and future work programmes. **Q1 Progress & Impact:** ICB Blueprint received and considered locally. Submission to NHSE and cluster arrangement approved – SSOT & STW. Awaiting Regional Blueprint and refreshed Long Term Workforce Plan expected end of Summer. **Planned Actions (Q2):** Once issued, consider the regional blueprint and impact on functions and responsibilities of ICS/ICB People Function. Locally interpret and consider the refreshed LTWP once published, working in collaboration with partners to agree local delivery and responsibilities.
2	Horizon Scanning for alternative workforce development funding sources.	Additional Assurance	Chief People Officer	Ongoing work via Sub-Committees and Delivery groups. **Q1 Progress & Impact:** Limited funds available, continued to explore via sub-committees and leads. Some externally funded ICS People Programme work ceasing or where feasible will continue to be delivered by partners e.g. Clinical education programme, T-Levels. **Planned Actions (Q2):** Continue to horizon scan, regularly monitor via sub-committees and connections with NHSE and other external partners.

Enclosure No: 08

Report to:	**Integrated Care Board**					
Date:	**18 September 2025**					
Title:	**Quality and Safety Report**					
Presenting Officer:	Heather Johnstone, Chief Nursing and Therapies Officer (CNTO)					
Author(s):	Lee George, Associate Director – Quality Assurance and Improvement					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☐
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICB?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Any impacts on ICB Undertakings?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Appendix A: Quality and Safety Report – Detail September 2025.					

(1) Purpose of the Paper:

To provide assurance to the Integrated Care Board (ICB) regarding the quality, safety, experience, and outcomes of services across the entire health economy.

(2) History of the Paper & Whether for I-D-S-A-R (as above):	**Date**
This paper is a combination of corresponding papers (D/S/I) presented and discussed at Quality and Safety Committee.	Click or tap to enter a date.
This paper is a combination of corresponding papers (D/S/I) presented and discussed at system Quality Group.	

(3) Implications:

Legal or Regulatory	Risks identified and managed via the Board Assurance Framework and Corporate Risk Register.
CQC or Patient Safety	Updates provided against relevant organisations. Continuous Quality Improvement update aligns to known links between providers and systems.
Financial (CFO-assured)	N/A
Sustainability	N/A
Workforce or Training	Details contained within the report relating to providers by exception.
Equality & Diversity	Details contained within the report.
Due Regard: Inequalities	Update contained within the report.

Due Regard: wider effect	Quality Impact Assessment update supports the ICB, and system partners, having due regard to all likely effects of decisions.

(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, signed off by QIA on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	

(5) Integration with the System Board Assurance Framework & Key Risks:					
SBAF1	Responsive Patient Care - Elective	☐	SBAF5	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☐	SBAF6	Sustainable Finances	☐
SBAF3	Proactive Integrated Community Services	☐	SBAF7	Improving Productivity	☐
SBAF4	Reducing Health Inequalities	☒	SBAF8	Sustainable Workforce	☐

(6) Executive Summary, incl. expansion on any of the preceding sections:

The paper summarises key areas discussed by the Quality and Safety Committee (QSC) and the System Quality Group (SQG) at the meetings held in August and September 2025.

Several key programmes of work were discussed, and the paper is intended to provide assurance to the Integrated Care Board in relation to:

- Quality Impact Assessments
- Patient Safety Quality Impact Assessment
- Maternity & Neonatal Independent Senior Advocacy Service Pilot
- Special Educational Needs & Disabilities
- Quality and Safety Through Transition

(7) Recommendations to Board / Committee:

Members of the Integrated Care Board are asked to:

- Receive this report, seek clarification, and further action as appropriate.
- Be assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.

Appendix A: Quality and Safety Report – Detail September 2025

1.0 Quality Impact Assessment (QIA)

1.1 NHS England's independent 'Quality Assurance Review' of SSOT ICB's QIA Process determined an Overall Assurance level of 'Significant Assurance; strong evidence that SSOT QIA process is robust and sustainable'. Throughout September and October 2025, the ICB, utilising a continuous improvement approach, is engaging across the ICB and system partners to update the ICB's QIA Policy. Incorporating both the National Quality Board published in June 2025 and NHS England areas for consideration received in July 2025. Once finalised the policy will be implemented across the ICB including updated training and awareness sessions.

1.2 Work continues to strengthen the visibility of reporting of the ongoing monitoring of quality impacts following the implementation of ICB efficiency schemes. Both Finance and Performance Committee and Quality and Safety Committee have received monitoring updates in August 2025 to support the improvement of joint oversight and monitoring. Maintaining our collective focus on the overall quality and safety of our services, remains our overarching priority.

1.3 The Quality and Safety Committee receive updates of any risks identified within QIAs scored eight or above. There were four QIAs, completed or presented to QIA panel during June 2025 to July 2025, which identified negative quality impacts with a risk rating of 8 or more. Further, Quality and Safety Committee were advised that in the same period there had been an increase in the number of QIAs that were completed at Gateway 1 or presented at QIA panel after the decision, meaning that the QIAs were retrospective. Work continues to promote the importance of QIAs to support effective decision-making processes and the role of all ICB employees. These areas will also be reflected upon as part of updating the QIA Policy.

2.0 Patient Safety Incident Response Framework (PSIRF)

2.1 ICBs have a responsibility to establish and maintain structures to support a co-ordinated approach to the oversight of patient safety incident responses in all the services within their system. Monthly oversight meetings have taken place between SSOT ICB and University Hospitals of North Midlands NHS Trust (UHNM), Midlands Partnership University Foundation Trust (MPFT), North Staffordshire Combined Healthcare Trust (NSCHT), National Unplanned Pregnancy Advice Service (NUPAS), GP Out of Hours Providers, and HealthHarmonie. These meetings focus on improvement and learning through engagement and empowerment. All providers are reporting positive compliance with required Patient Safety level 1 and level 2 training.

2.2 The system held our latest Patient Safety Conference on 4th June 2025 with a focus on Quality Improvement from PSIRF. Presentations were received from quality improvement leads from the ICB, NHS Trusts, Primary Care, Staffordshire Fire and Rescue Service and Health Innovation. Planning is already underway for the next conference to be held in January 2026.

2.3 As part of the 2025/26 GP Contract, all GP practices are now required to register for an administrator account with the Learn From Patient Safety Events (LFPSE) service. Most practices across the region are already taking this step to stay ahead of compliance and strengthen their patient safety processes. This means that organisations operating under the NHS Standard Contract (including primary care organisation who have already transitioned to PSIRF, must apply PSIRF principles in their approach to learning from safety events, including responses to safety events involving vaccinations. The ICB's Quality team are supporting the PSIRF Primary Care Pilot and the development of patient safety incident response plans for Primary Care. Practices across SSOT have been provided with key information about PSIRF and the expectations outlined in the Primary Care Patient Safety Strategy. A concise 7-minute briefing and accompanying communication have been shared with all practices, including further information and signposting to available support

3.0 Maternity & Neonatal Independent Senior Advocacy (MNISA) Service Pilot

3.1 The MNISA role was introduced by NHS England in 2023 in response to an Immediate and Essential Action in the independent Ockenden Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (2022). The role was established to ensure "families' voices are heard, listened to and acted upon" following adverse outcomes such as the death or serious injury of a baby or the mother during NHS care. MNISAs were piloted across ICBs (including Staffordshire and Stoke-on-Trent ICB and Shropshire,

Telford and Wrekin ICB) to offer independent support and advocacy for families, aiming to amplify their voices, navigate complex systems, and promote learning and system-wide change.

3.2 NHS England commissioned an independent mixed-methods evaluation of the pilot which was conducted from October 2024 to June 2025 by the NIHR Rapid Service Evaluation Team (RSET). It aimed to assess the implementation, impact, and value of the role. The evaluation included interviews with families, MNISAs, and staff at Trust, regional and national level; documentary analysis; a national MNISA survey; and analyses of costs and budget impacts and caseload data.

3.3 The System Quality Group received a presentation in September 2025 on the RSET findings and powerful, emotive feedback and learning from local families. This included feedback regarding candour, the need for simple compassionate communication and working in partnership (bereavement care). The RSET evaluation concludes that the MNISA role has demonstrated early value to families and services but requires strengthened infrastructure, clearer definition, and more consistent integration into local and national systems to achieve its full potential. Future evaluation should focus on long-term outcomes, including equity of access, safety and quality of care, and sustained system learning. A one-page summary of the pilot evaluation is available here: RSET MNISA One page summary.pdf

3.4 NHS England have confirmed that the MNISA pilot will not continue past March 2026. Discussions took place at System Quality Group about the need to embed the learning into our future ways of working.

4.0 Special Educational Needs & Disabilities (SEND)

4.1 The ICB's Designated Clinical Officer SEND presented an update to the System Quality Group on the key activities and the progress that have taken place between April and August 2025 in improving outcomes for Children and Young People (CYP) 0-25 years with SEND across the Staffordshire and Stoke-on-Trent footprint and a summary of the annual data for SEND published nationally every June.

4.2 As of January 2025, the total SEN population (including Education, Health, and Care Plan (EHCP) and SEN Support) across Staffordshire and Stoke-on-Trent is 35,464. This represents approximately 11% of the 0–25-year-old population, based on 2021 census data. The ever-increasing prevalence of need among CYP, requires an adaptation of service models to reflect the complexity and volume of emerging needs. This will need an expansion of capacity and resourcing to ensure services remain responsive, equitable, and effective. The NHS must adapt its service models to meet evolving needs across diverse educational settings.

4.3 In Staffordshire autism is the most common type of primary need (25%) in EHCP's, followed by Speech language and communication (SLCN) (29%). In Stoke-on-Trent this trend is reversed with SLCN being the most common primary neds in EHCP's (29%) followed by SEMH (22.6%) and then autism (19%). Many CYP with SLCN will be undiagnosed autism and social, emotional, mental health (SEMH).

4.4 Partnership actions in Staffordshire include: SEND Strategy development in 2025; MPFT improvements in SEND digital pathway; Exploring what a SEND joint Data Dashboard would contain/look like; Ongoing development of joint commissioning work. Partnership actions in Stoke-on-Trent include: Participation and engagement to embed coproduction charter, community inclusion, right support right time including EHCP quality, workforce development and preparations for adulthood.

5.0 Quality and Safety Through Transition

5.1 As part of the reform to ICBs, clustering conversations are taking place with Shropshire, Telford and Wrekin ICB. The ICB is committed to maintain our statutory duties including throughout the transition period. A Quality & Safety workstream has been set up, co-chaired by both ICB's Chief Nurses, to support the transition governance. Partnership meetings have taken place across the cluster to support understanding what our new functions will look like in a cluster with a focus on strategic commissioning and continued compliance with statutory responsibilities.

AAA Escalation & Assurance Report from Committees

Report To:	Board
Date:	18th September 2025
Reporting Committee / Group:	Quality & Safety Committee
Date of Meeting:	20th August 2025
Meeting Quorate Y/N?	Y
Presenter:	Siobhan Heafield, Non-Executive Member and Committee Chair
Author:	

Key Escalation & Discussion Points from the Committee Meeting:

ALERT
Quality Impact Assessment The committee received an overview of the QIA work programme and the actions being taken to ensure the ICB fulfils its statutory duty to have regard to all likely effects of decisions. The committee were informed there had been an increase in retrospective QIAs being completed between June and July 2025. This is a deterioration of the previous improvement. Assurance was provided that work is taking place to simplify processes and identify where a QIA is required.

ADVISE
Perinatal Quality Surveillance The committee received an update on maternity and neonatal services accessed by women and babies from Staffordshire and Stoke-on-Trent There is an increased ask of Maternity & Neonatal Voice Partnership Leads (MNVP) under Safety Action 7 from the Maternity Incentive Scheme Year 7. Whilst assurance was given a robust plan has been put in place until the end of the 2025/26 financial year, there is a

potential risk both for the ICB and UHNM. Work is taking place, including with the NHSE Regional Office, to mitigate the risks. The committee were informed this is a national issue and escalation to the national team will take place through various regional perinatal groups.

System Quality Group
The committee received an overview of the System Quality Group (SQG) with partners from across health, social care, and the wider ICS in attendance.

The committee discussed the ongoing issue of increased out of area placements for mental health patients. Assurance was provided that actions are in place with some improvement seen recently. However, the committee was made aware one of the factors driving the increase is the number of patients clinically ready for discharge.

The committee received an update on work taking place around staff sickness absence with a deep dive report due to be presented to the People, Culture and Inclusion Committee in September.

ASSURE

Public Sector Equality Duty Equality Diversity & Inclusion Annual Report 2024/25
The committee received the annual report which presented an analysis of patient access, experiences and outcomes from an equality, diversity and inclusion perspective in compliance with the Equality Act's Public Sector Equality Duty and publishing requirements.

The committee were assured by the contents of the report and requested a further update in six months, particularly looking at engagement with the ICB's population.

The committee **approved** the Public Sector Equality Duty Equality Diversity & Inclusion Annual Report 2024/25. The ICB Board will need to ratify this decision.

Quality Assurance Review – Quality Impact Assessment Process
The committee received an overview of the findings of the NHSE Quality Assurance review of the ICB's Quality Impact Assessment (QIA) process.

The review was undertaken following concerns raised by Staffordshire County Council and Stoke-on-Trent City Council directly to NHSE in relation to the ICB's 2025/26 Operating Plan and the impact of planning submissions on patient safety, clinical outcomes and the health and wellbeing of the local population. The scope of the review included looking at the QIA policy using the recently published National Quality Board framework as reference, training and awareness for staff, leadership, reporting and monitoring.

The committee were pleased to hear the findings of significant assurance overall with strong evidence that the ICB's QIA process was robust and sustainable.

The committee agreed the review should be presented to the ICB Board.

Right Care Right Person
The committee received an update and were assured on the actions taken in relation to serious concerns raised in relation to the Right Care Right Person process and the findings of

an overarching review of events. The final report is currently being drafted and will be presented to the committee for approval when completed and approved by all partners.

The committee agreed the following:

- Presentation to the Regional Quality Group to enable regional wide learning.
- Seek independent review from outside of the system to review the work carried out.

Leng Review – Physician Associates and Anaesthesia Associates
The committee received a summary of the findings and recommendations from the independent review into the roles of physician associates and anaesthesia associates.

The committee were assured on the work taking place to implement the recommendations and to ensure affected staff are supported. A further update was requested in six months.

Independent Inquiry into the issues raised by the David Fuller case: Phase 2 Report
The committee received a summary of the independent inquiry into the issues raised by the David Fuller Case published on the 15th of July 2025 and the subsequent recommendations.

The committee sought assurance that system partners are taking action against the recommendations. It was agreed this work should take place at the System Quality Group with a report back to the committee when completed.

All Age Continuing Care
The committee received an update and were assured on the progress that is being made in relation to All Age Continuing Care (AACC).

The KPIs for quarter one have been achieved with achievement predicted for quarter two. The overall AACC caseload had decreased by 1.5% at the end of June with the CHC caseload at its lowest for eight years at 747. Whilst there is still a high number of overdue reviews, particularly related to funded nursing care (FNC), assurance was given actions are in place to reduce this.

The committee were informed the ICB had received a visit from the Department of Health and Social Care in August to carry out a review of AACC. The visiting team took away the positive progress that has been made, whilst also setting some challenges for the ICB to consider.

Infection, Prevention & Control
The committee received an update on infection, prevention and control activities across the system.

An update was provided on primary infections driving bloodstream infections, particularly linked to urinary tract infections and cellulitis. A urinary tract infection pathway is being developed, aligned to national guidance, with the aim of improving outcomes, reducing avoidable admissions and supporting better flow. There is a focus on prevention with work targeted at primary and secondary care.

The committee were assured by the update received.

Quality Oversight Dashboard
The committee received a refreshed quality oversight dashboard.

The committee’s attention was drawn to sickness absence rates across the system and the wheelchair service where there are concerns around long waits and delays with contractual performance notices being issued.

System-ICB Risks / Board Assurance Framework (SBAF):
Risk Register The committee received and noted the Risk Register. The committee: • Discussed Risk 1236 Wheelchair Service and asked for this to be reviewed in light of concerns around service provision, with any new emerging risks to be added to the risk register. • Discussed Risk 1179 Children and young people delayed discharges from Tier 4 hospitals and asked for this to be reviewed and updated to reflect the current position. • Asked risk owners to ensure risks are reviewed and updated.

Policies Approved:
None discussed.

Decisions to be Escalated to ICB Board:
• The Quality & Safety Committee **approved** the Public Sector Equality Duty Equality Diversity & Inclusion Annual Report 2024/25

AAA Escalation & Assurance Report from Committees

Report To:	Integrated Care Board
Date:	18th September 2025
Reporting Committee / Group:	Staffordshire and Stoke-on-Trent Health and Care Senate
Date of Meeting:	14th August 2025
Meeting Quorate Y/N?	No
Presenter:	Rachel Gallyot, Interim Chief Medical Officer and Senate Chair
Author:	Rachel Gallyot

Key Escalation & Discussion Points from the Committee Meeting:

ALERT
None.

ADVISE
1) Integrated Medicines Optimisation Group (IMOG) Report May and June 2025 May a) A range of NICE TAs for highly specialised drugs, funded by NHSE, were considered in May. There was no May meeting, so approvals were undertaken electronically, and all were recommended for entry on the formulary as RED drugs for specialist use only. Acarizax, an oral treatment for dust mite allergies, was approved by NICE for the treatment of allergic rhinitis. As initiation includes special requirements it would be initiated in secondary care and, normally, it would be passed to general practice for ongoing prescribing, however, because it is a new drug, and there is not much experience of it locally, it was recommended for entry on the formulary as a RED drug, for specialist use only, at this time.

June

b) A number of NICE TAs, for NHSE funded, specialised drugs, were considered and these were recommended for entry on the formulary as RED drugs, for specialist use only.
c) NICE TA drugs were to be removed from the formulary, due to them no longer being available, including Voxelotor for treating haemolytic anaemia, caused by sickle cell disease, and Crizanlizumab for preventing sickle cell crises in sickle disease.
d) IMOG supported the recommendation of the Medicines Optimisation Regionwide Advisory Group (MORAG) recommendation that biosimilar drugs (generic versions of a biological drug) should be used if appropriate and less expensive than the originator. MORAG has set targets, for when a biosimilar is introduced, including the expectation that the new drug would be used in 90% of the cases and, within a year, there would be an expectation to move 80% of patients onto the biosimilar. The support of the MORAG statement can be noted on the ICB formulary.
e) The review of Chapter 1 (Gastrointestinal) of the formulary will be presented to next month's Senate meeting.
f) The policy for managing primary care pharmaceutical rebate schemes, which outlines the principles and processes followed for rebates was included for information. This policy will be presented to the Finance and Performance Committee (F&PC) for approval.

The Senate **approved** IMOG decisions (a) to (d), the virtual decisions made in May and from the meeting held on 4th June 2025. There was no adult social care representation at the meeting so the paper will be sent to them for ratification. The item was subsequently ratified by a representative from Adult Social care on

2) Excluded Restricted Policy Clinical Area Updates

The Senate received a presentation titled 'Excluded, Restricted Procedure Policy – Update v.2.1'.

- All procedures that have been included into the ERP Policy have been reviewed by Clinical Advisory Prioritisation Group (CPAG), the national Evidence Based Interventions (EBI) Programme or have a NICE Technology appraisal.

The amendments to the policy reflected 4 key areas:-

- Addition of simple ear wax removal, aquatic therapy for children & young people, aquatic therapy for inflammatory arthritis, animal therapy and sequential oral sensory (SOS) therapy.
- Additional narrative for the ICB's orthotic provision.
- Addition of weight management drugs as per NICE TA 1026 and NHSE Guidance
- Addition of bariatric surgery as per EBI recommendations, noting the inclusion of Mounjaro, as the final NICE Guidance for wasn't published until December 2024, which followed the Autumn 2024 EBI review.

Following the presentation the following clarification points were provided: -

- The ear wax policy covers simple ear wax removal only and there will be a separate complex pathway for things like long term follow up on the cholesteatoma tumour pathway following mastoid surgery. The Planned Care Team reassured that they will be working on further pathways, and the next one will be Ear, Nose and Throat and Head and Neck Cancer, which will include complex post ear surgery follow up.
- There has been a contract variation for hearing aid providers to undertake ear wax removal, and the simple ear wax removal policy has been through a rigorous process

including Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs) and there will also be a monitoring process.

- There is provision in the simple ear wax removal policy for people with learning disabilities.
- The purpose of the bariatric surgery section is to provide some clarity, in line with the Evidence Based Interventions (EBI) programme recommendation, that first line therapy should only be bariatric surgery for people with a Body Mass Index (BMI) of 50+ who do not wish to try Mounjaro, or another GLP-1 first.

The Senate **supported** the inclusion of the 'simple ear wax removal' that was approved at the April 2025 H&C Senate.

The Senate **approved**:-

- The inclusion of animal therapy, aquatic therapy for children & young people, aquatic therapy for inflammatory arthritis and SOS therapy as 'Excluded' procedures within the ERP policy.
- The inclusion of the strengthened orthotic criteria, which gives clarification and removes any ambiguity for both referrer and patient.
- The inclusion of the weight management drugs, noting a phased rollout to protect the ICB financially.
- The inclusion of bariatric surgery as a 'Restricted' procedure within the ERP as per the EBI recommendations, noting the inclusion of Mounjaro, as the final NICE Guidance was not published until after the EBI review.

ASSURE

None.

System-ICB Risks / Board Assurance Framework (SBAF):

The Senate receives the SBAF and Risk Register, for information, in May and October.

Policies Approved:

None discussed.

Decisions to be Escalated to ICB Board:

- The Senate **approved** IMOG decisions (a) to (d) from the virtual decisions made in May and from the meeting held on 4th June.
- The Senate **approved** the amendments to the Excluded Restricted Procedures (ERP) Policy V.2.1.

Enclosure No: 11

Report to:	**Integrated Care Board**
Date:	**18 September 2025**
Title:	**Report to the ICB Board on Performance and Finance**
Presenting Officer:	Claire Finn – Chief Finance Officer
Author(s):	Colin Fynn – Head of Intelligence and Analytics, Matt Shields – Head of System Finance
Document Type:	Report — If Other: Click or tap here to enter text.

<table>
<tr><td rowspan="2">Action Required (select):</td><td>Information (I)</td><td>☒</td><td>Discussion (D)</td><td>☐</td><td>Assurance (S)</td><td>☒</td></tr>
<tr><td>Approval (A)</td><td>☐</td><td>Ratification (R)</td><td>☐</td><td colspan="2">(check as necessary)</td></tr>
</table>

Is the decision within SOFD powers & limits	**Yes / No**	NO
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.
Any financial impacts: ICB or ICB?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.
Any impacts on ICB Undertakings?	**Yes / No**	YES *If Y, are those signed off by and date:* Click or tap here to enter text.
Appendices:		Performance and Finance report

(1) Purpose of the Paper:

The purpose of this paper is to provide the board with a summary of performance and finance as received at the System Performance Group (SPG) and discussed at the System Finance & Performance Committee (SFPC). It outlines at a high level the current position of key system metrics and aligned programme delivery against the Integrated Care System (ICS) Annual Operational Plan and our month 4 finance position.

(2) History of the Paper & Whether for I-D-S-A-R (as above):	Date
System Performance Group (I)	**27 August 2025**
System Finance & Performance Committee (S, D)	**02 September 2025**

(3) Implications:

Legal or Regulatory	Monitoring performance is a statutory duty of the ICB.
CQC or Patient Safety	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team and pursued through the Clinical Quality Review Meeting (CQRM).
Financial (CFO-assured)	As outlined in the body of the report.
Sustainability	N/a
Workforce or Training	N/a

Equality & Diversity	N/a
Due Regard: Inequalities	N/a
Due Regard: wider effect	N/a

(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, signed off by QIA on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Although there has been ICS Finance / DoF engagement in co-producing the strategy

(5) Integration with the System Board Assurance Framework & Key Risks:					
SBAF1	Responsive Patient Care - Elective	☒	SBAF5	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☒	SBAF6	Sustainable Finances	☒
SBAF3	Proactive Integrated Community Services	☒	SBAF7	Improving Productivity	☒
SBAF4	Reducing Health Inequalities	☒	SBAF8	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

The report was discussed at the System Finance and Performance Committee (SFPC) on the 2nd September 2025.

Performance

The group were updated on current operational performance. Areas of discussion focused on;

- **Consultant Outpatient Follow Up attendances** remain above plan with the significant driver being the volume of follow up activity with Independent Sector Providers. An Indicative Activity Plan is in place with the Independent Sector Providers from July 2025 to March 2026, requiring providers not to breach agreed levels of activity.
- The **Referral to Treatment** 52 week wait target, measuring the percentage of 52 week waiters against the overall waiting list is 0.1% off plan at month 3, though better than month 2 and a lower volume of patients.
- There were 152 patients waiting in **excess 65 weeks** at month 3, with the focus on zero waiters by the end of July through increased productivity and continued scrutiny of theatre occupancy via the weekly oversight group.
- **Virtual Ward** occupancy rates remain the same as the previous month at 60.9% against a target of 80%. In the North this equates to 65%, The South East 55% and South West 60%. Impacts associated with annual leave of a Pull Practitioner and suitable patient conditions relating to seasonality.
- The volume of inappropriate **adult mental health** out of area placements remains high in June with 26 reported in against a plan of 5. Reduced bed availability and a high number of patients clinically ready for discharge causing delays.
- The mean wait for an **autism assessment** for Children and Young People is 80 weeks, remaining above plan of 40 weeks, though performing better than the previous months mean average of 91 weeks.
- In June, the **brain injury** birth rate is 4.1 per 1000 births. The highest rate that occurred in the previous year was 4.2. The Quality, Safety and Oversight meetings continue to monitor to learn and understand themes and areas for improvement following every incident.

Finance

- At month 4 the **system YTD position** is a £19.5m deficit which is £0.4m favourable variance to a £19.9m deficit plan. The year-to-date (YTD) variance sits within the ICB (£11.4m), UHNM (£11.0m) and MPFT £2.9m with NSCHT on plan. The biggest driver of our variance to plan is the efficiency programme phasing. In response to the month 1 adverse variance, where appropriate organisations have developed recovery trajectories. At month 4 we are in a small favourable variance to the recovery trajectory of £0.8m ahead.
- The reported system **efficiency delivery YTD** is £13.5m behind our submitted plan of £83.3m, this is made up of the ICB (£8.3m), MPFT (£4.1m), NSCHT (£1.0m) whilst UHNM have delivered 100% efficiencies against YTD plan. As a system this equates to 84% delivery.
- As a system we are **forecasting** to meet our year-end financial plan of break even, subject to the receipt of £95m deficit support funding (DSF). **Net risk** has reduced to £59.7m at month 4 down from £70.5m at month 2 and £97.3m at the final plan submission, this is primarily made up of efficiency risk (£78.3m) and additional cost risk (£25.0m) offset by efficiency mitigations (£13.3m) and other non-recurrent mitigations (£34.2m). UHNM currently holds the largest net risk position of £32.0m with the ICB at £20.2m, MPFT £7.5m and NSCHT £0.0m.
- As a system we were able to submit a compliant **capital plan** which relied on successful applications for Return to Constitutional Standards capital, Estates Safety capital and Freedoms and Flexibilities capital. At month 4 we are underspending against plan by £5.4m although all providers remain on forecast to meet their plans. As previously highlighted, we continue to work with NHSE to gain final sign off for bids in the Return to Constitutional Standards allocation although all Estates Safety Fund schemes are now agreed.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

1. Acknowledge the performance overview.
2. Acknowledge the financial position.

Performance and Finance Report

August 2025

Prepared for the ICB Board by the ICB Intelligence Team & Finance Team

Planned Care

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target		Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Electives	Elective - ordinary spells	Number	ICB	Jun-25	2,085	▼	n/a		-	2,065	20	
	Elective - day case spells	Number	ICB	Jun-25	16,373	▼	n/a		-	15,640	733	
	First outpatient attendances - Consultant-led	Number	ICB	Jun-25	45,173	▲	n/a		-	42,029	3,144	
	Follow-up outpatient attendances - Consultant-led	Number	ICB	Jun-25	72,714	▲	n/a		-	66,602	6,112	
Referral to Treatment (RTT)	Time to first attendance, waiting less than 18 weeks	%	ICB	Jul-25	70.1%	▲	71.8%	March 2026	-1.7%	66.3%	3.8%	
	Total waiting list (Referral to Treatment - Incomplete Pathways)	Number	ICB	Jun-25	142,215	▼	147,032	March 2026	-4,817	154,673	-12,458	
	% Patients waiting less than 18 weeks (Referral to Treatment - Incomplete Pathways)	%	ICB	Jun-25	62.8%	▲	63.4%	March 2026	-0.7%	58.1%	4.7%	
	% Patients waiting more than 52 weeks (Referral to Treatment - Incomplete Pathways)	%	ICB	Jun-25	2.4%	▼	0.8%	March 2026	2%	2.3%	0.1%	
	Number patients waiting more than 65 weeks (Referral to Treatment - Incomplete Pathways)	Number	ICB	Jun-25	152	▼			152	0	152	
Diagnostics Tests	Diagnostic test activity	Number	ICB	Jun-25	51,357	▲	n/a		-	59,700	-8,343	
	Diagnostic Test Waiting List less than 6 weeks	%	ICB	Jun-25	66.0%	▲	n/a		-	65.6%	0.5%	
Cancer	People treated beginning first or subsequent treatment of cancer within 31 days	%	ICB	Jun-25	93.2%	▲	94.0%	March 2026	-0.8%	92.4%	0.8%	
	Total patients seen within 62 days (on cancer 62 day pathway)	%	ICB	Jun-25	68.2%	▲	75.2%	March 2026	-7.0%	68.3%	-0.1%	
	Cancer 28 day waits (faster diagnosis standard)	%	ICB	Jun-25	77.2%	▲	80.0%	March 2026	-2.8%	76.3%	0.9%	
	Lower gastrointestinal (GI) referrals with an Faecal Immunochemical Test (FIT) result (Year to Date Cumulative)	%	ICB	Jun-25	67.0%	▲	n/a		-	67.0%	0.0%	
Procedures Completed (Local Metric)	Increase the proportion of procedures completed in outpatients or as a day case (UHNM)	%	UHNM	Jun-25	89.1%	▲	n/a		-	87.2%	1.9%	
Community	Community care contacts	Number	ICB	May-25	155,100	▲	n/a		-	150,477	4,623	
	52+ weeks in community services	Number	ICB	Jun-25	2	▼	n/a		-	20	-18	
	Combined elective/non-elective length of stay (LOS) - community beds	Bed days	ICB	Jun-25	20	▼	n/a		-	20	0	

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▼	Deteriorated with a lower value than the previous month
⇨	Equal to the previous month
n/a	not available

Key to variation Colour	
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Planned Care National Planning Metrics off Plan and Actions, 1 of 2

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Follow-up Outpatient Attendances	Follow-up outpatient attendances - Consultant-led	• In June 2025, there were 72,741 Outpatient Follow-Up attendances, against a plan of 66,602 (a variance of 6,112 attendances). • The main driver for activity being above plan is the level of follow-ups in Independent Sector Providers (ISPs), which are over plan by 3,427, and above 2024/25 by 6%.	1. Indicative Activity Plans (IAPs) have been agreed with the two main Independent Sector Providers of acute care for ICB. These specify the new to follow up rates for outpatients by specialty. These IAPs are effective from 1st July 2025 to 31st March 2026 and require providers to not breach agreed levels of activity.
Referral to Treatment (RTT)	Number patients waiting more than 65 weeks (Referral to Treatment - Incomplete Pathways)	• Across all providers there were 152 patients waiting over 65 weeks to start treatment at the end of June 2025. This is a reduction from 254 at the end of May 2025. • Out of 152 patients waiting, 107 are at University Hospitals North Midlands (UHNM). Main specialties of concern are Orthopaedics (38 patients), Gynaecology (26 patients) and Ear Nose and Throat (18 patients). • For the specialties identified, the drivers for underperformance are staff shortage, increased Trauma cases (impacting Orthopaedics), increased demand (impacting ENT), and patient choice (patients declining appointments in Gynaecology).	1. For Ear Nose and Throat, UHNM business case approved, and insourcing capacity has also been utilised pending full implementation of business case to increase workforce and capacity. Weekend list taking place for Paediatrics. 2. In Orthopaedics weekend list taking place to reduce backlog. 3. For all specialties, theatre throughput and productivity reviews are now being scrutinised through internal weekly Elective Oversight Group. Inclusive of review of allocation of lists to support urgent recovery.
	% Patients waiting more than 52 weeks (Referral to Treatment - Incomplete Pathways)	• At the end of June 2025, there was 3,417 ICB patients waiting over 52 weeks at all providers. This is below the planned trajectory of 3,693, and a reduction from the number waiting at the end of May 2025 (3,693). As a percentage of the total waiting list, 2.4% of patients were waiting over 52 weeks, against a target of 2.3% (0.1% over plan).	

Planned Care National Planning Metrics off Plan and Actions, 2 of 2

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Diagnostics Tests	Diagnostic test activity	• There were 51,357 diagnostics tests carried out in June 2025, against a plan of 59,700 (8,343, 16% less than plan). • Main areas of underperformance are for Computed Tomography (7,859 less than plan, -38.1%), and Non-obstetric ultrasound (1,039 less than plan, -10%). • Non-obstetric ultrasound backlog is continuing to reduce with currently 13,100 patients waiting. This is the best waiting list position in terms of volume since September 2024. • The planned activity level for CT at University Hospitals North Midlands (UHNM) for 2025/26 is set 34% higher than the actual activity delivered in 2024/25. However, current performance has not increased in line with this plan and remains consistent with 2024/25 levels. This variance indicates a significant shortfall in delivery against planned capacity, contributing to underperformance.	1. Commence additional registrar-led Non-Obstetric Ultrasound activity at UHNM. Implementation to begin at the start September 2025, with weekly monitoring of scan volumes from launch. Expected to deliver additional 50 scans peer week. 2. Second cohort of Non-Obstetric Ultrasound patients being transferred to Cannock Community Diagnostic Centre now taking place. Also, Non-Obstetric Ultrasound referrals and backlog now being routinely triaged against British Medical Ultrasound Society (BMUS) guidelines. 3. Although Computed Tomography activity is below planned levels, at the end of June for both ICB and University Hospitals North Midlands (UHNM) patients, over 95% are waiting less than 6 weeks for a test.
Cancer	Total patients seen within 62 days (on cancer 62 day pathway)	• In June 2025, 68.2% of patients on the 62-day cancer pathway received their first definitive treatment within the target timeframe, falling just short of the 68.3% target (a variance of 0.1%). While the deviation is minimal, it still reflects underperformance against national standards. This data covers ICB patients across all providers. • At University Hospitals North Midlands (UHNM), current areas of concern contributing to this underperformance include delays in Skin and Colorectal Cancer pathways, which require targeted intervention to improve timeliness and pathway efficiency.	1. To address the backlog of skin cancer at UHNM additional theatre and outpatient capacity is being created. 2. UHNM have submitted an additional bid for in year funding to support insourcing within endoscopy (prior to opening of the Community Diagnostic Centre) and extended theatre sessions, to create additional capacity to surgically treat colorectal patients. Due to vacancies in Histopathology, a third bid is requesting support for outsourcing of pathology samples.

Urgent and Emergency Care

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target		Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Urgent and Emergency Care (UEC)	A&E Type 1-3 - less than 4 hours	%	UHNM	Jul-25	70.8%	▲	78.0%	March 2026	-7.2%	72.2%	-1.3%	
	A&E Types 1 & 2 - more than 12 hours	%	UHNM	Jul-25	10.0%	▼	16.65%	2025/26	-6.6%	13.6%	-3.6%	
	Ambulance handover time (average)	Minutes	UHNM	Jul-25	00:41:19	▼	00:43:00	March 2026	-00:01:41	00:44:00	-00:02:41	
	Total Non-Electives spells	Number	UHNM	Jun-25	6,988	▲	n/a		-	7,581	-593	
	Non-elective average of Length of Stay	Bed days	UHNM	Jun-25	7.23	▼	n/a		-	7.10	0.13	
	General and Acute bed occupancy	%	UHNM	Jul-25	90.1%	▼	n/a		-	90.9%	-0.8%	
	Average delay - bed days lost through discharge delays	Days	UHNM	Jun-25	4.1	▲	n/a		-	3.2	0.9	
	Virtual Ward Occupancy	%	ICB	Jul-25	60.8%	⇨	n/a		-	80.0%	-19.2%	
	Urgent Community Response (UCR) referrals	Number	ICB	May-25	945	▲	n/a		-	713	232	
Urgent and Emergency Care (UEC) (Local Metrics)	Childrens A&E Type 1 - 4hr performance	%	UHNM	Jul-25	82.7%	▲	78.0%	March 2026	4.7%	-	-	
	Urgent community response (UCR) - patients seen within 2 hours	%	ICB	May-25	84.7%	▼	70.0%		14.7%	70.0%	14.7%	
	Ambulance Hours lost due to Handover delays > 15min (UHNM)	Minutes	ICB	Jul-25	2,655	▼	n/a		-	4,292	-1,637	
	Ambulance Compliance - % Handovers within 45 minutes	%	UHNM	Jul-25	76.6%	▲	100%	March 2026	-	-	-	
	Readmissions	Number	ICB	Jun-25	270	▼	n/a		-	716	-446	

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Notes on data:
UCR Referrals and 2hr compliance data not currently available for June 2025. Expected to be updated in Final submission in September 2025.

Urgent and Emergency Care Metrics off Plan and Actions, 1 of 2

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	A&E Type 1-3 4hour Performance (UHNM)	• 4hr Performance at UHNM rose by 2.6% during July 2025 to 70.85% but was 1.3% below the plan for the month. • Reduced Type 3 attendances during July, falling by 1.3%. • Drivers include increased Type 1 attendances across both sites, increasing by 6.5% on the previous month with the usual high level of patients with complex needs.	1. Navigation and triage process revised, and Test of Change completed. New process rolled out with ongoing review. Positive feedback received and significant improvements noted in time to triage. 2. Ambulance triage process review underway. Changes planned over next 4-6 weeks with expected improvements in patient flow. 3. Amended daily flow model now in place focusing specifically on the 12-hour target and ambulance handovers/offloads.
	Average Non-elective Length of Stay (UHNM)	• The Average Non-Elective Length of Stay fell during July 2025, reducing by 0.3 days to 7.2 days, 0.1 days above plan. • Shortfall against plan equivalent to 2.4 hours and not deemed significantly above plan to warrant comment.	1. Co-design new standard work for Length of Stay across the UHNM sites. Test of Change ongoing on older persons ward, Plan-Do-Study-Act cycles continues before wider roll-out. Task and Finish Group to identify wards where roll out will be the most beneficial. 2. Proposal has been developed for the creation of the Criteria Led Discharge project. Funding secured to release clinical time to focus on mobilisation. 3. High Risk of Delayed Discharge project continues to demonstrate opportunities and to support flow. Appointment to coordination roles confirmed, start dates agreed for 17th September 2025. Anticipate full mobilisation thereafter.

	Average delay - bed days lost through discharge delays (UHNM)	• The average delay through discharge delays increased to 4.1 days in June 2025, from 3.41 days the previous month.
		• Drivers include increased
		  • constrained Discharge to Assess (D2A) capacity limiting flow with high volume of demand.
		  • IT implementation resulting is system outage through the start of the month incurred delays in processes and updating records.	

Urgent and Emergency Care Metrics off Plan and Actions, 2 of 2

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio

Urgent and Emergency Care (UEC)	Virtual Wards (VW) Occupancy	• Virtual Wards performance as per the last submission [of July 2025] showed no change from the previous month with an occupancy rate of 60.9% of the 130 available beds.
		• Drivers continue to be
		  • Lower than expected utilisation in the South Sectors where the Pull Practitioner has been on leave
		  • Acute and Frail Beds at Burton and Good Hope experiencing under-utilisation.
		• Sector Utilisation:
		    o North = 65%
		    o South-East = 55%
		    o South-West = 60%
			1. Virtual Ward workstream focus on maximisation of flow via utilisation of the management systems, Expected Dates of Discharge and the creation of a demand list.
			2. A Utilisation Improvement Plan is in place and to be discussed at the next Acute Care at Home Senior Management meeting before going to the System Performance Group
			3. Wolverhampton Step-Down beds for system patients aiming to transfer under VW Team at County from September 2025.

Provider Overview at Trust Site Level – Key Urgent and Emergency Care (UEC) Metrics for Out of ICB providers, June 2025

Metric	University Hospitals of Derby & Burton (UHDB) **Queens Hospital Burton** *(NHS Derby and Derbyshire Integrated Care Board)*	The Royal Wolverhampton (RWT) **New Cross Hospital** *(Black Country Integrated Care Board)*
4-hour Performance (%) – Type 1-3 ***[Provider level]***	• July 2025 reported performance of 76.2%, a slight deterioration of 0.4% from June 2025 (76.6%).	• July 2025 was 81.3%, a reduction of 0.9% against June 2025 (82.2%).
A&E Attendances - Type 1 ***[Site level]***	• 7,201 attendances during July 2025, an increase of 0.9% against the previous month, but down when viewed on a per-day basis.	• 13,260 attendances during July 2025, an increase of 0.4% against the previous month, but down when viewed on a per-day basis.
4-hour Performance (%) – Type 1 Paediatrics ***[Site level]***	• July 2025 reported performance of 91.4%, an improvement of 0.9% over the previous month (90.5%).	• July 2025 reported performance of 87.1%, an improvement of 4.6% over the previous month (82.5%).
12-hour Performance - Types 1 & 2 (%) ***[Provider level]***	• 10.9% of Types 1 & 2 attendances breached the 12-hour mark for 'Time in Department' in July 2025, a rise of 0.9% on June 2025.	• 9.5% of Types 1 & 2 attendances breached the 12-hour mark for 'Time in Department' in July 2025, a rise of 1.9% in comparison to June 2025.
Bed Occupancy (%) - General & Acute (G&A) ***[Site level]***	• G&A Bed Occupancy rose marginally during July 2025 to 96% from 95.9% the previous month.	• G&A Bed Occupancy rose marginally during July 2025 to 94.8% from 94.7% the previous month.
Virtual Wards ***[Provider level]***	• UHDB – 38 occupancy out of 40 bed capacity (95%) for last submission in month (31st July 2025).	• RWT – 84 occupancy out of 98 bed capacity (85.7%) for last submission in month (31st July 2025).
Average Ambulance Handover Time ***[Site level]***	• West Midlands Ambulance Service (WMAS) and East Midlands Ambulance Service (EMAS) combined average handover time for July 2025 was 30 minutes 26 seconds, rising on the 29 minutes 07 seconds reported in June 2025.	• WMAS average handover time for July 2025 was 28 minutes 34 seconds, rising on the 23 minutes 37 seconds reported in June 2025.
Ambulance Compliance - % Handovers within 45 minutes ***[Site Level]***	• WMAS & EMAS combined handover compliance for July 2025 was 86.3%, up 2.3% on June 2025.	• WMAS handover compliance for July 2025 was 86.9%, down 3.8% on June 2025.
Time Lost due to handover delays > 15 mins ***[Site level]***	• 5.8% decrease in time lost due to handover delays during July 2025, rising to a combined total of 381 hours between WMAS and EMAS.	• Increase of 50.1% during July 2025 in time lost, lifting the time lost by WMAS to 1,010 hours, from 673 hours in June 2025.

Primary Care and Medicines Optimisation

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Primary Care	Appointments in General Practice	Number	ICB	Jun-25	540,705	▲	n/a	-	507,358	33,347	
	Unique patients seen by an NHS dentist - adult	% (quarterly)	ICB	Q1	43.1%	▲	n/a	-	42.9%	0.2%	
	Unique patients seen by an NHS dentist - children	% (quarterly)	ICB	Q1	63.7%	▲	n/a	-	61.4%	2.4%	
	Units of Dental Activity delivered	% (quarterly)	ICB	Q1	72.7%	▼	n/a	-	82.2%	-9.6%	
	Urgent Dental Activity delivered	Number	ICB	Jul-25	5,223	▲	n/a	-	6,797	-1,574	
	Pharmacy First consultations	Number	ICB	Apr-25	15,390	▲	n/a	-	13,000	2,390	
Medicines Optimisation (Local Metrics)	Structured medication reviews (SMRs) conducted in general practice. (Year to Date Cumulative)	% (quarterly)	ICB	Jun-25	15.0%	▲	n/a	-	15.0%	0.0%	

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Notes on data:

- Structured medication reviews (SMRs) conducted in general practice – an update from the portfolio: The Medicines Optimisation SLA was not released to practices until 27th May 2025. Therefore practices were unable to complete SMRs for the correct cohorts. Some practices did enter SMRs and these will need to be validated (to see if correspond to intended pt cohorts). At end of Q1, SMRs still await to be validated however, as per figures recorded 5% of maximum amount of SMRS allowable have been completed.
- The Meds Op team will provide polypharmacy training to PCN pharmacy teams, continue monthly SMR monitoring and SMR validation quarterly and flag to practice teams where SMRs have no interventions or incorrect entries.

Primary Care Metrics off Plan and Actions

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Primary Care	Units of Dental Activity (UDA) delivered	• Covid pandemic had significant impact on dental services which resulted in lower levels of UDAs being delivered since 2020. • Since April 2025 the delivery of UDAs has improved due to the UDA uplift. • Although performance was below plan in Quarter 1 2025/26, there was an improvement on last year's performance (72.7% v 66.7%).	1. The Primary Care Team to continue to work with the Primary Care Commissioning Team at the Office of West Midlands (OWM) on redistribution of NHS contract activity from hand backs and contract terminations and increasing urgent activity delivered in the Community Dental Service (CDS). 2. OWM and commissioners are waiting further national contract amendments, details not yet available but targeted to driving up access. 3. Delivery of the Dental Local Delivery Plan (LDP) focusing on improving dental access through the Health Equity Audit to identify populations of greatest need, oral health and supporting dental workforce including the 'golden hello' offer. 4. Communications campaign to be launched from September 2025 and continuing throughout winter, with a focus on highlighting how patients can access urgent and routine dental appointments. 5. OWM are supporting with ensuring dental practices record activity in the right way.
	Urgent Dental Activity delivered	• There does not appear to be the demand for this level of urgent care access and available capacity is not being fully utilised by patients. • The Office of the West Midlands (OWM) advise that the latest 2 months of activity figures are synthesised using expected delivery activity percentages due to the 62 day claims window for FP17's (dental claim forms). This makes them subject to change. • Additionally, there is an issue with data quality in terms of how activity is being recorded.	

Mental Health and Learning Disabilities & Autism

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target		Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Mental Health	Active inappropriate adult acute mental health out of areas placements (OAPs)	Number	ICB	Jul-25	26	▲ (red)	n/a		-	5	21	
	Average length of stay for adult acute beds	Bed days	ICB	Jun-25	48	▲ (red)	41.1	2025/26	6.9	40.3	7.7	
	Number of people who are discharged having had at least 2 NHS talking therapy appointments	Number	ICB	Jul-25	1,330	▲ (green)	n/a		-	1,253	77	
	Access to NHS talking therapies for anxiety and depression - reliable recovery	%	ICB	Jul-25	51.8%	▲ (green)	50.0%	March 2026	1.8%	50.0%	1.8%	
	Access to NHS talking therapies for anxiety and depression - reliable improvement	%	ICB	Jul-25	74.4%	▲ (green)	68.0%	2025/26	6.4%	68.0%	6.4%	
	Access to Specialist Community Perinatal Mental Health Services	Number, Rolling 12 months	ICB	Jun-25	1,255	▲ (green)	1,216	March 2026	39	1,188	67	
	Access to Children and Young People Mental Health Services	Number, Rolling 12 months	ICB	Jun-25	16,435	▲ (green)	17,273	March 2026	-838	15,332	1,103	
	Access to Individual Placement Support	Number, Rolling 12 months	ICB	Jun-25	790	▲ (green)	1,015	March 2026	-225	846	-56	
Learning Disabilities & Autism (LD&A)	Learning disability registers, Annual health checks delivered by GPs	% (quarterly)	ICB	Q1	14.15%	▼ (red)	n/a		-	11.99%	2.2%	
	Reliance on MH inpatient care for adults with a learning disability	Number (quarterly)	ICB	Q1	15	▲ (red)	n/a		-	16	-1	
	Reliance on MH inpatient care for autistic adults	Number (quarterly)	ICB	Q1	8	▼ (green)	n/a		-	8	0	
	Reliance on MH inpatient care for people with a learning disability and/or autism - children	Rate (quarterly)	ICB	Q1	22.1	▲ (red)	n/a		-	22.1	0	
Learning Disabilities & Autism (LD&A) (Local Metrics)	Mean wait to complete autism assessment - Children and Young People (CYP) North	Weeks	ICB	Jun-25	80	▼ (green)	26	March 2026	54	40	40	
	Mean wait to complete autism assessment - Children and Young People (CYP) South	Weeks	ICB	-	-		26	March 2026	-	-	-	
	Learning from Lives and Deaths Review (LeDeR) reviews within 6 months of notification of death.	%	ICB	Jul-25	100.0%	⇨ (yellow)	100%	2025/26	0.0%	100%	0.0%	
	Oliver McGowan training - Tier 1 (NHS staff)	%	ICB	Jul-25	12.6%	▲ (green)	30%	2025/26	-17.4%	30%	-17.4%	
	Oliver McGowan training - Tier 2 (NHS staff)	%	ICB	Jul-25	22.8%	▲ (green)	30%	2025/26	-0.1	30%	-7.2%	

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Notes on data:

- Mean wait to complete autism assessment - Children and Young People (CYP) – not currently available because monitoring reports are being negotiated as part of this year's contract cycle. This situation remains unchanged from last month.

Mental Health and Learning Disabilities & Autism Metrics off Plan and Actions, 1 of 3

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Mental Health (MH)	Active inappropriate adult acute mental health Out of Area Placements (OAPs)	• Reduced Bed Availability: system-wide pressure continues due to a significantly reduced number of adult acute beds within North Staffordshire Combined Healthcare Trust (NSCHT), linked to the mandatory implementation of Project Chrysalis. This has resulted in the lowest available bed stock since September 2020. • High number of patients clinically ready for discharge remain an issue particularly within Stoke Local Authority; this is resulting in the increased length of stay (LoS) also.	1. The ICB is now in attendance at the weekly discharge calls to provide support and escalate actions. A range of recommendations have been made including membership change, action taking, accountability and frequency of the calls. This is on-going to improve process and accountability 2. Escalation via the Chief Transformation Officer to Stoke Local Authority (LA) has taken place in August 2025. Follow up calls between the Head of Portfolio – Mental Health and Stoke LA have commenced with a number of actions to address delayed Stoke LA patients.
	Mean average Length of Stay (LoS) for adult acute beds	• Clinically ready for discharge impacting on the average LoS. • Although over plan and higher than last month, the ICB continues to benchmark well against other ICBs in England and was joint 6th lowest in June 2025. England = 56 days, ICBs ranged from 30 to 76 days.	1. Retained from last month: continue to closely monitor adult acute bed length of stay, noting that no immediate actions are required at this stage due to acceptable benchmarking performance. 2. Actions noted above in OAPs metric.

Mental Health and Learning Disabilities & Autism Metrics off Plan and Actions, 2 of 3

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Mental Health (MH)	Access to Individual Placement Support (IPS)	• Whilst the target is not yet being met for IPS, NHSE noted that it is sitting around 94%, ICB to do some benchmarking in relation to other ICB's across the region. • Although the rolling 12 month figure is the highest it has been in the last four months, it has been identified that there is a need to get more people accessing the service. • Coding errors have led to underreporting in the national dataset.	1. Work continues regarding promotion of the service; there have been several grants funded recently via North Staffordshire Combined Healthcare Trust (NSCHT) which include some youth lounges, promotion to be done by the team once the lounges are open as NHSE identified the age demographic 18-25 is an area that needs to be targeted. 2. Data cleansing has now been done for NSCHT and identified approximately 50 coding errors which would improve the figures seen; work is underway to correct the coding in core systems with Mental Health Services Data Set (MHSDS) updating later in the year. 3. Midlands Partnership University NHS Foundation Trust (MPFT) are still working through the data cleanse currently with support from NSCHT. Update expected at the next IPS steering group (16th September 2025). 4. The expansion to achieve the revised target for 2025/2026 was 3.00 Whole Time Equivalent employment specialists (2 South, 1 North), all of these expansion posts are now filled. The ICB have requested a staffing/recruitment update on a monthly basis as assurance that both teams are fully established and holding the desired caseload to meet the target of 1,015 by the end of the year. 5. Planned submissions to the IPS 'Grow tool' expected by the end of September 2025; there has been a reporting difference identified that NHSE are looking into. 6. Work through the actions within the MPFT fidelity report and ensure all are embedded before the next fidelity review. (NB: A Fidelity review is the best way of measuring how a service is doing and how effective their delivery of IPS is. Evidence has shown that services with a higher fidelity score tend to get more job outcomes for their clients).

Mental Health and Learning Disabilities & Autism Metrics off Plan and Actions, 3 of 3

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Learning Disabilities & Autism	**Local Metrics:** Autism assessment completion waits	• Increasing referrals and caseloads. The number of children waiting for an assessment at North Staffordshire Combined Healthcare NHS Trust (NSCHT) increased by 40% between June 2024 and June 2025, new referrals increased by 15% and caseloads increased by 32%. • This sits alongside a national picture of increasing demand (e.g. the number of patients aged 0-17 with an open suspected autism referral rose nationally from 127,361 to 135,611 between June 2024 and June 2025, a 6% increase).	1. A business case has gone to the ICB Executive Management Team in August 2025, outlining systemwide options to address long waiting times and growing caseloads for Autism. The recommendation is for a person centred and needs based sustainable model. 2. The next stage would be approval via the Strategic Commissioning and Transformation Committee.
	Local Metrics: Oliver McGowan training - Tier 1 (NHS staff) Oliver McGowan training - Tier 2 (NHS staff)	• Workforce capacity constraints remain as last month. Achieving the 30% training target has been challenging due to limited workforce capacity. • The system currently relies on a single ICB trainer to deliver Tier 1 training across the entire footprint. • While the number of Tier 2 trainers has gradually increased, progress has been slow as new trainers are recruited and brought up to speed, impacting the pace and scale of training delivery.	Actions remain as per last month report (awaiting an updated position): 1. Maintain a regular review cycle with providers to monitor the delivery of Oliver McGowan training now being delivered within individual trusts. 2. Continue recruitment and onboarding of trainers, ensuring they are supported to become operational as quickly as possible.

Children and Young People, Maternity and Neonates

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Children and Young People (CYP)	Asthma emergency admission (≤18)	Number	ICB	Jun-25	1	▼	n/a	-	20	-19	
	Epilepsy emergency admission (≤18)	Number	ICB	Jun-25	14	▼	n/a	-	29	-15	
	Diabetes emergency admission (≤18)	Number	ICB	Jun-25	5	▼	n/a	-	10	-5	
Maternity and Neonates	Stillbirth rate	rate per 1,000	UHNM	Jul-25	1.9	▼	n/a	-	5.7	-3.8	
	Neonate Mortality rate per 1000	rate per 1,000 (quarterly)	UHNM	Jun-25	0.0	▼	n/a	-	0.0	0.0	
	Brain injury rate per 1000	rate per 1,000 (quarterly)	UHNM	Jun-25	4.1	▲	n/a	-	0.0	4.1	
	The % of full - term babies admitted to a neonatal unit	rate per 1,000 (quarterly)	UHNM	Jun-25	0	▲	n/a	-	0	0.0	

Key to arrows showing direction from previous month	
▲ (green)	Improved with a higher value than the previous month,
▼ (green)	Improved with a lower value than the previous month
▲ (red)	Deteriorated with a higher value than the previous month
▼ (red)	Deteriorated with a lower value than the previous month
⇨	Equal to the previous month
n/a	not available

Key to variation Colour	
Red	Negative impact / unwanted variation
Green	Positive impact / desired variation
Yellow	No change / equal
Black	Not applicable / not available

Notes on data:

- Maternity data is provided quarterly for Mortality, Brain Injuries and Neonatal admissions. Data is provided for the preceding months, each quarter.

Children and Young People, Maternity and Neonates Metrics off Plan and Actions

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Maternity and Neonates **(University Hospitals North Midlands (UHNM))**	**Local Metrics:** Brain injury rate (per 1,000 births)	• The rate in June 2025 is 4.1 – higher than the same month in 2024 (0.0). • Small numbers recorded each month cause large variation in the rate.	1. UHNM brain injury data is now verified and reported quarterly to improve data quality. 2. Ongoing monitoring of Brain Injury data / rate through the monthly Quality Safety and Oversight meetings (QSOF) with UHNM, which focuses on learning, themes identified and areas for improvement. 3. At the latest QSOF (18th August 2025) the ICB requested that UHNM table brain injuries at the next themed QSOF meeting (date to be confirmed) to deepen the discussion.

Notes on data:

- The Brain Injury data is provided quarterly and so no update is available for this metric. The June position is retained for information. No other escalation are required this month.

Community Transformation

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Community Transformation	Palliative and End of Life Care (PEoLC): Prevalence rate of patients on palliative care registers to 1%.	%	ICB	Jun-25	0.8%	▼ (red)	n/a	-	1.0%	-0.2%	
	Increase patients receiving all 8 care processes for Diabetes, receiving 3 treatment targets - Type 1 (Year to Date Cumulative)	%	ICB	Jun-25	8.3%	▲ (green)	n/a	-	7.3%	1.0%	
	Increase patients receiving all 8 care processes for Diabetes, receiving 3 treatment targets - Type 2 (Year to Date Cumulative)	%	ICB	Jun-25	11.9%	▲ (green)	n/a	-	10.3%	1.6%	
	Long-term conditions: Ensure referrals are made to the National Diabetic Prevention Programme – support for patients who are pre-diabetic	Number	ICB	Jun-25	610	▲ (green)	n/a	-	520	90	
	Urgent community response (LTC): Ensure patients commence on the National Diabetic Prevention Programme (NDPP) following referral	Number	ICB	Jun-25	325	▲ (green)	n/a	-	261	64	
	Reduction in number of conveyances for falls by WMAS	Number	ICB	Jun-25	685	▼ (green)	n/a	-	728	-43	
	Falls, Reduction in number of falls related emergency admissions - 65+	Number	ICB	Jun-25	158	▼ (green)	n/a	-	317	-159	
	Care Home, Reduction emergency admissions - 65+	Number	ICB	Jun-25	849	▼ (green)	n/a	-	767	82	
	Reduction emergency admissions - all 65+	Number	ICB	Jun-25	6,817	▲ (red)	n/a	-	6,686	131	

Key to arrows showing direction from previous month	
▲ (green)	Improved with a higher value than the previous month,
▼ (green)	Improved with a lower value than the previous month
▲ (red)	Deteriorated with a higher value than the previous month
▼ (red)	Deteriorated with a lower value than the previous month
⇨	Equal to the previous month
n/a	not available

Key to variation Colour	
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Yellow	No change / equal
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Community Transformation Local Metrics off Plan and Actions

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Community Transformation	**Local Metrics:** Prevalence rate of patients on palliative care registers to 1%.	• Palliative care identification across the ICB has plateaued, with a slight seasonal dip over winter, suggesting the system may have reached a natural ceiling.	1. Continue monthly monitoring of palliative care register prevalence, recognising that current levels may reflect a natural ceiling for the population, and assess any emerging trends that may warrant further action.
	Local Metrics: Emergency admissions for patients aged 65 and over (including care homes)	• For patients aged 65 and over, there were 6,817 emergency admissions in June 2025, against a target of 6,686. For patients aged 65 and over in Care Homes, there were 849 emergency admissions in June 2025, against a target of 767. • Overall, at main providers; University Hospitals North Midlands (UHNM), University Hospitals Derby and Burton (UHDB), and Royal Wolverhampton (RWT) there has been a reduction in emergency admissions for patients aged 65 and over. However, at University Hospitals Birmingham (UHB), and Midlands Partnership Trust (MPFT) there has been unexpected increase. Analysis needs to be undertaken to understand drivers.	1. ICB Business Intelligence Team to review data to understand increases at Good Hope Hospital. Also to review data relating to admission to MPFT, as this may be linked to rehabilitation admissions or discharge to assessment. To be completed by end of August 2025. 2. Severe frailty business case, focussing on a proactive model of care and including those within a care home, has been developed to be taken through the ICB governance route. 3. Severe frailty outcome framework to be finalised via the frailty programme board during quarter 2. 4. Review of Falls specification complete and outcomes framework drafted. Final documentation to through ICB governance route.

Improving Population Health

Programme	Local Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Baseline	Variance	Trend from April 2024 to current month
Improving Population Health	Children and Young People - Vaccination uptake - MMR2, at 5 years	% (quarterly)	ICB	-	-		n/a	-	-	-	
	Children and Young People Vaccination uptake - Pertussis maternal vaccination	%	ICB	May-25	77.2%	▼	n/a	-	63.5%	13.7%	
	Hypertension (CVDP007HYP): Patients treatment to recommended age specific thresholds	% (quarterly)	ICB	-	-		n/a	-	-	-	
	Cholesterol (CVDP003CHOL):Patients with QRISK 20% or more treated with lipid lowering therapy	% (quarterly)	ICB	-	-		n/a	-	-	-	
	Respiratory: Flu Vaccinations (65+years)	%	ICB	-	-		n/a	-	-	-	
	Respiratory: COVID Vaccinations (65+years)	%	ICB	-	-		n/a	-	-	-	

Key to arrows showing direction from previous month	
▲	Improved with a higher value than the previous month,
▼	Improved with a lower value than the previous month
▲	Deteriorated with a higher value than the previous month
▼	Deteriorated with a lower value than the previous month
⇨	Equal to the previous month
n/a	not available

Key to variation Colour	
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Green	Positive impact / desired variation
Yellow	No change / equal
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Notes on data:

- The following remains unchanged from last month:
- MMR2 vaccination - quarterly data published nationally. The latest data available is quarter 4 2024/2025.
- Hypertension (CVDP007HYP) and Cholesterol (CVDP003CHOL) measures. Data published every 3 months. Next release due 21st October 2025 (data for Quarter 1 2025/2026).
- Flu Vaccinations – Activity will start in October 2025. IMMFORM monthly data to be used with lag of 6-8 weeks.
- COVID Vaccinations - Campaign expected to be October 2025 to end of January 2026. Eligibility criteria not yet confirmed. Monthly data available in Federated Data Platform with one month lag.

Staffordshire & Stoke on Trent ICS

Financial Position (July 25)

System Performance Group – 27th August

Finance & Performance Committee – 2nd September

Executive Summary

This report details the aggregate financial position as at month 4 with high level metrics.

Year to date position

At month 4 the system position is a £19.5m deficit which is £0.4m favourable variance to a £19.9m deficit plan (month 3 £0.3m favourable variance). The year-to-date (YTD) variance sits within the ICB (£11.4m), UHNM (£11.0m) and MPFT £2.9m with NSCHT on plan. The biggest driver of our variance to plan is the efficiency programme phasing. In response to the month 1 adverse variance, where appropriate organisations have developed recovery trajectories. At month 4 we are in a small favourable variance to the recovery trajectory of £0.8m ahead.

Efficiency delivery

The reported system efficiency delivery YTD is £13.5m behind our submitted plan of £83.3m, this is made up of the ICB (£8.3m), MPFT (£4.1m), NSCHT (£1.0m) whilst UHNM have delivered 100% efficiencies against YTD plan. As a system this equates to 84% delivery. We are continuing to monitor the development of the efficiency plans weekly.

Forecast and net risk

As a system we are forecasting to meet our year end financial plan of break even, subject to the receipt of £95m deficit support funding (DSF). Net risk has reduced to £59.7m at month 4 down from £70.5m at month 2 and £97.3m at the final plan submission, this is primarily made up of efficiency risk (£78.3m) and additional cost risk (£25.0m) offset by efficiency mitigations (£13.3m) and other non-recurrent mitigations (£34.2m). UHNM currently holds the largest net risk position of £32.0m with the ICB at £20.2m, MPFT £7.5m and NSCHT £0.0m.

Workforce

The system workforce numbers (substantive + bank + agency) were 25,368 WTE in July 2025. This is an increase on month 3 of 313 WTE mainly due to an increase in bank of 310 WTE's. Month 4 workforce numbers were 309 WTE above plan which was seen in substantive (108 WTE) and agency (35 WTE) offset by bank which is over plan by 451 WTE.

Capital

As a system we were able to submit a compliant capital plan which relied on successful applications for Return to Constitutional Standards capital, Estates Safety capital and Freedoms and Flexibilities capital. At month 4 we are underspending against plan by £5.4m although all providers remain on forecast to meet their plans. As previously highlighted, we continue to work with NHSE to gain final sign off for bids in the Return to Constitutional Standards allocation although all Estates Safety Fund schemes are now agreed. As a system we are completing a detailed forecast of likely spend at a scheme level in time for month 6 reporting at the end of September.

Month 4 Position

The System is reporting a YTD **favourable position to plan of £0.4m** against a planned deficit of £19.9m. The main drivers for the aggregate YTD position are efficiency slippage (£13.5m) coupled with under recovery of income at UHNM. The efficiency programme phasing in response to the month 1 adverse variance, where appropriate organisations have developed recovery trajectories. At month 4 we are in a small favourable variance to the recovery trajectory of £0.8m ahead.

System	Month 4 £m Plan	Month 4 £m YTD	Month 4 £m Variance	Month 3 £m Plan	Month 3 £m YTD	Month 3 £m Variance
Income	1,836.4	1,835.0	(1.3)	1,357.5	1,355.8	(1.6)
Pay	(471.0)	(475.9)	(4.9)	(349.8)	(354.8)	(5.0)
Non Pay	(258.6)	(252.5)	6.1	(194.6)	(188.0)	6.6
Non Operating Items (exc gains on disposal)	(11.3)	(10.9)	0.4	(8.4)	(8.2)	0.2
ICB Expenditure	(1,115.2)	(1,115.2)	0.0	(822.9)	(822.7)	0.1
Total	(19.9)	(19.5)	0.4	(18.2)	(17.9)	0.3
			0.0%			

ICB	Month 4 £m Plan	Month 4 £m YTD	Month 4 £m Variance	Month 3 £m Plan	Month 3 £m YTD	Month 3 £m Variance
Allocation	1,103.8	1,103.8	0.0	812.3	812.3	0.0
Expenditure	(1,115.2)	(1,115.2)	0.0	(822.9)	(822.7)	0.1
TOTAL ICB Surplus/(Deficit)	(11.4)	(11.4)	0.0	(10.6)	(10.5)	0.1
			0.0%			

I&E Run Rate

NHSE Plan — Actual

*September - NR deficit support

UHNM	Month 4 £m Plan	Month 4 £m YTD	Month 4 £m Variance	Month 3 £m Plan	Month 3 £m YTD	Month 3 £m Variance
Income	432.4	429.3	(3.1)	322.0	318.6	(3.5)
Pay	(261.5)	(265.6)	(4.0)	(194.7)	(197.9)	(3.3)
Non-Pay	(169.1)	(162.8)	6.3	(127.5)	(121.2)	6.3
Non Operating Items (exc gains on disposal)	(12.7)	(11.9)	0.8	(9.5)	(9.0)	0.5
TOTAL Provider Surplus/(Deficit)	(11.0)	(11.0)	(0.0)	(9.6)	(9.5)	0.1
			0.0%			

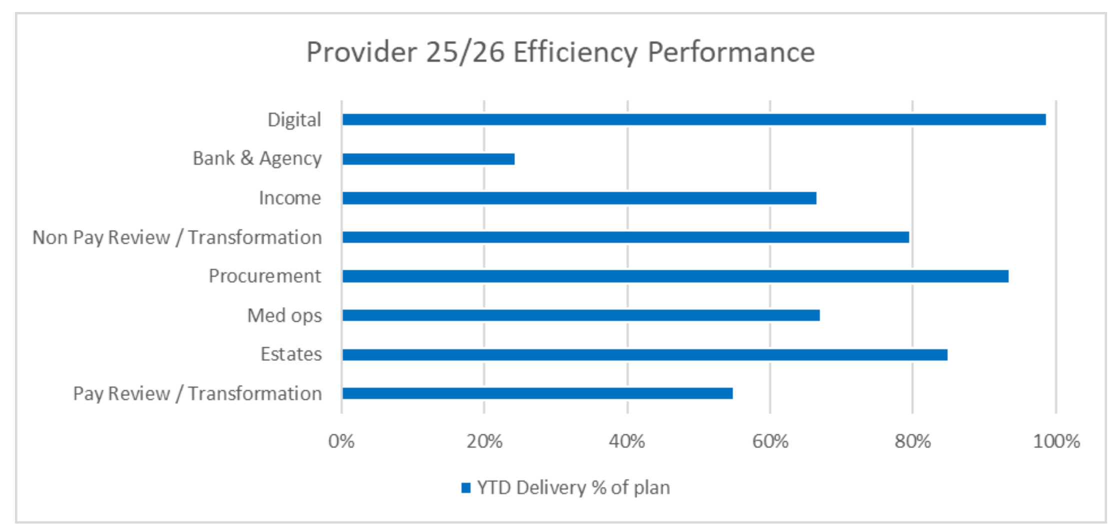
MPFT	Month 4 £m Plan	Month 4 £m YTD	Month 4 £m Variance	Month 3 £m Plan	Month 3 £m YTD	Month 3 £m Variance
Income	240.3	243.1	2.8	179.1	181.0	1.8
Pay	(172.8)	(174.2)	(1.4)	(128.6)	(130.0)	(1.4)
Non-Pay	(66.2)	(67.3)	(1.1)	(49.6)	(49.7)	(0.1)
Non Operating Items (exc gains on disposal)	1.7	1.4	(0.3)	1.3	1.0	(0.3)
TOTAL Provider Surplus/(Deficit)	2.9	2.9	0.0	2.3	2.3	(0.0)
			0.0%			

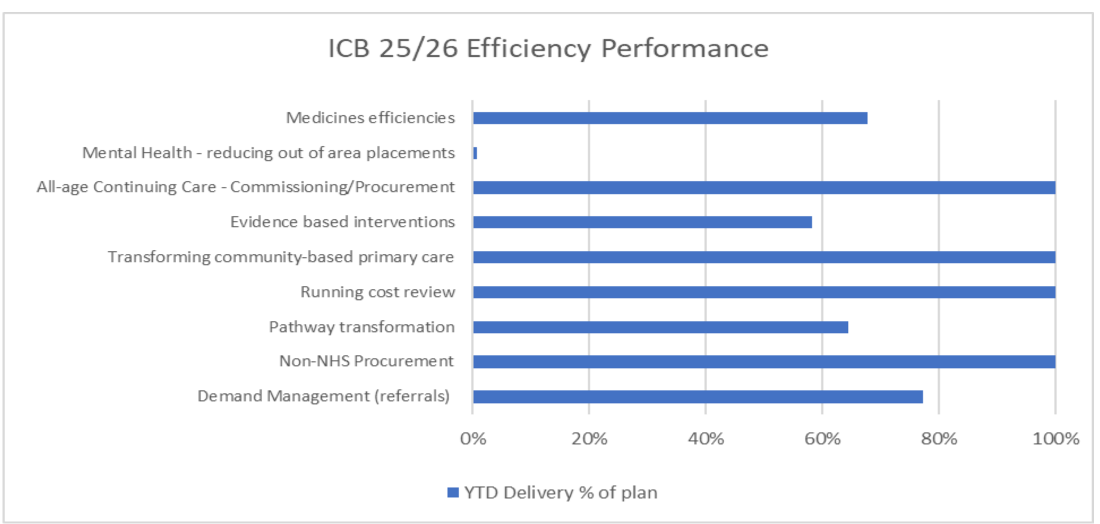
NSCHT	Month 4 £m Plan	Month 4 £m YTD	Month 4 £m Variance	Month 3 £m Plan	Month 3 £m YTD	Month 3 £m Variance
Income	60.0	58.9	(1.0)	44.0	44.0	(0.0)
Pay	(36.7)	(36.2)	0.5	(26.6)	(27.0)	(0.4)
Non-Pay	(23.3)	(22.4)	0.9	(17.5)	(17.1)	0.5
Non Operating Items (exc gains on disposal)	(0.3)	(0.3)	(0.0)	(0.2)	(0.2)	(0.0)
TOTAL Provider Surplus/(Deficit)	(0.4)	0.0	0.4	(0.3)	(0.2)	0.1
			-0.7%			

Efficiency

- The below table shows the forecasted risk rating of the efficiency schemes in each organisation with 25% remaining in high risk.
- Provider and ICB efficiency performance in each category is also detailed below.

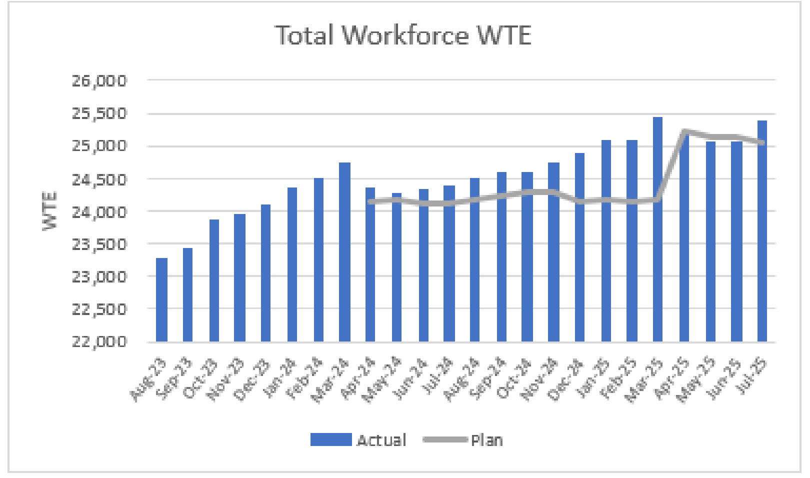
Efficiency risk FOT	Low	Medium	High	Total	% of high risk
MPFT	13,844	29,366	11,000	54,210	20%
NSCHT	5,615	1,203	549	7,367	7%
UHNM	21,251	9,266	44,282	74,800	59%
ICB	97,399	52,869	19,633	169,901	12%
System	**138,109**	**92,705**	**75,464**	**306,278**	**25%**

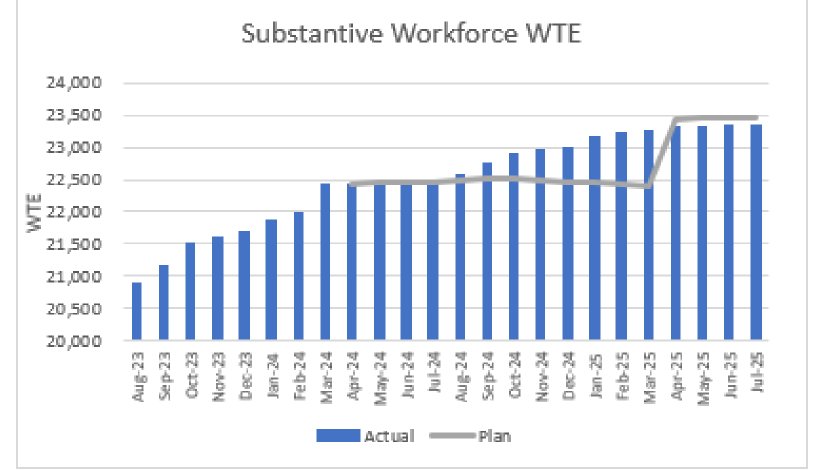


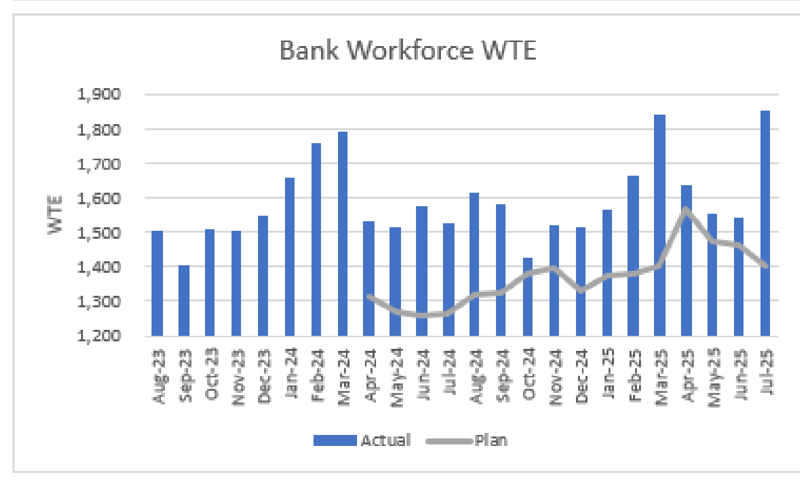


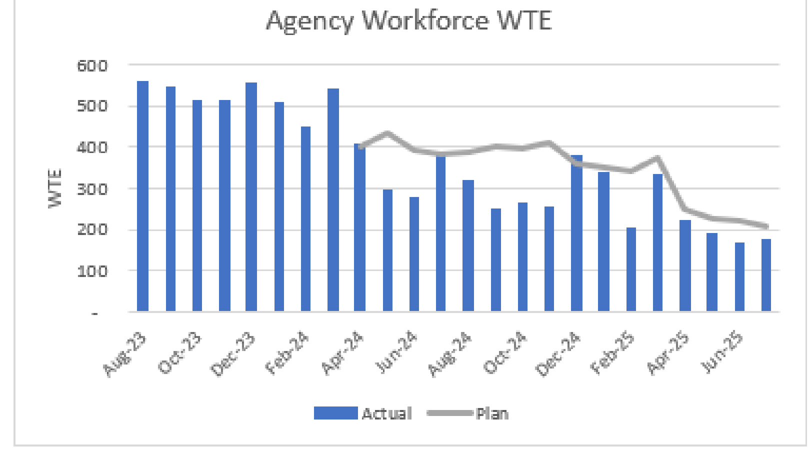
Workforce

- The system workforce numbers (substantive + bank + agency) were 25,368 WTE in July 2025. This is an increase on month 3 of 313 WTE mainly due to bank of 310 WTE's. The majority of this increase is at UHNM (282 WTE) being attributable to industrial action.
- Month 4 workforce numbers were 309 WTE above plan which was seen in substantive (108 WTE) and agency (35 WTE), offset by bank which is over plan by 451 WTE.
- As a system we were within our agency ceiling by 14.3% (£1.2m), however we were over our bank ceiling metric by 21% (£5.7m). The difference to plan within UHNM is linked to the industrial action.
- Agency spend was 1.4% of total staff spend therefore (1.8%) under the 3.2% ceiling/target.
- When we compare to July 24 there has been an overall increase in the workforce of 547 WTE equivalent to 2.2% growth, the majority of which is substantive and has been attributed to funded business cases or delivery of ERF.









Capital

- For Month 4 expenditure actuals were £5.4m behind plan.
- As a system we are completing a detailed forecast of likely spend at a scheme level in time for month 6 reporting at the end of September.
- The system is still forecasting to be on plan against the capital plan.

	YTD £000		
Category	**Plan**	**Spend**	**Variance**
Capital allocation	6,607	3,331	(3,276)
Return to Constitutional Standards	1,400	112	(1,288)
2025/26 Estates Safety	830	0	(830)
2025/26 Mental Health: Reducing Out of Area Placements	0	0	0
Total	**8,837**	**3,443**	**- 5,394**

	YTD £000		
By organisation	**Plan**	**Spend**	**Variance**
MPFT	4,053	792	(3,261)
UHNM	3,910	1,888	(2,022)
NSCHT	874	763	(111)
System total	**8,837**	**3,443**	**- 5,394**

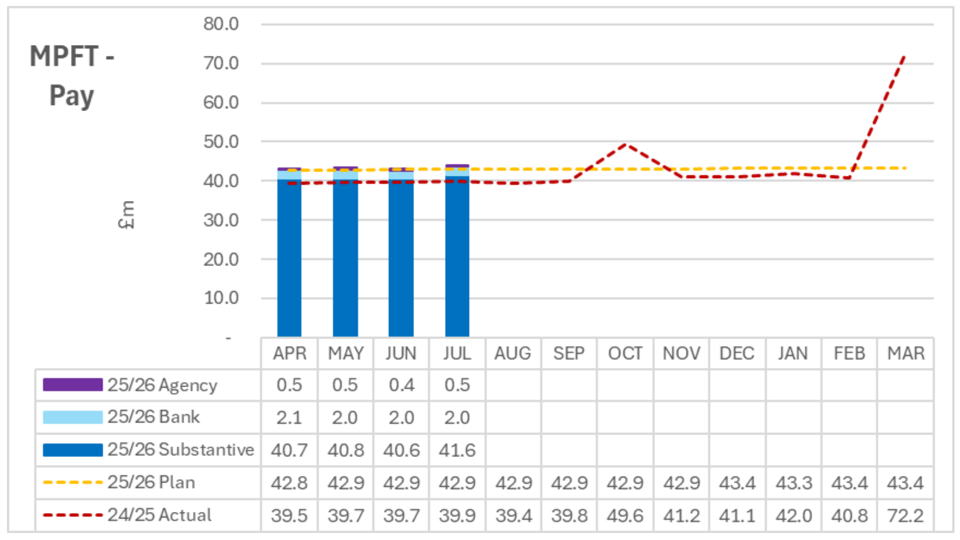
At month 4 key variances are:

- **MPFT -** PDC schemes remain behind plan due to delays in formal approval and IFRS16 due to timing of remeasurements review. It should also be noted that one of the 2025/26 Mental Health: Reducing Out of Area Placements schemes (Ellesmere in Patient Rehab £3.95m) was rejected post submission therefore the overall planned spend will be reduced to remain within allocation.
- **UHNM -** £1.0m of our £2.0m variance is the TIF2 breast unit, £0.5m is estates safety, the remainder being minor variances across smaller operational spend
- **NSCH** - £76k behind on Chrysalis (replacement of Dormitory Wards) and £33k behind on lease. Both of these are timing issues and plan will be delivered

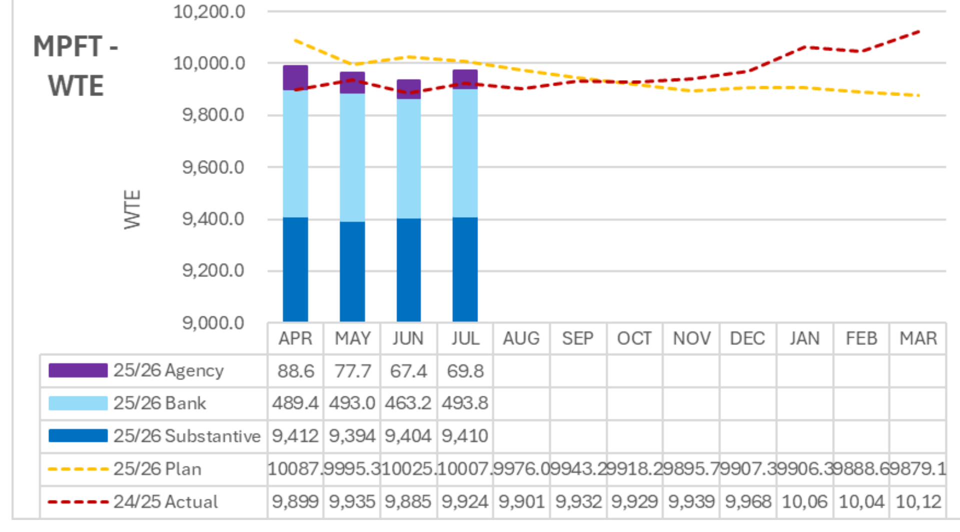
- The ICB remains on track to deliver the capital spend on GPIT and Utilisation and Modernisation Funding. This sits outside the monthly reporting process as ICB capital is reported within NHSE accounts.

Appendices

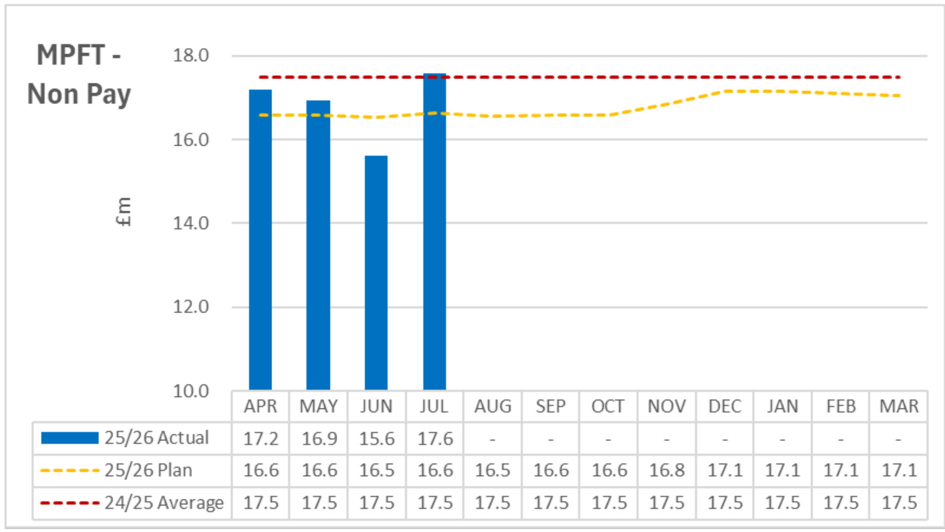
Provider – MPFT Run Rate



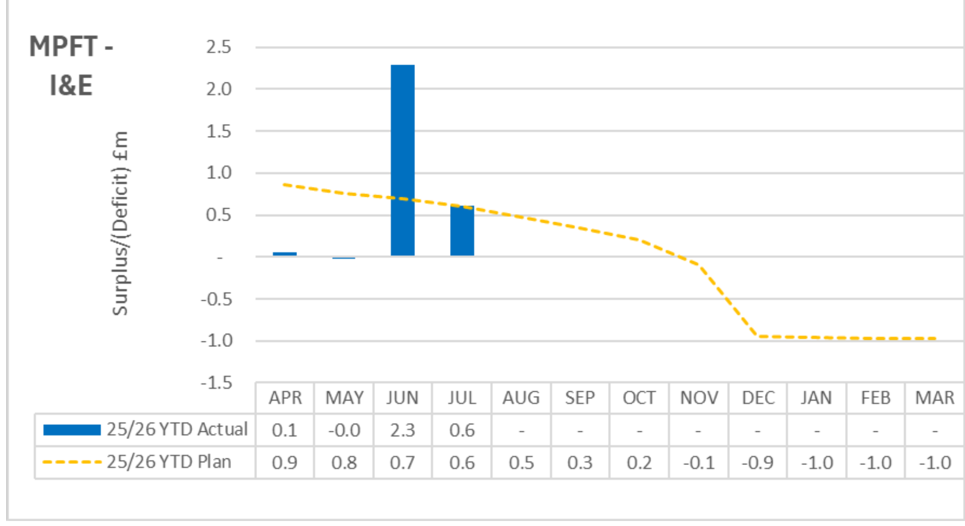
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 Agency	0.5	0.5	0.4	0.5								
25/26 Bank	2.1	2.0	2.0	2.0								
25/26 Substantive	40.7	40.8	40.6	41.6								
25/26 Plan	42.8	42.9	42.9	42.9	42.9	42.9	42.9	42.9	43.4	43.3	43.4	43.4
24/25 Actual	39.5	39.7	39.7	39.9	39.4	39.8	49.6	41.2	41.1	42.0	40.8	72.2



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 Agency	88.6	77.7	67.4	69.8								
25/26 Bank	489.4	493.0	463.2	493.8								
25/26 Substantive	9,412	9,394	9,404	9,410								
25/26 Plan	10087.	9995.3	10025.	10007.	9976.0	9943.2	9918.2	9895.7	9907.3	9906.3	9888.6	9879.1
24/25 Actual	9,899	9,935	9,885	9,924	9,901	9,932	9,929	9,939	9,968	10,06	10,04	10,12

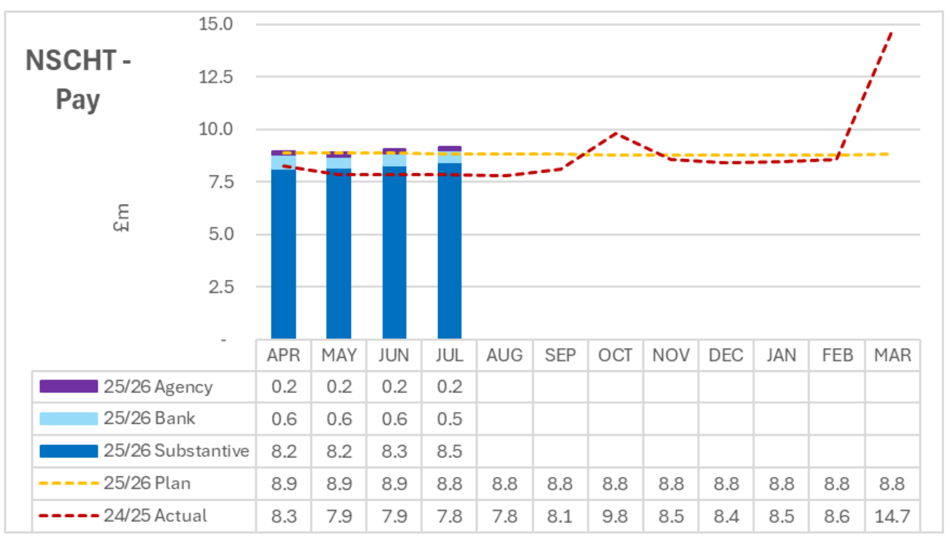


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 Actual	17.2	16.9	15.6	17.6	-	-	-	-	-	-	-	-
25/26 Plan	16.6	16.6	16.5	16.6	16.5	16.6	16.6	16.8	17.1	17.1	17.1	17.1
24/25 Average	17.5	17.5	17.5	17.5	17.5	17.5	17.5	17.5	17.5	17.5	17.5	17.5

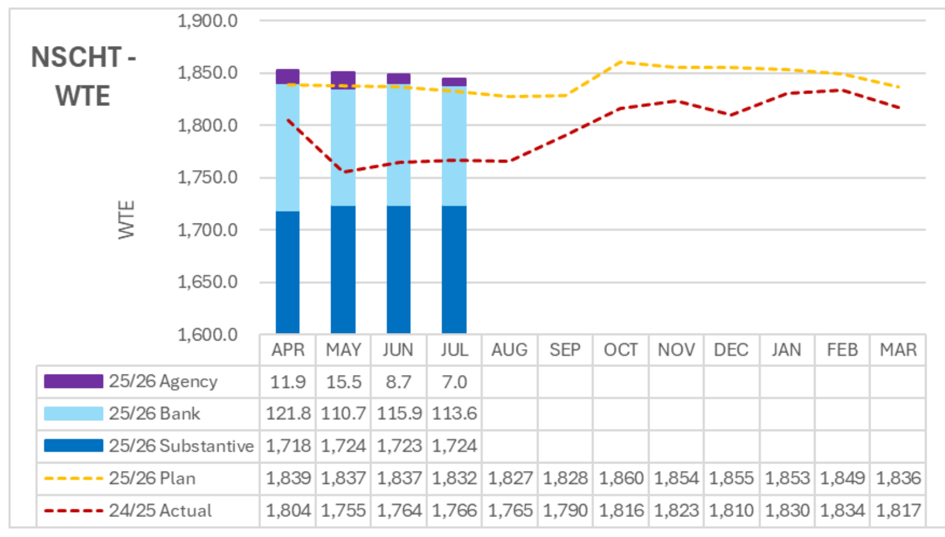


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 YTD Actual	0.1	-0.0	2.3	0.6	-	-	-	-	-	-	-	-
25/26 YTD Plan	0.9	0.8	0.7	0.6	0.5	0.3	0.2	-0.1	-0.9	-1.0	-1.0	-1.0

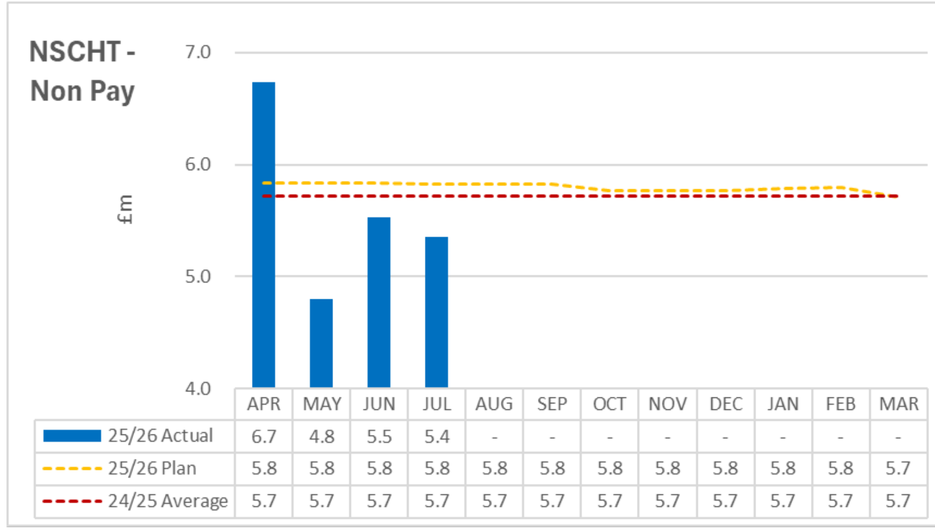
Provider – NSCHT Run Rate



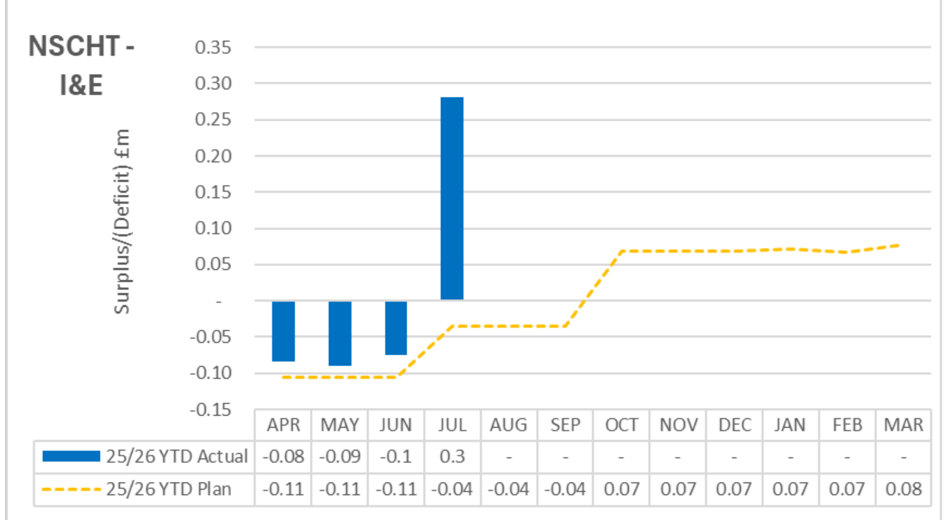
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 Agency	0.2	0.2	0.2	0.2								
25/26 Bank	0.6	0.6	0.6	0.5								
25/26 Substantive	8.2	8.2	8.3	8.5								
25/26 Plan	8.9	8.9	8.9	8.8	8.8	8.8	8.8	8.8	8.8	8.8	8.8	8.8
24/25 Actual	8.3	7.9	7.9	7.8	7.8	8.1	9.8	8.5	8.4	8.5	8.6	14.7



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 Agency	11.9	15.5	8.7	7.0								
25/26 Bank	121.8	110.7	115.9	113.6								
25/26 Substantive	1,718	1,724	1,723	1,724								
25/26 Plan	1,839	1,837	1,837	1,832	1,827	1,828	1,860	1,854	1,855	1,853	1,849	1,836
24/25 Actual	1,804	1,755	1,764	1,766	1,765	1,790	1,816	1,823	1,810	1,830	1,834	1,817

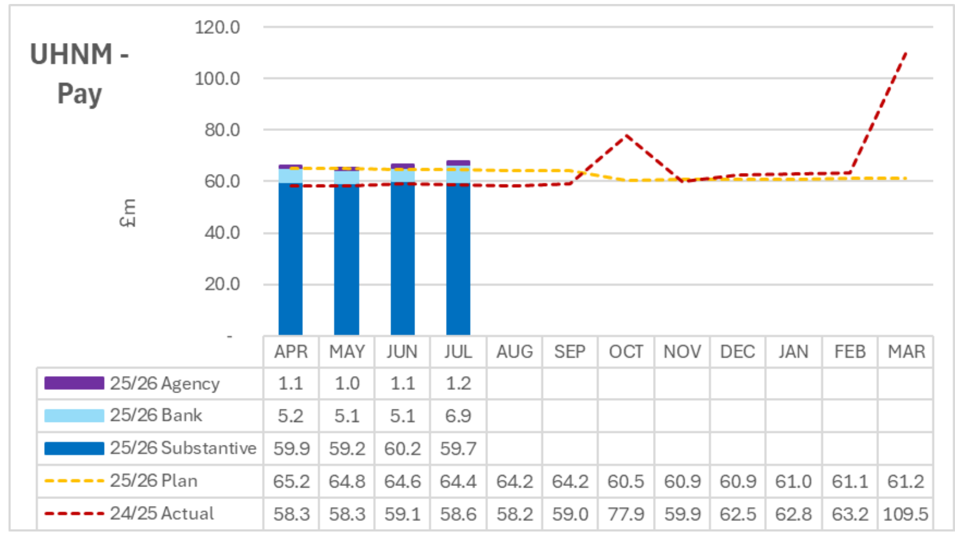


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 Actual	6.7	4.8	5.5	5.4	-	-	-	-	-	-	-	-
25/26 Plan	5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.7
24/25 Average	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7

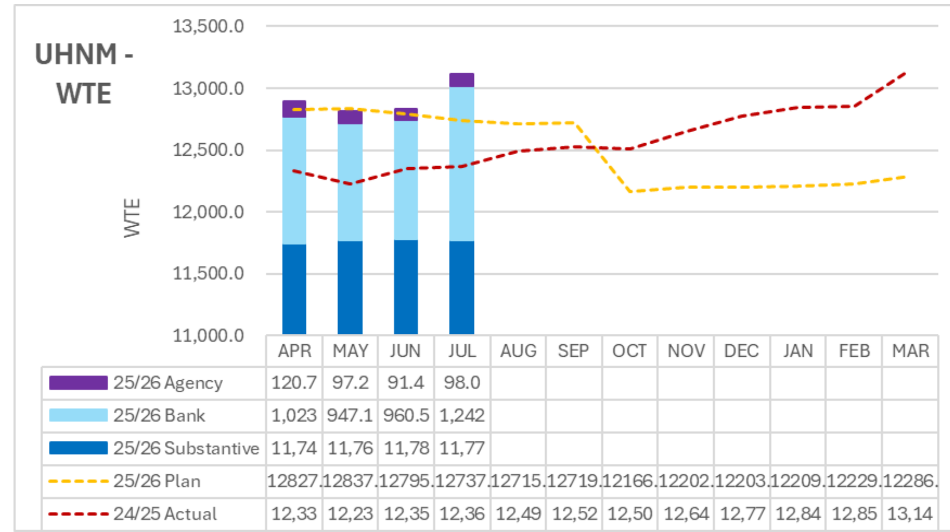


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 YTD Actual	-0.08	-0.09	-0.1	0.3	-	-	-	-	-	-	-	-
25/26 YTD Plan	-0.11	-0.11	-0.11	-0.04	-0.04	-0.04	0.07	0.07	0.07	0.07	0.07	0.08

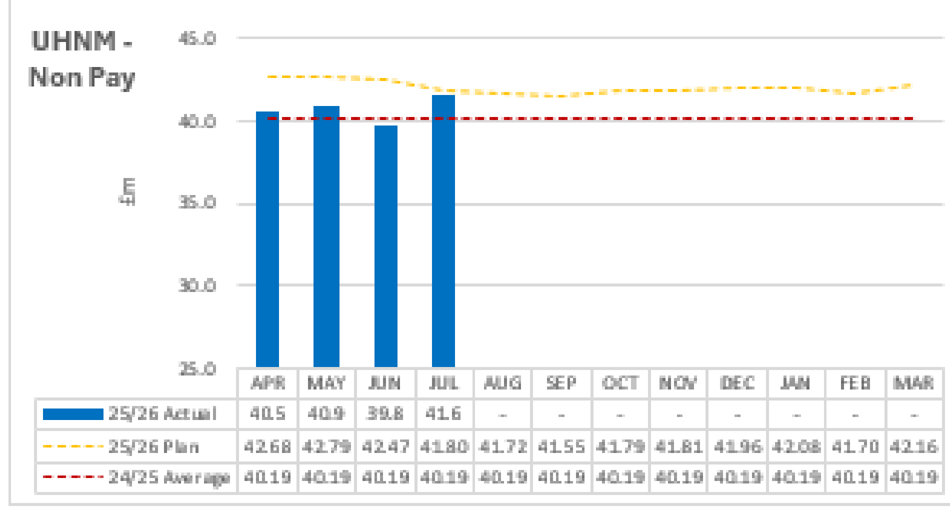
Provider – UHNM Run Rate



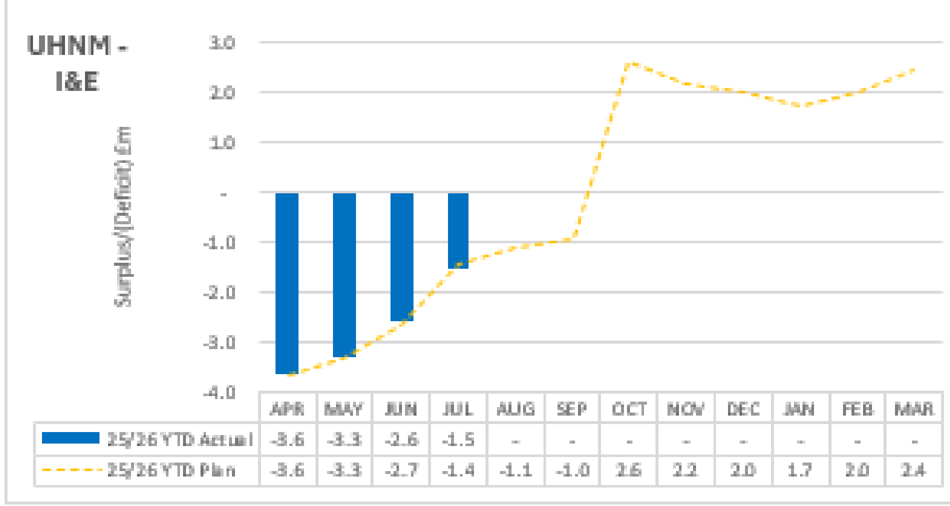
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 Agency	1.1	1.0	1.1	1.2								
25/26 Bank	5.2	5.1	5.1	6.9								
25/26 Substantive	59.9	59.2	60.2	59.7								
25/26 Plan	65.2	64.8	64.6	64.4	64.2	64.2	60.5	60.9	60.9	61.0	61.1	61.2
24/25 Actual	58.3	58.3	59.1	58.6	58.2	59.0	77.9	59.9	62.5	62.8	63.2	109.5



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 Agency	120.7	97.2	91.4	98.0								
25/26 Bank	1,023	947.1	960.5	1,242								
25/26 Substantive	11,74	11,76	11,78	11,77								
25/26 Plan	12827.	12837.	12795.	12737.	12715.	12719.	12166.	12202.	12203.	12209.	12229.	12286.
24/25 Actual	12,33	12,23	12,35	12,36	12,49	12,52	12,50	12,64	12,77	12,84	12,85	13,14



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 Actual	40.5	40.9	39.8	41.6	-	-	-	-	-	-	-	-
25/26 Plan	42.68	42.79	42.47	41.80	41.72	41.55	41.79	41.81	41.96	42.08	41.70	42.16
24/25 Average	40.19	40.19	40.19	40.19	40.19	40.19	40.19	40.19	40.19	40.19	40.19	40.19



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
25/26 YTD Actual	-3.6	-3.3	-2.6	-1.5	-	-	-	-	-	-	-	-
25/26 YTD Plan	-3.6	-3.3	-2.7	-1.4	-1.1	-1.0	2.6	2.2	2.0	1.7	2.0	2.4

AAA Escalation & Assurance Report from Committees

Report To:	Board
Date:	18th September 2025
Reporting Committee / Group:	Finance and Performance Committee (System & ICB)
Date of Meeting:	5th August 2025
Meeting Quorate Y/N?	Yes (both)
Presenter:	Josie Spencer, Non-Executive Member and Committee Chair
Author:	Kelly Weatherill, Executive Assistant

Key Escalation & Discussion Points from the Committee Meeting:

ALERT
System Finance and Performance Committee *(formerly Part A)* **Provider Collaborative Assurance Update** The Committee agreed that the Board should be alerted to the risks in relation to identifying and delivering the £14.2m which is currently aligned to the Provider Collaborative. In terms of the progress towards identifying opportunities that will contribute to the £14.2m, work is underway to explore potential opportunities from a Back Office and Tough Choices perspective. Whilst the target value sits within the ICB, this is recognised as a system wide challenge. Opportunities remain across the system however these are not progressing at the pace required and it is unlikely they will deliver in this financial year. It is important to recognise the risk associated with this. and the need for system partners to work collectively on a solutions to bridge the gap and identify mitigations.

ADVISE

System Finance and Performance Committee *(formerly Part A)* **Chief Finance Officer Update** The Committee were given an update from the Chief Finance Officer, the purpose of which was to advise members on strategic finance issues not otherwise covered elsewhere in the formal Committee reports. The paper covered the following areas:-

National and Regional NHS Finance Position – Month 2
£110m YTD overspend for the combined 42 Integrated Care Systems. ICS YTD variance has improved from £110m to £78m at month 3. Midlands have reported a YTD deficit of £354.2m. Risk to delivery of plans assessed nationally as £1.5bn.

Updates to the NHS Finance Business Rules
Key changes relate to revenue positions and deficit support. For 2025/26 the system has an £11m repayment linked to the system's prior year deficits.

Arrangements for Deficit Support Funding (DSF)
DSF is linked to the delivery of financial plans on a quarterly basis. Decisions on the quarter 3 DSF allocation will be based on month 5 performance.

NHS Operating Framework Revision
ICBs will not be segmented in 2025/26. The framework will be reviewed in 2026/27 to incorporate work undertaken to implement the ICB operating model and priorities in the NHS 10-year plan.

Contracts
Work is underway to resolve contracts between commissioners and providers within the required timescales.

Financial implications of the 10 year plan
Notable changes to the finance regime in relation to financial balance and sustainability, longer term financial planning and earned autonomy for high performing trusts.

System Performance Group - Escalation Report
The Committee were provided with a summary of key issues that had been discussed at the System Performance Group (SPG) on 30th July 2025 and the System Capital Group (SCG) on 18th July, including updates on system finance, performance, recovery planning, and capital investment, as well as a discussion on the current double lock process. The Committee were also updated on a deep dive that had taken place to review the efficiency plans owned by each organisation.

Aggregate Financial Position for Month 3
The system reported a £17.9m deficit, which is £0.3m favourable variance to the planned £18.2m deficit. Efficiency delivery is £14.2m behind plan (76% delivery), with the ICB (£10.0m), Midlands Partnership University Foundation NHS Trust (£3.3m), and North Staffordshire Combined Health Care NHS Trust (£0.8m) underperforming. University Hospitals of North Midlands met its efficiency target; however, the plan becomes more challenging as the year progresses due to phasing.

The system remains on track against the recovery trajectory, with a £3.6m favourable variance. Net risk has reduced to £59.6m, primarily due to efficiency risk reduction and cost risks being managed in the ICB. There is a Capital underspend of £4.9m due to timing delays in NHS England approvals.

Workforce
Total whole time equivalent (WTE) in June was 24,617 (41 WTE below plan). Bank staffing was over plan, whilst agency and substantive were under plan. Sickness absence rose to 5.3% but remains within the 2-year average.

Recovery Director Report
This report provided data up to w/e 11th July and therefore was more up to date than the finance report. In summary, aggregate efficiency plans have delivered £45.7m year to date vs £59.9m plan (76%) and therefore highlights that the likely delivery is £232.9m against the £306m plan, indicating a £73.4m risk.

System Capital Group
The group met on 18th July 2025 where the key focus was to update on the year-to-date capital spend and delivery of the overall capital plan.

Performance

The report covered month's 1 and 2 activity and operational performance, with key elements focusing on ambulance handovers, Non-Obstetric Ultrasound (NOUS) and virtual ward utilisation.

- Planned Care: 10 of 19 metrics underperforming. Key issues include 65-week waits, diagnostics, and cancer pathways.
- Urgent and Emergency Care (UEC): 6 of 12 metrics underperforming. Improvements noted in ambulance handovers and virtual ward utilisation, though challenges remain in discharge processes and average length of stay.
- Primary Care: 1 of 6 metrics underperforming. GP appointments slightly below plan; Pharmacy First uptake remains a focus.
- Mental Health and LDA: 7 of 17 metrics underperforming. Out of area placements and Oliver McGowan training remain key concerns.
- Children, Maternity, and Neonates: 2 of 7 metrics underperforming. Stillbirth and brain injury rates above target.
- Community Transformation: 2 of 9 metrics underperforming. Emergency admissions from Care Homes and Palliative Care register prevalence are areas of focus.

Main escalations to the Committee were in relation to CIP trajectory and phasing, recurrent efficiency and medium term planning, system forecasting, the Urgent Treatment Centre (UTC), virtual ward occupancy, and the Non-Obstetric Ultrasound (NOUS).

Update on plans to deliver the £306m system savings

The Committee were provided with an update on the work in support of the system as part of the Investigation & Intervention Regime (I&I) and the progress against development and delivery of the £306.3m 2025/56 CIP plan. Key headlines were covered as part of the SPG Escalation Report outlined above.

Digital Strategy Progress Report

ICB Blueprint - Digital Risk

The Committee were provided an update of the current responsibilities of the Digital Transformation Team for Staffordshire & Stoke-on-Trent ICB and to highlight the risks related to the 39% overall ICB budget cut and how this will impact the Digital function across the ICB, and the challenges to the system in respect of maintaining the digital investments as described in the NHS 10-Year Plan.

Digital Maturity Assessment (DMA) Update 2025

The Committee were presented with an update following the 2025 Digital Maturity Assessment for Staffordshire & Stoke-on-Trent. The system has continued to increase in Digital Maturity scoring 2.9 out of 5 (2024 score was 2.6) with improvements noted in Technical Infrastructure and Networking. Areas requiring improvement continues to be a central data repository for data management.

Digital leadership is limited, with a single Chief Digital and Information Officer at an ICB level with no corresponding CCIO, CXIO or CNIO to impact the realisation of opportunities, particularly in clinical and care provisions such as Virtual Wards and Remote Monitoring, where as a system we have limited adoption.

Provider Collaborative Assurance Update

The Committee were provided with an update on the work which is being undertaken in the Provider Collaborative. The work programme consists of three priority areas which have been agreed with the system Chief Executives:

- UEC/Community Transformation to support Winter
- Back Office Transformation
- Neighbourhood Health

The UEC/Community and Back Office Transformation Programmes each have activity and financial targets assigned to them in 2025/26 and therefore provide monthly assurance reports to the Finance & Performance Committee.

Updates relating to Neighbourhood Health are provided to the Strategic Commissioning & Transformation Committee.

UEC/Community Transformation
Respiratory Workstream - a project brief and delivery plan are currently being developed which will summarise the 'what, how and when' and the expected impact.
A Conveyance Workshop took place on 20th June which identified three areas where improvements could be made to existing pathways to reduce ambulance conveyances to the Emergency Department. Task and Finish Groups are currently being established to progress this work.

Back Office Transformation
The original plan to seek support from Deloitte has been paused whilst work is undertaken to explore opportunities across a wider ICB Cluster footprint. The current scope and approach includes the establishment of three priority workstreams; HR, Finance and Digital.

ICB Finance and Performance Committee *(formerly Part B)*

Month 3 Finance Report & 2025/26 Efficiency Report
The Committee were presented with an update on the Month 3 ICB financial position. The ICB reported a year to date breakeven position of a £0.1m favourable variance against plan. Representing an improving position to Month 1 & 2 reporting.

There continues to be ongoing risk in delivering the 2025/26 plan which NHS England are sighted on. The assessment of net risk following month 3 reporting is a reduction in risk from £28.1m to £22.2m, a favourable movement of £5.9m due to the on-going development and mitigation of the efficiency programme. Key risks to note:

- £14.2m Provider Collaborative enabling functions efficiency
- £8.0m ICB redesign efficiency

NHS England are introducing a new performance management framework titled 'Risk of Non-Delivery Assessment' (RoNDA). Regulators will use this framework to inform the financial recovery regime and to base their decision on the allocation of further Deficit Support Funding (DSF).

In terms of the Efficiency Programme, whilst the level of plans developed by the ICB is a positive position (£147.1m/87%), the ICB remains vigilant regarding the £28.1m risk to delivery, specifically the risk of implementation slippage, and therefore continues to operate within a financial recovery framework.

Procurement Operations Group Report
The Committee were presented with a paper reporting the key activities involving procurements being co-ordinated by the Procurement Operations Group (POG) and the current procurement programme and work in progress. The Committee were assured that the contract modifications and awards were reviewed in accordance with the Provider Selection Regime and supporting documentation completed accordingly.

ADHD /ASD Independent Sector Efficiency Programme
The Committee received an update relating to the work undertaken to date around the ADHD/ASD Independent Sector Activity Efficiency Programme. The purpose of the update was to discuss the impacts and risks of implementing a clinical triage function and other elements, to consider reducing independent sector activity, and to understand the risks of achieving the financial savings target set against this project and the potential financial forecasting for 2025/26.

In 2024/25, expenditure on non-contracted private ADHD/ASD activity was £2,427,483. Analysis of this expenditure has indicated that around £2m+ of this total related to Adult ADHD activity alone. Early

forecasts for 2025/26 demonstrate this could increase to £3.1m expenditure, representing a 25% increase year on year.

Given the scale of the expenditure, the options that have been explored to address this efficiency target include:

- Implementation of a clinical triage function
- Capping independent provider activity
- Implementing a longer-term sustainable model to address the increases in demand

The paper also sought to obtain approval from the Committee to implement a pre-referral screening and clinical triage process for all Right To Choose (RTC) Adult ADHD assessment referrals which will be commissioned through Midlands & Lancashire CSU. This was approved by the Committee.

ASSURE

There were no items of assurance to report to the ICB Board from August's Committee meeting.

System-ICB Risks / Board Assurance Framework (SBAF):

The Committee were presented with updates relating to the ICB and System Risk Registers.

Policies Approved:

The Committee did not receive or approve any policies this month; nor did any papers received under the Business Cycles of both parts have any likely future impacts on current policy matters.

Decisions to be Escalated to ICB Board:

There were no escalations to Board Assurance Committees or to the ICB Board.

AAA Escalation & Assurance Report from Committees

Report To:	Board
Date:	18th September 2025
Reporting Committee / Group:	Finance and Performance Committee (System & ICB)
Date of Meeting:	2nd September 2025
Meeting Quorate Y/N?	Yes (both)
Presenter:	Josie Spencer, Non-Executive Member and Committee Chair
Author:	Kelly Weatherill, Executive Assistant

Key Escalation & Discussion Points from the Committee Meeting:

ALERT
System Finance and Performance Committee *(formerly Part A)* **System Performance Group - Escalation Report** Aggregate Financial Position for Month 4 **The Committee alerts the Board of the level of unmitigated risk and the risk in terms of the delivery of the plan and continued receipt of deficit support funding.** Whilst net risk has reduced slightly from month 3 – this remains at £59.7m. In summary: - UHNM have the largest net risk at £32.0m. - MPFT forecasting a £4.1m efficiency shortfall, but currently ahead of recovery trajectory by £1.9m. - NSCHT are on track with financial plan; efficiency delivery is currently at 60%. - The ICB has £11.4m deficit; £8.3m efficiency shortfall; behind recovery trajectory by £0.9m. The Committee noted level of efficiency required for the second half of the financial year and the importance of maintaining progress in delivery. The Committee was assured on the work underway to address this. Winter Plan The Committee received an overview of the System Winter Plan and noted the coordinated approach to the winter period. The Committed noted that a key piece of work is still to be undertaken in terms of the associated costs of the plan. The Chief Finance Officer and Chief Delivery Officer agreed to progress

this at pace prior to the ICB Board on 18th September. However, due to the associated financial risk the Committee **alerts the Board that it was not fully assured on the Winter Plan**.

ADVISE

System Finance and Performance Committee *(formerly Part A)*

Chief Finance Officer Update
The Committee received an update from the Chief Finance Officer, the purpose of which was to advise members on strategic finance issues not otherwise covered elsewhere in the formal Committee reports. The paper covered the following areas:-

- An overview of month 4
- Newly updated guidance issued by NHS England setting out expectations for good financial management supported by intervention options and tools to support delivery.
- An overview of the planning approach launched on 12th August and associated workstreams.

System Performance Group - Escalation Report
The Committee received a summary of key issues that had been discussed at the System Performance Group (SPG) on 27th August 2025 and the System Capital Group (SCG) on 15th August, including updates on system finance, workforce, performance, winter planning and capital investment. As well as a detailed summary of the Cost Improvement Plan (CIP) update given by each organisation.

Discussions were had on key areas of non-delivery but overall, the Committee was assured by the SPG summary and associated supporting reports on Month 4 Finance and Performance.

Update on plans to deliver the £306m system savings
The Committee received the closure report relating to the Tough Choices Programme which provided an overview of the background, approach, conclusion and next steps. The Committee noted the report and the ongoing work.

Provider Collaborative Assurance Update
The Committee received an update on the work which is being undertaken in the Provider Collaborative. The work programme consists of three priority areas which have been agreed with the system Chief Executives:

- UEC/Community Transformation to support Winter
- Back Office Transformation
- Neighbourhood Health

The Committee noted the report and the ongoing work.

ICB Finance and Performance Committee *(formerly Part B)*

Month 4 Finance Report & 2025/26 Efficiency Report
The Committee received the Month 4 ICB financial position. The ICB reported a YTD breakeven position against the £11.4m plan. The ICB noted a net risk from £22.2m. The Committee noted the report and the ongoing work to eradicate the risk.

Medicines Optimisation - High Cost Drugs Update
The Committee received the Medicines Optimisation High Cost Drugs update, to advise the Committee on the local use of best value biological medicines in line with NHS England commissioning recommendations.

ASSURE

There were no further items of assurance to report to the ICB Board from September's Committee meeting.

System-ICB Risks / Board Assurance Framework (SBAF):

The Committee were presented with the System Board Assurance Framework (SBAF) for Q2 2025-26 for oversight and assurance.

Policies Approved:

The Committee received an updated Pharmaceutical Rebate Schemes Policy for approval as the document had reached the three-year review period. The Committee **approved** the policy.

Decisions to be Escalated to ICB Board:

There were no escalations to Board Assurance Committees or to the ICB Board.

Enclosure No: 13

Report to:	**Integrated Care Board**						
Date:	**18 September 2025**						
Title:	**Assurance and Performance Report – M04**						
Presenting Officer:	Mish Irvine, Chief People Officer						
Author(s):	Helen Conway - System Strategic Workforce Planning Lead Matthew Bewick – ICS Principal Workforce Information & Systems Manager						
Document Type:	Choose an item.		If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☐	
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*		
Is the decision within SOFD powers & limits	**Yes / No**	Choose an item.					
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.					
Any financial impacts: ICB or ICB?	**Yes / No**	YES *If Y, are those signed off by and date:* Click or tap here to enter text.					
Any impacts on ICB Undertakings?	**Yes / No**	YES *If Y, are those signed off by and date:* Click or tap here to enter text.					
Appendices:	Click or tap here to enter text.						

(1) Purpose of the Paper:

This summary paper provides an update on FY25-26 in year workforce position, position to plan FY25-26 plan and associated risks, challenges and mitigations.

(2) History of the Paper & Whether for I-D-S-A-R (as above):	**Date**
	Click or tap to enter a date.

(3) Implications:

Legal or Regulatory	There are several conflicts to the workforce agenda at a national level, i.e. financial control and long term workforce plan.
CQC or Patient Safety	Workforce has a direct impact on patients and the care they receive. In response to previous wider workforce challenges, Francis report, a number of mitigations have been developed since the report to ensure safer staffing tools and professional judgement are incorporated into staffing level decisions.
Financial (CFO-assured)	Workforce is the majority of NHS operating costs.
Sustainability	Need to ensure that workforce levels are safe, sufficiently resourced to deliver patient care.

Workforce or Training	As detailed in the exec summary below.
Equality & Diversity	Yes, workforce demographic should be representative of the population served.
Due Regard: Inequalities	As per Equality and Diversity.
Due Regard: wider effect	Our workforce is the means in which our patients receive care and is also our biggest asset.

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, signed off by QIA on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Although there has been ICS Finance / DoF engagement in co-producing the strategy

(5) Integration with the System Board Assurance Framework & Key Risks:

SBAF1	Responsive Patient Care - Elective	☒	**SBAF5**	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☒	**SBAF6**	Sustainable Finances	☒
SBAF3	Proactive Integrated Community Services	☐	**SBAF7**	Improving Productivity	☒
SBAF4	Reducing Health Inequalities	☒	**SBAF8**	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

Overall workforce levels, as at Jul-25 totalled 24,934 WTE. This represents a position +357 WTE above plan and a -461 WTE Year To Date (YTD) reduction.

Bank utilisation in M04, primarily but not exclusively driven by Industrial Action, is the main reason behind the position to plan. During M04 Bank utilisation totalled 1,850 WTE; 448 WTE above plan and the highest single month in available data (Mar-19 to present).

Agency utilisation in M04 was 175 WTE. This, along with M03 (168 WTE) represents 2 consecutive months of the lowest Agency utilisation since Mar-19. During these months, Agency WTE constitutes just 0.6% (M03) and 0.7% (M04) of the total workforce.

Agency spend, at £7m YTD, constitutes 1.4% of all staff spend in 2025/26 so far and remains £1.2m under plan. In contrast, the YTD spend associated with Bank staff totals £32.7m ; 6.9% of total staff spend and £5.7m above plan.

It is acknowledged that Industrial Action during M04 has had a significant impact, but it is anticipated that, when M05 data is available, it will confirm a return to a position more closely aligned with plan. However, UHNM have confirmed that the Bank usage increase in M04 is not entirely linked to Industrial Action and therefore detailed work is being undertaken to understand the position (utilising direct support from the ICB)

M03

(7) Recommendations to Board / Committee:

Operational Workforce Planning

Assurance & Delivery – FY25-26

August 2025

FYTD WF Plan Delivery - SSoT

SSoT				Overall	Substantive	Bank	Agency
SSoT	WTE	Against Plan	Actual	24,934.3	22,909.4	1,850.2	174.8
			Plan	24,577.4	22,965.8	1,402.2	209.4
			Vs Plan WTE	+357.0	-56.4	+448.0	-34.6
			Vs Plan %	+1.5%	-0.2%	+31.9%	-16.5%
		Change	In Month Change	+316.3	-0.8	+309.8	+7.3
			YTD Change	-154.2	-15.2	+18.8	-157.7
				-0.6%	-0.1%	1.0%	-47.4%
	£	Finance	In Month Spend	£120,869	£109,537	£9,472	£1,861
			YTD Spend	£475,114	£435,480	£32,676	£6,959
			YTD Plan	£465,094	£429,950	£27,022	£8,122
			YTD Actual vs Plan	+£10,020	+£5,530	+£5,654	-£1,163

Jul-25 position:

- **Overall SSoT is currently +357 wte above plan**. This is an aggregate position of the following (note more detail is in appendix 1):

↓ **Substantive -56.4 wte below plan**

↑ **Bank +448 wte above plan**

↓ **Agency -34.6 wte below plan**

FYTD 25-26 position:

- In terms of comparison to Mar-25, the workforce levels are currently -154.2 wte lower.
- Spend is currently +£10.0m above YTD plan, which is an aggregate of the following position:

↑ **Substantive spend is currently + £5.5M above plan**

↑ **Bank spend is currently + £5.7M above plan**

↓ **Agency spend is currently - £1.2M below plan**

Please note that planned NHS strikes by resident doctors took place during the period, Friday, 25 July (07:00) to Wednesday, 30 July 2025 (07:00) due to a dispute over pay and working conditions.

Operational Plan FY25-26

- Operational plans are developed via an MDT approach within each provider organisation, being signed off by Execs at respective Boards (including CNO and CMO). Operational plans are also signed off at system level prior to being submitted to NHSE
- At the time of submission of operational plans, although the cost improvement requirement is ascertained financially, the specific detail to deliver the plan will be subject to work in progress.
- The below details the WTE, spend levels and planned change from 2024/25 associated with clinical and non-clinical workforce:

		Spend (£,000)		Establishment		WTE		Planned Change					
		2024/25 (Actual)	2025/26 (Plan)	Mar-25 (Actual)	Mar-26 (Plan)	Mar-25 (Actual)	Mar-26 (Plan)	Spend		Establishment		WTE	
		£,000	£,000	WTE	WTE	Staff in Post	Staff in Post	£'000	%	WTE	%	WTE	%
SSoT	Clinical	£1,105,781	£1,143,247	19,817	19,461	19,887	19,186	+£37,466	+3.4%	-356	-1.8%	-701	-3.5%
	Non-Clinical	£269,169	£229,525	5,324	5,147	5,213	4,816	-£39,644	-14.7%	-177	-3.3%	-397	-7.6%
	Total Workforce	£1,374,951	£1,372,772	25,141	24,608	25,100	24,002	-£2,179	-0.2%	-533	-2.1%	-1,098	-4.4%

- The below details how the SSoT plan is formulated across the 3 Providers :

		Spend (£,000)		Establishment		WTE		Planned Change					
		2024/25 (Actual)	2025/26 (Plan)	Mar-25 (Actual)	Mar-26 (Plan)	Mar-25 (Actual)	Mar-26 (Plan)	Spend		Establishment		WTE	
		£,000	£,000	WTE	WTE	Staff in Post	Staff in Post	£'000	%	WTE	%	WTE	%
MPFT	Clinical	£386,690	£411,345	7,954	8,034	7,745	7,709	+£24,655	+6.4%	+80	+1.0%	-36	-0.5%
	Non-Clinical	£138,294	£102,979	2,525	2,445	2,378	2,170	-£35,315	-25.5%	-80	-3.2%	-208	-8.7%
	Total Workforce	£524,984	£514,324	10,479	10,479	10,123	9,879	-£10,660	-2.0%	+1	+0.0%	-244	-2.4%
NSCHT	Clinical	£82,481	£87,178	1,485	1,480	1,456	1,496	+£4,697	+5.7%	-4	-0.3%	+40	+2.7%
	Non-Clinical	£23,810	£18,224	382	358	363	340	-£5,586	-23.5%	-23	-6.2%	-23	-6.3%
	Total Workforce	£106,291	£105,402	1,866	1,838	1,820	1,836	-£889	-0.8%	-28	-1.5%	+17	+0.9%
UHNM	Clinical	£636,610	£644,724	10,378	9,947	10,685	9,981	+£8,114	+1.3%	-432	-4.2%	-704	-6.6%
	Non-Clinical	£107,065	£108,322	2,417	2,343	2,472	2,305	+£1,257	+1.2%	-74	-3.1%	-166	-6.7%
	Total Workforce	£743,675	£753,046	12,795	12,290	13,157	12,287	+£9,371	+1.3%	-506	-4.0%	-871	-6.6%

SSOT Workforce Variance to Plan by Provider NHS Trust (M04)

	MPFT	NSCHT	UHNM
Total Workforce (wte)	**-34** **(-0.3%)**	**+13** **(+1%)**	**+379** **(+3%)** ***UHNM are currently 489 wte above Funded Establishment**
Substantive (wte)	+13 (+0.1%)	+3 (+0.2%)	-73 (-1%)
Bank (wte)	-22 (-4%)	+12 (+12%)	+459 (+59%)
Agency (wte)	-25 (-26%)	-3 (-28%)	-7 (-7%)
Reasons for Variation		**Substantive** Overall there is a small discrepancy on total substantive actual position, in comparison to the submitted workforce plan. Currently, against the submitted plan Registered Nursing and Support to Clinical are all slightly over their respective plans. However, an ongoing review of Occupation Codes to reflect a more accurate position, would put Support to Clinical under Plan with Infrastructure Support marginally over. **Bank** **Registered scientific:** therapeutic and technical staff - the majority of this usage is related to our Crisis Care services and has been approved due to vacancies/establishment shortfall **Support to clinical staff:** The majority of the shifts being approved comes is for our 24/7 services, referencing establishment shortfall/vacancies and high acuity as the main reasons	**Substantive** Additional recruitment across Operating Dept Practitioners, Radiographers, Mamography and Pharmacy Technicians, to cover vacancies, above plan, in Registered S, T & T. **Bank** **Medical & Dental:** Increase due to Industrial Action. **Support to Clinical:** Increases primarily associated with Increased sickness, Higher than budgeted Maternity rates, increases Vacancies (Clinical Support) and increased use of 1:1s (Clinical Support). **Nursing & Midwifery**: Increases associated with Increased sickness, Higher than budgeted Maternity rates **Agency** **Medical & Dental:** 25 WTE over plan, primarily driven by Industrial Action, particularly in Neurosurgery. Medical and Dental offset by under plan wte for Registered Nursing (-30 wte), Support to Clinical (-3 wte) and Admin & Estates (-9 wte)

SSoT Position to Plan: +357 wte Total, -56 Substantive wte, +448 Bank wte, -35 Agency wte

People Metrics Appendices

- System Monthly Position
- System Trend

Staffordshire & Stoke-on-Trent NHS: July 2025

Staffordshire and Stoke-on-Trent Integrated Care System

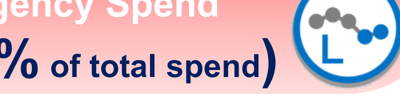
NHS Workforce

Total Workforce
24,934 WTE (H)

Substantive
22,909 WTE (H)

Bank
1,850 WTE (H)

Agency
175 WTE (L)



Temporary Workforce
8.1%

In Month Agency Spend
£1.9M (1.5% of total spend) (L)

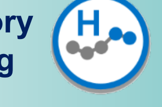
Vacancies
2,053 wte (8.2%) (L)

Joiners
149 wte

Leavers
126 wte

12 Month Rolling KPI's (%)

8.1% Turnover Rate (L)



5.5% Sickness Absence Rate (H)

94.7% Mandatory Training (H)

86.0% AFC Appraisal Rate

81.1% Medical Appraisal Rate (H)

Other Health and Care Workforce

SSOT ICB Workforce
336 WTE

Primary Care Workforce
3,490 WTE

Social Care Workforce
21,000 WTE

Dentistry Workforce
610 Headcount

Current Workforce Position: July 2025

Staff in Post (Total Workforce wte)

Current Month: **24,934**
Position to Plan: **+357**
12M Change: **+879**
FYTD Change: **+204**

Staff in Post (Substantive wte)

Current Month: **22,909**
Position to Plan: **-56**
12M Change: **+753**
FYTD Change: **+34**

Bank Workforce (Bank wte)

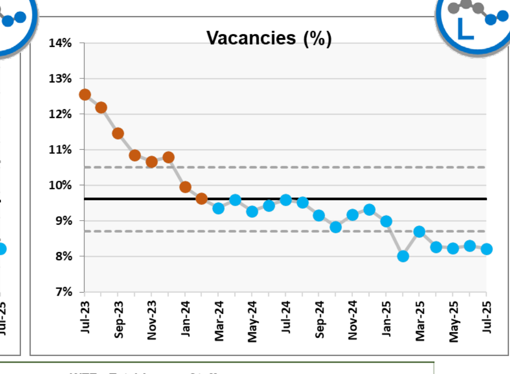
Current Month: **1,850**
Position to Plan: **+448**
12M Change: **+330**
FYTD Change: **+216**

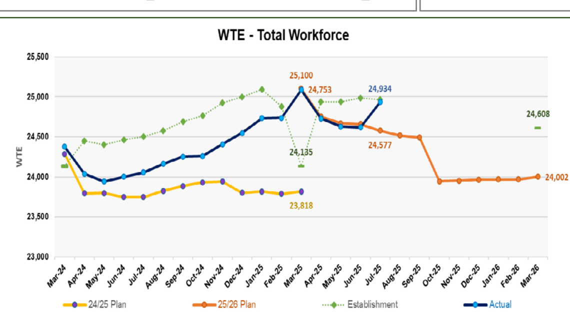
Agency Workforce (Agency wte)

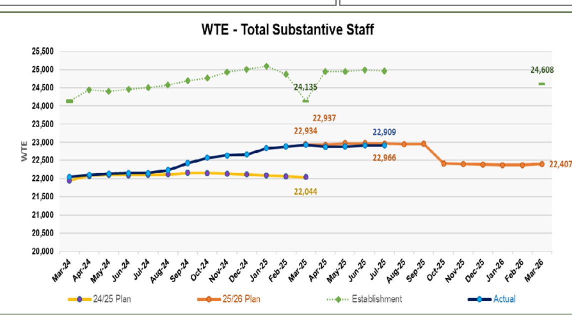
Current Month: **175**
Position to Plan: **-35**
12M Change: **-205**
FYTD Change: **-46**

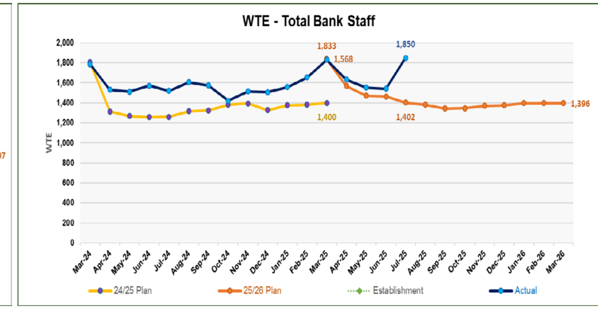
Vacancies (%)

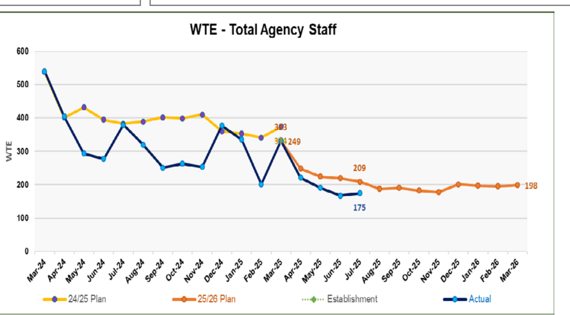
Current Month: **8.2%**
12M Change: **-1.4%**
FYTD Change: **-0.1%**











Total WF - Actual vs Plan

Overall: +357 wte above plan
Registered Nursing: +63 wte above
Registered S,T&T: +19 wte above
Support to Clinical: +123 wte above
NHS Infrastructure: +2 wte above
Medical and Dental: +151 wte above

Substantive - Actual vs Plan

Overall: -56 wte below plan
Registered Nursing: -24 wte below
Registered S,T&T: +5 wte above
Support to Clinical: -28 wte below
NHS Infrastructure: -1 wte below
Medical and Dental: -9 wte below

Bank - Actual vs Plan

Overall: +448 wte above plan
Registered Nursing: +126 wte above
Registered S,T&T: +7 wte above
Support to Clinical: +175 wte below
NHS Infrastructure: +12 wte above
Medical and Dental: +128 wte below

Agency - Actual vs Plan

Overall: -35 wte below plan
Registered Nursing: -39 wte below
Registered S,T&T: +7 wte above
Support to Clinical: -24 wte below
NHS Infrastructure: -9 wte below
Medical and Dental: +31 wte above

Sickness Absence

Deep Dive

August 2025

SSoT Key Headlines – Jul-25

- At 5.5%, in month sickness rates have increased since M03 (5.3%) but remains in line with the average over the last 24 months.

- Sickness absence has heightened in the last 2 years, indicating a correlation with reduction in turnover for the same period.

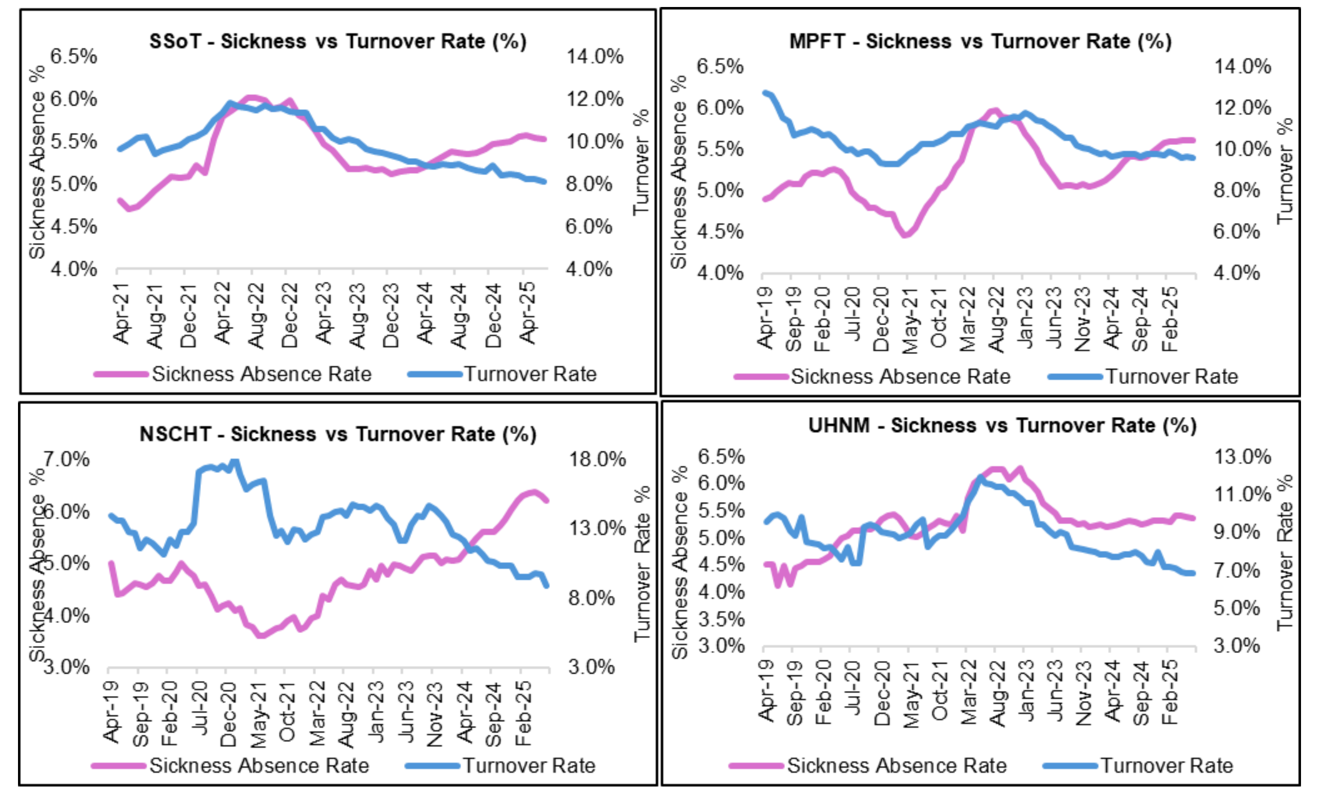
- Staff groups in terms of highest to lowest sickness absence rates are:
    1) Support to Clinical - 6.9%
    2) Registered Nursing, Midwifery & Health Visitors - 5.8%
    3) NHS Infrastructure - 4.6%
    4) Registered Scientific, Therapeutic & Technical Staff – 4.5%
    5) Medical & Dental – 3.7%

- The highest proportion of sickness absence occurs due to the following reasons:
    1) Anxiety/stress/depression/other psychiatric illnesses – 38.5%
    2) Gastrointestinal problems - 9.2%
    3) Other musculoskeletal problems – 8.6%

(For more detail see appendix 1-4 for SSoT and provider sickness absence position)

Sickness Absence vs Turnover

- In the last 2 years there has been a correlation between sickness and turnover, where turnover has decreased, sickness absence rates have increased.



- The charts to the left detail sickness absence and turnover for system and also for each provider.
- The table below provides an overview of the correlation analysis which shows in the last 24 months there is on the whole a moderate to high relationship between turnover decreasing and sickness increasing.
- This relationship was only observed in Jul-19 to Jun-20 in some providers where turnover ceased and sickness increased during the onset of the pandemic period.
- Recommended action – understand insights from exit interviews to inform health and wellbeing improvement strategies.

Sickness vs Turnover	Jul-19 to Jun-20	Jul-20 to Jun-21	Jul-21 to Jun-22	Jul-22 to Jun-23	Jul-23 to Jun-24	Jul-24 to Jun-25
SSoT	NA - NA	NA - NA	Positive - Very High	Positive - Very High	Negative - Moderate	Negative - High
MPFT	Negative - Moderate	Positive - Moderate	Positive - Very High	Positive - Low	Negative - Moderate	Negative - Low
NSCHT	Positive - Low	Positive - Moderate	Positive - Moderate	Negative - Moderate	Negative - Moderate	Negative - High
UHNM	Negative - Moderate	Positive - Low	Positive - High	Positive - Very High	Positive - Moderate	Negative - Moderate

NB: Positive = both values increase
Negative = one value increases whilst the other decreases)

PCI – Summary of Actions

Area of Work	Recommended Action
Operational Workforce Planning – Assurance & Delivery	1. Note position to plan and IA impact on bank usage 2. Direction of plan in respect of clinical WTE reductions and enhanced QIA process via Quality Group and Quality Board in respect of clinical workforce numbers. The work has focussed on several lines of enquiry and actions - Responsibility, Risk, Report & Respond – and the Francis Enquiry recommendations. 3. Provide further breakdown in papers of the sub-components of the Registered Nursing, Miwdwifery and Health Visitor staff group, to provide the differential between the sub-sets of the nursing workforce for a richer understanding of hospital and community settings.
Sickness Absence Deep Dive	1. Given the levels of sickness absence and concern regarding employee health and wellbeing, sickness absence is to form part of a standing agenda item for PCI. 2. The information shared at PCI will be reviewed at the Health and Wellbeing Sub-Committee to develop appropriate response and actions.
Other	1. Winter plan to be provided to Oct-25 PCI

AAA Escalation & Assurance Report from Committees

Report To:	Board
Date:	18th September 2025
Reporting Committee / Group:	People Culture and Inclusion Committee
Date of Meeting:	June 2025
Meeting Quorate Y/N?	Y
Presenter:	Mish Irvine
Author:	Stacey Robinson

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

ADVISE

ASSURE

The People, Culture and Inclusion Committee scheduled for 2nd June 2025 would not be quorate therefore, the decision was taken to cancel the meeting. It was agreed the Agenda would be considered virtually.

Statutory and Mandatory Training

1. As part of the national review led by NHS England, we have completed a review of our Statutory and Mandatory Training and can confirm the ICB is fully compliant with the core competencies set out in the Core Statutory and Mandatory Training Framework (CSTF).

2. We have also completed a review of our locally mandated training, including the content, frequency and scope, and made recommendations to the PCI Committee to streamline our locally mandated training approach and reduce the burden on colleagues through reducing some frequencies or refreshing eligibility criteria.

3. Finally to be consistent with the national review we require a Mandatory Learning Oversight Group (MLOG), and proposed the PCI Committee would undertake this role.

The report was noted, and the recommendation that the PCI Committee acts as the Mandatory Learning Oversight Group was agreed.

EDI Reports

1. The Committee received our annual Public Sector Equality Duty (PSED) Reports that evidence the ICB's commitment to addressing health inequalities for patients and the population through our commissioned services, and advancing Equality, Diversity, and Inclusion (EDI) within the workplace, including our Gender Pay Gap Report and equality objectives.

2. The Committee's attention was drawn to the fact that the ICB has been recognised by the Equality and Human Rights Commission for its reporting on workforce profile, recruitment process and selection data, disaggregated by protected characteristics.

3. The PCI Committee was asked to:
    a. Approve the reports to be published on the ICB website to evidence the ICBs compliance with the Equality Act's PSED publishing requirements.
    b. Approve the ICB PSED Workforce Equality Objectives for 2025-2027

The report was noted, and the recommendations were agreed.

System-ICB Risks / Board Assurance Framework (SBAF):

Policies Approved:
The following new policies were approved: On Call Policy - HR-P-039 SSOT ICB On-Call Policy -FINAL Sexual Misconduct Policy - HR-P-038 NHS SSOT Sexual Misconduct Policy - V1 Feb 2025 Security Management Policy - CG-P-008 Security Management Policy V4 Violence, Aggression and Abuse Management Policy - HR-P-037 Violence Aggression Abuse Management Policy v1.0 Changes to the following Policy were approved: Family Leave Policy (fostering, compassionate and neonatal leave) - c9online.sharepoint.com/sites/IAN/1/Forms/Newer to Older.aspx?id=%2Fsites%2FIAN%2F1%2FPolicies and Procedures%2FICB HR Policies%2FHR-P-010 Family Leave pan Staffs Policy - Sept 25%2Epdf&parent=%2Fsites%2FIAN%2F1%2FPolicies and Procedures%2FICB HR Policies

Decisions to be Escalated to ICB Board:

AAA Escalation & Assurance Report from Committees

Report To:	**ICB Board**
Date:	**18 September 2025**
Reporting Committee / Group:	**People, Culture, and Inclusion Committee (PCI) (Part1)**
Date of Meeting:	**4 September 2025**
Meeting Quorate Y/N?	**Y**
Presenter:	**Shokat Lal, Non-Executive Director & Committee Chair**
Author:	**Gemma Treanor, Head of ICS People Function**

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

ADVISE

(1) Strategic System updates:

NHS Reform / ICB Reset

The Committee were updated on the recent appointment of the new Chair for the SSOT and STW ICB Cluster, who brings with him a wealth of experience and commitment to the People agenda and our workforce. Members also heard that there is ongoing collaboration with STW colleagues to shape the new ICB Cluster operating model, acknowledging that the situation is fluid both regionally and nationally, with uncertainty around where some services and teams will ultimately sit. The Committee will be updated once there is further guidance on the regional blueprint and once the ICB model is further developed. Updates from the Regional People Board were received, highlighting temporary staffing targeted support and ensuring appropriate roles across the Midlands for newly qualified nurses.

The Committee will continue to monitor, identify risks and agree actions around the People elements of NHS Reform.

Feedback from the ICB Board

The Committee welcomed feedback from the Board on exploring current appraisal rates, committing to undertake a deep dive and hold a further discussion at the next meeting.

(2) Performance, Planning and Finance:

- **Finance**

The Committee received an update on a YTD favourable position to plan of £0.4m against a planned deficit of £19.9m. The main drivers for the aggregate YTD position are efficiency slippage (£13.5m) offset by several non-recurrent mitigations. The reported system efficiency delivery YTD is £13.5m behind our submitted plan of £83.3m, this is made up of the ICB (£8.3m), MPFT (£4.1m), NSCHT (£1.0m) whilst UHNM have delivered 100% efficiencies against YTD plan. As a system this equates to 84% delivery of the YTD plan.

ASSURE

(3) Performance, Planning and Finance:

The People Metrics were noted and assurance received by the Committee regarding ongoing monitoring and mitigation to improve metrics.

System-ICB Risks / Board Assurance Framework (SBAF):

(4) Risk Register /SBAF

The Committee received the SBAF and acknowledged the Risk Register has been circulated outside the meeting and approved. Members approved the SBAF and agreed to monitoring and further review as the landscape changes over the coming months, committing to revisit potential impact and risks around staff experience.

Policies Approved:
The Committee did not receive or approve any policies this month; nor did any papers received under the Business Cycles have any future impacts on current policy matters.

Decisions to be Escalated to ICB Board:
Nothing for escalation to ICB Board or other Committees.

AAA Escalation & Assurance Report from Committees[1]

Report To:	ICB Board
Date:	18 September 2025
Reporting Committee / Group:	Strategic Commissioning & Transformation Committee (SCTC)
Date of Meeting:	6 August 2025
Meeting Quorate Y/N?	Yes
Presenter:	Mike Lawton, ICB NEM and SCTC Chair
Author:	Vanessa Ridout, Executive Assistant

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

There were no alerts for the Committee.

ADVISE

NHS Strategic Transformation and NHS Reform (verbal update from ICB CTO):
The main consideration is what the operating model will be as a clustered organisation covering the geography of Staffordshire, Stoke-on-Trent as well as Shropshire, Telford and Wrekin. The ICB Blueprint was about how some functions would continue to be delivered by ICBs in the future with some functions either transferring or being delivered at scale. That work has progressed, and it is unclear if those functions can transfer because of statutory legislation i.e. in the areas of safeguarding and SEND the ICB is a statutory partner so to change our role in that would require legislative change.

The Committee were advised that there is work ongoing to understand the functions that the ICB will be required to deliver.

A joint executive session took place with STW colleagues and a Function Operating Model workshop took place on 21 August where more design work on the operating model was undertaken.

Update on research project with University of Manchester
The University had been observing the Committee in terms of place locality commissioning meetings and the ICB was one of 3 systems that had received national money to do some research in terms of looing at pace-based structures and commissioning arrangements at place level. Due to the reform work and the changing roles of the ICBs the University has paused this work but will submit their information at a later date.

Procurement Operational Group (POG)
The Committee discussed the role of POG and whether they should be reporting to this Committee or F&P. The reasons for this are

1. It would provide assurance to the Committee on the process run within the ICB, also jointly with other commissioners like local authority colleagues
2. It would allow the Committee to perform its role in developing a strategic commissioning intent given the number of contracts, particularly given that there are a number of historic contracts that were set some time ago.
3. The publication of the 10 Year Plan and the requirement to reorientate the operating model to be a strategic commissioner, and in delivering neighbourhood health, would give the Committee oversight into the commissioning portfolio. The POG is currently the main forum

[1] **Refers to Section 1.3(a) –** Adapted examples from the March 2024 Board papers – PCI / F&PC / Q&S reports to Board

that brings the commissioning function together but there is an opportunity to ask the group to provide reporting or agenda items that enable the Committee to then discharge that function.

It was recognised that there would still be a role for POG to report to F&P to provide assurance the the procurement has been delivered effectively.

The Committee supported this approach.

Tongue Tie Services
The Committee were advised that the current service provision is provided by the UHNM Maxillofacial team from the Royal Stoke University Hospital. This service is not formally contract and has historically been provided as a gesture of good will due to the previous provider (MPFT) withdrawing from the contract in August 2019. The Current consultant has not been able to pick up this work on a regular basis and is carry out procedures when time allows in between regular clinics.

The Paediatric directorate at UHNM have agreed to take on delivery of the service. The new clinic would be resourced by two band 6 Tongue Tie Practitioners and two band 4 Tongue Tie Support Workers. The service would run on a part time basis with two clinics per week.

The financial requirement for this service would be £51k which would be paid on a block basis to UHN as part of the contract.

The Committee approved the funding via the Commissiong Reserve for the current financial year (2025/26).

ASSURE

Service Transformation & Service change Update:

The Committee received and noted the content of an update report covering:

UEC
- Meeting with NHSE took place to discuss updated designation templates. Minor amendments to the template were requested and a proposed timeline for any service change proposals.
- Meeting with MP for Cannock took place on 14 July to provide an update on the position regarding the temporary closure of the MIU.
- Development of pre-consultation business case for Cannock ongoing.

Maternity
- Formal public consultation has now completed and ended on 03 August 2025
- All outputs are being developed into a report of findings between now and November. The recommendations will go through the governance processes and from November onward the decision making process for the closure of the freestanding maternity birthing unit will take place.

Neighbourhood
A conversation took place about have a GP representative at the Committee as they would be fundamental in providing feedback on how to develop neighbourhoods. This was agreed by the Committee.

Primary Care Forum (PCF) AAA Reports
Reports included no “Alerts” to SCTC; and no new risks.

- Finances are on track to deliver a break-even position across primary care.
- There have been a couple of quality issues and action plans have been approved within the forum.

- The Translation and Interpretation Services procurement has been approved.
- Digital Flexible Staff Pools – the Primary Care Forum approved for this to be delivered by the North GP Federation; this will provide better value for money and bring in local clinicians and is saving some of the budget.
- There have been some additional space requests for some practices which go through a robust process; they are assessed against the population growth sizes in the local area, current space in practice and any void space linking back to primary care estates plan.
- GP Action Plan – this looks at tackling unwarranted variations, improving contact oversight and looking at the commissioning and transformation overall, linking it back to improving the patient experience and patient access. This item will come back to the September meeting for assurance and oversight.

Voluntary Sector Report

The Committee received a presentation from Lisa Healings and Garry Jones which was received. Due to timing constraints this would be discussed further at the next Committee.

Provider Collaborative Update

The Committee were advised of the key steps that have taken place over July and August how the collaborative is developing its MOU across each of the partners and how it is developing its approach around neighbourhood health and repurposing the existing neighbourhood steering group

System-ICB Risks / Board Assurance Framework (SBAF):

System/ICB Risk Register update:

Only risks that score over 12 would be submitted to the Committee. Risk 1215 had been transferred to the finance directorate as an issue for monitoring by the finance team.

In order to provide assurance to the Committee a number of risks now included more detailed updates relating to how the risk are being managed/mitigated.

The Committee discussed the risk around ambulance handover delays and whether the mitigations were right for this risk and whether the risk should sit with this Committee as it is a WMAS risk. This risk would continue to be monitored to ensure the correct mitigations are in place going forward. It was recognised that this is a system risk due to the wider implications e.g. quality, safety, patient experience.

Discussions are ongoing with the Risk and Governance Network around ‘static’ risks. An example of this is cyber security which will always be a risk and there are mitigations around this however the score is likely to remain the same.

Policies Approved:

Not applicable – no policies required for approval at the August meeting.

Decisions to be Escalated to ICB Board:
☑ To ADVISE the ICB Board of the SCTC-endorsed decisions taken at August 2025 meetings; ☑ To ADVISE the ICB Board of the SCTC-endorsed approvals made pertaining to the Tongue Tie Service ☑ To ASSURE the ICB Board of the SCTC fulfilling its decision-making role effectively per its role and Terms of Reference, especially in the remit of Transformation consultation and engagement work. No other decisions or matter are escalated to the Board.

AAA Escalation & Assurance Report from Committees

Report To:	Board
Date:	18th September 2025
Reporting Committee / Group:	Remuneration Committee
Date of Meeting:	8th July 2025
Meeting Quorate Y/N?	Yes
Presenter:	Mike Lawton, NEM
Author:	Stacey Robinson

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

ADVISE

ASSURE
The Remuneration Committee received a report in accordance with the Committee's Terms of Reference - specifically its responsibility for overseeing the performance and appraisal of Executive Board members. The Committee noted that the Executive Director 2024/25 Appraisal process has been carried out appropriately and in line with NHSE guidance and noted the outcomes of the process.

System-ICB Risks / Board Assurance Framework (SBAF):
N/A

Policies Approved:
N/A

Decisions to be Escalated to ICB Board:
N/A

Accessibility Hints and Tips **DELETE BEFORE FINALISING**

Use the Accessibility Checker

Why is this important?

Helps catch issues that might impact accessibility.

Tips:

1. Go to the **Review** tab in the Ribbon.
2. Click **Check Accessibility**.
3. A pane will appear on the right side of the screen labelled **Accessibility**.

Use Headings Properly

Why is this important?

Screen readers use heading levels to navigate documents.

Tips:

Use built-in styles like **Heading 1**, **Heading 2**, etc., for structure.
Avoid using bold or larger font sizes to simulate headings.
Maintain a logical order (e.g., Heading 1 > Heading 2, not Heading 1 > Heading 3).

Make Tables Accessible

Why is this important?

Screen readers rely on proper structure to read tables accurately. Poorly constructed tables can confuse users and prevent them from understanding your data.

- **Tips:**

Use simple table structures
Avoid merged or split cells, especially in header rows.
Keep tables as simple as possible - complex nested tables or multi-level headers can cause issues with accessibility tools.
Avoid leaving blank rows or columns
If the table spans multiple pages, go to Table Layout > **Repeat Header Rows** so headers appear on each page.

Test Table Navigation:

Try navigating your table using only the keyboard:

Use **Tab** and **Arrow keys** to move through cells.
Ensure the reading order makes sense.

Merging PDFs

When merging with other supporting materials ensure content owners have checked each individual PDF is fully accessible *before* merging.

For further guidance see our 'Accessibility Hints and Tips Sheet for Microsoft Word'.